Team 15

Afffirmative Constructive

I. Introduction

Access to life-saving medication is a basic human right. Yet, intellectual property rights (IPR) deprive billions of people of that right, resulting in unnecessary casualties and exacerbating existing global inequalities. Although initially designed to encourage innovation in the pharmaceutical sector, IP rights have created major barriers to accessing essential drugs in countless nations. The World Health Organization reports that approximately 4.5 billion people do not have access to basic, crucial healthcare, with high drug prices being a key factor (WHO). Major health crises such as the COVID-19 pandemic highlighted these inequities, as medical supplies became scarce and unevenly distributed worldwide. Emerging statistics concerning widespread socioeconomic disparities caused by IPR, alongside the potential economic benefits of removing IP barriers, emphasize the urgent need to reconsider IP protections for life-saving drugs. Solutions prioritizing equitable access additionally have independent benefits, including faster innovation and production of medication. Thus, we proudly affirm.

I. Framework

Equitable access to pharmaceutical drugs entails that all humans "can attain their full potential for their health and well-being," regardless of economic, social, geographic, or demographic circumstances (Intellectual Property). This does not mean that equal access only exists in one country. Instead, the resolution will only be addressed when equal access, across nations, is provided for pharmaceutical drugs.

The Declaration on the TRIPS Agreement and Public Health 2001 "agree[s] that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health…..the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access

to medicines for all" (WTO). Thus, the term "prioritized" in the context of the resolution does not call for the complete elimination of intellectual property (IP) rights in the pharmaceutical industry. Instead, it declares that in situations where a direct conflict exists between maintaining intellectual property rights and ensuring equitable access to essential medicines, the latter must take precedence.

IPR often refers to the ownership of novel or innovative creations; however, in the pharmaceutical industry, they address the legal protections granted to drug manufacturers, such as patents and exclusivity for certain periods. This allows manufacturers to set higher prices for their products and exert full control over their products (WIPO). Therefore, this resolution is only concerned with situations where there is a conflict between equitable access and the protection of such IPR.

II. Global Economic Disparities

Today's pharmaceutical industry structure broadens global economic disparities, particularly in LMICs, where high drug prices stretch limited healthcare budgets. The WHO estimates that over 100 million people are driven into extreme poverty due to the cost of healthcare each year. These developments breach the 2001 Doha Declaration on the TRIPS Agreement, which confirmed that IP rights should not stand in the way of public health efforts, especially during health emergencies such as epidemics or outbreaks (WTO).

Firstly, patent monopolies allow pharmaceutical companies to charge exorbitant prices for life-saving medications, rendering them unaffordable for many LMICs. Treatments for chronic diseases like cancer are costly, leaving millions without access. Doctors Without Borders reports that high prices for patented drugs drastically reduce access to treatment, leading to wide disparities in health outcomes between wealthy and poor nations. The report explains, "US

pharmaceutical corporation Johnson & Johnson (J&J) slashed the price of bedaquiline by 50 percent … This occurred after two [tuberculosis] survivors … successfully blocked J&J's attempt to extend its patent monopoly on bedaquiline," This price reduction led to $26 million in savings over three years, allowing countries to purchase an additional 450,000 courses of medications (Doctors Without Borders). Despite such reductions, most drug prices remain high; this forces governments in LMICs to divert significant funds, preventing investments in critical areas like infrastructure or education. Subsequently, the reduced investment creates cyclical poverty within developing nations. Prioritizing affordable medicines would enable LMICs to allocate more resources to long-term economic development, combating entrenched global developmental imbalances. Evergreening, a practice where companies make minor changes to existing drugs to secure new patents, further entrenches these monopolies, blocking cheaper generics from entering the market (UNDP). Additionally, companies create patent thickets—layers of overlapping patents on a single drug—deliberately increasing legal barriers that prevent local manufacturers in LMICs from producing affordable alternatives (Day & Schuster).

In addition, the global research and development (R&D) landscape further exacerbates this inequality, as profit-driven motives lead companies to prioritize diseases that predominantly affect wealthier populations. According to the WHO, currently, only 1% of global health R&D funding is allocated to diseases that disproportionately impact LMICs. As a result, research surrounding life-threatening conditions present in poorer regions, such as malaria and tuberculosis, is severely underfunded. By promoting equitable access to pharmaceuticals, international collaboration in research across LMICs increases, mitigating the observed impacts. For example, when India issued a compulsory license in 2001 to produce generic HIV/AIDS

drugs, manufacturers within the country were able to collaborate with countries such as Brazil in developing regions. Consequently, the production of generic HIV/AIDS drugs was greatly improved. These collaborations increased supply, creating immense pressure on multinational drug companies to lower prices. Ultimately, drug prices were reduced by 99%, enabling millions in Africa and other developing regions to receive life-saving treatment (Global Report). Easing IP restrictions in countries such as India has significantly improved the affordability and availability of essential pharmaceuticals.

Moreover, improving access to affordable medications would lead to substantial economic benefits in LMICs, which are frequently overlooked. By addressing IP restrictions, LMICs could save significant amounts of money that would previously be spent on drug costs, allowing reinvestment into healthcare systems and critical infrastructure. A healthier workforce, in turn, boosts productivity and drives economic growth. Research by the Global Observatory on Health R&D suggests that lifting IP barriers could boost the economies of LMICs by up to $200 billion by 2030 (WHO). The benefits of improved access to pharmaceuticals extend beyond the healthcare sector. For instance, India's rise as a leader in generic drug production has made vital medications more affordable worldwide and strengthened its pharmaceutical sector, leading to enormous GDP growth and job creation (Global Business Reports). Enhancing access to pharmaceutical drugs conclusively leads to economic growth, which can diminish the existing economic disparities that push millions into poverty and hinder the development of LMICs.

The Affirmative's burden is to prove the status quo fails to ensure equitable access to pharmaceuticals and that prioritizing access over IPR creates better economic and health outcomes. This burden is clear when examining how the current IPR system reinforces economic disparities between HICs and LMICs.

III. Global Health Crises

Strict IPR for pharmaceutical drugs create barriers and foster a competitive environment, reducing cooperation among nations. However, prioritizing equitable access and reducing IPR can benefit society in two ways.

Subclaim A: Increased Scientific Cooperation

The implementation of restrictive IPR in the pharmaceutical industry creates significant barriers to data sharing among researchers from different nations. Currently, researchers remain unwilling to share research because they "consider their data proprietary [which provides] competitive advantage over other groups in terms of discovery and further acquisition of funds" (Carvalho 1). Furthermore, proponents of IPR argue that data sharing in early clinical trials will deter investors (Andando 2); instead, they advocate for withholding information to attain exclusive rights. This lack of data sharing particularly impacts researchers and drug developers in LMICs, who already lack the resources for early-stage research. For example, Ethiopia still faces significant challenges in terms of technical knowledge and resources in research despite the progress in its pharmaceutical infrastructure. The country has no active pharmaceutical ingredients, limiting its prospects to secondary manufacturing (Gebre-Mariam). A decline in collaboration and data sharing would only hinder countries like Ethiopia, further disabling their ability to research niche drugs. According to Rakesh Jalali, an internationally renowned neuro-oncology researcher, clinical trials and drug developments already have "several barriers in LMICs to conducting drug development trials, such as limited research infrastructure … and limited funding opportunities" (3). Lack of international cooperation will continue to exacerbate existing inequalities regarding access to and production of pharmaceutical drugs in LMICs.

In turn, the detrimental repercussions of reduced scientific cooperation become clear; it decelerates the rate of scientific advancement and excludes researchers from countries such as Ethiopia. Although global powerhouses will continue to develop pharmaceutical drugs, without the multiplicative effect of international collaboration, the field of research will reap far fewer benefits with fewer countries involved (Jia). A decline in international cooperation creates lower accessibility to diverse expertise and resources. It also establishes a cycle of dependence in which LMICs must rely on other countries to import pharmaceutical drugs, leading to continuously higher prices and reduced access to essential medicine (Ndagije). Compounding upon existing political barriers to international cooperation, IPR creates obstacles in research that particularly disadvantage developing nations. However, when equitable access is prioritized, IPR will not pose a great threat to sharing data, as scientists will no longer foster competition that limits cooperation.

While the pharmaceutical industry's current closed model hinders cooperation, a more collaborative, problem-solving model has proven historically effective in other sectors. For example, the Open Source Movement in the early 1980s fostered significant technological advancements within just a few years. The movement highlighted a collaborative approach to software development, emphasizing community-driven innovation that emerged as a response to proprietary software models. One of the key characteristics that produced significant technological advancement was its open software, which could be freely shared and edited by anyone (Raymound). This allowed multiple developers to edit and build upon existing research, boosting innovation within the industry. The movement also allowed for direct feedback on code and software from other developers, greatly improving the efficiency at which new features were produced (Athey & Ellison). When viewing this example through the lens of the pharmaceutical

industry, prioritizing equitable access over IPR could accelerate drug development and improvement, allowing researchers to build upon existing knowledge without the restrictions or impediments of legal issues. Furthermore, a related aspect of the Open Source Movement was its ability to significantly lower costs for developers. If equitable access is similarly prioritized pharmaceutically, the industry could reduce drug development costs since researchers would save money that would otherwise be spent replicating existing research. A 2023 research review corroborates that data sharing and open research could have numerous cost-effective benefits for later research (Emanuele). The author also acknowledges its potential in addressing disparities among contributors in LMICs. Since LMIC countries can prioritize building upon existing knowledge more efficiently, they can produce far more rapid innovation. From a comprehensive standpoint, global R&D can only be accelerated by reducing IPR when necessary.

Subclaim B: Rapid Production and Distribution

Prioritizing equitable access serves to not only foster development but also enhance production and accelerate distribution, particularly in LMICs. A 2022 systematic review examining the impacts of IPR on medication accessibility found that "stronger pharmaceutical monopolies created by TRIPs-plus intellectual property rules are generally associated with increased drug prices, delayed availability and increased costs to consumers and governments" (Tenni 1). Government support for equitable access may be implemented through policy reforms. Such changes provide for exceptionally more efficient production and widespread distribution in times of need; there are two concrete ways to implement these policy reforms.

The first is through compulsory licensing, which provides a concrete example of such policies. Compulsory licensing is a form of government-sanctioned "use of copyrighted materials without the explicit permission of the copyright owner" in exchange for reimbursement to the

patent holder (Compulsory License). In 2001, Cipla, an Indian generic drug company, was able to produce triple therapy HIV treatments, which were sold at a significantly reduced cost of approximately $350. In comparison, patients were previously charged $10-15,000. The change in the price of the patented medicine occurred after the Indian government issued a compulsory license, allowing for the continued production of Cipla's low-cost treatment. The license also ensured the distribution of the medicine in India, as well as LMICs in Africa (Bognar 293). As a clear example of the government stepping in to prioritize more accessible treatment by granting a compulsory license, Cipla's success resulted from the continued promotion of equitable access. The initiative had a profound, successful impact on the lives of millions, facilitating widespread treatment of HIV/AIDS and simultaneously reducing production costs.

Secondly, the prioritization of equitable access over IPR can also be implemented through government policies such as those called for during the COVID-19 global health crisis. COVID-19 was the most lethal pandemic since the 1918 Spanish influenza outbreak, resulting in the loss of over 14 million lives worldwide (Global Excess Deaths). Scientists around the world worked to find a preventative measure for COVID-19. Once the vaccine was finally produced, COVAX was introduced. As a global health initiative designed to expand equitable access to the vaccine across 146 countries, COVAX pushed for higher international vaccination rates. However, this initiative fell short when high-income countries(HICs) refused to approve an IP waiver, resulting in vaccine hoarding and an inequitable global distribution of the treatment. Effects were exemplified by vaccination rates: over half of the population in the U.S. and UK was vaccinated by May 2021, while LMICs in Asia and Africa suffered with less than 10% vaccination rates (Sunder and Sun). Infection and mortality rates in these areas mirrored those of

vaccination. As a result, the burden of disease was far greater upon LMICs throughout the pandemic.

The prioritization of IPR over equitable access not only slowed vaccination rates from a distribution standpoint but also hindered vaccination production. The refusal to provide access to vaccination development data resulted in significantly stalled vaccine output, straining a limited number of producers in HICs. As stated in an interview with Lawrence Gostin, Director of the World Health Organization Collaborating Center on National and Global Health Law, effectively addressing a global crisis is exceedingly difficult without "waiving intellectual property rights and technology transfer. It is literally impossible to ramp up vaccine supplies unless we have more manufacturing hubs, including in lower-income countries" (Usher 2325). The shortcomings of COVAX demonstrate the importance of the temporary suspension of IPR for global benefit during international crises. The impacts of this refusal to prioritize equitable access to life-saving vaccinations resulted in the loss of "hundreds of thousands of lives" in LMICs around the world and slowed international production and distribution rates (Sunder and Sun). Thus, when comparing failures during the pandemic to the successful compulsory licenses granted during global health crises such as the HIV epidemic, the necessity of prioritization of equitable access is demonstrated. Ultimately, these policies, paired with IP waiver proposals, save countless lives and enable rapid production and distribution to LMICs, as well as HICs, in times of need.

IV. Economic Advantages of Equity

Opponents argue that prioritizing equitable access over IPR may destabilize the status quo, uprooting current systems. Many facilities report heavy reliance on funding obtained from patented pharmaceutical sales. Prioritizing equitable access over IP protection implies the introduction of lower market prices, an implication that companies are reluctant to accept; they

attempt to justify obscene price gouging by citing $1 billion typically spent in the R&D stages of development (Austin et al.). Without the market incentive of IPR protection, concerns with innovation arise, as the economic motivation to innovate is supposedly no longer present. Due to this trend, critics claim that reducing market incentives results in financial losses for companies that are no longer able to cover "developmental" costs; furthermore, it is often argued that a decrease in the market incentive would hinder the development of potentially vital cures.

However, corporate concerns for economic instability are simply unjustified. A study conducted on 60 FDA-approved drugs found that there was no existing correlation between R&D costs and the initial market price of a drug (Wouters 8). In short, high development expenses held no correlation with raised drug prices, indicating no rationale for spiked drug costs. Contrarily, the research demonstrated the existence of an irrational corporate fuel for excessive profit, beyond the amounts necessary to cover expenses. Even with reduced drug prices, it is reasonable to believe the pharmaceutical industry will still recoup more than enough profit to continue R&D. In fact, nations investing in healthcare equity have seen economic benefits as opposed to losses. US Chief Health Equity Officer Kulleni Gebreyes estimates that "reducing health inequities can create significant economic value, including a gain in GDP and benefits for businesses," demonstrating that economic prosperity follows prioritization of equitable access, ultimately supporting a healthier population (Gebreyes). Gebreyes continues, "[b]y 2040, the potential gains in GDP could reach $2.8 trillion, including $763 billion for corporate profits," (Gebreyes) This generates a cycle: in times of upward-trending GDP, R&D tends to accelerate because the growing economy generates greater financial resources for businesses and governments to invest in innovation. As exemplified through these estimates, economic losses caused by mitigatable market impacts are far exceeded by quantifiable

innovative benefits. In summary, equitable access does not have the disastrous impact on R&D that critics may claim but rather creates the opposite effect, accelerating investment in innovation and economic development worldwide.

V. Conclusion

Every day, billions face the devastating reality of being denied access to life-saving medicines—a fundamental human right. This denial stems directly from the pharmaceutical industry's profit-first model, reinforced by intellectual property rights (IPR) that prioritize corporate monopolies over global health. Prioritizing equitable access, especially in LMICs, breaks this cycle. By easing restrictive patents, drug prices fall, governments can purchase more medicine, and health outcomes improve. In turn, healthier populations drive economic growth, allowing LMICs to invest in infrastructure and education. History already proves this: India's leadership in generics, enabled by relaxed IPR, made essential drugs affordable globally and boosted its economy. Equitable access encourages international research cooperation, accelerating responses to crises like pandemics. Concerns that innovation will suffer are disproven by countries like Australia, where strong public health systems coexist with robust innovation. Ultimately, prioritizing equitable access is both a moral and economic necessity for sustainable global health equity, thus we proudly affirm.

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Team 16

Negative Constructive

Introduction

In past decades, debates over intellectual property (IP) protections for pharmaceutical innovations have intensified. In light of the recent COVID-19 pandemic, support has grown for the view that equitable access to medications should be prioritized over protecting intellectual property rights (IPR). In reality, pro-equitable access stances overlook the critical role of IPR in spurring innovations capable of addressing international health concerns. Strong IPR fosters international innovation ecosystems capable of scaling up equitable access to medications during times of crisis. Protections maximize the reach of pharmaceuticals, with significant implications for improving the quality of life for **all** through pre-existing mechanisms for access. Thus, we negate the resolution.

Framework

The Affirmative has assigned themselves two separate burdens; they need to prove both to win. Their burden "is to prove the status quo fails to ensure equitable access to pharmaceuticals AND that prioritizing access over IPR creates better economic and health outcomes" (Affirmative Constructive). Thus, if the Negative disproves either claim, negation of the resolution is more favorable.

The Negative concurs "prioritized" does not entail abolition of IPR; thus, the Affirmative can only defend the reforms outlined in the constructive—compulsory licensing and open access systems. The Negative constructive will systematically prove that each mechanism fails to secure access while also undermining global healthcare innovation. Additionally, the Negative contests the Affirmative's characterization that equity and IPR are only sometimes in conflict. Tradeoffs always exist between the two because a temporary monopoly always precludes universal equity.

As such, in the Affirmative's world, compulsory licenses and open access systems are issued after the innovation of every new drug, creating massive uncertainty and losses for pharmaceutical companies.

The Negative asserts that the debate should be evaluated using utilitarianism. Even if IPR systems propagate healthcare inequities, they are critical to the development of pharmaceuticals which save millions of lives. The St. Andrews Law Journal concludes that "even if an act may result in some negative socio-economic consequences…medical patents are acceptable as they allow for more lives to be saved in the long run than if they were to not exist" (Tuncel). Eventually, monopolies expire, meaning generic markets always open in the long run, guaranteeing equitable long term benefits. Thus, utilitarianism is the best metric, maximizing overall societal wellbeing while maintaining egalitarianism and impartiality (Tuncel). Thus, the Negative wins if IPR systems save more lives in the long term than the Affirmative's alternatives.

An Innovation Economy

Only IPR maintains continued innovation across every sector of technology. Affirmative arguments find premise in isolating negative externalities of IPR without considering empirically proven macroeconomic theories.

In the pharmaceutical sector, patents generate innovative competition by guaranteeing a fair environment for development and deployment of novel inventions. IPR promises "profit-maximization" by granting innovators temporary monopolies which allow them to recoup their investments. Intellectual property is the only system that can generate sufficient return on investment (Pretnar). A key economic principle justifying the role of IP within innovation is the

"first-mover advantage." An absence of IPR would allow any company to replicate a competitor's product without repercussion. Consequently, any positive effect generated by novel inventions would be nullified as less-innovative companies would lie in wait to copy new technologies. Those who claim the first mover advantage monopolizes technological advantages ignore the necessity of IPR to maintain consistent and productive innovation (Maronero and Bichlmayr).

"Evergreening" is an economic fallacy and often promotes innovation rather than detracting from it. Secondary patents are often mistakenly rendered as purely ingenuine attempts to extend a rightsholder's exclusivity. However, strict secondary patent standards in healthcare mandate significant alterations to an original invention (Geneva). Instead of a whole-scale critique of the evergreening method, case-by-case analysis is critical to maintain sustainability of innovation and patenting (Geneva). Gradually extended innovation proves better than Affirmative alternatives.

Critics of IPR often weaponize the supposed prevalence of patent thickets. However, their proliferation is empirically low and results in more empirical innovation than less (Teece, Council). Healthcare patents generate deployment of medicine and other medical technology to spread the cures to as many patients as possible. The coronavirus pandemic demonstrated the strength of the intellectual property system as the spread of vaccines reached the billions, largely due in part to healthcare patents (Mossoff and Adalja). This represents a clear response to the Affirmative argument concerning scientific diplomacy and cooperation. Intellectual property has historical examples of generating discussions and forums to promote diffusion of technologies to counter emerging threats such as pandemics. Moreover the strength of intellectual property rights

in recent history such as COVID-19 should force a deep interrogation as to the empiricism and academia underlying much of the Affirmative arguments.

Finally, the Affirmative has forwarded a stance supporting systematic weakening of IP through constant, unrelenting waivers of rights. The result of this action would be disastrous to the economy of the United States and subsequently of the world economy. Stranded assets or inventions separated from value would envelop the economy and be detrimental to critical innovations. Even if the Affirmative can isolate a futuristic rationale to support weakening the IPR system, it is impossible to contend with the near immediate effects felt by the economy. Thus, an Affirmative ballot would require resolute evidence to prove equitable access to pharmaceuticals would support our already fragile economy and undermine sustainability within industries (Olhaussen).

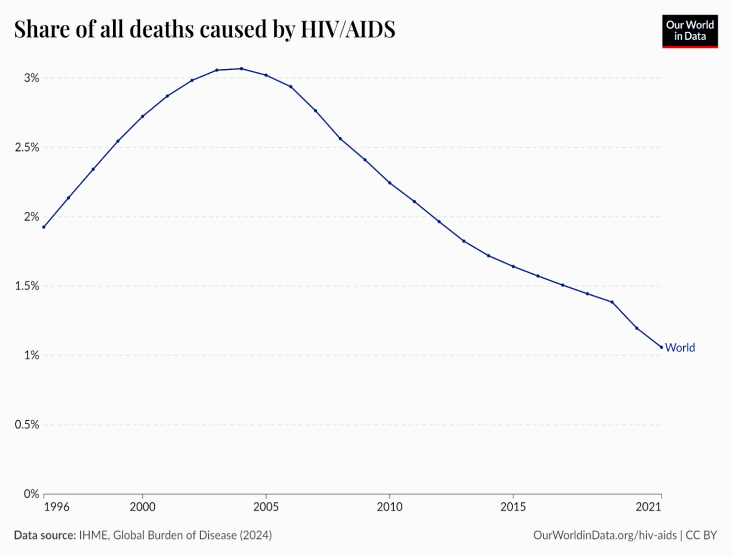
Diagnostic Innovation

Diagnostic technologies demonstrate the necessity of strengthened IPR. These technologies, critical to identifying emerging health threats, cancers, and unique diseases empirically only find success through private innovation (Chen). For emerging technologies like diagnostics, only strengthened IPR could provide the sufficient profits from investments. Alternative solutions would fail because they lack the certainty and security guaranteed by patent rights (Pretnar). In a world in which diagnostic technology does not receive adequate protection, patients within LMIC's would be subject to false treatments suffering more in the long run, turning their equity arguments. Diagnostics uniquely rely on IP law to commercialize and provide its services to the public—disrupting IP law ruins any chance for public access and diagnostic R&D funding. For example, researchers developed a diagnostic test for Systemic

Lupus Erythematosus (SLE). However, when the patent application for the diagnostic was denied, the costs of R&D and commercialization became restrictive to researchers due to uncertainty that expenses would be recouped through temporary monopoly rights. Ultimately commercialization and further development was stopped, resulting in losses to patients and public health (Michel et al). Thus, strengthened IP in fact accesses the impacts of the Affirmative to a larger scale by promoting diversity and development of disease-curing technologies.

On Global Economic Disparities

The late 20th and 21st centuries have been marked by remarkable increases in human health due to global pharmaceutical innovations developed under robust IPR frameworks (CDC). In the past century, average global life expectancies have risen by over 25 years and innovations in antiretrovirals have cut global HIV mortality rates in half (CDC, UNAIDS). “Equitable access” only matters when drugs exist for distribution—these drugs cannot and would not reach conception in a world without robust global IPR protections.



HIV/AIDS deaths have decreased by over 50% in the last 15 years (Roser and Ritchie)

While price gouging occasionally occurs under IPR frameworks, it is undeniably unconventional. For every cherry-picked Affirmative example of corporate abuse, dozens of others highlight voluntary equitable actions by pharmaceutical corporations (Anderson). Through the Medicines Patent Pool (MPP) and other regulatory frameworks, pharmaceutical companies grant non-exclusive licensing agreements for critical drugs (Chandna). These voluntary licenses occur **without coercion** from government bodies and have resulted in massive savings for LMICs—the MPP has saved 2.3 billion dollars for dozens of drugs (PlosOne). AstraZeneca voluntarily licensed its vaccine during COVID-19, selling to LMICs for 2-3 dollars per dose (Amnesty International). In the presence of health inequities, pharmaceutical companies step in with targeted price reductions, proving that the status quo solves equity (Amnesty International).

The patent extension for Johnson and Johnson's Bedaquiline was not rejected on the grounds of "equitable access" rather because it did not meet standards for "novelty" or "inventiveness" (Patent Opposition Database). The Affirmative's argument merely highlights that current legal frameworks effectively prevent abusive evergreening while promoting access. Under the Affirmative's framework, they must win that the status quo fails to correct for IPR-created inequities; this example proves they do not meet this burden.

The Affirmative fails to cite evidence for the claim that "1% of global health R&D funding is allocated to diseases that disproportionately impact LMICs." The most comprehensive survey of R&D funding finds over 4 billion USD annually allocated towards these diseases, with investment steadily increasing by 7% each year – an intense global financial focus (EurekAlert). Even if these inequities in R&D existed, the Affirmative proposes no mechanism to resolve them. Compulsory licenses only affect existing drugs—they do not compel pharmaceutical companies to invest in new R&D for diseases that affect LMICs. Compulsory licenses create

barriers for corporations to innovate, meaning that high-risk investments such as **diseases that primarily affect LMICs would be abandoned** (Maronero and Bichlmayr).

New drugs are key to the creation of a healthy workforce and can only be innovated under robust IPR frameworks. The Affirmative cites the WHO, stating that removing IP barriers would increase the GDP of LMICs by 200 billion dollars. The Negative is unable to identify this statistic—the source also never mentions any form of IPR. Thus, we assume the statistic refers entirely to the benefits of a healthier workforce, which the Negative acknowledges and resolves. The prevalence of voluntary licensing proves LMICs frequently benefit from equitable access initiatives in the status quo, disproving their argument. Still, the idea that LMICs would have substantial growth and savings from lowered IPR relies on the idea that LMICs internally fund drug procurement. This is false. Firstly, drug costs in LMICs are primarily covered by external philanthropic organizations or by patients; In low-income countries (LICs), out-of-pocket/private spending typically accounts for over 75% of total medicine expenditure (Center for Global Development). Expanding access would not alter LMIC budgets; it would simply end the need for foreign philanthropic initiatives.

Secondly, the Affirmative's mechanisms cannot reproduce Indian generics growth in other LMICs. India's generics market is the result of unique circumstances: a large domestic workforce and bans on all pharmaceutical patents in the 1900s, which the Affirmative **does not endorse** (Business Standard). Compulsory licensing alone does not increase the availability and investment in domestic manufacturing capacities of LMICs. Furthermore, despite India's GDP growth in pharmaceuticals, and its status as the 3rd largest global economy, the country has extreme poverty and 49% of the population live in households without access to improved water, access to improved sanitation, sufficient living area, housing durability, or security of tenure

(World Bank). The affirmative claims that prioritizing access will boost GDP, but what happens when pharmaceutical investment dries up? The real economic cost is in lost innovation—future cures that never get developed, jobs that never get created, and health crises that go unsolved. Brand name cures or prerequisite to generics.

The Affirmative has not proved that the status quo fails to secure equitable access, nor have they proved their mechanisms effectively resolve the issue.

On Increased Scientific Cooperation and Open Sourcing

Although open-sourced software innovations have generally resulted in success, open-sourced pharmaceutical models are destined for failure (Marden). The Affirmative argues that open-source innovation models in the software industry can easily scale to the pharmaceutical sector, but key differences in their regulatory and IPR landscapes complicate the issue. Unlike the software industry, the pharmaceutical sector has intense regulatory oversight and far longer periods of R&D per invention. The significantly higher costs associated with pharmaceutical R&D preclude open-source projects from attracting enough funding for clinical trials, regulatory approvals, and sustained innovation (Marden).

Table 1: IP Practices: Software v. Biotechnology

	Software	Biotechnology
Predominant Form of IP protection	Copyright	Patent
Development Timeline	Short with high turnover	Long
Need for equipment/laboratory space	Low	High
Regulatory review and oversight	Low	High
Product Granularity	Low	High

Differences in IP practices between Software and Pharmaceuticals/Biotech (Marden)

Additionally, the highly regulated nature of the industry fundamentally conflicts with the decentralized nature of open-source development, making compliance coordination nearly impossible without a central authority (King). Effective collaboration in drug development requires structured leadership, and without it, managing R&D, clinical trials, and compliance becomes chaotic, causing investors and innovators to flee the industry (Marden). Open source drugs would enjoy costly legal requirements, management complexities, insufficient financial incentives, low quality from cut development costs, and empirically low participation, "offering uncertain impacts on cost and accessibility" (Marden). Private participation in Open Source programs would be unlikely, with companies shifting to trade secrets over disclosure (Kline). These would eliminate knowledge diffusion from patents, rendering collaboration impossible (Kline, Marden).

On Rapid Production and Distribution [Compulsory Licensing and Waivers]

Compulsory licenses and waivers temporarily strip pharmaceutical companies of monopoly rights needed to recoup drug R&D costs. They crush investor confidence in profit returns, chilling investments in the pharmaceutical industry (Stevens, Feldman). During COVID-19, a waiver was issued for vaccines and shortly after "companies making COVID-related medications and diagnostics saw their stock prices decline by 73% more than companies focused on different therapeutic areas" (Busch). By issuing floods of waivers and compulsory licenses, governments crush future R&D investments in the pharmaceutical industry, especially for diseases that disproportionately affect LMICs. Thus, the Affirmative's proposals worsen both equity and innovation broadly.

Data analysis indicates the benefits of these mechanisms are also greatly overestimated—the Affirmative's Cipla anecdote does not accurately reflect compulsory licensing's role in the HIV/AIDS epidemic. In general, the prices of antiretroviral therapies subject to compulsory licenses **cost 25% more** than those procured through international aid channels (Beall et al). Compulsory licenses face immense bureaucratic and structural barriers to success (Stevens). They eliminate manufacturing information disclosure requirements and implement stringent protocols which create resentment between pharmaceutical companies and generic manufacturers. Thus, LMICs struggle to mass produce generic pharmaceuticals during health crises, making direct purchases preferable (Stevens; Van Loy and Petrichenko). Voluntary licensing, presents a far more compelling and empirically effective alternative.

Contrary to Affirmative claims, COVAX's failure wasn't to blame for "inequitable global distribution of the [COVID-19 vaccine]." Rather, criticism of IPR during the pandemic is rooted in a "profound misunderstanding about the role of patents in facilitating the invention and mass production of COVID-19 vaccines… The blockades to global distribution of vaccines are found elsewhere" (Mossoff and Adalja). Public and private entities entered into approximately 379 production agreements for COVID-19 vaccines—each supported by IP protections. Over 50 of those agreements involved LMICs, establishing a legal foundation for domestic manufacturing and knowledge sharing (Mossoff and Adalja). A European Union statement concludes that "no evidence [indicated] IP rights in any way [hampered] access to COVID-19-related medicines" (Mossoff and Adalja). Disparities in access were driven by regulatory and trade barriers, the lack of pre-existing domestic distribution infrastructure in LMICs, and vaccine hesitancy (Jeon). LMICs received vaccines and manufacturing knowledge but lacked the refrigeration facilities and personnel for production and distribution at scale. Coupled with local skepticism towards

Western medicines, these factors explained the lower vaccination rates and higher mortalities in LMICs, proving the loosening of IPR would not account for these challenges.

Voluntary licensing and global partnerships solve both innovation and access. The Affirmative prioritizes short-term access but risks permanently terminating life-saving innovation while failing to address true barriers to health disparities.

On Economic Advantages of Equity

The Affirmative Wouters source, a singular survey, does not account for the true life cycle of pharmaceutical development—when including costs of capital and drug failures, average R&D costs lie around $900 million USD—an increase from their survey by a factor of five (Jama). These costs prove the necessity of high costs for recouping investments. Moreover, the survey selects only 60 drugs and is not indicative of the pharmaceutical market as a whole (Wouters). Rather, industry trends of the 20 largest pharmaceutical companies spanning 30 years show that the rent-seeking behaviors described by the Affirmative are less common compared to other industries (Hawksbee).

The Affirmative's proposals cannot reap the economic benefits of equitable access. The Gebreyes evidence describes massive U.S. health inequities in the status quo but never associates them with IPR protections. Instead, Gebreyes assigns health inequities to "access to healthy food, digital resources, and transportation, alongside disability status and race…with at least 80% of health being impacted by [them]" (Gebreyes). Their study contends that only large-scale "community engagement" and "multisectoral collaborations" can resolve the massive societal

inequities at the root of healthcare issues; neither of these solutions trade off with strong IPR nor are impacted by surface-level Affirmative proposals (Gebreyes).

Ultimately, IPR protections are short-lived monopolies. If IPR protections worsen equity, disparities will dissipate after the ten-year period of exclusivity. Mitigated short term losses are far outweighed by the long-term innovative benefits of IPR supported drugs (Tuncel). Still, the proliferation of voluntary licensing and funding for LMIC focused diseases proves existing issues are heavily mitigated and resolved by status quo policies.

Conclusion

Governments must prioritize intellectual property rights because they provide the best avenue to mitigating the next generation of biological threats and act as a prerequisite for global access. Only IPR can generate and deploy innovation suitable for efficiency and effective pharmaceuticals. As evidenced by COVID-19, international IP infrastructure best facilitates mass production and distribution of vaccines. Weakening IPR in favor of compulsory licenses and open-sourcing risks undermining existing protections that have greatly increased global health standards and guarantee long term innovations (Roser). Strong IPR must remain a cornerstone of global healthcare systems in order to maintain the upward trend of global access and drive the innovations necessary to save the lives of those needing treatment. We too prioritize saving lives – and that's why we focus on solutions that save the **most** lives. To suffer from a lack of medicine is tragic, but dismantling the incentive to develop new cures will *condemn even more people to suffer in the future*. In weighing this debate, consider the short-term relief of the Affirmative against the long-term harm to medical innovation we have demonstrated. Our side secures **both** continued innovation and eventual equitable access, as evidenced by historical

trends and current practices, whereas their side risks cutting the lifeline of innovation. Thus, vote Negative.

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Team 15

Affirmative Rebuttal

I. Framework

The Negative misrepresents the Affirmative's burden by falsely claiming that we must prove both the failures of the status quo and the improved outcomes of prioritized access as separate burdens. In reality, these are two parts of a single claim— the only way to solve the failures of the status quo is by prioritizing equitable access over IPR, which leads to better economic and health outcomes. Thus, the Negative must not simply critique solutions, but prove that the status quo already ensures equitable access. Rather, they concede that current systems perpetuate inequities and instability. Since the Negative admits the status quo is failing, then the only way they can win this round is by proving that the Affirmative's approach would worsen the status quo.

Furthermore, the Negative argues that IPR and equitable access are always in conflict. Contrarily, the TRIPS Agreement proves that IPR and equity can coexist, allowing for a regulatory framework where innovation is protected while ensuring access to life-saving medicines. The problem is not IPR itself, but IPR abuse through evergreening, price gouging, and legal barriers in the status quo. This *exploitation* creates inequities. Affirmative amends this by strengthening regulatory policies, ensuring compulsory licensing (CL) is used when cooperation is denied, and promoting open-access systems that boost both international collaboration & innovation. Affirmative's approach does not eliminate IPR— it rebalances it so that both innovation and access can thrive.

Ultimately, the winner should be the side that not only provides solutions to the failures of the status quo but also provides solutions that impact *the people*— short and long-term.

II. Innovation Economy & Economic Advantages

The Negative claims that abolition of IPR would allow companies to replicate a competitor's product. However, the Affirmative never advocates for the complete abolition of IPR, as agreed upon in the Framework. The Negative agrees that IPR would remain, but pushes arguments under complete abolition, meaning their impacts only materialize in a world where IPR is fully abolished. Therefore, their argument is irrelevant under conditions agreed upon. But even considering their argument at its highest grounds, it has significant flaws.

Firstly, the Negative argues that evergreening promotes innovation and patents generate access, but fails to justify how extending patents on existing drugs contributes to meaningful innovation and a link chain on how patents generate access. The Negative cannot assume such correlation by mere statements.

The Negative's claim that COVID-19 demonstrated IPR strength is misleading. COVAX facilitated access— not IPR. In fact, when COVAX was introduced, IP holders lobbied to protect monopolies (Fang). It was only after CL that distribution became equitable.

Negative claims that IPR promotes the diffusion of medical technology, but is completely unsubstantiated—they provide no concrete "historical" evidence of IPR facilitating diffusion of technology; history finds that tech inventors are hesitant to patent their technology as they aim for accessibility as international IP laws are "often in the economic interests of developed countries"(Chao & Mody). As seen recently, companies like Pfizer & Moderna refused to share mRNA technology (Doctors Without Borders). COVAX & TRIPS waivers demonstrate that reducing IPR barriers was key to expanding access.

The assertion that "constant, unrelenting waivers of rights" fundamentally mischaracterizes Affirmative stances. It has been explicitly stated that prioritizing access only applies when direct conflicts arise. The Negative's economic collapse scenario ignores that these

waivers are implemented only during limited timeframes, affecting singular medications. Their catastrophic predictions are unsupported and the notion that a temporary waiver of 1 product would collapse global economics defies both logic & historical precedent.

Finally, the Negative contradicts themselves, arguing that IPR boosts economic growth while somehow the economy remains fragile. If IPR truly drove economic stability, we should have already seen positive effects given that IPR has been strong in developed countries since the early 1900s. Persisting economic disparities prove that IPR has not fulfilled this promise. Ultimately, the Negative never disproves that the status quo is failing or proves how the Affirmative's models make the status quo worse.

III. Diagnostic Innovation

Diagnostic "innovation" arguments of the Negative are simply unjustified, immoral, and rooted in distortion. The Negative claims that without adequate IPR protections, LMICs will suffer in the long-term. However, they fail to acknowledge the prerequisites to their argument. Even with technologies, LMICs do not have *access* to technologies due to IPR. The Negative never correlates IPR for technology and promoting access. Unless the Negative can disprove that monopolies hike prices and corroborate correlations between monopolies & access, their impacts never materialize.

Even taking the Negative at their highest grounds, SLE research was denied patents for lacking innovation. Their own evidence claims that they had no substantial additions to the field by "rejection under Section 101 based on Mayo and Myriad" (Michel et al.). This is an explicit misinterpretation of the evidence to defend pharmaceutical companies that use evergreening for monopoly & to exploit IPR.

The Negative doesn't prove how Affirmative solutions worsens the status quo since monetary compensation is available with CL, with TRIPS dictating compensation *without* the negative effects of monopolies that they so proudly champion.

IV. Economic Disparities

The Negative claims that drugs cannot develop in a world without IPR. First, the Affirmative doesn't argue for the complete abolition of IPR. Even so, innovation would be sustained because of the niche small firm-big firm dynamic that *truly* spurs innovation. Small firms make up "62% of all drug discoveries" that the Negative refers to as innovation (Kennedy). The incentive for these small firms to make groundbreaking innovations is the end goal of getting acquired by large firms (Kennedy), not IPR, meaning innovation happens both with and without IPR.

Negative attributes exploitative costs under IPR to "recouping for losses"; however, as mentioned, there was "no existing correlation between R&D costs [&] the initial market price." (Wouters 8) They poorly discredit this evidence by comparing it to other industries, but fail to recognize that despite differences, companies price hike, which they concede by stating "price gouging occasionally occurs under IPR." Despite significantly undermining evergreening frequency, the Negative fails to both prove how price gouging recoups for losses and how Affirmative solutions worsen status quo, arguing against the 4.5 billion people. (WHO)

Negative cites Voluntary Licensing (VL) to show that the status quo protects accessibility. However, it was found that VLs are just another method of exploitation. VLs are private contracts allowing companies to hike prices, making access more difficult in the countries they are "helping." Additionally, VLs allow the companies to *choose* which countries gain access

largely “based on country income…which may leave out many countries …..where more affordable generic medicines are desperately needed” (Doctors Without Borders).

Negative dismisses evergreening as an "economic fallacy". Yet, they proceed to claim that Bedaquiline was denied patents to "prevent" this "abusive evergreening". If the negative truly supported "innovation spurred by monopolization," evergreening would be seen as an economic benefit in the Negative’s world. By contradicting themselves, they fail to support their monopolization claims. If they argue for innovation through monopolies & evergreening— which was not proven to help— they cannot argue that the status quo mitigates evergreening effectively.

Finally, Negative illogically argues that increasing access won’t impact GDP. Currently, philanthropic money mentioned is spent on getting access; if access increases, funding is redirected towards infrastructure building, ensuring long-term healthcare quality. Furthermore, lower out-of-pocket spending results in more saved money, allowing for economic stimulation.

V. Open Source

The Negative agrees that "companies [are] shifting to trade secrets," yet fail to recognize that this is a direct consequence of IPR, as Affirmative argues. This link chain, completely conceded, proves that IPR discourages cooperation, making regulatory changes— like Affirmative proposes —necessary for long-term sustainability. Instead of idly watching cooperation decline, seen with the U.S. withdrawal from the WHO, systematic reforms must be implemented immediately to ensure sustainability (The White House). Empirical evidence demonstrates that reducing IPR fosters collaboration & accelerates drug development as seen with successes in tuberculosis treatments (Bhardwaj et al.). Negative has failed to prove open access would worsen the status quo.

VI. Compulsory Licensing

The Negative claims that CL crushes R&D investment; however, recall the small firm-big firm relationship aforementioned. As long as this unique dynamic exists separate from IPRs—as proven— R&D in the pharmaceutical industry will not disappear, especially if the reason is 1CL calling for 1 drug for a period of time. The Negative has still yet to prove how either of the Affirmative's solutions worsens the status quo.

The claims about Cipla are simply untrue. The evidence cited by the Negative has been found to be "misreported by Beall.. the lowest price reduction resulting from a [CL] is 15.6%" (Urias). Even taken at its highest grounds, this argument is illogical. International aid is unreliable and depends on the goodwill of countries & organizations. Turning away from CL to rely on international aid leaves countries defenseless when no aid is given. Furthermore, turning to voluntary licensing would just continue the exploitary manner of companies as detailed before.

Claims about CL eliminating manufacturing disclosure are wrong by definition. However neither does it *mandate* that a country manufacture the vaccine by itself. According to Article 31bis, if a country cannot manufacture the product domestically, it can import the product from another country that has issued a CL for production (TRIPS). VL on the other hand, allows companies to dictate which rights they hand over, allowing for far more elimination of disclosure than the Negative assigns to CL.

Furthermore, the Negative downplays the impact of IPR in creating barriers to access by blaming cold chain distribution (CCD). Despite CCD prevalence, it doesn't undermine the barriers imposed by IPRs in gaining access to medicines in the first place. The problems mentioned by the negative are distributions within the country; this doesn't affect access to the

medicine for the country as a whole, meaning before a country can consider internal distribution, they must have access. Maintaining IPRs never addresses this issue because LMICs currently spend the bulk of available time and resources just securing access; by reducing these access challenges through CL, as aforementioned, countries could redirect resources toward building infrastructure, ultimately strengthening CCD and ensuring long-term sustainability of quality healthcare and short-term benefits of garnering access.

VII. Voting Issues

Ultimately, the Negative fails to prove that the status quo is successful, meaning no change is needed. Because they agree that the status quo is failing, they have to prove that Affirmative solutions make it worse, which they have not done. In order to win this debate the Negative must prove that CL and open source make access worse.

The Affirmative outweighs Negation on both short-term and long-term sustainability for the *people*, as CL and Open Source has immediate impacts in access as proven. As for the long-term, the Affirmative has proven that by reducing IPR, countries can divert attention to developing infrastructure, and ensuring quality internal distribution and production in the future— a problem the Negative addresses but offers no solution to. In the Negative world, you sit idly defending profit-driven pharmaceutical industries in both the short- & long-term, whereas the Affirmative offers solutions based on advancing regulatory frameworks that are known to help the *people* .

Ultimately the logic in which the Negative argues is the reason why healthcare inequality and inequity is a persisting issue. Prioritizing the ***profits*** of billion dollar pharmaceutical companies ***over millions of lives*** perpetuates the disproportionate system we live in. In order to

counter this we must start prioritizing lives over industries that would choose profit over humanity.

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Team 16

Negative Rebuttal

Framework:

This debate can be likened to a scale—one side with strong IPR protections and the other with perfect equity. To win this debate, the Affirmative must demonstrate that weighing more towards "equitable access" merits the tradeoff with strong IPR. Thus, if the Negative wins either a balanced scale or IPR-skewed scale secures better healthcare, then the debate must result in a Negative win.

The Affirmative explicitly defended a double burden in their constructive—they must prove that the status quo fails while simultaneously advocating for policy change which successfully resolves equity concerns. They cannot revoke a framework claim explicitly defended in their constructive. They have not met either burden, presenting mechanisms which worsen innovation while failing to prove the need for new policy. Any world where one doubts the sustainability of the Affirmative or questions the 'failure' of the status quo should result in a Negative win.

While defending CL and open access, the Affirmative conceded major Negative arguments about the innovative effect and economic advantages of IPR. Furthermore, they have not contended with the tech diffusion benefits of strengthened IPR, which they have conceded to substantially weakening.

Finally, the most glaring concession made by the Affirmative concerns support for a utilitarian framework. It often becomes difficult to reject appeals to 'short-term ethics' and 'morality' in debates like these, but in the case of medical patents, it is a necessary and justifiable evil (Tuncel). It is more ethical to prioritize safeguarding IPR's innovative qualities because more and higher quality innovations maximize the number of lives saved in the long-term. Affirmative prioritizes short-term relief at the expense of future generations, but sacrificing long-

term innovation to address present inequities ensures that tomorrow's inequities are infinitely worse. Because current solutions at least partially mitigate unequal access, it is morally preferable to wait for patent expiration than risk the stability of pharmaceutical innovation. Thus, negate.

Voting:

Affirmative evidence consistently demonstrates biases and lack rigor, begging the question of data accuracy. Sources like Wouters contain poor data methods indicted by our authors; Doctors Without Borders exhibits clear bias as an activist organization; and the multiple WTO sources are not rigorous, scholarly works but rather short website blogs. In addition, we encourage skepticism towards their White House memo, WHO source, WIPO web pages, and Encyclopedia Britannica citation. When debating over highly technical subjects, we contend that judging should not only consider argumentative ethos but also rigor and empiricism in well-conducted research.

Innovation, Diagnostics, and Economic Advantages

Diagnostic Advantage

Without strong IPR protections, diagnostic innovation stalls—companies struggle to justify high R&D costs and commercialization becomes unviable (Michel). Diagnostic innovations uniquely create health equity in LMICs by costing less, facilitating early detection, and containing long-term health crises. The Negative's SLE example was not an instance of evergreening but rather a primary patent rejected as a result of weakened IPR, demonstrating the necessity of IPR in securing equity (Michel).

First Mover Advantage

Open access, CLs, and waivers allow competitors to replicate initial products without consequences by justifying generic markets and mandating total knowledge sharing. If competitors can copy products without consequences, neither the original company nor the competitor has incentive to innovate—one fears the inability to recoup investments, the other profits more from stealing than innovating (Maronero). Empirical evidence supports the necessity of patents in securing First Mover advantage, proving risks of affirming (Pretnar).

On Evergreening

The Negative forwards three arguments to resolve the evergreening debate:

I. Secondary patents produce life-saving innovations, outweighing costs suffered from isolated abuses. By monetarily incentivizing improvements to original drugs, they maximize patient quality-of-life and drug efficacy (Holman). Evista (oncological drug), and Zyprexa (schizophrenia therapy)"would have never been made available to patients without the availability of a secondary patent" (Geneva).

II. Abusive evergreening is rare; patent approvals require novelty and innovativeness, rejecting ingenuine secondary patents. Bedaquiline's secondary patent was rejected by Indian courts because it was not novel, proving that international judiciaries restrict price gouging behaviors. Abusive evergreening is fictional as "companies are free to market a generic version of the original product" allowing access to still exist without added benefits provided by secondary patents (Geneva, Holman). Thus, status quo provides adequate access.

III. The Affirmative mechanisms cannot resolve threats to equity presented by evergreening. They do not abolish IPR. Compulsory licenses and waivers typically apply to primary

patents and span between 1-3 years, while secondary patents can extend rights by 10 years (Love). Previous licensing attempts left evergreening intact (Feldman).

COVAX and COVID

The affirmative has zero evidence for their CL-COVID claims. The June 2022 TRIPS waiver *postdated* the distribution of over 12 billion vaccines to LMICs—access accelerated under a framework of strong IPR (Borges). The COVID pandemic is the quintessential case of historical evidence for IP-driven diffusion. 379 vaccine production and manufacturing agreements – with over 50 occurring in LMICs – facilitated diffusion and knowledge sharing. LMICs only experienced higher mortality due to vaccine skepticism and poor infrastructure (Mossoff).

Small Firms

IPR is the lifeblood of small firms. Stronger patents for small firms correlate with successful market launch, knowledge spillover, commercialization, and investor attention (Slater). Small firm acquisition hinges on IP—it's what signals credibility and potential to big firms (Tran). Further, pharmaceutical giants have vastly higher research productivity than startups. Only big firms have the resources to acquire and support external innovation (Schuhmacher).

Economic Disparities

The Affirmative falsely equates justified pricing with exploitative price gouging regarding the Wouters study. The survey's estimate of R&D costs draws from an inadequate sample size and doesn't account for failures or capital expenses. Large-scale studies invalidate

the conclusion and methodology of Wouters' study (Hawksbee). Thus, research best supports the necessity of temporary monopolies in allowing companies to recoup investments.

Weakening IPR would not increase the GDP of LMICs—no piece of Affirmative evidence attempts to correlate the two. Over 75% of LMIC drug acquisitions are funded by private organizations or borne by patients themselves (Center), meaning governments wouldn't have new money to spend after Affirmative proposals.

Mechanisms (Compulsory Licensing and Open source)

The Affirmative's model severely undermines access, innovation, and the economy. The Affirmative has only cited evidence supporting the success of open source for software technologies—our authors prove the pharmaceutical industry has distinct considerations. Pharmaceutical-specific regulatory barriers and lack of a sustainable business model make large-scale funding and compliance coordination for Open Source impossible; investors and inventors would flee the industry (Marden). Companies opting for patents in the status quo shift to trade secrets under weakened rights, hindering collaboration and patent-driven knowledge diffusion (Kline, Marden).. Separately, CL stifles R&D surrounding high-risk disease, deterring investors who fear they won't recoup costs—COVID proves it (Stevens, Feldman).

CL destroys economies instead of creating the opportunity to "redirect resources towards building infrastructure" (Affirmative Rebuttal). After a wave of compulsory licenses, international aid in Thailand declined by 10 billion dollars. Egypt's aggressive compulsory licensing nearly **halved** its FDI from $948 million to $509.4 million in less than two decades (McGill). Contrarily, strong pharmaceutical patents nurture the economy, generating return on investment, a significant form of assets (Pretnar, Olhaussen). New, high quality drugs are critical

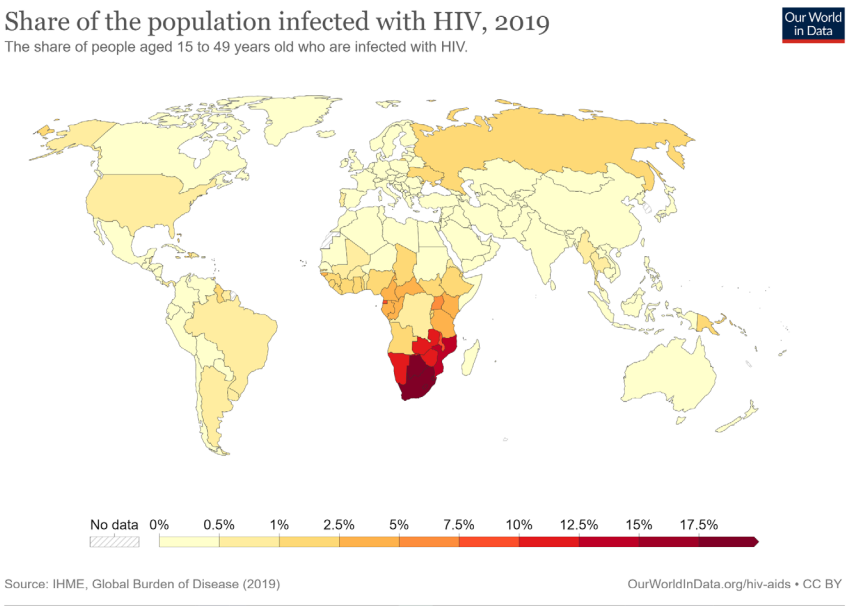
for public health which in turn supports economic growth. No matter how little access patents maintain, they are preferable to disastrous open sourcing and CL.

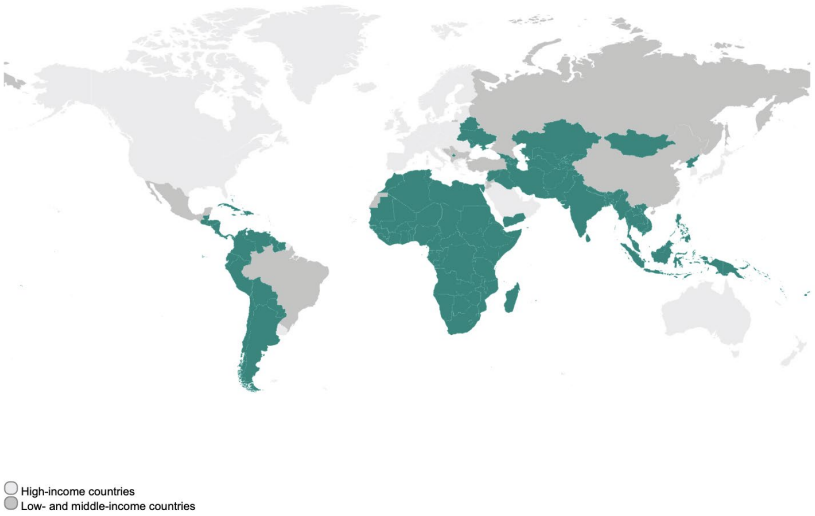
Beyond destroying innovation, Affirmative measures heighten access disparities. CL's inefficiencies result in *costlier* drug prices than those secured through international aid, making voluntary licensing a more effective alternative (Beall, Stevens, Urias). The Affirmative Urias evidence concludes Negative: Urias examines price changes "after a compulsory license threat" instead of licensing itself and concludes that VL results in greater price reductions (Urias, Beall).

CL and open sourcing cannot impact vaccine access or economic inequality. The Affirmative concedes that disparities stem from regulatory hurdles, poor domestic distribution infrastructure, and vaccine hesitancy; However, the affirmative model doesn't propose any domestic infrastructure initiatives in LMICs nor does it support the partnerships between LMICs and patent holders created through VL that alleviate the impacts of these roadblocks (Mossoff, Jeon, Van Loy, and Petrichenko).

The Affirmative claim that VLs allow companies to hike prices is false—agreements are explicitly designed to reduce costs and increase affordability. VLs enable generic competition, driving prices **down** (Chandna). Furthermore, the claim that VLs exclude certain LMICs is wrong. Our sources demonstrate that VLs effectively target LICs, ensuring that the countries most in need receive benefits first (Anderson, Amnesty). When comparing ARTs supplied through voluntary licensing with the global disease burden of HIV (Roser and Ritchie maps), VLs clearly secure access for all LMICs. Rather than restricting access, VLs make essential medicines available and affordable. Furthermore, Negative forwards specific examples proving the status quo supports equitable access; 43.56 billion doses administered through VLs in the

past 11 years, a 25x increase in **global life expectancy**, and ARTs that have cut global HIV mortality rates **in half** (CDC, UNAIDS, MPP).





Conclusion

The Affirmative's proposed changes cannot improve access without causing exponential harm to pharmaceutical innovation. Weakening IPR discourages *critical* research and development in integral medical advancements, leading to healthcare stagnation. Furthermore, the Affirmative claim that IPR reduction creates better infrastructure has weak evidentiary basis. The Negative has unambiguously shown that the status quo at least partially facilitates equity (VL, international aid, COVID, higher life expectancies) while supporting high innovation. Ultimately, even if IPR truly crushes access, it expires after a 10 year period, facilitating the emergence of generic markets which solve equity concerns. Access is always possible in the

status quo; thus an Affirmative model could only worsen global healthcare, jeopardizing future medical breakthroughs so that all populations are vulnerable to new diseases. Effective, robust innovation must exist before any level of access; thus, negate.

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