Zach and I affirm resolved: The United States federal government should impose price controls on the pharmaceutical industry.

Our sole contention is bridging the gap.

Drug prices are unbearable, as **the Kaiser Family Foundation 18** finds that 41% of Americans skip, or never fill prescriptions due to high costs. This is worsening, as **Johnson 18 of the Associated Press** analyzes 30,000 price changes in 2018, finding that there were 96 price hikes for every cut. Comparatively, **Hirschler 18 of Scientific American** confirms that American drug prices are three times higher than elsewhere.

Without action, the situation will only continue to worsen, as **Johnson '17 of MIT** warns that the cost of prescription drugs will rise by 6.4% yearly.

Insurance doesn't help, as **Olen 17 of the Atlantic** calculates that out of pocket costs for insured people have increased by 50%.

This harms three vulnerable groups.

First, the poor. The Center for Disease Control 15 reveals that 25.3% of low-income Americans choose to not take medicine as prescribed to save money on expensive drugs. This is worse for critical, high cost therapies, as **Kelley 18 of Managed Care** calculates that nonadherence was 49% for those. Thus, **Amstislavski '12 of the University of Alaska** concludes that many low-income communities are "medication desserts" that cannot afford critical drugs.

Second, racial minorities. The Federal Reserve 17 finds that black and hispanic households are only worth around 15% that of white households. As a result, **Tseng 08 of the Pacific Health Research Institute** reveals that, compared to white people, hispanic and black people are 55.6% and 26.7% more likely to avoid medicating due to costs.

Commented [1]: Just calculated the percentage difference between 23%/17% and 13%, with the former two being hispanic and black stats respectively and the latter being white.

Doing nothing changes nothing, as **Pearl 15 of Forbes** warns that not only do people of color experience 40 percent worse health outcomes, but the gap is growing because of prevailing barriers to care access.

Third, people with disabilities. Kennedy of the University of Illinois explains that because people with disabilities often have to medicate frequently across a long timeframe. Even if people can afford the upfront cost, they cannot afford refills if prices increase. Thus, **Kennedy**

furthers that cost prevented more than 1.3 million adults with disabilities from medicating, and over half suffered health problems as a result.

Fortunately, affirming solves in two ways.

First, making healthcare more accessible. Katz 18 of the New York Times finds that as the cost of insurance has risen millions can no longer afford coverage. **Goozner 18 of Modern Healthcare** explains that even as hospital stays and length of admissions has shrunk, the rising cost of drugs has ballooned the price of health insurance. **Heath of Patient Engagement 18** confirms that drug prices alone accounted for 25% of all healthcare costs, a number that is rising every year.

Affirming is crucial, as health insurance keeps patients healthy. **HC '15** finds that insurance covers large medical bills and reduces -- if not alleviates entirely -- the financial burden of healthcare, a critical step in providing care to low- and middle-income families.

Second, lowering drug prices Pieters 17 of Utrecht University assures that affirming locks prices lower while increased consumption offsets corporate profit losses. Thus, **Pieters** quantifies that decreasing prices by 20% would increase affordability by 23% while only decreasing revenue by 1%.

There are two impacts.

First is saving lives.

Affordability is crucial, as **Sipkoff 09 of Managed Care** quantifies that 1.1 million Americans die annually from medical non-adherence. Even when non-fatal, **the World Health Organization** continues that illnesses make low-income people unable to work, trapping them in cyclical poverty.

Even if one purchases costly drugs, **Tran 18 of Duke University** warns that high expenses means less disposable income, perpetuating poverty

Second is helping the vulnerable by decreasing health disparities.

Montesdeoca 13 of Illinois State University articulates that preventable health disparities are structural inequalities, as they result from historically unequal resource distribution. Consequently, access lessens disparities and structural inequality.

Ultimately, **Farmer 06 of Harvard University** concludes that developing effective therapies strengthens inequality if kept from the vulnerable, as the rich get them while disadvantaged groups suffer untreated diseases.

Thus, we are very proud to affirm.

Weighing OV for rebuttal

Four reasons our argument about access to medicine outweighs their case.

The first is on the magnitude of impacts. The impacts that we are talking about is literally the difference between life or death for hundreds of thousands of people in the United States. The impacts that they are talking about are super nebulous things like innovation with no terminalization of what that means.

The second is on strength of link and probability. The resolution literally concedes the link into our case. Any form of price controls inherently means lower prices which inherently means that there is more access. The probability of our impacts is 100%. At this high magnitude of impacts of life or death for hundreds of thousands, you can't pass up affirming for a really low probability impact of their stuff.

The third is because access is a prerequisite. It doesn't matter if there is good innovation if there isn't accessibility to these drugs that they are innovating.

The fourth is because discrimination outweighs on timeframe. The cyclical nature of the discrimination argument that we make means that there will be discrimination for literally decades. It won't be solved unless you affirm. This is really problematic because the HRW writes in 2013 that discrimination is the root cause of inequality, poverty, and violence for the entire country, which outweighs their arguments again.

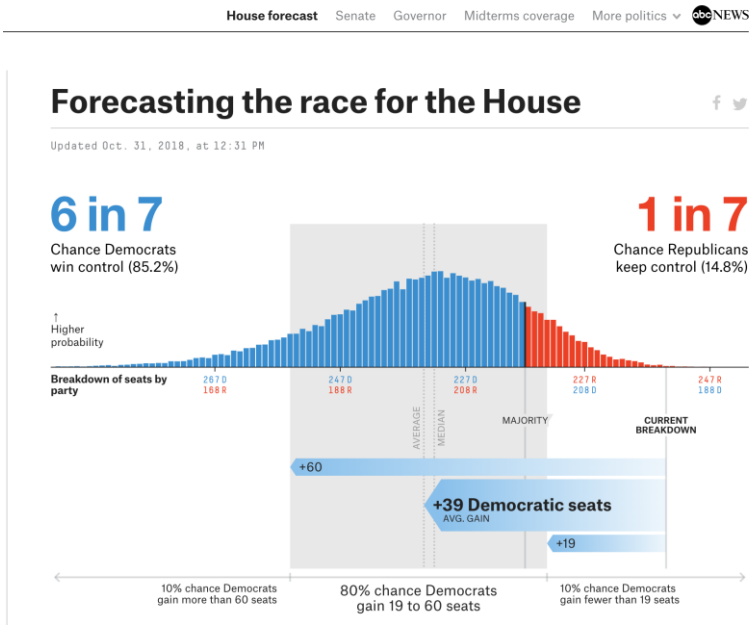
Frontlinz

AFF Frontlinz

AT Lobbying

1. **The resolution fiats that prices go down, and because we are debating the merits of decreasing prices this argument is irrelevant.**
2. **Nonunique- they are always going to lobby in both worlds, the only difference is in their world you know people are dying because they can't afford medicine, our world has a risk of prices going down, and that is sufficient to affirm.**
3. **Defense- Blue tide, FiveThirtyEight as of Wednesday found that democrats have an 85.3% chance of taking control of the house, this is critical, as Facher of StatNews on Tuesday found that democrats are in overwhelming support of price control legislation and are less susceptible to lobbying.**
4. **Timeframe- Outweigh this argument, because Americans want price controls, and they are fed up with big pharma, meaning that if politicians cave to big pharma Americans are going to vote them out of office in the long term, Democracy checks back.**

Nate **Silver** 18, 10-31-**2018**, "2018 House Forecast," **FiveThirtyEight,**
https://projects.fivethirtyeight.com/2018-midterm-election-forecast/house///ZS



Lev **Facher** @Levfacher 18, 10-30-**2018**, "Pharma braces for a Pelosi speakership and Democrats' drug pricing agenda," STAT, https://www.statnews.com/2018/10/30/what-happens-to-pharma-if-democrats-take-the-house///ZS

Pelosi's foreboding words, first described to STAT by multiple sources with knowledge of the encounter and later confirmed by the **Democratic** leader's office, **were intended as a "come-to-Jesus" moment for the [pharmaceutical] industry**, according to one individual familiar with the meeting. The boardroom ambush from **Washington's most powerful Democrat could prove the first of many such moments for drug manufacturers,** which have come under fire from the White House and lawmakers from both parties in the past two years. Interviews with drug industry lobbyists and Democratic aides across the Capitol suggest the same: that the wing of **Pelosi's party outlining an ambitious agenda to combat high drug costs could turn 2019 into PhRMA's doomsday scenario."Democrats have made real action to lower prescription drug prices central" to the party's campaign strategy,** Pelosi told STAT in a statement. "It will be one of our first legislative priorities in the majority." Among the scariest planks of a Pelosi-controlled House, beyond the threat she made in the meeting: direct negotiating authority for Medicare's prescription drug benefit, which spent $90 billion on prescription medicines in 2015. Another: the installation of **a Senate-confirmed "price-gouging enforcer**," who would monitor drug companies' financial models and fine those found to have increased prices unjustifiably

Cut Cardz

Kaiser Family Foundation

Published 16, 1-5-2016, "New Kaiser/New York Times Survey Finds One in Five Working-Age Americans With Health Insurance Report Problems Paying Medical Bills," Henry J. Kaiser Family Foundation, https://www.kff.org/health-costs/press-release/new-kaisernew-york-times-survey-finds-one-in-five-working-age-americans-with-health-insurance-report-problems-paying-medical-bills///ZS

New Kaiser/New York Times Survey Finds One in Five Working-Age Americans With Health Insurance Report Problems Paying Medical Bills Published: Jan 05, 2016 Facebook Twitter LinkedIn Email Print Among the Insured with Medical Bill Problems, 63% Report Using Up Most or All Their Savings and 42% Took on an Extra Job or Worked More Hours Half of People Without Health Insurance Report Problems With Medical Bills, and They Face Similar Financial and Personal Consequences As Those With Insurance Among people with health insurance, one in five (20%) working-age Americans report **having problems paying medical bills in the past year that often cause serious financial challenges and changes in employment and lifestyle, f**inds a comprehensive new Kaiser Family Foundation/New York Times survey. As expected, the situation is even worse among people who are uninsured: half (53%) face problems with medical bills, bringing the overall total to 26 percent. While insurance can protect people from problem medical bills, the survey suggests that those with employer coverage or other insurance suffer similar consequences as the uninsured once such problems occur. Among those facing problems with medical bills, almost identical shares of the insured (44%) and uninsured (45%) say the bills had a major impact on their families. People with insurance who face problem medical bills also report a wide range of consequences and sacrifices during the past year as a result, including delaying vacations or major household purchases (77%), spending less on food, clothing and basic household items (75%), using up most or all their savings (63%), taking an extra job or working more hours (42%), increasing their credit card debt (38%), borrowing money from family or friends (37%), changing their living situation (14%), and seeking the aid of a charity (11%). These shares generally are as large as or larger than the shares among uninsured people with problem medical bills. Medical Debt Table for Email Alert v1 Overall, 62 percent of those who had medical bill problems say the bills were incurred by someone who had health coverage at the time (most often through an employer). Of those who were insured when the bills were incurred, three-quarters (75%) say that the amount they had to pay for their insurance copays, deductibles, or coinsurance was more than they could afford. People with health insurance who have problems with medical bills also report skipping or putting off other health care in the past year because of the cost, such as postponing dental care (62%), skipping doctor-recommended tests or treatments (43%), or **not filling a prescription (41%).** In general, people with medical bill problems are two to three times as likely to report each of these problems as those without problems paying medical bills. The Kaiser/Times survey provides an in-depth, quantitative look at the extent and causes of Americans' medical-debt issues and their impact on people's lives, families, finances and access to health care. The New York Times is reporting on the findings this week, and the Foundation is issuing a report detailing the survey's results and implications.

Johnson

Linda A. Johnson and Nicky Forster 18, 9-24-2018, "AP investigation: Drug prices going up despite Trump promise," AP NEWS, https://apnews.com/b28338b7c91c4174ad5fad682138520d//ZS

Over the first seven months of **the year, there were 96 price hikes for every price cut**, the AP found. Health and Human Services Secretary Alex Azar, the administration's point person for efforts to lower drug prices, conceded in

a recent AP interview that it will be a while before drug prices fall. He noted the complexity of the medicine market and its incentives for drugmakers to boost prices so they and middlemen make bigger profits. “I am not counting on the altruism of pharma companies lowering their prices,” said Azar, who was a senior executive in Eli Lilly & Co.’s U.S. business for a decade when it dramatically raised prices for its insulin products. The AP analyzed 26,176 U.S. list price changes for brand-name prescription drugs from Jan. 1 through July 31 in the years 2015 through 2018, using data supplied by health information analytics firm Elsevier. The AP focused its analysis on the first seven months of each year because of the seasonality of price changes and to make meaningful year-to-year comparisons. The data included more than 97 percent of price changes during those periods and, for many drugs, several dosages and drugs forms, such as pills, liquids and injectable drugs. (In the 3 percent of cases not analyzed, the AP couldn’t determine how the new price compared with the previous one or whether it was for a product new on the market.)

Hirschler

Ben Hirschler xx, xx-xx-xxxx, "How the U.S. Pays 3 Times More for Drugs," Scientific American, https://www.scientificamerican.com/article/how-the-u-s-pays-3-times-more-for-drugs///ZS

LONDON (Reuters) - U.S. prices for the world's 20 top-selling medicines are, on average, **three times higher than in Britain**, according to an analysis carried out for Reuters. The finding underscores a transatlantic gulf between the price of treatments for a range of diseases and follows demands for lower drug costs in America from industry critics such as Democratic presidential candidate Hillary Clinton. The 20 medicines, which together accounted for 15% of global pharmaceuticals spending in 2014, are a major source of profits for companies including AbbVie, AstraZeneca , Merck, Pfizer and Roche. Researchers from Britain's University of Liverpool also found U.S. prices were consistently higher than in other European markets. Elsewhere, U.S. prices were six times higher than in Brazil and 16 times higher than the average in the lowest-price country, which was usually India. The United States, which leaves pricing to market competition, has higher drug prices than other countries where governments directly or indirectly control medicine costs. That makes it by far the most profitable market for pharmaceutical companies, leading to complaints that Americans are effectively subsidizing health systems elsewhere. Manufacturers say decent returns are needed to reward high-risk research and prices reflect the economic value provided by medicines. They also point to higher U.S. survival rates for diseases such as cancer and the availability of industry-backed access schemes for poorer citizens.

CNBC

CNBC xx, xx-xx-xxxx, “US prescription drug spending as high as $610 billion by 2021: Report,” https://www.cnbc.com/2017/05/04/us-prescription-drug-spending-as-high-as-610-billion-by-2021-report.html//ZS

Spending on prescription medicines in the United States will increase 4 percent to 7 percent **through 2021, reaching** $580 billion to **$610 billion**, according to a report released by QuintilesIMS Holding on Thursday that lowered its prior long-term forecast. QuintilesIMS, which compiles data for the pharmaceutical industry, had previously forecast average spending growth of 6 percent to 9 percent through 2021. It reduced its projections due to fewer new medicines approved in 2016 than prior years and as drugmakers face increasing pricing pressure and competition. Taking likely manufacturer discounts and rebates into account, spending would grow 2 percent to 5 percent to $375 billion to $405 billion in 2021, as net price increases for patent-protected branded drugs slows, the report said.

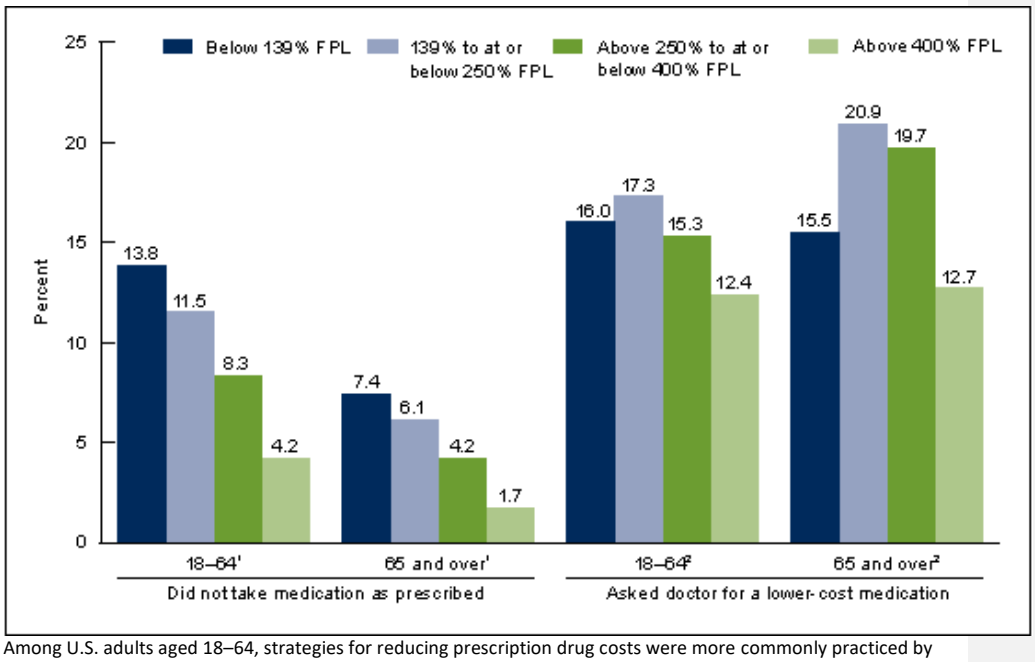
Olen

Helaine Olen 17, 6-18-2017, "Even the Insured Often Can't Afford Their Medical Bills," Atlantic, https://www.theatlantic.com/business/archive/2017/06/medical-bills/530679///ZS

The current debate over the future of the Affordable Care Act is obscuring a more pedestrian reality. Just because a person is insured, it doesn't mean he or she can actually afford their doctor, hospital, pharmaceutical, and other medical bills. The point of insurance is to protect patients' finances from the costs of everything from hospitalizations to prescription drugs, but **out-of-pocket spending for people even with employer-provided health insurance has increased by more than 50 percent since 2010,** according to human resources consultant Aon Hewitt. The Kaiser Family Foundation reports that in 2016, half of all insurance policy-holders faced a deductible, the amount people need to pay on their own before their insurance kicks in, of at least $1,000. For people who buy their insurance via one of the Affordable Care Act's exchanges, that figure will be higher still: Almost 90 percent have deductibles of $1,300 for an individual or $2,600 for a family. Even a gold-plated insurance plan with a low deductible and generous reimbursements often has its holes. Many people have separate—and often hard-to-understand—in-network and out-of-network deductibles, or lack out-of-network coverage altogether. Expensive pharmaceuticals are increasingly likely to require a significantly higher co-pay or not be covered at all. While many plans cap out-of-pocket spending, that cap can often be quite high—in 2017, it's $14,300 for a family plan purchased on the ACA exchanges, for example. Depending on the plan, medical care received from a provider not participating in a particular insurer's network might not count toward any deductible or cap at all. At the same time, the most recent Report on the Economic Well-Being of U.S. Households, an annual survey conducted by the Federal Reserve Board, found that 44 percent of adult Americans claim they could not come up with $400 in an emergency without turning to credit cards, family and friends, or selling off possessions. When this reality combines with healthcare bills, the consequences can be financially devastating. A 2015 poll by the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health discovered that 26 percent of those who took part in the survey claimed medical bills caused severe damage to their household's bottom line. A poll conducted earlier this year by Amino, a healthcare-transparency company, with Ipsos Public Affairs, found that 55 percent of those they surveyed claimed they had at least once received a medical bill they could not afford. No surprise, then, that the Consumer Financial Protection Bureau reported earlier this year that medical debt was the most common reason for someone to be contacted by a debt collector.

CDC

Adults To xx, xx-xx-xxxx, "Products," No Publication, https://www.cdc.gov/nchs/data/databriefs/db184.htm//ZS



Among U.S. adults aged 18–64, strategies for reducing prescription drug costs were more commonly practiced by those who were uninsured than those who had public or private coverage. Lack of health insurance coverage and poverty are recognized risk factors for not taking medication as prescribed due to cost (2). This cost-saving strategy may result in poorer health status and increased emergency room use and hospitalizations, compared with adults who follow their recommended pharmacotherapy (6-7). It is unknown whether adverse health outcomes and higher health care costs are also associated with the cost-reduction strategies of alternative therapy use or obtaining prescription drugs from abroad (8-9). Among adults aged 65 and over, those covered by both Medicare and Medicaid were more likely to have not taken their medication as prescribed to save money, but were less likely to have asked their doctor for a lower-cost prescription, than those who had private insurance coverage. Differences in cost-saving strategies by insurance coverage may be interrelated with socioeconomic and other patient characteristics. Belief that the recommended pharmacotherapy is needed, and an understanding of the recommended treatment, have been found to be lower among older adults who are economically vulnerable, compared with those with higher income (10). Income was also associated with the use of cost-reduction strategies. Among adults aged 65 and over, those living with incomes at 139%–400% FPL were more likely than adults living in lower or higher income thresholds to have asked their provider for a lower-cost prescription to save money. These patterns in the estimates by insurance status and poverty level are similar to those previously reported using the 2011 NHIS data (5)

Kelley

Maggie Alston 18, 6-3-2018, "When the Cost of Medications Keeps Patients from Taking Them," Managed Care magazine, https://www.managedcaremag.com/archives/2018/6/when-cost-medications-keeps-patients-taking-them//ZS

What kind of costs are we talking about? Looking at 2012 claims data, she and her colleagues found that Medicare patients with Part D prescription--drug coverage who didn't qualify for special low-income subsidies had to shell out an average of $6,322 in a year for specialty drugs to treat chronic myeloid leukemia, $3,949 a year for rheumatoid arthritis, and $5,238 for multiple sclerosis. One needn't be poor to feel pinched by pill prices like those. Besides, many Medicare beneficiaries are people of modest means; in 2014, half had annual incomes below $24,150. The cost-sharing structure of Medicare Part D doesn't help matters because it results in those costs peaking at the beginning of the year when many people have large credit card bills from holiday shopping. Leukemia patients in the study had to pay $2,452 in January alone, says Doshi. Nonadherence has been studied quite a bit, but much of the research has used insurance claims data that included information on filled prescriptions only, Doshi explains in a study published in the Feb. 10, 2018, issue of the Journal of Clinical Oncology. This makes it hard to know how often patients receive a new prescription but opt not to fill it. She and her coauthors reviewed 2014 and 2015 data on more than 38,000 patients, both commercial and Medicare, to see how many prescriptions for 38 oral anticancer agents were "abandoned"—that is, approved by insurance but not picked up by the patient. Abandonment became more common as out-of-pocket costs increased. "Whereas only 10% of patients in the lowest out-of-pocket cost cate-gory **abandoned their prescriptio**n," Doshi and her coauthors wrote, "almost **half of patients (49%) in the highest out-of-pocket cost category did."**

Amitslavaski

Philippe Amstislavski,1 xx, xx-xx-xxxx, "Medication deserts: survey of neighborhood disparities in availability of prescription medications," PubMed Central (PMC), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3517332///ZS

The findings suggest that geographic access to a neighborhood pharmacy, the type of pharmacy, and availability of commonly prescribed medications varies significantly across communities. In extreme cases, **entire communities could be deemed "medication deserts" because geographic access to pharmacies and the availability of the most prescribed medications within them were very poor.** To our knowledge, this study is first to report on the relationship between SES and geographic access to medications using small area econometric analysis techniques. Our findings should be reasonably generalizable to other urban areas in North America and Europe and suggest that more research is required to better understand the relationship of socio-economic environments and access to medications to develop strategies to achieve equitable medication access.

Federal Reserve

Race And 17, 9-27-2017, "The Fed," No Publication, https://www.federalreserve.gov/econres/notes/feds-notes/recent-trends-in-wealth-holding-by-race-and-ethnicity-evidence-from-the-survey-of-consumer-finances-20170927.htm//ZS

We first analyze trends in total net worth among families classified, according to their self-identification during the interview, as white non-Hispanic, black or African American non-Hispanic, Hispanic or Latino, and other or multiple race (we will henceforth refer to these groups as white, black, Hispanic, and other, respectively).1 Net worth is defined as the difference between families' gross assets and their liabilities.2 We will describe patterns at the median (the typical household within each group) and at the mean (the average within each group). In 2016, white families had the highest level of both median and mean family wealth: $171,000 and $933,700, respectively (figure 1). Black and Hispanic families have considerably less wealth than white families. **Black families' median and mean net worth is less than 15 percent that of white families, at $17,600 and $138,200, respectively. Hispanic families' median and mean net worth was $20,700 and $191,200, respectively.** Other families--a diverse group that includes those identifying as Asian, American Indian, Alaska Native, Native Hawaiian, Pacific Islander, other race,

and all respondents reporting more than one racial identification--have lower net worth than white families but higher net worth than black and Hispanic families. The same patterns of inequality in the distribution of wealth across all families are also evident within race/ethnicity groups: For each of the four race/ethnicity groups, the mean is substantially higher than the median, reflecting the concentration of wealth at the top of the wealth distribution.

Tseng

No Author xx, xx-xx-xxxx, "," No Publication,
http://care.diabetesjournals.org/content/diacare/31/2/261.full.pdf//ZS

RESEARCH DESIGN AND METHODS — We surveyed 5,086 participants from the multicenter Translating Research Into Action for Diabetes Study. Respondents reported whether they used less medication because of cost in the past 12 months. We examined unadjusted and adjusted rates of cost-related medication underuse, using hierarchical regression, to determine whether race/ethnicity differences still existed after accounting for economic, health, and other demographic variables. RESULTS — Participants were 48% white, 14% African American, 14% Latino, 15% Asian/ Pacific Islander, and 8% other. Overall, 14% reported cost-related medication underuse. Unadjusted **rates were highest for Latinos (23%) and African Americans (17%) compared with whites (13%),** Asian/Pacific Islanders (11%), and others (15%). In multivariate analyses, race/ethnicity significantly predicted cost-related medication underuse (P 0.048). However, adjusted rates were only slightly higher for Latinos (14%) than whites (10%) (P 0.026) and were not significantly different for African Americans (11%), Asian/Pacific Islanders (7%), and others (11%). Income and out-of-pocket drug costs showed the greatest differences in adjusted rates of cost-related medication underuse (15 vs. 5% for participants with income $25,000 vs. $50,000 and 24 vs. 7% for participants with out-of-pocket costs $150 per month vs. $50 per month. CONCLUSIONS — One in seven participants reported cost-related medication underuse. Rates were highest among African Americans and Latinos but were related to lower incomes and higher out-of-pocket drug costs in these groups.

Pearl

Robert Pearl, M.D. 15, 3-5-2015, "Why Health Care Is Different If You're Black, Latino Or Poor," Forbes,
https://www.forbes.com/sites/robertpearl/2015/03/05/healthcare-black-latino-poor///ZS

The foundation estimates **Latinos and African-Americans experience 30 to 40 percent poorer health outcomes than white Americans.** This disparity leads not only to shortened lives and increased illness, but also costs the nation more than $60 billion in lost productivity each year. Access to care remains a prevailing problem. From the most recent National Healthcare Disparities Report: 35 percent of Latinos and low-income individuals reported difficulties getting the care they need, compared to 25 percent of white Americans and 15 percent of high-income.

Kennedy

Jae **Kennedy 02** [PhD, Department of Community Health, University of Illinois at Urbana–Champaign. Christopher Erb is with the Medical Scholars Program, University of Illinois at Urbana–Champaign. Erb C. Prescription Noncompliance due to Cost Among Adults With Disabilities in the United States. American Journal of Public Health. 2002;92(7):1120-1124. // JY

Objectives. This study estimated national prevalence rates of medication noncompliance due to cost and resulting health problems among adults with disabilities. Methods. Analyses involved 25 805 respondents to the Disability Follow-Back Survey, a supplement to the 1994 and 1995 National Health Interview Surveys. Results. Findings showed that about **1.3 million adults with disabilities did not take their medications as prescribed because of cost, and more than half reported health problems as a result**. Severe disability, poor health, low income, lack of insurance, and a high number of prescriptions increased the odds of being noncompliant as a result of cost. Conclusions. Prescription noncompliance due to cost is a serious problem for many adults with chronic disease or disability. Most would not be helped by any of the current proposals to expand Medicare drug coverage. Medicare prescription drug insurance is a recurrent focus of American health policy,1 and a combination of rapidly escalating drug costs2 and insurance industry trends3,4 have again thrust the issue to center stage. One of the more compelling rationales offered for expanding drug coverage is that affordability problems have clinical as well as economic consequences; that is, patients who have difficulty paying for medications are less likely to take them and can suffer adverse health effects as a result of noncompliance.5,6 **Although this argument has intuitive appeal, no national data are available on cost-associated noncompliance**, leading commentators to question both the scope of affordability problems and the remedies proposed to address them.7 In the present study, we sought to illuminate a critical aspect of the policy debate by developing the first national prevalence estimates of prescription noncompliance due to cost and resulting health problems among adults with disabilities, a population known to be heavy users of health care,8,9 including prescription drugs.9–11 Medicare recipients with drug coverage are more likely to fill their prescriptions than those without coverage.12–14 **Total and out-of-pocket drug costs are heavily skewed toward individuals with poor health or chronic conditions, even among recipients with drug coverage** 15 **Noncompliance with prescription regimens is a widely recognized clinical problem**,16 **particularly in the case of treatment of chronic illnesses** such as hypertension,17 and it has been identified as an important predictor of emergency room visits18 and hospital admissions.19,20 Numerous studies have linked rates of noncompliance to (1) sociodemographic factors, including age,21–23 sex,17 and race/ethnicity24; (2) socioeconomic factors, including insurance coverage25 and out-of-pocket costs18,19; and (3) treatment factors, including type26and number of drugs prescribed27 and complexity of drug regimen.21 We examined the relative influences of these factors on self-reported noncompliance due to cost. The Disability Supplement and the Disability Follow-Back Survey (DFS) are special supplements to the National Health Interview Survey (NHIS), a continuing probability survey of households representative of the civilian noninstitutionalized population of the United States.28 The Disability Supplement was administered to all respondents at the same time they completed the 1994 and 1995 NHIS core surveys. The DFS was administered 6 to 18 months later to respondents who reported impairments, functional limitations, chronic conditions, or receipt of disability benefits in the core NHIS surveys or the Disability Supplement.29 We used data from the adult supplement, which was administered to 25 805 respondents 18 years or older with disabilities (about 17% of the NHIS sample). Adults selected for the DFS differed from the general population selected for the NHIS in predictable ways. They were older (according to weighted estimates, 35% of DFS adult respondents were 65 years or older, compared with 13% of NHIS adult respondents), had lower incomes (19% of DFS respondents had incomes at or below the poverty level, compared with 12% of NHIS respondents), and were in worse health (69% of DFS adult respondents rated their health as fair or poor, compared with 34% of NHIS respondents). Data Analysis We used a case–control design to examine risk factors associated with prescription noncompliance due to cost. We weighted all data so that they would be generalizable to the overall US population. SUDAAN statistical software was used to account for the clustered sample design of the NHIS and the lack of independence in the error terms.30 Unadjusted and adjusted odds ratios (ORs) were calculated for demographic (age, sex, race/ethnicity), socioeconomic (income, health insurance coverage), and health and disability (self-assessed health status, severity of activity limitations, number of prescriptions) factors. Respondents who were not prescribed any medications and those who reported that they did not take their medications as prescribed for reasons other than cost were omitted from comparisons. **Almost 70% of the disabled adult population—about 28 million people—reported having been prescribed 1 or more medications** (Table 1), and more than 85% of this group indicated that they always used their medications as prescribed. However, **an estimated 3.8 million adults reported that they did not always use their medications as prescribed.** These respondents were asked to select 1 or more of 8 reasons for their

Katz

Margot Sanger-Katz 18, 7-3-2018, "When Health Insurance Prices Rose Last Year, Around a Million Americans Dropped Coverage," No Publication, https://www.nytimes.com/2018/07/03/upshot/when-health-insurance-prices-rose-last-year-around-a-million-americans-dropped-coverage.html//ZS

Last year, as insurance prices rose by an average of just over 20 percent around the country, people who qualified for Obamacare subsidies hung onto their insurance. But the increases appear to have been too much to bear for many customers who earned too much to qualify for financial help. A**ccording to a new government report, about a million people appear to have been priced out of the market for health insurance last year.**

Goozner

Anne Peticolas 18, 1-13-2018, "Goozner: The indisputable fact is high drug prices are the most serious cost problem for healthcare.," Modern Healthcare, https://www.modernhealthcare.com/article/20180113/NEWS/180119961//ZS

High hospital prices, overpaid doctors, overutilization, disparate regional care patterns all have come in for a share of the blame in recent years. There is a modicum of truth in each of those claims. But, **after closely examining the latest CMS expenditures report, the indisputable fact is that rising drug and medical-device prices remain the most serious contemporary cost problem the healthcare industry has. Indeed, it threatens to overwhelm all other efforts at cost control, many of which are showing signs of progress.** Let's do a quick tour through the math. When the Affordable Care Act passed in 2010, healthcare's share of the national economy stood at 17.4%. It fell to 17.2% by 2013, but by 2016 was back up to 17.9%. The small but noticeable increases in recent years are raising fears we're re-entering a period of uncontrolled spending. However, not all sectors are increasing at the same rate. Total personal healthcare consumption, not adjusted for inflation, rose 16.7% between 2013 and 2016. But its hospital spending component rose at a slower pace-15.5%. Professional services, which is mostly physician office-based care, also rose more slowly-16%. On the other hand, drug spending, whether purchased through pharmacies, mail order or online, rose by 23.9% over the past three years. That led to the drug industry gaining nearly a full-percentage-point share of the overall healthcare economy since 2013. In an economic sector where change is glacial, an increase of 1 percentage point is huge. And the share grab is actually much worse. Retail drug sales don't include the most expensive drugs-those delivered in hospital outpatient and physician offices. The CMS doesn't track that data separately, but one can get a glimpse of what's happening by examining the latest financial reports from major hospital systems. Ascension, for instance, saw its margins collapse in its most recent quarter. Total operating expenses at the nation's largest not-for-profit hospital system rose 12.9% over its last three full fiscal years, an average of 4.3% a year. Salaries, its single largest expense, rose about at the same rate. But supply costs rose 15.8%, or 5.3% a year-a full percentage point higher. Are the rising cost of bed pans, hospital gowns and syringes to blame? It seems unlikely when hospital admissions and lengths of stay are shrinking every year.

Heath

Patientengagementhit 18, 5-23-2018, "High Drug Prices Account for One-Quarter of Patient Insurance Costs," PatientEngagementHIT, https://patientengagementhit.com/news/high-drug-prices-account-for-one-quarter-of-patient-insurance-costs//ZS

High Drug Prices Account for One-Quarter of Patient Insurance Costs An AHIP analysis revealed that high drug prices are taking up a considerable portion of a patient's premium and insurance costs.The majority of a patient insurance costs go toward paying for prescription drugs, with high drug prices accounting for 23.2 cents of each dollar spent on an insurance premium, according to a recent analysis from America’s Health Insurance Plans (AHIP) and research firm Milliman. The analysis of commercial health plan data from between 2014 and 2016 revealed each of the categories patients’ healthcare dollars go toward. The analysis specifically looks at how premium costs are distributed. This comes as a part of AHIP’s efforts to increase healthcare price transparency for patients who are paying increasing amounts for their health insurance. The finding that most of a patient’s premium costs go toward prescription drug prices confirms growing industry concerns about rising drug costs. As it stands, patients are facing increasing out-of-pocket costs for their prescription medications. The finding that patients are also footing the bill for medications via their insurance premiums highlights just how much patients must pay to access their treatments.

Collins

Sara R. 18, 5-1-2018, "Health Insurance in 2018 Finds ACA Gains Reversing," No Publication, https://www.commonwealthfund.org/blog/2018/first-look-health-insurance-coverage-2018-finds-aca-gains-beginning-reverse//ZS

In this post, and another soon to follow, we will look at people's recent **experiences with their insurance coverage and the affordability of their health insurance and health care**.1 The ACA Tracking Survey is a nationally representative telephone survey conducted by SSRS that tracks coverage rates among 19-to-64-year-olds and has focused in particular on the experiences of adults who have gained coverage through the marketplaces and Medicaid. The latest wave of the survey was conducted between February and March 2018. Forthcoming results from large federal surveys like the National Health Interview Survey will shed more light on the trends our survey has identified.2 Findings UNINSURED RATE AMONG WORKING-AGE ADULTS IS UP SIGNIFICANTLY SINCE 2016 The uninsured rate among working-age people — that is, those who are between 19 and 64 — is at 15.5 percent, up from 12.7 percent in 2016, meaning an estimated **4 million people lost coverage** (Tables 1 and 2). Rates were up significantly compared with 2016 among adults with lower incomes — those living in households earning less than 250 percent of poverty (about $30,000 for an individual and $61,000 for a family of four).

Pieters

Addressing The 17, 8-16-2017, "Addressing the challenge of high-priced prescription drugs in the era of precision medicine: A systematic review of drug life cycles, therapeutic drug markets and regulatory frameworks," No Publication, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0182613//ZS

Schemes to reduce drug prices are used most often to reduce overall healthcare spending. For example, according to one calculation **setting prescription drug prices 20% lower than the current list price would increase the number of users who can afford the drug by 23%, while decreasing revenues for the drug company by only 1%.**[33] More examples with comparable outcomes exist.[4] Of course, the outcome is completely dependent on specific market conditions, prices and regulations. The general consensus is that reducing prices increases the number of users, and this could at least partially offset losses due to lower pricing. A popular argument against paying less for drugs is that innovation would not be financially worthwhile, and society would not enjoy the possible benefits of new innovator drugs.[77] This argument will be discussed later on. 4.2.1 Biosimilar substitution regulation and resistance to substitution. Both the EMA (since 2003) and the FDA (since 2010) have regulations for accepting biosimilars to bring down the price of treatments by increasing competition without reducing safety.[65;72;159;160] However, unlike the EMA, the FDA only allows for an interchangeability label if the manufacturer has shown that a biosimilar drug has the same effect and safety as the originator or for switching between them.[65] The regulatory framework for biosimilars is designed with similar intent as regulation for small molecule generic drugs, but its effect is thought to be less significant. This is due to a smaller price difference between the originator drug and generics,[143;161] as previously mentioned. Research and production costs for designing a biosimilar are significantly higher than for designing small molecule generics.[65;135;161] Thus, innovators can prevent biosimilars market penetration by offering discounts on the original biological[135].

Skipoff

Maggie Alston 9, 10-1-2009, "Improved Adherence Highlights Specialty Pharmacy's Potential," Managed Care magazine, https://www.managedcaremag.com/archives/2009/10/improved-adherence-highlights-specialty-pharmacy%E2%80%99s-potential//ZS

According to PCMA, one example of the ability of specialty pharmacy to control cost is in managing care for rheumatoid arthritis patients. One study of nearly 30,000 specialty and retail prescription drug claims shows that specialty pharmacy helped reduce annual treatment costs from nearly $25,000 per patient to approximately $20,000 per patient. Furthermore, research demonstrates that nonadherence can add significantly to overall medical costs. A New England Healthcare Institute report published in August 2009 states that across all drug classes, the cost of poor adherence, measured as "otherwise avoidable medical spending," is $290 billion a year, which is 13 percent of the nation's total health care expenditures. Through an evaluation of published studies, the NEHI found that nonadherence to medication therapy results in: Additional physician visits (at a cost of $24.2 billion a year) Additional hospital admissions ($197.8 billion) Emergency department visits ($23.3 billion) Long-term care admissions ($58.8 billion) Additional prescriptions ($5.9 billion**) The study states that nonadherence results in 1.1 million deaths a year.** Not all of that morbidity and mortality is associated with the drugs distributed by specialty pharmacies, but a great deal of it is because they handle the most expensive drugs and treat the most expensive illnesses.

WHO

No Author xx, xx-xx-xxxx, "," No Publication,
http://www.who.int/tobacco/research/economics/publications/oecd_dac_pov_health.pdf//ZS

The poor suffer worse health and die younger. They have higher than average child and maternal mortality, higher levels of disease, and more limited access to health care and social protection. And gender inequality disadvantages further the health of poor women and girls. For poor people especially, health is also a crucially important economic asset. Their livelihoods depend on it. **When poor people become ill or injured, the entire household can become trapped in a downward spiral of lost income and high healthcare costs. Investment in health is increasingly recognised as an important means of economic development and a prerequisite for developing countries – and particularly for poor people within them – to break out of the cycle of poverty**. Good health contributes to development in a number of ways: it increases labour productivity, educational attainment and investment, and it facilitates the demographic transition. The human and economic rationale for investing in health is mirrored by a growing consensus on the importance of a broad agenda in improving the health of the poor. This Reference Document identifies the essential components of a pro-poor health approach and provides a framework for action within the health system – and beyond it, through policies in other sectors and through global initiatives. Within this framework, the support of development agencies will vary according to the needs, capacities and policies of each partner country.

Tran

George Tran1 xx, xx-xx-xxxx, "Financial toxicity and implications for cancer care in the era of molecular and immune therapies," PubMed Central (PMC), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5985271///ZS
Studies have also shown a link between financial burden and poorer quality of life. **Patients are often forced to make many adjustments in response to their cancer, and financial stress can have a harmful impact on their overall well-being.** When asked to subjectively report perceived financial burdens and to rate quality of life in the 2010 National Health Interview Survey, patients with "a lot" of financial problems were 4 times less likely to report "good" or better quality of life than those without financial problems (44). Other studies support this link between financial toxicity and poorer quality of life across

different cancer types such as colorectal and lung cancer (33,45), multiple endocrine neoplasia type I-related cancers (46), and advanced cancers (breast, colorectal, lung, or prostate) (47).

Galea

Nicholas Bakalar 11, 7-4-2011, "Social Ills Like Poverty Can Cause Death, Researchers Say," New York Times, https://www.nytimes.com/2011/07/05/health/05social.html//ZS

The study also calculated **the effect of an area's overall poverty level, income differential and low social support.** For 2000, the study attributed 176,000 deaths to racial segregation **and 133,000 to individual poverty**. The numbers are substantial. For example, looking at direct causes of death, 119,000 people in the United States die from accidents each year**, and 156,000 from lung cancer**. Social factors are not the same as diseases or accidents, but Dr. Galea argues that they are equivalent to a behaviors like smoking, and that, as with smoking, there is evidence of the mechanism involved. He said that the causal chain between, for **example, poverty and death from heart disease has many well-established links.**

Montesdeoca

Cecilia Montesdeoca 13, 9-8-2013, "Inadequate Access to Healthy Opportunities and Structural Violence: A Case Study of Health Disparities among Hispanics in McLean County," ISU ReD: Research and eData, https://ir.library.illinoisstate.edu/sta/5///ZS

Significant disproportionate human suffering is experienced by socially disadvantaged populations as a result of preventable difference in the burden of disease, injury, violence, and/or opportunities to achieve optimal health. Disparities in health refer to differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death (CNHEOa 2013). **Health disparities are discriminatory and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources (CDC 2007)**. While such disparities are more visible when comparing health status of whole countries, they are also embedded in the structure within individual countries and even with local communities. In this thesis I argue that **significant health disparities exist between ethnic-minorities and whites in the United States as a result of social and governmental structures, such as national and local policies and lack of accessibility** to community social services. **Structures that allow such indirect yet noteworthy forms of human suffering are forms of structural violence. On various structural levels, scholars, policy makers, and ordinary people alike, must recognize health disparities as an issue of injustice for the specific groups subjected to systematic racial discrimination.** First, I explore the value of health care in the United States, and then examine differences in health statuses in various social determinants among ethnic-minorities and whites in the United States. Second, I discuss how barriers of inadequate access of healthier opportunities are an act of structural violence. Thirdly, I provide a small case study of health disparities among Hispanics in McLean County Illinois where the Hispanic population has significantly increased in recent years in a predominately white community. Lastly, I explore innovated strategies to eliminate health disparities and strive for health equity. I conclude that (1) health care is fundamentally a ethical issue and a matter of basic human rights, (2) health disparities can be viewed as an act of structural violence and exist on various structural levels, including the community level, and (3) health disparities can be reduced and eventually eliminated by advancing policies, programs or practices that address factors that impact health.

Farmer

Sumaya Cv. xx, xx-xx-xxxx, "Structural Violence and Clinical Medicine," PubMed Central (PMC), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1621099///ZS

Pioneers of modern public health during the nineteenth century, such as Rudolph Virchow, understood that **epidemic disease and dismal life expectancies were tightly linked to social conditions** [55,56]. Such leaders might not have employed the term "**structural violence,"** but they were well aware of its toll and argued compellingly for

proximal interventions: education, basic sanitation, land reform, sovereignty, and an end to political oppression. These interventions are no less needed now that we have **better distal tools, including vaccines, diagnostics, and a large armamentarium of effective therapeutics**. It does not matter what we call it: structural violence remains a high-ranking cause of premature death and disability. We can begin to address this by "resocializing" our understanding of disease distribution and outcome. Even new diseases such as AIDS have quickly become diseases of the poor, and **the development of effective therapies may have a perverse effect if we are unable to use them where they are needed most. By insisting that our services be delivered equitably, even physicians who work on the distal interventions characteristic of clinical medicine have much to contribute to reducing the toll of structural violence.** The poor are the natural constituents of public health, and physicians, as Virchow argued, are the natural attorneys of the poor. In this struggle**, equity in healthcare is our responsibility.** Only when we link our efforts to those of others committed to initiating virtuous social cycles can we expect a future in which medicine attains its noblest goals.

Mcelwee 16 of Salon contextualizes that local governments make policies on housing, education, and crime

Commented [2]: https://www.salon.com/2016/08/27/they-have-the-money-and-the-political-power-wealthy-whites-are-more-represented-than-people-of-color-at-every-level-of-government/?fbclid=IwAR1y3Oz0YnygHmvodT_UZdRzMM0WApeWd15QRzaNtbQ_aANzRVW2nwMIgjY

McGreal '17 of the Guardian finds that the pharmaceutical industry spent $125 million on lobbying in 2016 alone, with twice as many lobbyists as members of Congress. However, **Stephanopoulos 15 of the Atlantic** reassures that while political activity doesn't help vulnerable communities, politicians listen to money. Thus, **Graham 16 of NPR** concludes that economic power is a prerequisite to political power. Lessening expenses means more money. **Rhodes 16 of UMass** furthers that in local government, wealth catalyzes favorable policies.

This is crucial, as **Livingstone 08 of the Overseas Development Institute** impacts that local governance has a unique insight and ability to affect regional economies, making it critical to poverty reduction.

1. **Kappeler 95 of Al-Akhawayn University** proclaims that debate is a starting point for future action and is key to disrupting structural violence through discourse to improve the political future. Thus, affirming is a key starting point for future action.
2. **Kappeler** continues that structural violence happens every day. As a result, we outweigh on probability, as focusing on the magnitude of violence fails to account for the means of violent action. We can't compare the size of violent action, as it creates the pretext to postpone and even ignore personal, structural forms of violence that are actually happening every single day. The neg's focus on a silver bullet to save lives is what allows us to remain complicit in the everyday violent action that is occurring even as we speak.
3. **Cuomo 96 of the University of Cincinnati** elaborates that without prioritizing structural violence, error replication and movement burnout become inevitable because we just focus on the harms that keep appearing instead of on what causes them to happen. This outweighs on magnitude and timeframe because it controls the internal link to all future policy benefits.
4. **Petro 74 of Wake Forest University** explains that any invasion of someone's liberties must be emphatically resisted with undying spirit because without doing so, you let chaos and tyranny run rampant without consequence. Thus, you should affirm to rectify unjust preventable health disparities.
5. **Nixon 11 of the University of Wisconsin-Madison** finds that social bias underrepresents the effects of structural inequity. When society under-represents an impact based on it happening to a group deemed "less relevant", we outweigh on magnitude and timeframe because it becomes structural and gets exponentially larger with each generation of people added to those who suffer from it.
6. **Scheper-Hughes 04 of UC Berkeley** reveals that structural violence causes dehumanization. Dehumanization is an impact beyond calculation and outweighs war, plague, famine, and any environmental disaster. Remaining complicit in dehumanization

Commented [3]: https://www.theatlantic.com/politics/archive/2015/06/black-political-representation-power/395594/?fbclid=IwAR1y3Oz0YnygHmvodT_UZdRzMM0WApeWd15QRzaNtbQ_aANzRVW2nwMIgjY

Commented [4]: http://www.michiganradio.org/post/black-political-power-grows-prosperity-remains-elusive?fbclid=IwAR00bjPR4qChh0NjncUT3UBVP-9KfXaVmNPCkvFnQpqmVDjX1WvgL3NfpYg

Commented [5]: http://people.umass.edu/schaffne/schaffner_rhodes_laraja_apsa_2016.pdf?fbclid=IwAR1d6DLg_AW869MxrvtZqTwQFkTmcIgEYFrczkJMPGMn2DFGO5sJjzCxILw

Commented [6]: https://www.odi.org/events/282-innovations-poverty-reduction-role-local-government

allows any and every atrocity to be justified, which is why our contention is a reason to affirm because acts of dehumanization must be vehemently opposed.