Committee: World Health Organization

Issue: Assessing the issue of universal and affordable healthcare

Student Officer: Baran Mohammadi

Position: Deputy President

PERSONAL INTRODUCTION

My name is Baran Mohammadi, I am a Year 11 IGCSE student in Byron College – The British International School, and I am very excited to be serving as a Student Officer in the 4th ACGMUN. This will be my third time chairing and I chose the WHO as I am very interested in medicine; it is something I aspire to pursue professionally. In my free time, I enjoy drawing, reading and kickboxing. This quarantine has been hard on everyone, but I believe that it has been a learning curve all the same, as it does tie in with the conference's main theme, Global Unity. In order to save people's lives and livelihoods, we all must unite and contribute to our community in any way that we can, as the quarantine poses many social, medical and financial problems for billions around the world; one being the lack of accessibility of healthcare, especially in poverty-stricken regions. Nonetheless, it is upsetting that we were not able to meet face-to-face, however I believe that this online conference will lift our spirits in this sorrowful period of time.

TOPIC INTRODUCTION

There has been a debate for many years questioning whether healthcare is a privilege or a right, yet the answer has become vital following the COVID-19 pandemic, which has claimed the lives of 1.95 million people. According to article 25 of the United Nations Declaration of Human Rights, medical care and necessary social services are human rights, yet universal health coverage is not present in many countries to this day, i.e. the United States of America, a country which was greatly impacted by the COVID-19 pandemic, partly due to the instability of their healthcare system. Nevertheless, healthcare is a service that needs to provide for everyone, regardless of social and economic status.

The goal of universal health coverage is to guarantee that all members of the population have access to the following healthcare services: primary, preventive, curative, rehabilitative, and palliative care; that are of suited quality and do not put a financial strain on any members of the population and their communities. Countries which have implemented full universal healthcare coverage include Canada, Thailand, Costa Rica and Cuba.

However, there are some flaws in universal healthcare systems that must be addressed. For example, healthcare costs may overwhelm government budgets, which can cause a deficit especially in countries suffering from financial crises or countries involved in conflict. Furthermore, doctors and nurses may be underpaid, thus lowering the quality of healthcare services. Lastly, it is the healthiest people that pay for the sickest. In order for healthcare systems to be fully reliable, these barriers must be overcome.

DEFINITION OF KEY TERMS

Healthcare

Healthcare is the protection or restoration of health of individuals by the prevention, diagnosis, therapy, rehabilitation, or remedy of sickness, injury, disability, and other physical and mental conditions. Healthcare is rendered by health practitioners and associated areas of health.

Universal Healthcare Coverage (UHC)

Having affordable health coverage available to everyone, meaning that individuals are not pushed by healthcare prices into poverty.

Private Health Insurance

Instead of a state or federal government, health care coverage is issued by a private company. Both insurance brokers and corporations fall under this grouping.

Types of healthcare:

- **Promotive:** The goal is to engage and inspire people and communities to lead healthier lifestyles and to make improvements that decrease the risk of acquiring chronic diseases and other morbidities. It encourages people to develop influence over their own health.
- **Preventive:** health care that prevents disease, injury, or illness, rather than treating a condition that has already become catastrophic or acute. The goal of preventive care is to help people stay healthy[1].
- **Curative:** corresponds to health care procedures that treat patients, not only reducing their suffering or discomfort, with the intention of healing them.
- **Rehabilitative:** Special healthcare services that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost

[1] Amadeo, Kimberly. "Preventive Care: How It Lowers Healthcare Costs in America." The Balance, 29 Nov. 2020, www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074.

or impaired as a result of disease, injury, or treatment. Rehabilitation services help people return to daily life and live in a normal or near-normal way[2].

- **Palliative:** Advanced medical treatment for patients dealing with a chronic condition. This method of treatment is based on offering relief from the disease's symptoms and stress. The aim is to increase the quality of life for both the patient and the family[3].

Primary Health Care (PHC)

Beyond the conventional health care system, PHC is an alternative to health that relies on health equity-producing policy making. It refers to "essential health care" based on procedures and technologies that are technically sound and socially appropriate. It makes universal health coverage affordable in a society for both residents and families. PHC programs facilitate the full engagement of members of the society in implementation and decision-making. All aspects that play a role in wellbeing, such as access to health care, the environment, education and lifestyle, are protected by PHC. Main interventions in the area of health care and public health, taken together, should also be called the fundamental precepts of universal health systems.

Sin taxes

A sin is imposed at the time of payment of particular goods and services. Because of their potential, or belief, to be dangerous to society, these items obtain excise tax. Tobacco goods, alcoholic beverages, and gambling ventures are all applicable items. Sin taxes aim to inhibit individuals from engaging in socially destructive habits and attitudes, but they also provide a means of income for governments[4].

Accessibility

- **Physical:** Good health facilities that are available within fair reach of those that require them, as well as opening hours, appointment schedules and other facets of clinical organization and delivery that help patients to access services when they need them.
- **Economic:** This is an indicator of the ability of persons to pay for care without financial distress. Not only the expense of health care, but also secondary and incentive expenses are taken into account.

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[2] "NCI Dictionary of Cancer Terms." National Cancer Institute, www.cancer.gov/publications/dictionaries/cancer-terms/def/rehabilitation-services.

[3] "What Is Palliative Care?: Definition of Palliative Care." Get Palliative Care, getpalliativecare.org/whatis/.

[4] Kagan, Julia. "Sin Tax Definition." Investopedia, Investopedia, 16 Sept. 2020, www.investopedia.com/terms/s/sin_tax.asp.

- **Information:** The right to discover, obtain and impart knowledge and insights related to health problems.

BACKGROUND INFORMATION

The agenda of universal health care is an umbrella for 3 categories: national healthcare systems, research and development, and pharmaceutical accessibility. The 2030 Agenda for Sustainable Development Sustainable Development Goal 3.8 aims to achieve "universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"[5]. Goal 3.b vows to "support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all"[6].

The types of issues that these 3 categories face which hinder the accessibility of healthcare are mostly either limitations to active policies, expensive cost of research, market corruption, especially in the pharmaceutical industry, and employment issues. The issue of corruption also exists in private health insurance schemes, and also needs to be addressed. Good governance should ensure public accessibility to medicines and provide and reinforce sound institutional frameworks, schemes and policies which promote and advocate public welfare.

National healthcare systems

The heart of national healthcare lies in its practitioners; hospitals, clinics, and therapy centers are all relevant in this case. A primary issue that lies here is employment and the treatment of healthcare workers. A Medscape survey taken in 2012 by 24,000 health practitioners representing 25 specialties showed that 45% of workers regret their career choice, and 59% regret their choice of specialty. After the COVID-19 pandemic, these numbers have drastically dropped, as 60% of nurses and 20% of physicians are planning to/have already quit their jobs as healthcare workers,

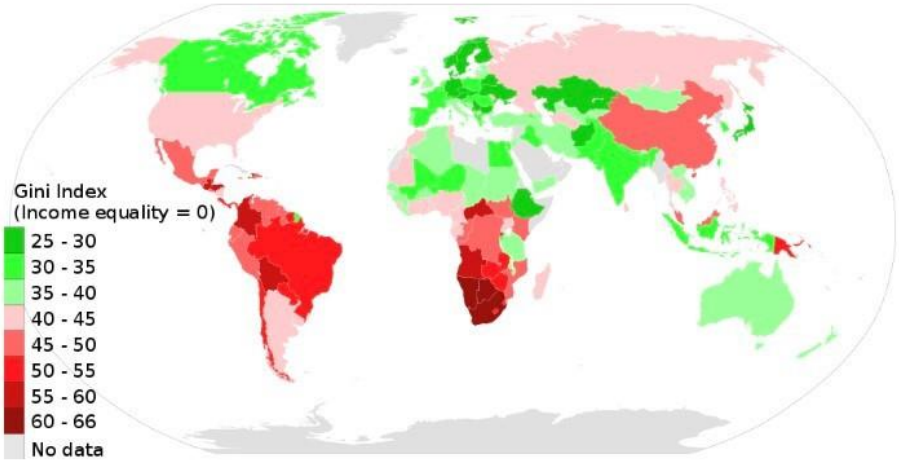
[5] "Goal 3 | Department of Economic and Social Affairs." United Nations, United Nations, sdgs.un.org/goals/goal3.
[6] "Goal 3 | Department of Economic and Social Affairs." United Nations, United Nations, sdgs.un.org/goals/goal3.

predicted to cause an average of $5 million turnover rate – per hospital. The main issues concerning employment in healthcare which hinder accessibility include:

- Staff shortages: this issue is prevalent mainly in countries which are densely populated, war-torn, or LEDC's. Medical professionals mainly choose to live in places which have better living conditions, thus not found often in countries which lack the adequate standards of living. In many places, the staff are just outnumbered by patients.
- Lack of advancement opportunities: staff do not have the opportunity to be promoted in their careers, mainly due to the poor organizational cultures of such healthcare systems.
- Low salary (especially nurses): in many countries, doctors and nurses, particularly those working in the emergency care sector, are underpaid considering the intensity of their line of work.
- Overload of work due to insufficient resources: this was something that played a huge role in the handling and spread of COVID-19. Hospitals lacked many essential resources such as masks, gloves, equipment for disinfection and anesthesia, surgical equipment and even hospital beds.
- Outdated systems: despite going through major changes throughout the years, many governments still have not adapted their healthcare programs to their populations. Moreover, they have not updated hospital equipment to obtain the newest technologies, hindering the effectiveness and ease of their work.
- Unreasonable work hours: many people in the healthcare sector work as long as 12 hour shifts, which causes burnout and deteriorates the quality of their work.

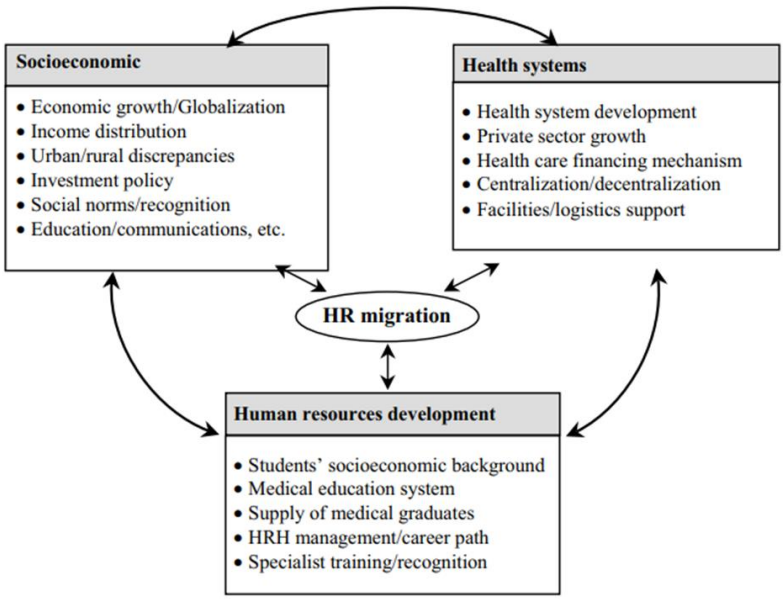
Maldistribution of staff

Another issue with national healthcare is the maldistribution of human healthcare resources, which can be found in many forms. The first and greatest concern is the inequitable distribution of healthcare professionals globally. The pattern seems to follow that of the Gini Coefficient (see below), in which there is a higher concentration of healthcare workers in developed countries and cities, which is expected as the living standards are better, the income is higher and there is more social recognition, but nevertheless harmful to about 700 million people, 10% of the world population, which live in extreme poverty, earning less than $1.90 a day.



Countries' income inequality (2014) according to their Gini coefficients measured in percent: red = higher than average, green = lower than average inequality.

Another form of maldistribution is in skill mix, the number of different health practitioners who have different specialties. For example, the doctors vastly outnumber the nurses in countries such as Bangladesh, China, Brazil and Pakistan. Other forms include maldistribution in overspecialization, and institutional and gender maldistribution.



Source: Adapted from Wibulpolprasert S., 1997 [2]

Advantages and Disadvantages of Universal Health Coverage

Advantages	Disadvantages
Lovers the overall healthcare costs, as the government controls costs through regulation and mediation.	The healthiest people pay for the sickest. 90% of healthcare costs are made up by chronic diseases. The sickest 5% of the population create 50% of total health care costs, while the healthiest 50% only create 3% of costs[7].
Lowers administrative costs as doctors do not deal with multiple insurance companies, but one government agency. Doctors in the USA (No UHC) spend 4 times the amount that doctors in Canada (with UHC) spend on such costs.	As there are no out-of-pocket payments, people may have less financial incentive to stay healthy, and may misuse or overuse emergency rooms, burdening healthcare workers.
All hospitals, regardless of the social status of the area, provide the same quality of service to all its citizens, as the opportunity of competing for wealth is taken away.	The wait-times for elective procedures may be longer as governments are fixated on providing basic and emergency care.
By enforcing preventive care, the cost of emergency room usage is reduced, and thus the workload of healthcare workers are also reduces, creating a stronger workforce.	If healthcare workers remain underpaid, then the quality of care may be reduced to cut costs and increase salaries.
Health education is a big part of UHC, and it mentors families on leading healthier lifestyle to prevent chronic diseases such as diabetes. It also aids in the prevention of crime, welfare, and dependency.	Provincial budgets are overwhelmed. For example, Canadian provinces spend around 40% of their budgets on healthcare costs.
Sin taxes and other regulations can be imposed by the	Certain services with a low likelihood of effectiveness can

[7] Medical Expenditure Panel Survey. "The Concentration of Health Care Expenditures and Related Expenses for Costly Medical Conditions", 2012, https://meps.ahrq.gov/data_files/publications/st455/stat455.pdf

government to guide their citizens towards making healthier lifestyle choices.	be restricted by the government. This entails medications and costly end-of-life treatment for rare conditions. For the last six years of life, coverage for patients in the USA covers a quarter of the Medicare budget.

Everybody, including healthy individuals, must pay premiums or extra taxes to provide for health coverage in order for universal health care to operate successfully. For all people, this finances the security health blanket. Ideally, everyone will have access to affordable treatments at low prices in a healthcare system under federal oversight. Such a framework will provide preventive care that is very accessible and tightly regulate the costs and quality of medicines and medical facilities.

Corruption in the pharmaceutical industry

An estimated 2 billion people do not have access to medicines; universal health coverage relies on the appropriate provision of quality-assured, sustainable health technology – including medicines. Corruption is the main obstruction to the wide accessibility of medicines. Despite the advancements in medicine over recent years, there are still approximately 6.1 million people dying of treatable diseases, most of which are in tropical LEDC's. UHC cannot be achieved if the status quo does not change; the WHO predicts that 90% of low income and low-middle income families purchase medicines through out-of-pocket payments, and these payments are the ones which can cause families to fall under the poverty line, burying them in the cycle of intergenerational poverty.

Accessibility is hampered by many factors: malfunctions in local health systems delaying delivery of medicines, unjust prices of these medicines, barriers created by tax and tariff policies, trafficking and misuse, ineffective counter-measures for diseases in LEDC's and the prioritization of commercial interests over health interests; the latter is what leads to market corruption. Nonetheless, if prices reduce to the point in which they preclude profits, companies will drop out of the market, leaving gaps in the availability of products; such occurred with anti-snakebite venom medications.

Furthermore, counterfeit drugs are a serious threat to accessibility of quality medicines, as not only do they not contain the appropriate quantities of active ingredients, but also may contain hazardous substances causing dangerous health consequences. An obstruction to combatting counterfeit medicines is that it is very difficult to detect, trace and stop their production. Nevertheless, in 2003 the WHO

estimated that the global profit made off of the distribution of counterfeit drugs was $32 billion.

MAJOR COUNTRIES AND ORGANISATIONS INVOLVED

UHC 2030

UHC 2030 is an NGO whose mission is "to create a movement for accelerating equitable and sustainable progress towards universal health coverage". They work in alignment with SDG 3, good health and health coverage, and it provides various stakeholders with a global forum and space to interact, collaborate together, and impact national and international commitments. These are their four main objectives:

- Improve coordination of HSS efforts for UHC at global level, including synergies with related technical networks.
- Strengthen multi-stakeholder policy dialogue and coordination of HSS efforts in countries, including adherence to IHP+ principles and behaviors in countries receiving external assistance.
- Facilitate accountability for progress towards HSS and UHC that contributes to a more integrated approach to accountability for SDG3.
- Build political momentum around a shared global vision of HSS for UHC and advocate for sufficient, appropriate and well-coordinated resource allocation to HSS[8].

Canada

Canada is one of the pioneers for the single-payer model UHC plan. The system is government funded for the most part, although most of the services are rendered by private entities or private corporations, whereas the majority of hospitals are public. Many practitioners do not receive an annual salary, but per appointment or operation, they receive a fee. The private sector pays for about 29 percent of Canadians' health coverage. Private (supplemental) insurance pays for dental care, vision and prescription drugs.

China

Even though China is known to be the origin of the COVID-19 virus, it is also known to have handled and tackled the spread of the virus very successfully. Despite its large population of 1 billion people, there were only 90,000 cases and 4700 deaths confirmed in total (meaning as of December 2019 till present day) as of October 2020.

[8] "Our Mission." UHC2030, www.uhc2030.org/our-mission/.

Although, as rightfully stated by a professor at the Imperial College of London, Han Fu, "As each country has its own health system and epidemic curve, measures implemented in one country may not be easily replicated by another. Other factors such as coordination between government sectors and civil compliance with regulations may also affect the effectiveness of the response", China has done an excellent job in adapting to the situation and their healthcare workers have received praise from the executive director of the WHO Health Emergencies Programme, Michael Ryan.

Thailand

Thailand was one of the first low-middle income countries to introduce universal coverage back in 2001. A modern and more inclusive insurance program, formerly known as the 30 baht project, replaced means-tested health coverage for low-income households. People entering the program get a gold card that they use in their health district to access care and, if necessary, get referred elsewhere for specialist care. The majority of funding is from the taxes of the public. According to the WHO, 65% of Thailand's health care expenditure in 2004 came from the government, 35% was from private sources[9]. The system has proved successful in its affordability as even people under the poverty line living in rural areas are satisfied, saying their healthcare needs are met. In 2016, due to its prominent public health care system, Thailand became the first country in Asia to eradicate HIV transmission from mother to child.

United States of America

The USA's current healthcare system is private (opposite of UHC), although there are government schemes that aid in providing healthcare to people in poverty. The Affordable Care Act, a law reform act introduced in 2010 by President Barack Obama, provides families with an income less than 400% of the federal poverty level a subsidy that lowers costs for their households. However, under President Trump's administration, any features of the act were altered and its individual mandate was not enforced as highly, and USA was withdrawn from WHO. The US suffered one of the largest COVID-19 crises in the world, with 386,000 deaths thus far. Although the death rate has decreased, part of its failure to handle the COVID-19 crisis was due to the many flaws in its private healthcare system. 9% of the US population remain uninsured and not covered for healthcare, and the issues surrounding distribution took its toll on the American citizens who could not access healthcare. Lastly, the privatization of healthcare in the US costs 18% of their GDP, double the cost of healthcare in countries with UHC.

[9] "World Health Organization Statistical Information System: Core Health Indicators". Who.int

TIMELINE OF EVENTS

Date	Description of event
January 2001	Thailand: 30 baht universal coverage program
18th February, 2006	Declaration of Rome
23rd March, 2010	USA: Affordable Care Act
26th December, 2013	Ebola Outbreak
25th September, 2015	Establishment of the 2030 Agenda for Sustainable Development
14th September, 2016	Report by the UNSG HLP (United Nations Secretary General's High Level Panel)
22nd September, 2016	Establishment of UHC2030
8th December, 2019	COVID-19 outbreak
1st June, 2020	China's "Law on Promotion of Basic Medical and Health Care"

RELEVANT RESOLUTIONS, TREATIES AND EVENTS

A/RES/70/1: Transforming our world: the 2030 Agenda for Sustainable Development, 25th September, 2015: the establishment of the SDG's, one of them being universal access to medicines.
A/RES/67/81: Global health and foreign policy, 12th December, 2012: a GA resolution exploring ways to enforce universal health coverage in each Member State.
Declaration of Rome, 2006: Conclusions and recommendations of the WHO International Conference on Combating Counterfeit Medicines.

PREVIOUS ATTEMPTS TO SOLVE THE ISSUE

USA Affordable Care Act

For those who apply, the ACA was intended to reduce the expense of health care coverage. In order to further reduce costs for lower-income persons and households, the legislation involves premium tax credits and cost-sharing reductions. On March 3, 2016, the Department of Health and Human Services (HHS) declared that, based on the open enrollment figures from November and December 2015, 20 million persons obtained health care benefits for 2016 as a result of the ACA. This represents around 12.7 million persons who signed up for the federal or state-sponsored health care markets for coverage. However, the initiative misses the mark of its original

targets. In 2010, it was stated that 47 million people were uninsured, and by 2019, this number would be reduced to 15 million, yet in 2019, there were 27.5 million uninsured people, so more than double of the desired goal. The USID (United States Insurance Department) put HealthyCT, a cooperative participating in the state pf Connecticut's health insurance exchange, under surveillance on July 5, 2016, and told its 40,000 policyholders that they would seek replacement plans no later than the end of the year. This marks the 14th collapse of the initial 23 operating cooperatives formed under the ACA, and many others are still on rocky ground.

Ebola outbreak

In December 2013, the initial case was registered. It is suspected that an 18-month-old boy residing in a small village in a rural area of Guinea was bitten by bats. After 5 new cases of deadly diarrhea in that area occurred, an official medical warning was given to district health officials on January 24, 2014. The Ebola virus quickly spread to the Guinean capital of Conakry, and a warning for an unexplained epidemic was released by the Ministry of Health in Guinea on March 13, 2014. The Pasteur Institute in France reported the disease shortly afterward as an EVD caused by the Zaire ebolavirus. With 49 confirmed cases and 29 deaths, the WHO formally announced an outbreak of EVD on March 23, 2014.

Bad monitoring networks and weak public health facilities therefore led to the difficulties of controlling the epidemic, spreading steadily to the neighboring countries of Guinea, Liberia and Sierra Leone. The epidemic spread to the capitals of all three countries in July 2014. This was the first time that EVD had spread to heavily populated urban centers from more remote, rural areas, creating an unparalleled potential for transmission.

On 8 August 2014, the WHO proclaimed a Public Health Emergency of International Significance (PHEIC) for the worsening situation in West Africa, designated only for incidents at risk of future international dissemination or needing a comprehensive international response.

The participation of civic officials in awareness campaigns and communication, along with diligent national and global policy enforcement, ultimately helped to control the transmission of the virus and bring an end to this epidemic, with Guinea being finally declared as Ebola-free in 2016. In 2019, a vaccine for Ebola was approved by the US Food and Drug Administration (FDA).

POSSIBLE SOLUTIONS

Chronic illnesses that are either preventable or likely to be manageable with daily access to health services cause four out of the five leading causes of death (cancer, heart disease, strokes, and lower respiratory diseases). These chronic conditions are costly to treat, well before they even hit the stage of urgent care. 90 percent of the $3.5 trillion of annual health care costs in the United States are for persons with chronic and mental health problems. When patients have frequent access to affordable preventive medical services, the discovery and treatment of their chronic illnesses is more efficient. This decreases the probability of visits to emergency departments as well as potentially costly procedures for illnesses that have spread before standard management. As these reduce, the total healthcare rates for everyone decrease since hospitals don't try to compensate the expense of treating patients who are not covered.

Sin taxes discourage practices that have socially adverse implications. They increase the expense of the activity such that fewer people do it and the revenue allows states to pay for the effects of the increased loss to the general good. For example, when a $0.62 sin tax was added on cigarettes, teenage smoking rates dropped by 10%. However, there must be some criteria when assigning sin taxes. Firstly, a group of professionals should decide on what products these taxes are actually applied to, and secondly, the price decided upon should be one high enough to prove effective, yet low enough to inhibit black market behavior.

Thirdly, government institutions of national health insurance authority and medicines regulation authority must be established in order to target corruption and maintain a centralized system, as decentralization blocks the pathway for affordable care. All Essential Medicines Lists must be updated, and research and development programs should launch with the goal of finding affordable medicines, especially for LEDC's / war-torn countries. Medicines should be tested in an ethical manner.

Lastly, the problem of misdistribution must be addressed. This is a problem which will be solved on the long term, either in a decade or a generation. This is because there are many factors influencing distribution: training institutions and universities, health and educational ministries, civil service, professional associations, and many more. Furthermore, opportunities must be created in areas with a lower density of healthcare practitioners, and the work conditions must remain satisfactory in order for them to perform their jobs at a high quality. Investments must be sustained and political gain should be put aside. Licensing requirements should be reviewed to further ensure high quality healthcare, thus educational systems must also be of great standard. As part of an equal, efficient system, the national healthcare system must build a variety of employment opportunities in remote and rural communities.

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