STUDY GUIDE

WHO

IașiMUN 2019

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Welcoming Letter

Distinguished delegates,

We are delighted to welcome you to IasiMUN 2019! It is our greatest pleasure to chair what is surely going to be a lively committee. As your chairpersons, we intend to turn the committee room into the the ideal environment for you to have a pleasant time and to grow academically. Seen that there are plenty first timers we are more than honored to be the ones guiding you through your first MUN and encouraging you to unlock your potential abilities.

But while IasiMUN prides itself on having a well trained board of Chairs and Secretariat, superior resources, and support for delegates before and during each conference, the quality of the debates is largely contingent on the preparation of the delegates. The key to being successful in the WHO Committee is thorough and comprehensive preparation. Thus, we recommend that all delegates become familiar with all aspects of the the topics.

The present document exists merely to guide you through the proposed issues and outline the key points. However, in order to be an eligible candidate for the position of Best Delegate, we strongly urge you to conduct your own more detailed research according to your country's policies. Keep in mind that you will be required to write a position paper, which will reflect the depth of your research and therefore lead us to our first impressions.

With that in mind, you are advised to combine your knowledge and critical thinking skills so as to come up with original yet viable solutions and contribute to a remarkable and high quality committee session.

Should any questions arise regarding the topic or the conference, please do not hesitate to contact us. Feel free to reach us on all social media accounts, we would be glad to address any of your concerns.

On a final note, we thank you all for your commitment and we wish you a most stimulating conference!

Your Chairpersons,

Ioana Celmare

Andrei Alexinschi

Ioana Tamaciuc

Introduction to the Committee

The **World Health Organization** (**WHO**) was established on April 7th, 1948 as specialized agency of the United Nations. Its headquarters is located in Geneva, Switzerland but operates in fully in 150 countries. The WHO acts as an advisor on matters of public health as well as a research facility that collaborates with other UN related agencies, NGOs such as MSF (Doctors without borders), and prestigious medical research facilities

The WHO's Constitution states that its objective "is the attainment by all people of the highest possible level of health". WHO officials periodically review and update the organization's leadership priorities. Over the period 2014–2019, WHO's leadership priorities are aimed at:

- Assisting countries that seek progress toward universal health coverage
- Helping countries establish their capacity to adhere to International Health Regulations
- Increasing access to essential and high-quality medical products
- Addressing the role of social, economic, and environmental factors in public health
- Coordinating responses to noncommunicable disease
- Promoting public health and well-being in keeping with the Sustainable Development Goals, set forth by the UN.

Recently, the WHO has been shifting some of their attention towards mental health issues. The World Health Organization is currently compiling detailed reports and studies on mental health issues and disorders more than ever before.

Despite instinctive beliefs, one does not need an MD or a doctorate degree to be successful within the WHO Committee. Being knowledgeable about your country's healthcare system and having educated ideas regarding implementing viable solutions can prove to be pivotal. Considering the budget of most developing nations, striking a balance between effectiveness and cost efficiency will be useful when you write your resolution. Good luck Delegate!

Topic A: Depression

1. Overview of the Topic

Depression is a common illness worldwide, with more than 300 million people affected. Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. Especially when long-lasting and with moderate or severe intensity, depression may become a serious health condition. It can cause the affected person to suffer greatly and function poorly at work, at school and in the family. At its worst, depression can lead to suicide. Close to 800 000 people die due to suicide every year. Suicide is the second leading cause of death in 15-29-year-olds.

It is a part of normal experience to feel unhappy during times of adversity. The symptom of depressed mood, however, is a component of many psychiatric syndromes, and is also commonly found in certain physical diseases such as viral hepatitis and some neurological disorders. In order to diagnose someone with depression, we need to understand that we are not fighting against normal feeling of unhappiness nor depressed moods as *symptoms* other disorders but with the syndromes known as *depressive disorders*.

The central features of these syndromes are:

· Depressed mood

· Negative thinking

· Lack of enjoyment

· Slowness

Epidemiology

· **Incidence and prevalence.** Mood disorders are common. In the most recent surveys, major depressive disorder has the highest lifetime prevalence (almost 17%) of any psychiatric disorder. The annual incidence (number of new cases) of a major depressive episode is 1.59% (women, 1.89%; men, 1.10%). The annual incidence of bipolar illness is less than 1%, but it is difficult to estimate because milder forms of bipolar disorder are often missed.

· **Sex.** Major depression is more common in women; bipolar I disorder is equal in women and men. Manic episodes are more common in women, and depressive episodes are more common in men.

· **Sociocultural.** Depressive disorders are more common among single and divorced persons compared to married persons. No correlation with socioeconomic status. No difference between races or religious groups.

Etiology

A. Biggest neurotransmitters

Serotonin. Serotonin has become the biogenic amine neurotransmitter most commonly associated with depression. Serotonin depletion occurs in depression; thus, serotonergic agents are effective treatments. The identification of multiple serotonin receptor subtypes may lead to even more specific treatments for depression. Some patients with suicidal impulses have low cerebrospinal fluid (CSF) concentrations of serotonin metabolites and low concentrations of serotonin uptake sites on platelets.

Dopamine. Dopamine activity may be reduced in depression and increased in mania. Drugs that reduce dopamine concentrations and diseases that reduce dopamine concentrations (e.g., Parkinson's disease) are associated with depressive symptoms. Drugs that increase dopamine concentrations, such as tyrosine and amphetamine, reduce the symptoms of depression. Two recent theories about dopamine and depression are that the mesolimbic dopamine pathway may be dysfunctional in depression and that the dopamine D_1 receptor may be hypoactive in depression.

B. Psychosocial

Psychoanalytic. Freud described internalized ambivalence toward a love object (person), which can produce a pathologic form of mourning if the object is lost or perceived as lost. This mourning takes the form of severe depression with feelings of guilt, worthlessness, and suicidal ideation. Symbolic or real loss of love object is perceived as rejection. Mania and elation are viewed as defense against underlying depression. Rigid superego serves to punish person with feelings of guilt about unconscious sexual or aggressive impulses.

Psychodynamics. In depression, introjection of ambivalently viewed lost objects leads to an inner sense of conflict, guilt, rage, pain, and loathing; a pathologic mourning becomes depression as ambivalent feelings meant for the introjected object are directed at the self. In mania, feelings of inadequacy and worthlessness are converted by means of denial, reaction formation, and projection to grandiose delusions.

Cognitive. Cognitive triad of Aaron Beck:
i. negative self-view ("things are bad because I'm bad");
ii. negative interpretation of experience ("everything has always been bad");

iii. negative view of future (anticipation of failure).

Learned helplessness. A theory that attributes depression to a person's inability to control events. Theory is derived from observed behavior of animals experimentally given unexpected random shocks from which they cannot escape.

Stressful life events. Often precede first episodes of mood disorders. Such events may cause permanent neuronal changes that predispose a person to subsequent episodes of a mood disorder. Losing a parent before age 11 is the life event most associated with later development of depression.

2. Key Terms

DSM- The Diagnostic and Statistical Manual of Mental Disorders (DSM) (latest edition, the DSM-5, published in 2013) is a publication for the classification of mental disorders using a common language and standard criteria. It is used by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, and policy makers. It is published by the American Psychiatric Association (APA).

Dopamine- Dopamine is known as the feel-good neurotransmitter—a chemical that ferries information between neurons. The brain releases it when we are very happy, such as when we eat food that we crave contributing to feelings of pleasure and satisfaction as part of the reward system. This important neurochemical boosts our mood, motivation, and attention, and helps regulate movement, learning, and emotional responses.

Serotonin- Serotonin is a neurotransmitter that does several jobs within the human body. It is believed to regulate mood, intestinal activity and appetite, memory, and sleep. Many antidepressant medications are thought to work by increasing the levels of serotonin in the body. Some non-medical treatments for depression have also been shown to raise serotonin levels.

Syndrome- A syndrome is a set of medical signs and symptoms and collection of diseases which are not correlated with each other and often associated with a particular disease or disorder.

Ambivalence- Ambivalence is a state of having simultaneous conflicting reactions, beliefs, or feelings towards some object. Stated another way, ambivalence is the experience of having an attitude towards someone or something that contains both

positively and negatively valenced components. The term also refers to situations where "mixed feelings" of a more general sort are experienced, or where a person experiences uncertainty or indecisiveness.

3. Historical Background

The Ancient Greek physician Hippocrates described a syndrome of melancholia as a distinct disease with particular mental and physical symptoms; he characterized all "fears and despondencies, if they last a long time" as being symptomatic of the ailment. It was a similar but far broader concept than today's depression; prominence was given to a clustering of the symptoms of sadness, dejection, and despondency, and often fear, anger, delusions and obsessions were included.

Although melancholia remained the dominant diagnostic term, depression gained increasing currency in medical treatises and was a synonym by the end of the century; German psychiatrist Emil Kraepelin may have been the first to use it as the overarching term, referring to different kinds of melancholia as depressive states.

Adolf Meyer put forward a mixed social and biological framework emphasizing reactions in the context of an individual's life, and argued that the term depression should be used instead of melancholia. The first version of the DSM contained depressive reaction and the depressive neurosis, defined as an excessive reaction to internal conflict or an identifiable event.

In the mid-20th century, researchers theorized that depression was caused by a chemical imbalance in neurotransmitters in the brain, a theory based on observations made in the 1950s of the effects of reserpine and isoniazid in altering monoamine neurotransmitter levels and affecting depressive symptoms. The chemical imbalance theory has never been proven.

The term Major Depressive Disorder (MDD or as we know it, depression) was introduced by a group of US clinicians in the mid-1970s as part of proposals for diagnostic criteria based on patterns of symptoms (called the "Research Diagnostic Criteria")

4. Current Situation and Issues

In 2014, 45 percent of the world's population lived in a country where there was less than one psychiatrist to serve 100,000 people," according to WHO.

Depression is one of the priority conditions covered by WHO's mental health Gap Action Programme (mhGAP). The Programme aims to help countries increase services for people with mental, neurological and substance use disorders, through care provided by health workers who are not specialists in mental health. WHO, among other agencies, has developed brief psychological intervention manuals for depression that may be delivered by lay workers. An example is, Problem Management Plus, which describes the use of behavioural activation, relaxation training, problem solving treatment and strengthening social support. Moreover, the manual Group Interpersonal Therapy (IPT) for Depression describes group treatment of depression. Finally, Thinking Healthy covers the use of cognitive-behavioural therapy for perinatal depression.

5. Position of Major Actors

According to WHO, the most depressed populations are in:

India

A study reported in WHO, conducted for the NCMH (National Care Of Medical Health), states that at least 6.5 per cent of the Indian population suffers from some form of the serious mental disorder, with no discernible rural-urban differences. Though there are effective measures and treatments, there is an extreme shortage of mental health workers like psychologists, psychiatrists, and doctors. As reported latest in 2014, it was as low as "one in 100,000 people".

The average suicide rate in India is 10.9 for every lakh people and the majority of people who commit suicide are below 44 years of age.

China

The WHO estimates that 91.8 per cent of all Chinese people with a mental disorder such as depression will never seek help for their condition. China is another large country with a huge number of depression and anxiety patients. The situation is quite similar to India's. The country only spends 2.35 per cent of their budget on mental health.

United States

About one in five adults in the U.S. experiences some form of mental illness each year, according to the National Alliance on Mental Illness, but only 41 per cent of those affected received mental health care or services in the past year. There is again a shortage of medical professionals. According to most people, they're just expected to get over it without spending a dime on treatment.

Brazil

Brazil has the most number of depressed individuals, in Latin America. Some important social factors especially present in this country such as violence, migration and homelessness probably contribute to a large number of people suffering from different forms of depressive and anxiety disorders.

Indonesia

In Indonesia, approximately 3.7 per cent of the population, or nine million people, suffer from depression. When those numbers are expanded to include anxiety, they increase to 6 per cent of the population over the age of 15.

Russia

According to the World Health Organisation, 5.5 per cent of its population has depression. As reported in 2012, the country's rate of teenage suicide was three times higher than the world average, which clearly depicts the serious issue of low mental health in Russia.

Pakistan

You'll be shocked to know that Pakistan has only 750 trained psychiatrists, as reported in 2012. The cases of mental illness usually go unreported due to high social stigma in the country, thus the exact number of patients suffering from depression can't be revealed.

6. Points to address

- How can we diminish social stigma towards depression and all other mental disorders?
- How can we stop the rapid increase of depression?

- What policies should the states adopt regarding people who are clinically depressed?

7. Further Reading

https://www.psychiatry.org/patients-families/depression/what-is-depression

https://www.who.int/news-room/detail/30-03-2017--depression-let-s-talk-says-who-as-depression-tops-list-of-causes-of-ill-health

https://www.who.int/mediacentre/news/notes/2012/mental_health_day_20121009/en/

https://www.who.int/en/news-room/fact-sheets/detail/depression

Topic B: Universal Health Coverage

1. Overview of the Topic

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

UHC enables everyone to access the services that address the most significant causes of disease and death, and ensures that the quality of those services is good enough to improve the health of the people who receive them.

Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children.

Achieving UHC is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015. Countries that progress towards UHC will make progress towards the other health-related targets, and towards the other goals. Good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.

Despite the fact that at least half of the world's population still do not have full coverage of essential health services, all UN Member States have agreed to try to achieve universal health coverage (UHC) by 2030, as part of the Sustainable Development Goals.

2. Key terms

Universal health coverage means all people receiving the health services they need, including health initiatives designed to promote better health (such as antitobacco policies), prevent illness (such as vaccinations), and to provide treatment, rehabilitation, and palliative care (such as end-of-life care) of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship.

Health service consist of medical professionals, organizations and ancillary health care workers who provide medical care to those in need within an area or country.

Full health coverage means you can receive whatever treatment you need that's offered by your healthcare provider. Generally, full coverage means you should be able to see a doctor for everything from regular check-ups to emergency situations.

Basic health coverage is a health insurance policy that provides only minimal coverage; it is usually restricted to limited preventive care and check-ups and some emergency services.

Primary health care (PHC) addresses the majority of a person's health needs throughout their lifetime. This includes physical, mental and social well-being and it is people-centred rather than disease-centred. PHC is a whole-of-society approach that includes health promotion, disease prevention, treatment, rehabilitation and palliative care.

Private healthcare sector is highly heterogeneous. It is defined as those individuals and organizations providing health services or products that are not owned or directly controlled by government. The private sector can be classified into the subcategories: for-profit and not-for-profit, formal and informal, domestic and foreign. The subcategories represent a wide spectrum of entities with very different attributes and purposes.

Health taxes are imposed on products that have a negative public health impact (e.g. taxes on tobacco, alcohol, sugar-sweetened beverages, fossil fuels) and result in healthier populations and generate revenues for the budget even in the presence of illicit trade/evasion.

Scandinavian healthcare system has a long heritage. It is especially well-established with regard to primary and preventive healthcare. These couple into sophisticated occupational health standards which are considered to be models by the outside world. All Nordic countries also have highly-developed hospital services. Nordic healthcare systems are taxation based, and locally administrated with every citizen having equal access to services. All countries, however, require co-payments by patients for hospital care and medicines.

Out-of-pocket (OOP) payment consists of direct payment made to health-care providers by individuals at the time of service use, i.e. excluding prepayment for health services –for example in the form of taxes or specific insurance premiums or contributions – and where possible, net of any reimbursements to the individual who made the payment.

NHS short for The National Health Service is the publicly funded national healthcare system in the United Kingdom. The organization, funded primarily by taxation, provides free or low-cost healthcare to all legal residents of the U.K. Medications are subsidized as well and prescriptions may be free when situations warrant. Specific policies vary among England, Scotland, Wales and Northern Ireland; It is the largest single-payer healthcare system in the world.

3. Historical Background

On 12 December 2012, the United Nations General Assembly endorsed a resolution on Global Health and Foreign Policy urging countries to accelerate progress toward universal health coverage (UHC) – the idea that everyone, everywhere should have access to quality, affordable health care - as an essential priority for international development then Member states also recognized that the importance of universal coverage in national health systems, especially through primary health-care and social protection mechanisms, to provide access to health services for all, in particular for the poorest segments of the population.

On 25 September 2015, the resolution on Transforming Our World: the 2030 Agenda for Sustainable Development adopted the target of universal health coverage by 2030, 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.

On 12 December 2017, the UN passed a third resolution on Global Health and Foreign Policy: addressing the health of the most vulnerable for an inclusive society, which called on Member States to promote and strengthen their dialogue with other stakeholders, including civil society, academia and the private sector, in order to maximize their engagement in and contribution to the implementation of health goals and targets through an intersectoral and multi stakeholder approach.

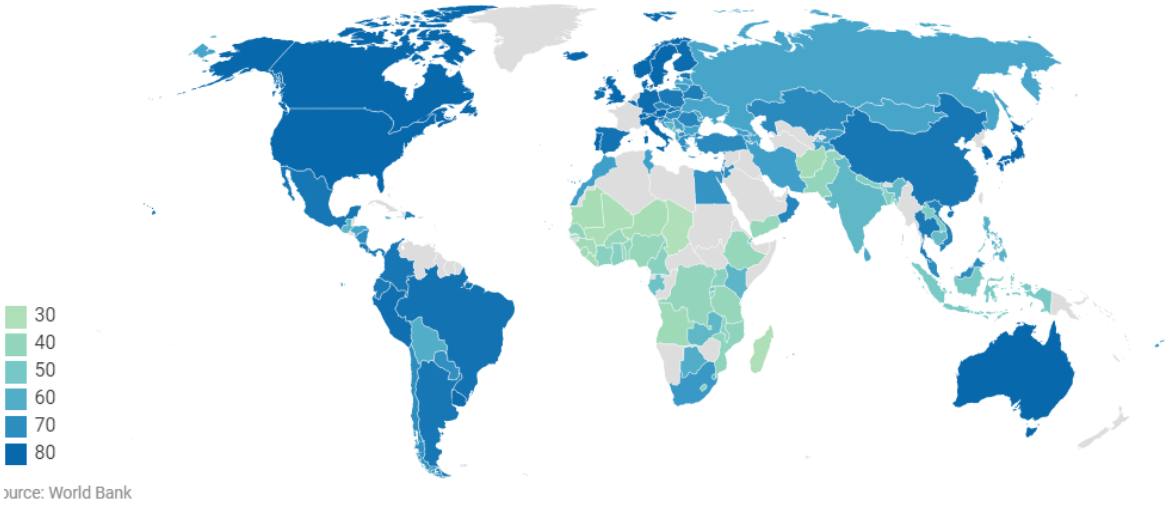
Since 2017, 12 December has been proclaimed by the UN as International Universal Health Coverage Day (UHC Day). UHC Day aims to raise awareness of the need for strong and resilient health systems and universal health coverage with multi-stakeholder partners. Each year on 12 December, UHC advocates raise their voices to share the stories of the millions of people still waiting for health, champion what we have achieved so far, call on leaders to make bigger and smarter investments in health, and encourage diverse groups to make commitments to help move the world closer to UHC by 2030. The theme for the 2018 UHC Day was: "Unite for Universal Health Coverage: Now is the Time for Collective Action."

4. Current Situation and Issues

Over the last several years the once-obscure idea of Universal Health Coverage (UHC) has blossomed into a movement embraced by leading authorities in global health. Both the World Bank and the World Health Organization have designated UHC as a core objective. Further, UHC is a leading candidate as one of the United Nation's post-2015 goals. One possible explanation for the appeal of this concept is its consistency with humanitarian views widely held by practitioners of public health, namely that

governments should assure as many services as equitably as possible for the greatest proportion of citizens. In keeping with this explanation, normative and ethical justifications have been invoked by leaders of opinions and institutions as motivation for the pursuit of UHC.

However, the ascendance of UHC on the global health agenda and the general acceptance of a broad definition have not been accompanied by a clarification of many conceptual and practical issues that are important for actually making progress toward UHC. Thus, far the discussion of how countries should pursue UHC has been conducted almost exclusively in technical terms, with particular emphasis on financing mechanisms. This includes user fees, which have been discussed critically and denounced by the World Bank's president as “unjust and unnecessary.” The centrality of financing suggests that many analysts see the difficulty of providing financial risk protection as the most important barrier to the advancement of UHC by low- and middle-income countries.



5. International Framework

WHO Constitution

UHC is firmly based on the 1948 WHO Constitution, which declares:

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.

- The achievement of any State in the promotion and protection of health is of value to all.

- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.

- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

UHC law

- means any legal rule existing and applicable within a country that regulates UHC including: formal written laws such as statutory laws (enacted by a legislative body such as a parliament), regulatory and administrative laws (passed by executive authorities of the government), contracts, case law (court rulings), and customary laws.

- works by providing the means to create the institutional framework for UHC made up of UHC principles, the rule systems needed for UHC, legal capacity, rights and relationships, organisational frameworks and partnerships.

- The country context for UHC law reform is essential to understand work on UHC law: including the health sector context, the legal and regulatory context, and the political context for reform

- It is essential to understand whether UHC law reform is feasible, whether there is acceptance of (or opposition to) the proposed reform, whether there is authority to proceed (especially authority from political decision-makers) and whether the country has the ability to complete the work (does it have the capacity to make, implement and administer the planned law(s).

https://www.who.int/health-topics/health-laws-and-universal-health-coverage#tab=tab_1

Declaration of Astana

On 25–26 October 2018, WHO in partnership with UNICEF and the Ministry of Health of Kazakhstan hosted the Global Conference on Primary Health Care, 40 years after the adoption of the historic Declaration of Alma-Ata. Ministers, health workers, academics, partners and civil society came together to recommit to primary health care as the cornerstone of UHC in the bold new Declaration of Astana. This Declaration envisions:

- Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;

- Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;

- Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;

- Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

6. Position of Major Actors

United States of America

The U.S. health care system is unique among advanced industrialized countries. The U.S. does not have a uniform health system, has no universal health care coverage, and only recently enacted legislation mandating healthcare coverage for almost everyone. Rather than operating a national health service, a single-payer national health insurance system or a multi-payer universal health insurance fund, the U.S. health care system can best be described as a hybrid system through a combination of private health insurance and public health coverage The public programs, known as Medicare and Medicaid, are specifically designed for the elderly, people with disabilities, and low-income families and individuals. Everyone else needs to obtain private plans, either through their employer or on their own. Without one, you will still get treated in an emergency, but you are responsible for all of your medical expenses—and the

bills can be astronomical. Health care facilities are largely owned and operated by private sector businesses.

Russia

Healthcare in Russia is provided by the state through the Federal Compulsory Medical Insurance Fund, and regulated through the Ministry of Health.

From a purely statistical standpoint, the Russian healthcare system needs work. The Bloomberg Healthcare Efficiency Rankings place Russia at 53rd out of the 56 countries measured. America sits at 54th. They spend $524 per-capita on healthcare, which is one-eighteenth what the U.S. spends but is more in line with a developing country than an industrialized one. Due to its poor organisational structure, lack of government funds, outdated medical equipment and poorly paid staff, many Russian citizens fail to access an acceptable level of healthcare in Russia. While in theory, every citizen has health care out of a public fund, in practice everybody is required to have private insurance.

United Kingdom

Each of the countries of the United Kingdom has a National Health Service (NHS) that provides public healthcare to all UK permanent residents that was originally designed to be free at the point of need and paid for from general taxation; but changes included introducing charging for prescription medicines and dentistry (those below 16 and those on certain benefits may still get free treatment). The NHS constitution makes it clear that it provides a comprehensive service, available to all irrespective of age, gender, disability, race, sexual orientation, religion, or belief; that access to NHS services is based on clinical need and not an individual's ability to pay; and that care is never refused on unreasonable grounds. Patient choice in terms of doctor, care, treatments, and place of treatment is an important aspect of the NHS's ambition, and in some cases patients can elect for treatment in other European countries at the NHS's expense. Waiting times are low, with most people able to see their primary care doctor on the same day or the following day.

Governments designing and implementing their UHC models declare that there is huge demand to learn from how the NHS works, and more often than not a nuanced appreciation of the strengths and weaknesses of its model against those of others

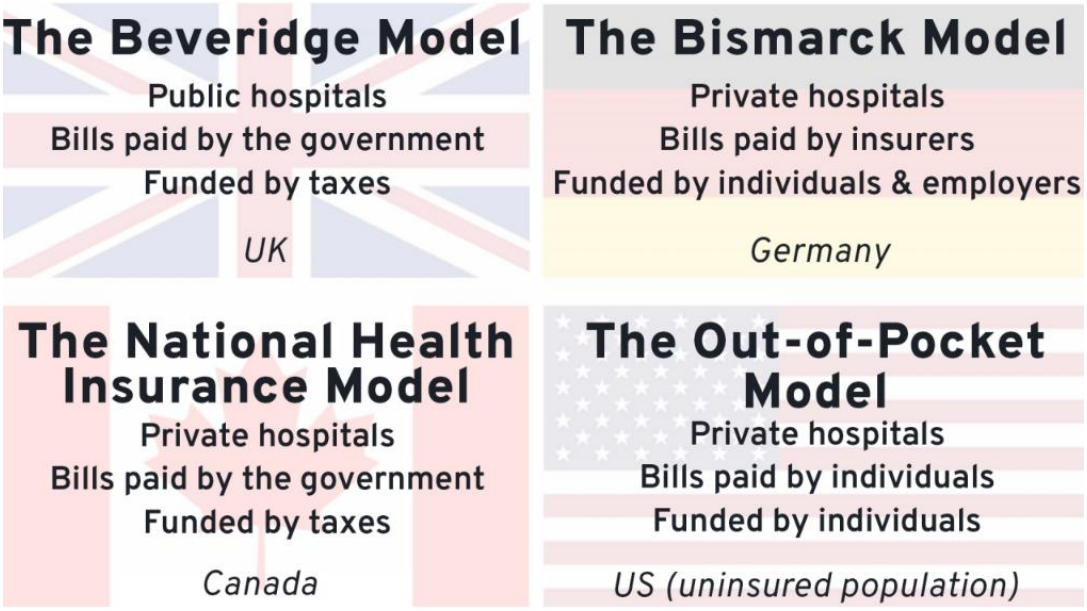
People's Republic of China

In China, patients do pay their medical bills. Although public hospitals are owned by the state, only a small share of their costs are covered directly by taxes. The remainder comes from insurance payments and the patients themselves.

Almost the entire Chinese population is covered by state-run health insurance. But since the coverage doesn't extend to many essential services, people still have to pay a large share of medical expenses from their own pockets. Some key medical services are paid for by the state, such as mandatory vaccinations and treatment for certain infectious diseases like HIV and tuberculosis.

European Union

The region is home to some of the best and most established health care systems in the world. Public, universal provision is the norm and standards are generally very high on a global scale but there is a booming private sector catering for those who want extra comforts, choice, and shorter waiting times. As such, many employers provide health insurance for their international personnel. Different rules apply to accessing treatment and emergency services in each country, but EU citizens use their European Health Insurance Card (EHIC) to access emergency treatment within the EU, while those from outside the region will need to consider private health insurance.



7. Points to address

- What are the major impediments that prevent UHC from happening?
- How can it be financed?
- What are the main requirements for countries to achieve UHC?
- Isn't it too ambitious? Are countries succeeding in implementing?

- How can we measure UHC?
- How does universal health coverage contribute to sustainable development?
- How can UHC contribute to continued progress on the current Millennium Development Goals (MDGs) while taking into account new health priorities?
- Does UHC improve equity and meet the needs of vulnerable populations?
- Would it be better to have separate targets for each of the individual disease areas rather than them being under the umbrella of UHC?

8. Further Reading

https://www.aetnainternational.com/en/about-us/explore/living-abroad/culture-lifestyle/health-care-quality-in-europe-and-scandinavia.html

https://en.wikipedia.org/wiki/List_of_countries_with_universal_health_care

https://www.who.int/healthsystems/topics/financing/uhc_qa/en/

https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf

https://www.who.int/medicines/areas/policy/5-DavidEvansmedicines.pdf

https://www.healthpolicy-watch.org/wp-content/uploads/2019/06/f736fefa-3c34-47e2-b6f7-0218bffe0075.pdf

https://www.who.int/contracting/documents/QandA_UHC_post-2015.pdf