WHO

Letters from your Chairs

Hi Everyone!

I'm a current senior who will be chairing this StuyMUNC's amazing WHO Committee along with Harper. I have been active on Stuyvesant's Model United Nations team since the start of freshman year. This is my third year chairing at StuyMUNC so I am very familiar with parli-pro, if you have any questions!

I also act as the Vice President of an Alumni Mentoring Program that Stuyvesant organizes, work at a political consulting firm, and like to run when I find the time. I'm always up for philosophical discussions or talks on foreign policy and enjoy being educated on just about anything, so please feel free to start up a conversation after committee!

These two topics, infant mortality and the privatization of healthcare, are growing ever more prevalent and we hope that you will be able to engage in mature and intellectual debate as these matters arise on the global stage. Please take the time to conduct proper research so that we can better facilitate debate at StuyMUNC.

Can't wait to meet you all soon in committee!

Best,
Emily Furman
efurman@stuy.edu

Hello Delegates!

My name is Harper (current junior at Stuyvesant) and this will be my second experience on the dais at StuyMUNC. I'm very excited to meet you all and engage in some great discussion about the topics of WHO :)

I've been in Model UN my entire high school career as well as other clubs like the track team and Student Union. I am actually most passionate about STEM topics like biology and math, but I love Model UN for its challenges and intricacies. Outside of school, I pursue interests in medicine and social activism.

I am really excited this year to (co)chair for the first time, and dive into an interesting and immersive committee. I hope everyone throws themselves into the subject and proceeds with thoughtfulness. Looking forward to meeting you all come April, but feel free to email me before then if you have any questions!

With exhilaration,
Harper Andrews
handrews00@stuy.edu

Committee Description

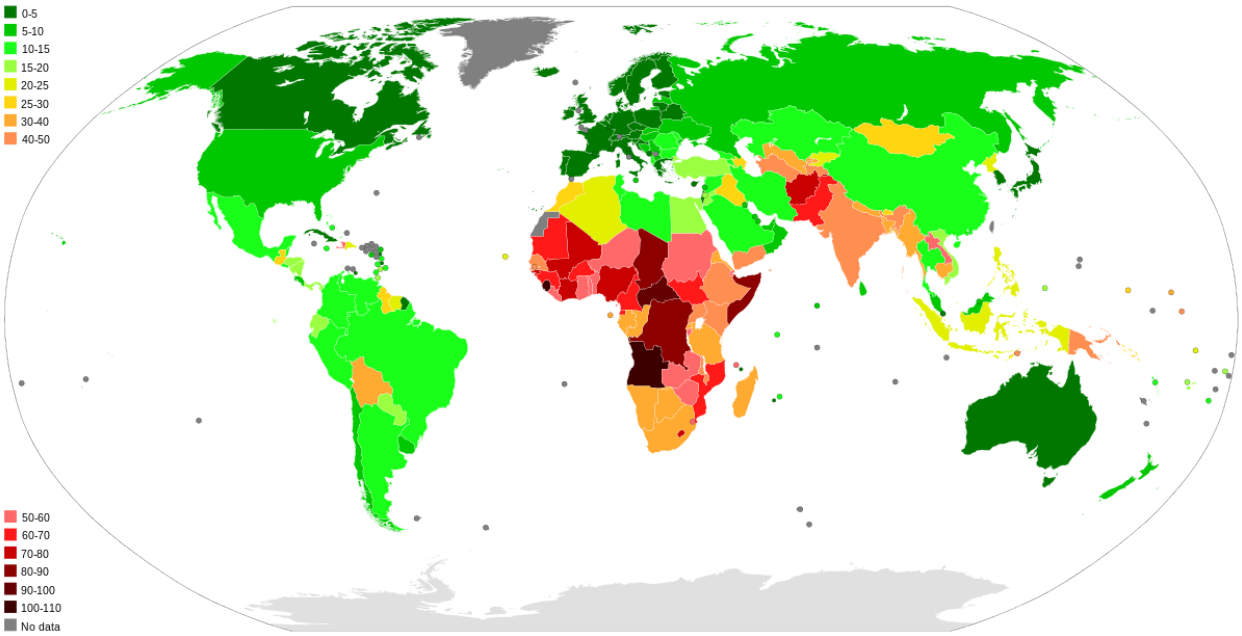
The World Health Organization (WHO) was established on April 7, 1948 following the creation of the United Nations (UN) in 1945. The goals of providing leadership on emerging health issues, setting health-based norms and standards, conducting research, disseminating knowledge, using evidence and ethics in policy, providing technological support, and monitoring and assessing healthcare trends. In the seventy years that the WHO has existed, it has combated a wide variety of diseases with a myriad of healthcare initiatives and many major successes. In this committee's session, the delegations of WHO will focus on addressing global infant mortality and the privatization of healthcare. The risk of a child dying before completing the first year of age in the WHO African Region is highest at a rate of 51 per 1000 live births. This committee will work on ameliorating this ongoing crisis. For our second topic, the WHO committee will debate on the ethicality of the privatization of healthcare. Healthcare privatization is not only an issue that affects first world countries, but is a developing discussion in the MENA area as well.

https://www.who.int

Topic A: Addressing Global Infant Mortality

Introduction

Infant mortality is defined as the death of a child before their first birthday. Given advances in technology throughout the twentieth century, as well as social reform, the international infant mortality rate (IMR) has decreased significantly. Despite this, there exists a great disparity between developed and developing nations. The most pressing proportion of infant deaths out of every 1000 live births exists in Africa and South Asia. Within these regions, the cause can be attributed to poverty, poor social security, institutional social issues and lack of sanitation. The greatest contributor to infant mortality across the world is premature birth.



Biological Aspects of Infant Mortality

Infant mortality can be further divided into perinatal, neonatal and postneonatal depending on the timeframe of death. The greatest percentage of deaths occured in the neonatal category at around 40%-60%. Each classification has its own connotations and lethal causes.

Perinatal

Perinatal death is the period of late fetal death up to one week postpartum. It can be ascribed to the health status of the mother, such as malnutrition or other disease, death during birth or other late-term complications. Some of the most common causes of infant mortality are perinatal asphyxia, birth injuries and troubled delivery. It brings

into question the support systems of women in all stages of pregnancy and the importance of intervention leading up to childbirth.

Neonatal

Neonatal death includes the period within 28 days postpartum. This most crucial interval can decide the life of a newborn on the primary basis of access to basic medical healthcare. It must be addressed during committee in both topics as it plays an integral role in the infant mortality question. Premature babies are most often affected in this category as defects and disease have a greater impact on them. Availability of resources is something to consider to address neonatal deaths.

Postneonatal

Postneonatal is the period following neonatal up to one year of age. The common causes of mortality in this class is malnutrition, infection and many environmental factors that follow mother and child. The postneonatal frame is seemingly the most simple issue to face, with common answers such as continuous breastfeeding, vaccines and nutrition, but there are more deeply rooted issues. Furthermore, the committee needs to consider when safety nets are removed, and how to help prepare for that.

Socioeconomic Contributors

Beyond the surface level biological aspects of infant mortality are factors affecting men, women and their children, even in developed countries. There is a direct, negative correlation between GDP and infant mortality. Among impoverished groups, inaccess to clean water leads to lower rates of sanitation and greater probability of disease and infection. In the United States alone, a lower income is associated with higher infant mortality, and if a father were to lose his income, then the probability skyrockets. The differences between rich and poor have also divided the benefits of new age technology that should decrease the IMR.

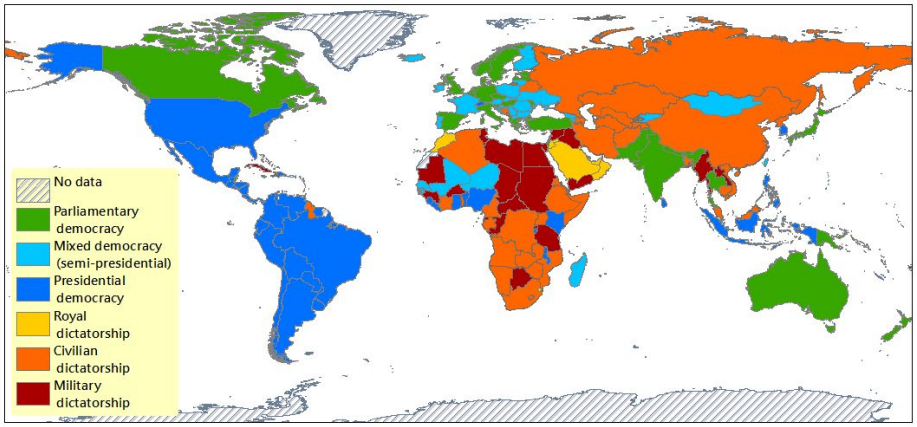
Social issues that affect developed and developing nations alike are institutional racism and institutional sexism. Within the United States, studies have shown that African Americans have a disproportionately high infant mortality rate. Furthermore, it

is not solely an issue of status, as rates do not improve greatly up the socioeconomic ladder. What remains is the emotional trauma and stress of being marginalised. Every country has the issue and a conscious effort needs to always apply to promote the health and longevity of all lives at all stages of all people.

Another issue facing women that affects infant mortality rates is a lack of freedom and income in some countries. This leads to higher rates of infanticide as there is less availability to basic healthcare and medicine. In a similar vein, lack of education also strongly impacts the survival of a child.

The Politics and Resolution

The differences between democracies and non-democracies illustrates that even political systems can even affect infant mortality rates. Among democracies, there exists a higher responsiveness to social movements and public outcry, which plays an essential role in developing countries and legislature. In contrast, a non democratic nation might be more corporately motivated and less keen on discussing health issues like infant mortality.



Resolutions can and must address the many different characteristics of the infant mortality issue, but the crux of it cannot be decided by policy alone. Considering the bio-psycho-socio-politico-economics of infant mortality, many approaches to the issue at hand must be taken. For one, public health sanitation must be fortified and available to pregnant women of all class. Basic access to healthcare and medicine must be addressed thoroughly. The social issues that women and children face should also be considered while approaching this topic. Altogether, if a resolution combats all these aspects of infant mortality, it will be a powerful step in the right direction.

Questions to Consider

How can the UN impact countries without infringing on political sovereignty or religious expression?

For how long should systems be implemented for a mother and child to maximise prevention and minimise reliance?

How can resources (human, material or monetary) be acquisitioned, organised and distributed?

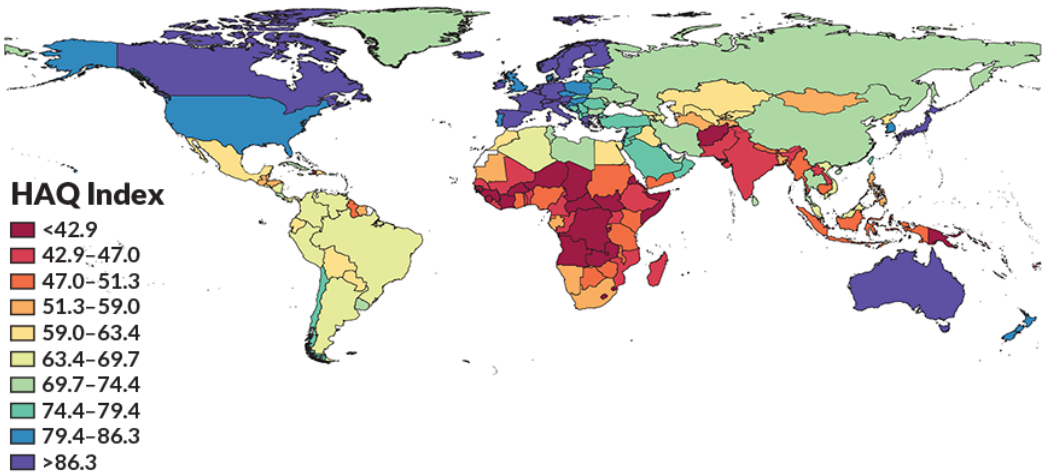
How can developed and developing nations collaborate and support each other? Who will lead efforts? Where might there be resistance?

What is the importance of changing/challenging beliefs in the infant mortality issue?

Topic B: Privatization of HealthCare

Private vs Public Insurers

Private Insurers: companies that cover the cost of health provision by periodically collecting money, in the form of premiums, paid by individuals or their employers.
Public Insurance: government programs that collect money from taxpayers for health provision and medical costs.



Varying Systems of Healthcare

Single Payer System Case Study: Canada

Canada has a public insurance system where the government funds healthcare for everyone through taxation. Doctor's offices tend to be private businesses that get paid directly by the government. But, hospitals and operating tables are public property, while the hospital staff are public employees of the government. Healthcare systems such as that of Canada's, are often called single payer systems, since the government is doing the majority of the paying for healthcare. Canadians still have to pay for prescription drugs, eyeglasses and dental care themselves or recieve them through supplemental private insurance.

Semi-private Healthcare System Case Study: France

Unlike Canada, France doesn't technically have a single payer system because healthcare providers are paid by several non-profit insurance funds. All citizens are required to get health insurance and they're free to choose their doctor. Another distinction of healthcare in countries such as France from single payer system, countries, is that most French providers, including hospitals, are private businesses.

Socialized Healthcare System Case Study: United Kingdom

Countries such as the UK have what is known as a socialized healthcare system, which is funded and controlled by the government through taxes not unlike under a single payer system. The majority of doctors, specialists, and hospitals are all paid by the government instead of insurance companies.

Multivariate Healthcare System Case Study: United States

In the U.S., we have a bit of everything. We have a single payer system, multi-payer health insurance plans (mark-driven healthcare), and free-market (100% out-of-pocket) healthcare. Almost all providers— hospitals, clinics, doctor's practices— are private firms. Most households with adults under 65 are covered by private insurances, either through their employer or through individual policies (multi-payer and free-market). But the U.S. also has a single payer system, for those over sixty-five and those below the poverty line. Medicare is a taxpayer-funded public insurer that pays providers to care for seniors we have in the U.S., which is taxpayer-funded. It pays healthcare providers to care for Seniors. Medicaid is a similar program for low-income households. The U.S. also has a small U.K.-style government-run hospitals and doctors, although it only exists for veterans in Veterans Affairs.

Evaluating Strength of Healthcare within a Developed Nation

Economists evaluate the effectiveness of a healthcare system on three criteria: access, cost, and quality. According the U.S. Census Bureau, in 2014, 10.4% of American did not have health insurance coverage, down from 13.3% in 2013. Two thirds of Americans had health insurance through a private insure. The vast majority got coverage through their employer and the rest bought individual plans. About a third of Americans had insurance through a taxpayer funded government insurance plan. Those who are uninsured, for whatever the reason may be, carry the burden of extremely high medical costs.

The highest cost is within the United States at $10, 224 on average per person, which is about twice the amount of cost than in most other developed nation. Some argue that this spending is due to the high quantity of care per person. Since insurance companies pay providers rather than the patients, patients may want more care than necessary. The Ran Health Insurance experiment found that requiring patients to pay for a portion of their own medical costs, deters them from over consuming healthcare. That is why many form of insurance have what is known as deductibles, a form of cost-sharing where the patient is required to pay a specific amount before the insurance kicks in. Another problem in countries such as the U.S. is the prices of treatment; as compared to the

price of a $200 MRI abroad, a scan can roll up to $1,500 in expenses. In almost every case, U.S. providers are paid 4-5 times more.
Quality is something that always must be considered when assessing healthcare. Developed nations such as U.S. and Switzerland stack up pretty well for treating curable diseases such as heart disease and diagnosing cancer, but again, spending per capita is significantly higher in these countries.

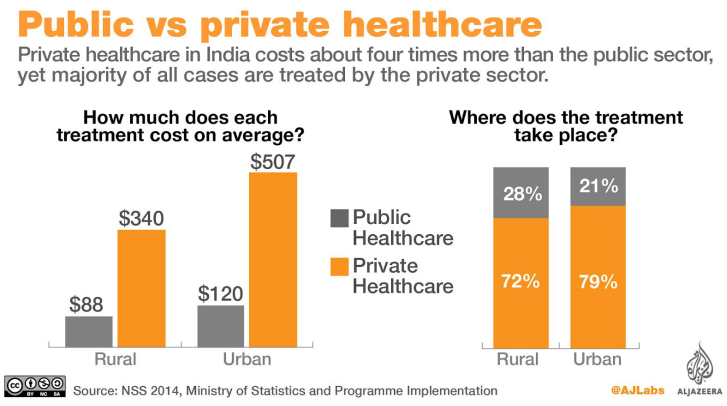
Changing Healthcare Systems

Changes in healthcare policy provision are difficult to change because of mutually beneficial relationships between lobbyists, politicians, and corporations that make the status quo difficult to alter. But still, health care reform can be made such as with ObamaCare or the Affordable Care Act. The ACA attempts to increase health coverage by requiring everyone to have health insurance and also subsidizes those who cannot afford to pay market rates. It is still very controversial as it has increased regulation and government involvement and raised healthcare prices for some.

Private Health Care in Developing Countries

The seven countries that finance more than 20% of their health care via private health insurance are Brazil, Chile, Namibia, South Africa, the United States, Uruguay and Zimbabwe. Private healthcare provision is rapidly growing in developing countries such as India and in the Sub-Saharan region of Africa in places such as Ethiopia. The poor, as well as the rich, often seek health care from private providers, including for conditions of public health importance such as malaria, tuberculosis, and sexually transmitted infections. The facilities are often more accessible, require shorter waiting periods, and offer greater confidentiality as well as sensitivity to user needs.

The benefits and harms of this movement towards privatization are heavily muddled and misunderstood by international policymakers. It appears as though the movement towards privatization is the clear solution: they offer consumers greater



choice, increase competition, and remove state responsibility for service provision, thereby encouraging its role as regulator and not provider.

However, as further examined by studies conducted, even by the World Health Organization itself, private health insurance can have severe negative implications for developing countries. When examined, the quality of care offered by many private providers is poor. Furthermore, impoverished people spend a greater proportion of their income on health care (private or public) than do the rich, often using less qualified or totally untrained private providers. The World Bank has stated that the private sector performs far worse on technical quality than the public sector. In addition, the privatization of healthcare has been proven to lead to inequality in Sub-Saharan African countries and only benefits under 50% of the general population.

But is the privatization of health care necessarily a bad thing? It leads to economic relief on part of the government as well as promotes economic prosperity. If policy recommendations that are made by WHO are adhered to, developing countries can harness private health insurance to serve the public interest. If governments implement effective regulations and focus public funds on programs for those who are poor and vulnerable, private health insurance can truly be a transformative tool.

Possible Bloc Positions

Nations should stay on policy and agree with the general desire for a certain healthcare system that corresponds with their country. Countries such as the U.S., South Africa, Brazil, and Zimbabwe, that have heavy private health insurance systems, should follow suit. Nations like Canada and the U.K., that have more socialized systems of healthcare, would most likely fall in line with anti-privatization policies.

Questions To Consider

- Should the determination a country's healthcare system have international suggestion?
- When, if ever, should the government get involved to help markets achieve the most effective, efficient, and fair outcome?
- How can governments efficiently regulate the private sector of healthcare in developing countries?
- Should general costs of healthcare be lowered or procedures set to an international price?
- How do we encourage nations to develop welfare states without infringing on sovereignty? With the provision of more aid? What about a longer-term solution?

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