WARMUN 2021 - WORLD HEALTH ORGANISATION (WHO)

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Introduction

Dear Delegates,

My name is Henry de Oliveira and I will be co-chairing the World Health Organisation committee at WARMUN 2021. Please do not hesitate to contact me if you have any questions before/during the conference. I am a third year student at King's College London reading War Studies and History.

The topics chosen for this committee affect all member states being represented in a variety of different ways. Hopefully this will give all delegates - regardless of their confidence and experience - a chance to participate fully throughout the weekend.

The importance of addressing inequalities in the quality and price of medicine has never been greater for global development. The large difference in the relative price of lifesaving drugs across the world highlights that a person's location/nationality continues to be a significant factor determining their access to necessary treatment.

I hope you enjoy your time as a delegate and I look forward to meeting you.

Kind regards,

Henry de Oliveira

The question of addressing medical inequality and price disparities

Historical background and committee scope

A Special Session of the World Health Assembly - the committee which regulates the World Health Organisation's (WHO's) activities - is scheduled to commence in November 2021.[1] This presents a golden opportunity to revisit and provide more effective solutions to the problem of differing access to necessary and affordable healthcare around the world.

Delegates aim to influence the creation of Resolutions (policy documents drafted and adopted by the Assembly), in order that their state's issues and points of view are addressed in the future strategy of the WHO. The Organisation was founded in 1948 and was tasked with coordinating international responses to human health issues. Its focus on female health issues, particularly around childbirth, has been a key area of expertise and the Organisation has often helpfully looked at healthcare availability challenges through the lens of gender. Its remit has expanded further in recent decades, giving the Assembly a greater variety of investigative and educational tools at its disposal.

One of these tools is the creation of Expert Committees. Usually (but not necessarily) meeting biannually, these committees are composed of medical experts who advise the Assembly and the wider community through nonpartisan reports and press releases. Since 1977 the Expert Committee on Selection and Use of Essential Medicines has produced a list of medicines hospitals in each member state should possess regardless of their financial situation.[2] Findings are often combined with efforts to produce educational resources to be distributed through mass media. This is particularly important in Less Economically Developed Countries (LEDC's) where citizens may only

[1] World Health Assembly, WHO.int (https://www.who.int/about/governance/world-health-assembly) accessed 07/11/2021.

[2] Expert Committee on the Selection and Use of Medicines, WHO.int (https://www.who.int/groups/expert-committee-on-selection-and-use-of-essential-medicines) accessed 07/11/2021.

infrequently meet medical professionals and thus may be unaware of effective newly released drugs.

Increasing multilateral programmes with other international organisations has been another way the WHO's effectiveness has been increased. Partnerships with relevant stakeholders can allow for a unified strategy which more effectively deals with the many problems impeding the equal distribution of healthcare. The WHO Global Preparedness Monitoring Board is a fine example of such a partnership. A joint project with the World Bank, it coordinates action to contain outbreaks of specified diseases.

Working alone the WHO has had celebrated successes including overseeing the elimination of smallpox and a 99% reduction in Polio cases. However due to its bureaucratic organisation and a sometimes low moving Executive Board (the 34 person body in charge of carrying out the Assembly's recommendations), it has been criticised for its ineffective leadership such as during the 2014 Ebola outbreak.[3]

Background information on the topic

Health inequality refers to the unequal distribution of medical equipment and expertise across population groups. Nationality has a measurable impact on life expectancy with children in Sub-Saharan Africa being 14 times more likely to die before their fifth birthday than children from the rest of the world. Looking globally the WHO has calculated that children from the poorest 20% of households are twice as likely to die before they turn six compared to those born in the richest 20%.[4] Maternal mortality is another key indicator of a state's ability to provide adequate health coverage and unfortunately many are unable to do so. Less Economically Developed Countries (LEDCs) account for 99% of maternal deaths as of 2018.

Even within More Economically Economically Developed Countries (MEDC's) race/ethnicity is a factor which may exacerbate medical inequality, often ethnic minorities are not accounted for in government healthcare decision making. In the USA African Americans make up 13% of the population but half of new

[3] cfr.org, (https://www.cfr.org/backgrounder/what-does-world-health-organization-do) accessed 08/11/21.

[4] WHO.int, (https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes) accessed 08/11/21.

HIV cases. Romani communities in Eatern and Central Europe also have a lower than average life expectancy.

There are a multitude of reasons why medical inequality persists, one is the long standing inability to increase multiethcnic participation in groundbreaking medical research. Black women are especially susceptible to being overlooked as they are underrepresented in 'key biomedical research datasets' which can be used to develop effective pharmaceutical drugs.[5] There is a fierce and ongoing debate as to whether black researchers are less likely to receive grants than their white counterparts,[6] which could explain why some demographics are neglected.

Similarly, diseases that only primarily affect LEDC's are not a priority for researchers. Neglected Tropical Diseases including Zoonotic diseases have been deemed a threat that the WHO is looking to tackle through innovation and preventive chemotherapy.[7] Nonetheless the lack of research on diseases rare in the northern hemisphere continues to widen that gap in worldwide healthcare outcomes.

After a drug or treatment plan has been developed inequality is still evident. Whilst the WHO recommends countries set aside 1% of GDP for primary medical services there is no official record of which member states do so; lack of investment is an important factor which has led to rising cases of cancer and diabetes amongst other conditions. Infectious diseases are similarly left untreated and kill 4 million people annually with the elimination of Polio only being of limited benefit as other deadly diseases remain in affected areas.

Infectious diseases can be rendered increasingly deadly by malnutrition. In fact a third of all diseases are caused by food or water insecurity which is a daily reality faced by millions.[8] Healthcare equipment and technology is of very little use in such a situation as more fundamental factors preclude the success of a purely medical intervention.

A life saving technology vital in the modern day are pharmaceutical drugs. Unfortunately their price varies by country with the result being that in many parts of the world poorer individuals and families struggle to afford life saving care. A vial of insulin in the USA costs $500 compared to just $10 in Hungary.

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[5] Endofund.org, (https://www.endofound.org/the-disparities-in-healthcare-for-black-women) accessed 08/11/21.
[6] Nih.gov, (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3412416/) accessed 08.11.21
[7] WHO.int, (https://www.who.int/teams/control-of-neglected-tropical-diseases) accessed 08/11/21.
[8] Endofund.org, eadem 1.

Both the pharmaceutical companies and government regulation play a role in setting the price of drugs in a given jurisdiction.

Many countries attempt to contain drug prices using a mechanism called External Reference Pricing (ERP). Pegging the prices of a particular drug in one country at a certain percentage of the relative price in another country (e.g. the UK) can allow governments a de facto price control mechanism.[9] However, if the drug is new governments do not have the same leverage to negotiate with pharmaceutical multinationals. Furthermore, many governments do not have the resources or will to distribute healthcare in a centrally managed fashion. WHO Director-General Dr Tedros Adhanom Ghebreyesus has acknowledged that new cancer drugs on the WHO's 'Essential medicines' list are often extremely expensive, sometimes unaffordable, despite everyone having the right to access them.[10]

Though cutting edge drugs are often unaffordable in LEDC's that is not necessarily because they are more expensive in relative terms. Medical literature has shown that in the 21st century drugs are often sold more cheaply to poorer customers with those in MEDC's paying more, a form of international subsidy.[11] Whilst there are often proposals in the USA and other similar countries to reduce drug prices through ERP or other methods the effect this would have on prices in other areas of the world is a cause for concern.

Addressing health inequalities and drug price disparities as an international community will require grappling with a variety of factors and careful negotiation. Information which will aid you in this process is provided below.

National and Bloc positions

Less multilateralist MEDCs and geopolitically important nations (USA, Russia, China, India, also including other economically stable conservative governments e.g. Brazil, Philippines)

All these nations stress the importance of meeting the United Nations Sustainable Development Goals 2030 which includes reduction in health

[9] Rand.org, (https://www.rand.org/pubs/research_reports/RR240.html) accessed 08/11/21.
[10] WHO.int, (https://www.who.int/news/item/09-07-2019-who-updates-global-guidance-on-medicines-and-diagnostic-tests-to-address-health-challenges-prioritize-highly-effective-therapeutics-and-improve-affordable-access) accessed 07/11/21.
[11] Healthaffairs.org, (https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0923) accessed 07/11/21.

inequality. Nonetheless they are wary of creating a multilateral strategy that is too prescriptive and would involve excessive financial commitment. Often they have individual aid priorities driven by domestic policy which precludes investment in WHO controlled schemes (e.g. America with AIDS reduction and Russia with foreign aid to neighbouring states).[12] Many of these countries are the major holders of patents and/or are manufacturing hubs for pharmaceutical drugs and thus are wary of combative policies against economically profitable companies.

More multilateralist MEDC's (EU excluding Visegrad four, Canda, Australia, New Zealand)

More willing than the bloc above to take radical action to combat health inequality. Often these nations (especially the Scandinavian countries) are large voluntary per capita donors to the WHO and its attendant organs and would welcome the creation of further initiatives at the UN level.

Recipients of international assistance (South America, Myanmar, Pakistan)

These states are already net receivers of WHO and wider UN assistance due to their economic and social difficulties vis-a-vis healthcare provision. Often a lack of infrastructure and qualified professionals inhibits timely medical intervention. Worryingly it is estimated that an extra 18 million healthcare workers and the infrastructure necessary to support them will be necessary by 2030.[13] Respect for local cultural norms and increasing translation services are key areas of interest for this bloc who understand the issues involved when attempting to increase healthcare provision through external intervention.

African bloc (African Union countries, West Indies and Caribbean islands including Haiti, Jamaica)

These states have similar concerns to the aforementioned bloc but with an added emphasis on the racial dimension to healthcare inequality discussed in the 'background information' section. The UN Expert Working Group for

[12] Wilsoncenter.org, (https://www.wilsoncenter.org/publication/russias-global-health-engagement) accessed 08/11/21.
[13] Globalcitizen.org, (https://www.globalcitizen.org/en/content/most-urgent-health-challenges-for-the-2020s/) accessed 08/11/21.

People of African Descent has highlighted the importance of further assistance to ensure rising development amongst this demographic, though one important impediment to improvement is debt. A large number of African countries have huge debt burdens which forestalls investment in medical services. As of April 2019 half of African countries were or were nearing unserviceable levels of public debt, Zambia had to cut health investment by 27% from 2015-18.[14]

Guiding Questions

How to reach minority populations?
In many nations healthcare outcomes are dramatically lowered for those with little influence in government decision making. The international community should find a way of working with member states to ensure effective improvement if possible.

How to reduce transmission of disease?
Prevention is vital to reducing the lethality of many infectious diseases; LEDCs are often underserved in this regard.

What to do about underlying problems?
Cooperation with agencies such as the World Food Programme will be vital to ensuring malnutrition and other contributors to ill health are lessened in severity.

How will aid and development be effectively delivered?
Working with trusted local partners - including traditional leadership structures and media outlets - will increase social trust in new medical measures which could save lives. Both digital and analogue outreach should be considered as some LEDCs have limited communication infrastructure.

How to deliver healthcare to refugees and stateless individuals?
Many such persons live in irregular encampments and may not have the legal right to access healthcare services in their country of residence. In countries where the UN does not operate dedicated refugee aid programmes, the WHO may be well placed to fill the void. Many governments are unwilling to allow policy to be dictated by a High Commissioner for Refugees but as a purely medical body the committee could provide alternative solutions.

[14] News.un.org, (https://news.un.org/en/story/2020/01/1055711) accessed 08/11/21.

Keeping drug prices low worldwide, is it possible?
Negotiating a compromise between delegates intent on lowering prices in MEDCs, whilst allowing pharmaceutical companies to continue providing these drugs to those in need at a lower price, will be key to finding a long term solution to this issue.

Cutting edge drugs, how will they be shared?
Many populations may not be able to afford new or experimental drugs. International action in terms of sharing patent technology, donation of excess doses etc. could be vital to saving lives.

Definition of Key terms

Health inequality - the unequal distribution of medical equipment and expertise across population groups.

Less/More Economically Developed Countries - a classification assigned to a state to denote its level of economic and social development. More Economically Developed Countries are those with a large tertiary (services) sector and a high rate of urbanisation coupled with a high GDP per capita.[15]

Further research

For further investigation into the necessary medicines which every state should possess in ample quantities please see the 2021 'Necessary medicines' list: (https://apps.who.int/iris/rest/bitstreams/1374779/retrieve).

A further summary of health inequality and its relevant subtopics is available in the form of this presentation: (https://www.who.int/docs/default-source/documents/social-determinants-of-health/hiap-ppt-module-2-part-2.pptx?sfvrsn=6097ae24_2).

[15] Financial-dictionary.com (https://financial-dictionary.thefreedictionary.com/More+economically+developed+country) accessed 08/11/21.

Information on unequal distribution of vaccines: (https://www.un.org/press/en/2021/ecosoc7039.doc.htm).

Further information on how pharmaceutical companies price their drugs and the factors that affect their decision: (https://www.investopedia.com/articles/investing/020316/how-pharmaceutical-companies-price-their-drugs.asp).

Statistics on the global drug prices around the world in US dollars: (https://www.statista.com/statistics/1134293/prescription-drug-prices-min-max-by-country/).

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Introduction

Dear Delegates,

Welcome to the WHO committee of WARMUN 2021. My name is Tabbie, and I am co-chairing this committee. I am currently a first year student studying English Literature at King's College London, and have been an active member of MUN for about 6 years. I am super excited to be chairing our debate on misinformation in the medical field. This guide should direct all of you into a direction for your research, but I can't wait to see what you each individually bring to debate.

Following the COVID-19 pandemic, the spread of rumors and misinformation has been rife. Due to a lack of regulations in the media, mass feelings of fear surrounding not only the pandemic, but about trusting medical professionals has been prolific. It is up to our committee today to discuss prevention of this as well as tackling the damage that has been done. I am looking forward to chairing this debate, and seeing what progress our committee can achieve.

Please do not hesitate to send me an email with any questions regarding the conference or the topics we will be discussing. I look forward to seeing you all!

Kind Regards,
Tabbie McLeod-Clarke, Chair of WHO

Statement of the Issue

Not only is this an issue about medicine, it is one of human rights and the laws surrounding media reporting. This issue of misinformation about medicines, vaccines and doctors themselves have been scattered over all countries around the globe. However, due to a lack of international law about the media, there is little room to crack down on the issue due to a fear of infringing on national sovereignty. The media has only exacerbated the issue, as medicine and the pandemic have become a political focal point. As the masses have no option but to stay at home, many of us have the news on constantly. We were exposed to constant streaming of the latest news of the pandemic and it allowed misinformation to spread like wildfire. During the pandemic, there was a huge lack of clarity when it came to lockdowns and vaccine reports. Those against vaccinating have been given a huge voice, this means that misinformation can spread quicker than ever. The World Health Organisation has coined the term 'infodemic'[16] to describe an overabundance of information and the rapid spread of misleading or fabricated news, images, and videos.

In late October 2020, the WHO, in collaboration with Wunderman Thompson, conducted an international study to better understand how young adults are engaging with technology during the COVID-19 communication crisis.The research was conducted in 24 countries with over 23,500 respondents. The study concluded 3 major points:

1. Science content is seen as shareworthy
2. Awareness of false news is high, but so is apathy
3. Gen Z and Millenials have multiple worries beyond getting sick.[17]

History

[16] WHO infodemic, https://www.who.int/news-room/feature-stories/detail/immunizing-the-public-against-misinformation

[17] WHO international and the media, https://www.who.int/news-room/feature-stories/detail/social-media-covid-19-a-global-study-of-digital-crisis-interaction-among-gen-z-and-millennials

The World Health Organisation was set up as a specialised committee of the UN in 1948 to encourage international cooperation to provide better international healthcare. When first set up, it was given a mandate to promote the attainment of “the highest possible level of health” by all peoples.

Through 2014-19, the WHO established 6 leadership priorities which are as follows:

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

Misinformation and disinformation has always been an issue, especially since the rise and influence of social media. In 2017, ‘fake news’ became Collins Dictionary’s word of the year and it’s remained in the headlines ever since. Although the phrase might appear to be a modern invention, examples of it can be found throughout history.[18]

Relevant International Actions

Within the past year the WHO has established the Information Network for Epidemics (EPI-WIN) that unites technical and social media teams working closely to track and respond to misinformation, myths and rumours and provide tailored information and evidence for action. They have also set up close relations with popular social media outlets in order to share critical guidance on COVID-19.

The WHO also partnered with the UK to build a campaign called “Stop the Spread”, which encourages the spreading of well researched information, and stops the spread of incorrect information.

[18] Fake news, https://www.bbc.co.uk/bitesize/articles/zwcgn9q

As the rise of social media, and mass media has been relatively recent, there is a lack of international intervention. Each country has outlined their own media laws around medicine and thus, it becomes almost impossible not to infringe on national sovereignty in this issue.

The very formation of the World Health Organisation in 1948 can be viewed as international action against the crisis of misinformation and lack of unity. Unfortunately misinformation and disinformation is a very current issue as the methods of spreading false information are relatively new, thus giving us lots of opportunity to expose the loopholes within the UN surrounding health.

Possible Solutions and Guiding Questions

Social Media Laws
Should there be tighter regulations of content allowed on social media?

Rights of those practicing medicine
Perhaps there needs to be tighter privacy laws on those in medicine who wish to speak publicly

Guarantee of official information in the news or online
Should governments be thinking about a seal of approval for public health messages? This would allow for less room for rumour?

Underlying issues, tight government restrictions

Bloc Positions

MEDC's, developed countries in the medical field such as, United Kingdom, United States of America, Spain, Portugal, Netherlands

More developed countries have implemented strong structures around media laws and their link to reporting standards regarding medicine and medical professionals. For example, Google has implemented a trusted COVID-19 page. In the UK, OFCOM regulates the media, by a form submission method. This has been a large success and creates a strong bond of trust between media and civilians. In the US, The Federal Communications Commission

(FCC) regulates interstate and foreign communications by radio, television, wire, satellite, and cable[19]. It was created by the Communications Act of 1934 to regulate interstate and foreign communications by wire and radio in the public interest. However, due to the first amendment, free speech is very much upheld within the US. Spain and Portugal both stress the importance of the right for information and freedom of the press in their respective constitutions. Similarly, the Netherlands have strong guidelines which regulate their media landscape, importantly the news is not allowed to be sponsored thus eliminating a risk of corruption.

Countries with stricter regimes, China, Russia, Syria, Republic of Korea, Iraq, Kuwait

More socialist states such as China, Russia, Iraq, Syria, Uzbekistan have strict rules and regulations when it comes to state media. Punishment such as imprisonment, harassment and higher levels are enforced when censorship rules are broken. Kuwait has banned over 5000 books over the last 7 years.[20]

Less medically developed countries, Ghana, Morocco, Pakistan, Congo

UNESCO has long championed media development, with particular attention to the developing countries in general and Africa in particular. Despite UNESCO's agenda to improve media development, the major problems incurred when journalists work in poor conditions and are underpaid persist. The predominantly polarized political terrain, as well as journalists' struggles for survival in the context of severe economic crises, have spawned practices that provide context for (re)examining the relevance of the predominant Anglo-American epistemological imperatives of journalism in Africa.[21]

In 2017, the UN published an article that states that less than 2% of medicine used on the continent is actually manufactured in Africa. About 80% of Africans rely on public health measures, as reported by the World Food Bank in 2013[22]. This is not widely reported in mainstream media, often countries

[19] Media Law overview, Cornell https://www.law.cornell.edu/wex/media
[20] Kuwait media laws, https://agsiw.org/controlling-the-narrative-press-and-publication-laws-in-the-gulf/
[21] Media laws in Africa, http://www.unesco.org/new/en/communication-and-information/resources/publications-and-communication-materials/publications/full-list/media-legislation-in-africa-a-comparative-legal-survey/
[22] Dying from a lack of medicines https://www.un.org/africarenewal/magazine/december-2016-march-2017/dying-lack-medicines

that can afford to help less developed countries, only do so through charities and donations. Perhaps this should be a point in debate.

The Difference between ‘Misinformation’ vs ‘Disinformation’

Misinformation is “false information that is spread, regardless of intent to mislead.”
Disinformation means “false information, as about a country’s military strength or plans, disseminated by a government or intelligence agency in a hostile act of tactical political subversion.”

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