L'Amoreaux Collegiate Institute
Model United Nations 2019

World Health Organization

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Hello Delegates,

My name is Vernina Gozum, and I am honoured to be your chair for the L'Amoreaux CI Model UN World Health Organization! I am the Co-President of our Model UN team and I am currently in grade 12 with studies focusing on business and law. This will be the second time chairing a committee and I am very excited for this year's debate.

My name is Hazal Dasci, and I will be your co-chair for this committee. I'm currently in grade 11 and have been in the MUN club for three years. Each week, I love to debate at our meetings about interesting and controversial topics. Vernina and I are looking forward to meet and listen to each delegate as we find resolutions to the topics in our committee.

The first topic we have selected for discussion is improving quality of healthcare for children. Over the years, the issue of access to health care has been a very prominent focus of global health. Now, the focus is turning towards how countries can further develop child healthcare. Child mortality is becoming a serious issue around the world, more so in some countries than others. Although steps have been taken to adjust standards of healthcare for children, there are still a large number of children who have died before reaching their fifth birthday, many from conditions that are readily preventable or treatable with the use of cost-effective resources. In order to decrease mortality rates of children, the WHO must establish more methods to ameliorate issues regarding quality of healthcare for children.

The second topic we have chosen is medical tourism, which refers to travelling to another country to receive medical care. In many cases, people choose to travel abroad to receive medical, dental or surgical care for different reasons such as affordability or better quality of care. Medical tourism is a growing business around the world and so it is crucial to recognize the issues associated with it. For example, cosmetic surgery tourism and transplants have raised not only multiple ethical concerns, but concerns for the safety of patients who travel abroad for these medical services.

If you have any questions feel free to contact me at: verninag@gmail.com Once again, best of luck and I hope to see some interesting debates regarding the current state of worldwide health.

Topic 1: _Improving Quality of Healthcare for Children

Overview

In many places around the world, children lack access to quality healthcare, whether it's because of the financial situation of their families or their countries or due to issues with healthcare infrastructure and distribution of medical resources. The result of this lack of access is a wide variety of public health issues that predominantly affect children, especially those living in countries whose medical systems are underdeveloped in general. These issues can include infectious childhood diseases such as malaria, polio, and others, as well as the overall lowered quality of life as a result of the proliferation of health issues that specifically target children. Health disparities are also amplified by the lack of access to proper medical care, especially when correlations between wealth and geographical distribution and healthcare access are examined.

Despite healthcare being a right guaranteed to children since 1959 by the Declaration of the Rights of the Child and the additional widespread ratification of the Convention of the Rights of the Child in 1989 that guarantees the same thing, many children don't have reliable access to high-quality healthcare or healthcare at all in some cases. Access is worse for children in developing countries, especially ones in political and military conflict; the Security Council recognized in resolution 2225 adopted in 2015 that armed conflict greatly affected access to healthcare in a negative manner. For example, the Central African Republic's political conflict has destroyed infrastructure including healthcare infrastructure and left a shortage of medical supplies and personnel, with only 55% of facilities running 5 years after the conflict. Lack of (quality) healthcare can lead to serious setbacks in human development, such as the risk for infectious diseases, the child malnutrition rate, and the infant mortality rate in the country skyrocket.

Meanwhile, in wealthier countries, barriers to accessing pediatric care, especially emergency pediatric care, are more often socioeconomic--the result of language barriers, involvement with child services/immigration enforcement, and other legal/financial issues. Issues with the infrastructure itself in these countries are often rooted in healthcare facilities not accommodating for the needs of children, such as having personnel that are inadequately educated in pediatric care or medical supplies not suitable for use on children. Currently, the socioeconomic barriers are most prominent in the United States, especially in the face of current events. In 2015, 7% of children did not have healthcare insurance that would grant them reliable access to healthcare. In recent years, there has been a crackdown on undocumented immigrants, prompting families to avoid seeking pediatric care for fear of involvement with immigration enforcement. Regarding financial access to healthcare, in 2012, the General Assembly adopted a resolution that urged its member states to implement affordable healthcare for citizens. The high costs associated with healthcare, which impacts 150 million around the world and pushes 25 million

households into poverty per year, particularly affects women and children, forcing them to choose between education and healthcare.

Currently, the major causes of infant and child mortality are infectious diseases, including acute respiratory infections, malaria, diarrhea, and measles, as well as child malnutrition. According to the Office of the United Nations High Commissioner for Human Rights, infant mortality and health is greatly impacted by maternal death, making maternal and children's health inextricably linked; in this sense, to improve children's health, states must also focus on women's and reproductive health. Additionally, children are increasingly at risk for HIV transmitted from mothers during pregnancy/childbirth/breastfeeding--this further highlights the need for comprehensive maternal healthcare, including prenatal HIV testing, affordable drugs, and family planning/information campaigns to prevent HIV transmission from mothers to children.

The Office of the United Nations High Commissioner for Human Rights also recognizes that special attention must be paid to children of minority and/or marginalized groups. Specifically, children of indigenous groups/ethnic minorities and young/adolescent girls are prevented from many services, including healthcare in many cases, and the Office of the United Nations High Commissioner for Human Rights recognizes that governments and healthcare officials should treat these children in a non-discriminatory manner. In addition to being prevented from accessing healthcare in cases, many girls are forced to undergo harmful procedures that affect girls specifically, including female genital mutilation, as well as higher rates of neglect than boys.

Timeline

1930: Founding of the American Academy of Pediatrics.

1959: UN General Assembly adopts the Declaration of the Rights of the Child, which outlines that children have a right to healthcare.

1979: General Assembly adopts resolution 34/58 titled "Health as an integral part of development", calling for member states' cooperation in the WHO in furthering public health as a part of human development.

1989: Adoption of the Convention on the Rights of the Child, the most rapidly and widely ratified international human rights treaty in history. It guarantees children protection of their health by the state.

1997: American Congress passes the bipartisan Children's Healthcare Insurance Program (CHIP), reducing the rate of uninsured children from 14% to 7% between 1997 and 2012.

2002: Thailand introduces universal healthcare, which covers 99% of the population through a comprehensive healthcare package.

2012: General Assembly adopts a resolution urging states to provide affordable healthcare for all citizens.

2015: Security Council adopts resolution 2225, recognizing the negative effects of armed conflict on children's access to healthcare.

2018: World Health Organization publishes standards for improving healthcare and outcomes for children and young adolescents.

Past UN/International Action

Up until now, most action taken by international organizations, including the Security Council, General Assembly, and World Health Organization, in regards to quality pediatric care has been to recognize healthcare as a human right to be guaranteed to children as part of resolutions on children's rights or other issues affecting children. The most notable of these resolutions are the Declaration of the Rights of the Child naming pediatric healthcare as a human right, adopted in 1959, and the Convention on the Rights of the Child, which guarantees healthcare as part of their protection by the state, and as indicated by its widespread ratification is one of the most readily accepted human rights treaty in history, despite being neither legally binding nor properly enforced. Other resolutions have been passed mentioning pediatric healthcare in passing, but these have not substantially improved access to or quality of care children are receiving. In addition to affirming pediatric healthcare as a human right of children, other resolutions have recognized the causes of lack of quality pediatric care or posited possible solutions to improve pediatric care, both in terms of availability and quality. Between 2012 and 2018, multiple bodies in the UN have made efforts to prioritize the improvement of healthcare infrastructure and pediatric care standards as a part of human development. However, none of these resolutions have had a tangible effect on the service and availability of pediatric healthcare around the world, as member states are either not bound to their terms or the resolutions do not state specific solutions to outlined problems.

Despite international organizations having been unable to implement any method of improving children's healthcare, individual countries have been able to improve access to healthcare, both for children and the general population, through the adoption of universal and/or affordable healthcare. Two notable examples are the United States and Thailand; the first implemented government-subsidized health insurance for children in 1997 in response to 14% of children in the country not having insurance and reliable access to healthcare, while Thailand is considered the pioneer of universal healthcare in Asia with a comprehensive government subsidized healthcare package that covers 99% of the Thai population. While both of these measures have improved access to healthcare for children and the general population, it doesn't seem like they have significantly improved the overall quality of the healthcare their populations receive.

Current Situation

Lack of access to quality pediatric care and its associated effects have been amplified by political and military instability as well as extreme poverty in certain regions, especially rural ones. An example of damage to health infrastructure by instability and conflict is the Central African Republic, which has little over half of its healthcare infrastructure intact. Damage to healthcare infrastructure is associated with the spread of easily prevented diseases, such as cholera; this was the case in Yemen, where cholera kits were transported as part of vital medical shipments by the World Health Organization in the wake of medical supply shortages. Accompanying the issues mentioned above are usually public health crises consisting of high risks for infectious diseases, especially vector, foodborne, and waterborne diseases. The latter two tend to happen especially in cases of food scarcity and problems with water infrastructure. Indeed, coinciding with the Central African Republic's loss of almost half its functional healthcare facilities to political and military conflict is a high risk for malaria, a vector disease, and bacterial diarrhea, a water-/foodborne disease, among other infectious diseases.

Additionally, there are empirically proven socioeconomic barriers to accessing pediatric healthcare as of today. The high costs of healthcare is one widespread example. There are 150 million people around the world who face impacts of exorbitant healthcare costs, and annually 25 million households become impoverished as a result of these costs. Inability to pay for insurance or healthcare leaves many unable to access it reliably; 7% of American children today are not covered by insurance, even 15 years after the implementation of an affordable healthcare insurance program aimed at children.

In middle and lower income countries, many pediatric care methods commonly used and proven effective in higher income countries are widely inaccessible and therefore not used to improve pediatric care. Because of this, 99% of maternal, infant, and child deaths occur in these countries. Infant mortality can be greatly reduced by antenatal steroids or newborn temperature management, the former of which is only used in 5% of births and the latter of which is only used in 20% of births in middle and lower income countries.

Possible Solutions

Universal Healthcare

One issue many children face around the world when trying to access quality healthcare is socioeconomic barriers. The first step to improving the quality of children's healthcare is to ensure that all children have access to healthcare services in the first place; this includes ensuring proper distribution of healthcare infrastructure and providing more

equitable access to said infrastructure, especially in cases where marginalized groups and minorities are more at risk for being unable to access healthcare.

There are multiple countries that have implemented universal health care programs, including Canada, Thailand, South Korea, and many European countries. This does not include countries like the United States that have implemented affordable healthcare programs such as the Children's Healthcare Insurance Program, which halved the number of American children that didn't have reliable access to healthcare.

In recent years, there has been more support for affordable healthcare in the international community, especially coming from Margaret Chan, the former Director-General of the World Health Organization, with a resolution in 2012 urging member states to implement affordable healthcare programs that would benefit all citizens. Despite this resolution being supported by most member states and later adopted, healthcare is still exorbitantly expensive in many places, pushing many households into poverty. This solution must be further advocated if member states desire to break down socioeconomic barriers in healthcare

International Funding for Pediatric and Maternal Health Programs

In countries where there is sufficient healthcare infrastructure for the general population, lower quality of children's health is often caused by lack of education in treatment methods, pediatric healthcare guidelines, and equipment designed to be suitable for children. Part of this problem is also a lack of proper maternal healthcare, as the quality of maternal and pediatric healthcare are intrinsically linked with each other. Infant and child mortality are greatly determined by the survival of the mother, especially in middle and lower income countries. This is especially applicable to diseases like HIV/AIDS that are transferred from mother to child, as the chances of a child being infected with these diseases during pregnancy, birth, or breastfeeding greatly decreases when the mother has access to treatment that slow down the progression of these diseases.

Poor neonatal and pediatric health occur mainly in middle and lower income countries also because commonly used practices in higher income countries to improve neonatal and pediatric health are much less frequent in middle and lower income countries. These practices have been proven to greatly improve infant and child mortality in higher income countries, and if implemented globally, could improve these indicators of health in countries that currently do not have access to them. If implemented in these countries, child and infant mortality could decrease by an estimated 40-70%.

Through international funding for health programs aimed at pediatric and, to a lesser degree, maternal health, countries that currently have a disparity between the health of children and the health of the general public can begin closing that gap by ensuring that the care children receive are specifically designated for them.

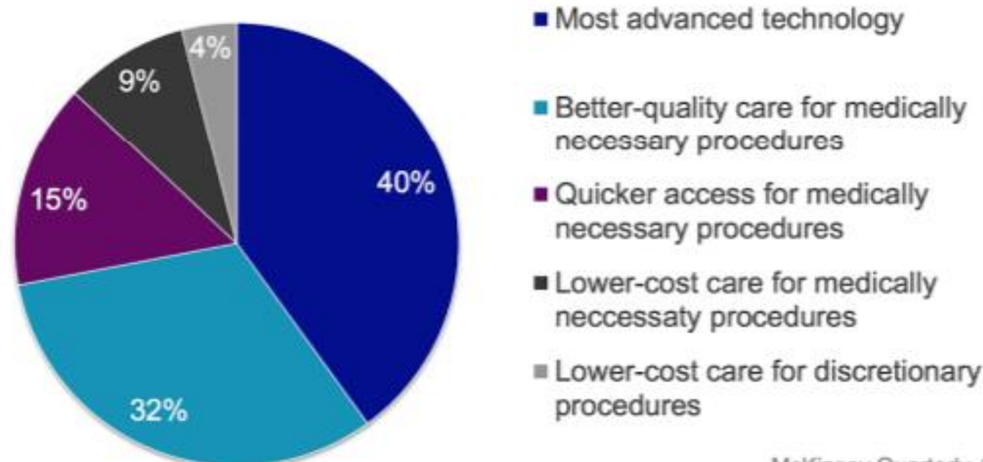
Questions to Consider:

1. How can countries assess their current pediatric care standards in order to understand what needs to be done to improve the current quality? What steps need to be taken to get there?
2. What barriers exist that could potentially inhibit improving pediatric healthcare?
3. What are currently the most prevalent barriers preventing children from receiving healthcare of adequate quality, if they receive it at all?
4. How large of a role does each country's financial situation play into improving the quality of healthcare of children?

Topic 2: Medical Tourism

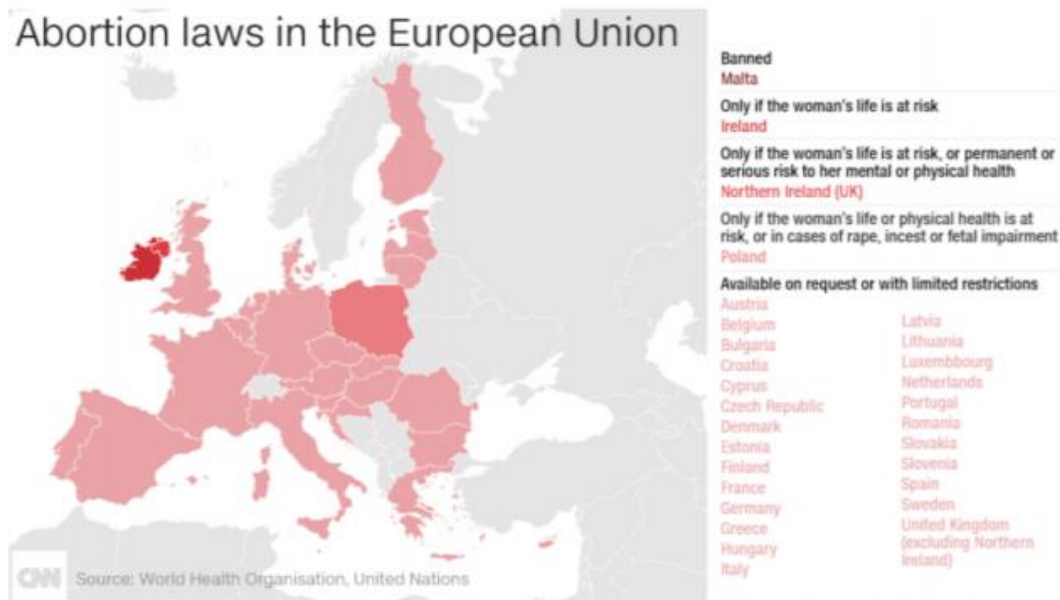
Overview

Medical tourism in modern times has been popular for patients seeking shorter waiting times, lower costs of care, or procedures restricted in the country where they live. Procedures sought abroad include fertility, cosmetic, dental, and internal procedures. Medical tourism intersects with the commercial organ market where the recipient and/or a (possibly unwilling) donor of an organ cross border lines to transplant an organ outside of an established medical system for profit in a process known as "transplant tourism". Subtracting expatriates receiving treatments in their country of residence plus emergency cases, medical tourists made up 35-45% of patients receiving care abroad in 2013. In 2008, there were 49,980 medical tourists seeking medical treatment abroad for a variety of reasons from lower costs to shorter waiting times. Of these patients, 40% travelled for better medical technology, 32% and 15% for better quality and shorter waiting time for necessary procedures respectively, 9% for cheaper necessary procedures, and 4% for cheaper elective procedures.



One popular form of medical tourism is what is known as "circumvention tourism", where a patient travels to a country to undergo a desired procedure that is illegal in their home country. Notably, Ireland and Poland, countries with some of the most restrictive abortion laws in the European Union, are the primary sources of female medical tourists seeking abortions in nearby countries where the procedure is legal; for Polish women, Germany is the primary destination, with the Netherlands and Austria also appealing to Polish women with online advertising in the language. From 1980 to 2018, approximately 170,000 women have travelled for abortions abroad, almost them to the UK. However, circumvention tourism is not limited to abortion; many 6 travel abroad for non-abortive

reproductive as well as elective treatments (including but not limited to assisted reproductive technology and assisted suicide) that are not legal where they live. Commercial surrogacy has been banned in two countries completely and in parts of two other countries. Seven countries and part of an eighth have banned anonymous sperm donation. Many others outright prohibit all forms of surrogacy or limit it to certain populations. The destinations of medical tourists when it comes to surrogacy vary based on what domestic prohibitions they seek to circumvent; for those from Sweden, Norway, and the Netherlands, Denmark is an ideal location as it permits anonymous donation, while those in western Europe seeking compensated surrogacy travel to Romania or Spain, and those in China and Japan seeking compensated surrogacy are drawn to Taiwan.



In certain cases, certain procedures are not available in a medical tourist's home country, hence their travel to another location where they can receive the treatment. In one case, a Nigerian woman seeking a kidney transplant travelled to India for the operation when she was told by her physician that it was not available in Nigeria. For Africans, India is a popular location, with state-of-the-art doctors and equipment and better prices, and the process of obtaining a visa is easier than in the UK and US. Countries like India that have a quickly growing medical tourism industry, or already have a monopoly over it, often have their hospitals coordinate with hospitals in countries that have a large output of medical tourists. This is also profitable for those not directly involved in the running of a hospital; many looking to profit from medical tourism often buy stock for industries that are patronized by medical tourists, which can be the hospitals themselves, but can also be airports and medical record management companies.

In other cases, cost is an important factor in a patient's decision to travel for medical treatment. This is especially prevalent in the United States, where healthcare is often exorbitantly expensive, driving patients to other countries for treatment, especially to Asia.

Compared to the United States' average of $300,000 for a liver transplant, Taiwan charges only approximately $91,000. In India and Thailand, internal procedures can be less than 10% of the price in the US.

Transplant tourism is also a prevalent problem, involving not only the sale of the organ tissue itself but also the commercialization of elements surrounding organ transplantation. Middlemen, including healthcare providers, often arrange the movement of international recipients in addition to recruiting donors; 69 out of 118 Taiwanese transplant patients questioned by the Department of Health reported their operations as being facilitated by doctors. This happens alongside allegations of Middle Eastern embassy officials facilitating commercial kidney transplants abroad in Pakistan and the Philippines. In certain cases, middlemen offer not just the organs but sometimes all-inclusive packages on the internet, the prices of which range from 70,000 to 160,000 USD.

Timeline

2003: Centre of Excellent Health Care of Asia initiative started by the Thai government to recruit international patients.

2004: Adoption of WHA57.18 in response to transplant tourism urges member states to protect vulnerable populations from the commercial use of tissues and organs

2004: Passing of ECOSOC Resolution 2004/22 "Preventing, combating and punishing trafficking in human organs."

2007: Founding of Medical Tourism Magazine, a business-to-business and business-to-consumer healthcare magazine that provides information on the logistics of medical tourism.

2008: China lifts restrictions on its citizens travelling to Taiwan. This pushes Chinese mainland citizens to travel to Taiwan for elective procedures.

2008: Declaration of Istanbul passed at a meeting of over 150 representatives to address the problems of organ sales, transplant tourism and trafficking in organ donors in the context of the global shortage of organs.

2015: GA Resolution 70/179 "Global Report on Trafficking in Persons" calls for the gathering of data on human trafficking for organ removal.

2016: UNODC's Commission on Crime Prevention and Criminal Justice writes Resolution 25/1 titled "Preventing and combating trafficking in human organs and trafficking in persons for the purpose of organ removal."

2017: General Assembly adopts without a vote document A/71/L.80, introduced by Spain, urging member states to prevent and combat human organ trafficking in line with

international law and asked the WHO to address its health, criminal and human rights aspects.

2018: Ireland votes to repeal its 8th Amendment, which prohibited abortion in almost all cases and forced around 170,000 women since 1980 to travel abroad for abortive care.

Past UN/International Action

In 2004, the World Health Assembly passed WHA57.18 , which was designed to protect vulnerable populations from the transplant tourism industry. The same year, ECOSOC passed Resolution 2004/22 titled "Preventing, combating and punishing trafficking in human organs" specifically addressing transnational organ trafficking. Similarly, the Declaration of Istanbul addressed transplant tourism specifically and Resolution 25/1 passed during the UNODC's Commission on Crime Prevention and Criminal Justice 2016 meeting. However, none of these resolutions have curbed the growth of the medical tourism industry, especially since many countries are actively promoting the benefits of their medical system to potential international customers, such as Thailand, which created the Centre of Excellent Health Care of Asia in 2003 to attract foreign patients prior to any of the aforementioned proposals, and Canada, which attracts wealthy medical tourists from Central America and the Gulf Countries to a system of hospitals and university facilities in Ontario and Quebec that have set out specific sections for international patients. Despite their limitations, resolutions do address the unambiguously urgent issue of transnational organ trafficking by calling on member states in each of these organizations to mobilize their law enforcement to better enforce laws restricting the sale of organs, whether domestic or international, as well as invoking resolutions previously passed by UN bodies.

Current Situation

The growth in the Medical Tourism industry is mainly due to affordability, accessibility and availability. Among many popular destinations for medical procedures, Asian countries have been attracting more tourists as the procedures are less expensive than those of other parts of the world, such as the US or European countries. According to the Global Medical Tourism Report, the Global Medical Tourism Market was worth USD 19.7 billion in 2016 and estimated to be growing at a CAGR of 18.8%, to reach USD 46.6 billion by 2021. According to past and estimated future trends, medical tourism will only continue to grow due to economic development in most countries; however, there have been concerns raised throughout the past few years about the risks and complications of medical procedure in foreign countries. Currently, there have been numerous amounts of information released online to inform the public about the issues and concerns related to medical tourism.

An increasingly popular form of medical tourism includes transplant tourism which involves the transport of organs/organ donors/organ recipients across international borders--this can happen concurrently with organ trafficking if the organs are obtained illegally or transplanted in an extrajudicial medical system. This can be dangerous due to the lack of government regulations that would otherwise exist within a judicially sanctioned system. Currently, transplant tourism occurs in either well developed countries where there are long waiting lists, or in very underdeveloped countries with no prohibitory regulations for buying and selling organs and for many people, it is their source of income. Both developed and underdeveloped countries have issues with transplant tourism and ethical issues being the most imperative.

Possible Solutions

Universal Decriminalization of Elective Procedures

As analyzed briefly in the overview (and will be analyzed in bloc positions), Ireland's criminalization of abortion has led to over 170,000 women travelling abroad for abortions. However, in 2018, after much debate, Irish citizens voted to repeal the amendment to its constitution that prohibited the procedure--this allows Irish women to access abortion up to 12 weeks, with exceptions made past that point for cases where the mother is in danger or where the fetus is not viable. As over 90% of abortions are performed before 12 weeks, it is reasonable to conclude that the decriminalization of abortions within this timeframe when most operations are performed will dramatically reduce the number of women who travel for the procedure.

Organ Donation "Opt-Out" System:

Part of the problem is the trafficking of organs and donors across international lines. As stated in the Declaration of Istanbul, the cause of these problems is mainly the shortage of transplantable organs worldwide. In England, 457 patients on the organ transplant list died due to a shortage of suitable organs, and the lack of organs can partially be attributed to families being unsure of the deceased wishes in regards to donating organs. In 2017, while 66% of English citizens were willing to donate, only 39% were registered to do so. In 2015, Wales introduced an "opt-out" system, where people must request to be taken off the list instead of having to request to be put on it, following which there was an increase of available organs. Scotland followed suit with similar plans soon later, and the topic is up for debate in England.

Questions to Consider:

1. How does medical and transplant tourism affect supply and demand of medical resources in both sources of medical tourists and their destinations?
2. How does internal legislation and regulation of medical procedures in a country either attract medical tourists or cause citizens of that country to seek treatment abroad?
3. The cost of care is not the same in all countries, which leads to patients seeking cheaper treatment abroad. Is this correlated with how regulated medical practices are in those countries or the quality of care given to patients in those countries?
4. Sometimes, procedures are done on tourists outside of established medical systems and regulations, especially when it comes to transplant tourism. Are these procedures more dangerous than if they were done in these established systems?
5. How can international organizations ensure that medical tourists receive healthcare whose quality is not compromised by lower costs/fewer regulations?
6. How can countries work together to hold doctors accountable for the negative effects of certain treatments on foreign patients?