WHO

Background Guide

AGENDA

Deliberation upon the effects of globalisation and capitalism on healthcare with emphasis on private healthcare facilities.

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Welcome Letter from the Dais

Dear Delegates,

We are beyond excited to meet you and are eager to welcome you to two days full of productive and stimulating debate. For us, Model United Nations have become an integral part of our lifestyle; we view it as educational as much as it's empowering to have the ability to construct opinions on global issues through the eyes of several different countries. We hope that as soon as you join into the committee session you learn something new and that hopefully by the end of the conference you have grown in one way or another; whether it's your ability to overcome your fear of public speaking or your ability to lead large groups of people. If this is your first Model United Nations Conference, then don't worry too much and feel free to approach any of us at any point in the conference if you need any form of support. Please do not hesitate to reach out to any member of the Secretariat or Executive Board and even your fellow delegates if you have any concerns.

Regards,

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Notice

Greetings Delegates

This is to inform you that the position papers need to be submitted '**compulsorily**' by 18.08.2023 (6 PM) and would be marked upon. The mail ID to submit the same is **adisharma1976@gmail.com**.

What is a Position Paper?

A position paper is a document written by a delegate explaining their stance regarding the issue at hand.

What is the structure or How to write a position paper?

- Good introduction, having a sound idea on the country's stance on the matter.
- What are the issues to be addressed?
- What are the affirmative actions taken by your country for the same? And to what extent is your country involved with respect to the agenda.
- What are your country's expectations from the global forum?
- What are they trying to establish during the course of the committee? This can also include new solutions.

What is the Format of a Position Paper?

1. Delegate Name:
2. Committee:
3. Country:
4. Agenda:
5. Body (included in the structure)

Note: everything should be in Times New Roman, font size 12, font colour black. (A sample of the same is attached at the end of the document)

Best Practices to Research before an MUN:

(You can take these best practices into account, not only for this MUN but for other MUNs as well.)

· Read the Agenda Guide, least 3-4 days prior to the conference, and make a note of everything that needs to be understood. In case of a crisis situation always read and look for the analysis and plausible rational on the updates that may be issued a week before the MUN.

· Google/Search everything and find related documents (UN, News articles, Scholarly articles) for whatever was not really understood.

· After wholly understanding (subject to how in-depth you wish to go for the research), try understanding your allotted country's perspective on the agenda.

· Make the stance in accordance with the country's perspective on the agenda which shall also define your foreign policy (history, past actions, etc.)

· Understand the cues and hints that are given minutely in the Background Guide that may come handy while the presentation of contentions in committee.

- Take a good look at the mandate of the council as to what you can discuss and what you can do in this council. This point is placed here, just because your knowledge base shouldn't be limited to the mandate of the council. Know everything, speak whatever the mandate allows.

- Follow the links given alongside and understand why they were given. Read the footnotes and the links and hyperlinked text.

- Predict the kind of discussions and on what subtopics can they take place, thereby analyzing the subtopic research you have done and prepare yourself accordingly. Make a word/pages document and put your arguments there for better presentation in the council.

- Download the United Nations Charter, the Geneva Conventions of 1949 and additional protocols thereto and other relative treaties and documents given.

Introduction to the agenda

What was the relation between capitalism and the dramatic decline in the death rate that occurred in England between 1850 and 1950? The decline could not have been due to the market-based health care available at the time, since it had hardly any effective treatments for diseases. Until recently the prevailing view was that improved nutrition, resulting from rising real incomes, was chiefly responsible, but further historical research has shown this to be at best a partial explanation. During the first two-thirds of the nineteenth century death rates in the cities, where incomes and nutrition levels were rising, did not fall; death rates were lower in rural areas, where incomes remained low. A significant fall in urban mortality began only when the effects of the 'sanitation movement' began to be felt from the 1870s onwards, providing sewers and clean water supplies, improved housing and uncontaminated food. The sanitation drive was often resisted by capitalists for example by employers who did not want to pay higher taxes for sewage or spend money on replacing unfit workers' housing, and by private suppliers of water and purveyors of unclean food. But the sanitation movement gradually prevailed, thanks to the fear of epidemics, to which the middle and upper classes were not immune; to the determination of leaders in the local government reform movement of the period; and, towards the end of the nineteenth century, to the impact on educated public opinion of the advances that were beginning to be made in understanding the causes of illness.

The sanitation movement was initially based on mistaken ideas about what caused diseases (especially the idea that they were caused by foul air, or 'miasmas'). The discovery in the 1870s that infections were caused by germs showed that good sanitation was indeed a key part of the solution; but the new knowledge also led to an extension of the scope of public health activity and to health education for schools and households – in hygiene, baby and child care, and so on. The source of one infectious disease after another was identified, and new preventive measures were adopted, including immunisations. The overall result was dramatic. Between 1871 and 1940 the share of infectious diseases in total annual deaths in England and Wales fell from 31 per cent to 10%. By 1951 infectious illnesses accounted for only 6 per cent of deaths, while the overall annual death rate had fallen from 22.4 to 6.1 per thousand people. It is important to stress, once again, that almost all this decline was due to prevention. For most of this time there were still no effective cures for most infectious diseases (sulphanilamide drugs only began to be available in 1935, penicillin in 1941, and broad-spectrum antibiotics from 1947 onwards). Richard Easterlin has summed up the historical verdict on the relation between the capitalist market and health as follows. First, life expectancy remained stagnant, or at best mildly improved, throughout most of the nineteenth century in the areas of the world that were undergoing rapid economic growth. Life expectancy (and physical stature) improved dramatically only when disease prevention became effective; increased nutrition due to rising workers' incomes did not on its own produce this effect.

Second, most of the preventive measures involved in bringing about the mortality revolution – clean water supplies for all, sewage, etc – are public goods, requiring collective action, and benefiting everyone whether or not they contribute to their cost. Capitalist markets will not deliver such goods, and did not. The same applies to vaccination and immunisation – they only work reliably if they are applied as universally as possible. Since a majority will be unlikely to pay for it, the state must do it. Similarly with household hygiene: 'because the new knowledge was not proprietary, the market could not be relied on to disseminate it'. Third, the cost of the dramatic improvements in health that were achieved by medical science and preventive measures was modest. They did not depend on the major increases in national income that capitalism produced, and indeed dramatic advances in longevity have been achieved in recent times in even very poor countries, from China in the 1950s to Cuba in the 1960s and Kerala in the 1970s. Finally, the cost of the research which led to these advances in health was itself quite small, and did not depend on capitalist-driven growth.

'When one considers the rudimentary laboratories of scientists like 'Pasteur, Koch and Fleming,' Easterlin comments, 'it is hard to believe they involved requirements that much exceeded those of their predecessors two centuries earlier.' As late as 1929 the total cost of research and development, public and private, in all fields of science in the USA was just 0.2% of GDP, and biomedical research was a small fraction of that. Today the costs of medical research have hugely increased, but the social benefit derived from it is another matter, as we will see.

What was certainly important was science itself. The physical sciences – especially physics and chemistry – had prospered because they had amply proved their worth for capital accumulation. Advances in the biological sciences came later, and showed their full profit potential later still. But support among the capitalist class for science in general, resulting from the economic benefits derived from the physical sciences, was an important factor in enabling the crucial advances in both sanitation technology and medical science to be made, and this in turn was a consequence of the intellectual freedoms secured by the preceding bourgeois revolution. So while the mortality revolution was not a willed achievement of capitalists, the rise of the bourgeoisie did provide, though often in indirect and complex ways, the context in which the scientific basis for it could be developed. It is worth noting, though, that at the height of the mortality revolution in the late 19th century medical research was still relatively disinterested and critical. It had not yet begun to lose its integrity, as Marx pointed out was the case with mainstream economics:'[The class struggle] sounded the knell of scientific bourgeois economics.'

Also, while the world was gasping for breath, due to the novel coronavirus, the scenario had again brought into relevance about Marx and Engel's take on capitalism, health, and the healthcare system. According to Marx and Engels, capitalism is a system of conflicting social relations that is based on a fundamental social antagonism. This happens between the few who have capital, and the ones who have only their labour power to sell.

Poverty, Illness, Capitalism

The past health emergency throughout the world and the failure of the healthcare systems had again projected the vicious cycle of poverty, illness, capitalism. Slums or closed living quarters of the workers are the by-products of the labour that is needed in a capitalist economy. Engels pointed out that these living areas in which the workers are crowded together are the breeding places of all those epidemics which from time to time have struck humanity.

Cholera, typhoid fever, smallpox, and other ravaging diseases spread their germs in the air and the water of the working class living spaces. This explains why the poor and the migrant workers all over the world including India are facing unimaginable difficulties and becoming victims of the COVID-19 pandemic.

Health And Healthcare Systems

Marx and Engels' historical materialism throws light on the contemporary health, healthcare, and healthcare systems. The current systems of healthcare, have been produced through struggle and conflict and continued to change with the emergence of new forces of production or forms of exchange, new technologies, the opening or closing of markets, and shifts in world trading patterns. According to Marxian-inspired sociologists, the current healthcare industry is a product of the marketplace of the capitalist. They see the healthcare system as a site for commercial transactions.

To them the current healthcare system is a marketplace – and a site for the production and consumption of capitalist commodities. As privatization of the healthcare systems in India began with the reforms, the healthcare sector was polarized between the classes of affordable and unaffordable, which made healthcare systems very expensive in the private institutions run by the capitalist. This snowballed into issues like increased out-of-pocket expenditure in the private healthcare systems, leading to health payment-induced poverty. This is evidenced from many cases that were reported during the pandemic that there are differential benefits as well as price systems between the public and private healthcare systems.

Shift Towards Public Health Care Rather Than Private

The country has witnessed the inadequacy of the capitalist model and realized the limitations of healthcare industry privatization in solving the public health crisis faced with the COVID-19 pandemic, especially in the time when the medical and health industry is facing the problem of market failure. Although privatized healthcare systems help in improving efficiency and growth, it reduces the countries' long-term preparedness for dealing with pandemics such Covid. In general, public hospitals are responsible for providing public healthcare services and medical welfare.

In the outbreak of large-scale infectious diseases, the local public departments can integrate medical resources through macro-control, coordination, and intervention to better control the virus. The public healthcare sector must be encouraged to continue and increase its efforts to safeguard the welfare of underprivileged and low-income beneficiary populations while pursuing a privatization policy.

Their role is irreplaceable in coping with the public health crisis and provide the basic needs of healthcare services to the general public. The Pandemic had exposed the inadequacy of private healthcare and the importance of spending and strengthening public healthcare. In the long term; the crisis must be a learning lesson for the governments to re-evaluate and drastically improve upon the funding in public healthcare, infrastructure, and capacity building of the human resources.

Healthcare in the USA

The USA does not have a universal, free healthcare program, unlike most other developed countries. Instead, in line with the free-market-virtue mindset, most Americans are served by a mix of publicly and privately funded programs and healthcare systems.

Most hospitals and clinics are privately owned, with about 60% being non-profits, and another fifth being for-profit facilities. Coverage by federal and state programs is partial, and most insured Americans have employment-based private insurance.

Group plans funded by the employer cover about 150 million Americans.

Private insurance

These include health maintenance organizations (HMOs), which are networks of providers. Insured patients see a primary care physician (PCP), whose refers them to a specialist if necessary.

A more popular option is to use preferred provider organizations (PPOs), which allow patients to see external providers, choose their PCPs, and see a specialist without a PCP referral provided the former is willing.

These are now used by over 55% of insured employees, compared to 25% in HMOs or point- of service (POS) plans.

With POS plans, patients must have a PCP in the provider network, but can go out of the network for a fee.

Federal insurance

The Indian Health Services and Veteran Health Administration provide care for Native Americans and military veterans, respectively. The Military Health System, operated by the Department of Defense, provides paid care to serving military personnel.

Publicly funded insurance

Public spending accounts for at least half of all healthcare expenditure, while third-party payers pay only 27%.

About a third of the population is covered by three publicly funded programs – Medicare, for people above 65 years and some disabled people, Medicaid, for those living in poverty. and the Children's Health Insurance programs, which cover children from families that are not eligible for Medicaid, at above 300 percent of the Federal Poverty Level (FPL).

The ACA act of 2010 ("Obamacare'), which was enacted in 2010, revamped health insurance. It created health insurance marketplaces, which cover about 17 million Americans. However, these plans are often small, exclusive, and restricted in provider choice.

At the same time, the expansion of Medicaid under the ACA act has possibly saved many lives at less than $900,000 per life saved, vs $7.6 million under other public insurance plans.

The good and the bad

Among 11 high-income countries, the US healthcare system is the most expensive, with 17% of the GDP being spent on healthcare in 2018. Many American health indicators far surpass world standards.

Its rate of specialized scans (computerized tomography – CT – and MRI) – are among the highest in the world, at double the OECD average. So is its utilization of hip replacements, influenza vaccines, and breast cancer screenings.

However, among developed countries, the American system is among the least accessible, efficient and equitable. The number of physicians, and rate of physician visits, is among the lowest. Ethnic and disadvantaged social groups suffer massive inequalities.

About 14% of Americans (over 27 million) were uninsured against illness at the end of 2018, causing an estimated 60,000 avoidable deaths. High medical costs have led to bankruptcy for a fourth of senior citizens, says an earlier study.

Preventable and lifestyle conditions such as obesity, hypertension and diabetes are rampant: this indicates poor access to primary care and primary prevention of disease, compared to its peers.

Meanwhile, US suicide rates are highest among all members of the Organization for Economic Cooperation and Development (OECD).

Overall, the US healthcare system allows providers to inflate prices and expensive services, but poorly compensates essential services such as primary care and behavioral advice. It also draws healthcare services away from rural and poor communities.

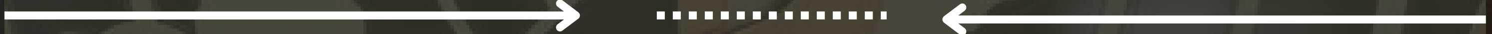
Nonetheless, the US leads in medical innovation, boasting many of the world's leading hospitals. For those who can pay, it provides high-quality care.

COVID-19 response

Even though the US healthcare system serves 4% of the world's population, a quarter of global COVID-19 cases and a fifth of global COVID-19 deaths occurred here. The reasons are not primarily related to the healthcare system, however.

Rather, they include a disjointed, reluctant and often contradictory public health response to the pandemic, driven by political apathy toward the virus threat.

There is no central command and control for healthcare in the country: this obstructs infection spread control.



Healthcare in the UK

The UK healthcare system covers the whole population via the National Health System (NHS), which is 79% publicly financed from taxes, and operated by the Department of Health. About 20% is paid for by national insurance, and private patients and copayments make up the rest.

NHS England supervises and funds local Clinical Commissioning Groups. These provide comprehensive care, including preventive screening programs and vaccinations, inpatient and outpatient care in hospitals, maternity care, mental health care and palliative care

Like the USA, the UK has public, private profit and nonprofit hospitals. The first type is operated as hospital trusts or foundation trusts, in three tiers: community hospitals, district hospitals, and regional-level hospitals. Dedicated hospitals offer specialized treatment

General practitioners (GPs) offer primary care to locals through their practices. Many such practices are overtaxed: one alternative is registration-free walk-in centers. GPs refer patients as necessary for secondary care.

All residents of England, as well as anyone with a European Health Insurance Card, are entitled to NHS care: primary care is mostly free. Others receive emergency or infection-selective treatment.

Even though the US healthcare system serves 4%Patients in the NHS can choose a hospital and specialist. Currently, 12% of the population also opts for private health insurance, mainly to avoid the waiting period for elective care, to have a choice of specialists, and better facilities.

Private hospitals typically offer specialized treatments, such as bariatric surgery, and do not offer trauma care, emergency services or intensive care.

The UK spends about a tenth of its GDP on healthcare, with almost 80% being spent on the NHS. 18 | P a g e Unlike the American healthcare system, the NHS's administrative spending is only 16% of healthcare costs.

The good and the bad

Universal free healthcare is widely considered to be good for the country, health-wise as well as economically.

The UK NHS provides free healthcare for all and higher life expectancy than in the USA, at half the cost. Patient satisfaction is relatively high, at 61%, compared to 29% in the US.

Taxes for healthcare may appear higher but are actually equivalent to the total medical expenses in the US. Moreover, drugs are cheaper, and there are no surprise medical costs

Austerity cuts have led to a reluctance to recruit staff and to upgrade equipment, which may eventually affect the quality of care. Waiting times for consultations and surgeries are long.

A third issue is health tourism, where non-residents exploit the NHS to get high-quality medical care at a lower cost than is available where they live, but without a corresponding contribution through taxes.

Ethnic minorities and the poor face inequality in the healthcare system. Social care measures need to be implemented.

COVID-19 response

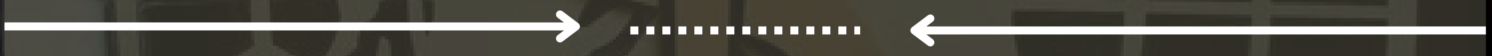
When the pandemic hit the UK, the government built seven temporary hospitals to cope with the sudden demand.

Case finding, contact tracing and isolation were woefully inadequate, allowing community spread to occur and forcing local authorities to take over.

Routine medical care was affected by the pandemic. Patients avoided the emergency department for fear of infection. At least 160,000 patients waited a year for diagnoses, vs the standard 18 weeks. Restoration of this standard may take years.

Mental health care, already pressured, is under massively increased stress, with an estimated 10 million new patients influenced by the pandemic.

Many staff were infected or exposed to infection: to compensate, others have been asked to forego or limit planned leave.



Healthcare in the European Union

Each country in the EU has its own healthcare system. However, EU members generally share the same goal as the UK model.

All healthcare systems in Europe automatically include all citizens irrespective of paying capacity. Secondly, all are mostly funded by taxes paid by the employer and by the public. Healthcare is free, except for some elective and specialist services.

Three models

There are fundamentally three models at work within the EU: single-payer, socialized, and privatized-regulated.

In a single-payer system, the government provides universal insurance or coverage, but the actual care is by private practices and hospitals.

Individuals may opt for additional private insurance to cover services that are not covered by public healthcare, but not for those already available. The payment for such providers may be feeforservice, or capitation, based on the number of patients enrolled.

More recently, lump-sum payments have been adopted to cover all services per year per person enrolled. However, fee-for-service tends to encourage excessive use of manpower and capital resources.

Hospital funds are allocated as diagnosis-related groups (DRGs), per-diem, or as lump-sum payments for all services.

The socialized system is one where the government both provides insurance and runs the hospitals. It is thus the only health insurance provider. The NHS is a version of this model, which is also used in France, Italy, Norway and Sweden.

Patients may opt for supplemental private insurance, to get services not supplied within the public health service, or to see doctors not employed by this service.

France, cited by some as having among the best healthcare systems in the world, has a significant private healthcare system as well as statutory health insurance, offering a wide choice of coverage.

However, recent amendments to the law made it mandatory for employees to pay half of the insurance sponsored by their employers. This is especially so for dental and vision expenses, not covered by the state health insurance.

This system strongly resembles the American Medicare, Medicaid and Veteran Affairs schemes.

The privatized but regulated healthcare systems within the EU are exemplified by Germany. Here, though all citizens earning below a threshold must take health insurance, their unemployed spouses and dependents are also covered without any extra cost.

Above this threshold, employees may buy private insurance. However, other than self-employed and government servants, most people prefer not to.

In Switzerland and the Netherlands, health insurance is mandatory and provided exclusively by private providers. The government subsidizes the premiums through taxes, making it possible for even low-earning citizens to afford health insurance.

All insurers are legally required to accept any applicant. This costs the patient much less than it would in the US, the system is easier to navigate, and the coinsurance is capped at a reasonable ceiling.

Thus, European healthcare provides primary and some secondary medical care, with some places allowing private companies to sponsor more insurance for their employees.

Privatized programs allow for specialized care, cut down the waiting time for a procedure, or expand the patient's choices.

The EU average for healthcare expenditure is about 8% of the GDP, but Cyprus and Latvia are at 3.5%, with other East European nations at 5%. Public spending in this sector typically makes up about 15% of the total government budget.

The good and the bad

Most EU members enjoy the approval of the majority of their people for their healthcare systems, with less than 5% of people in four-fifths of European countries reporting unmet needs.

National health systems tend to control costs better. The introduction of internal markets may increase the healthcare economy and efficiency.

Nonetheless, funding pressures are likely to go up as patients expect more advanced treatments and as technology develops. The greying of Europe may impede fund flows to these programs, given that about 70% of the funding comes from the public sector in most countries.

At the same time, aging is associated with different patterns of disease, typically conditions that are both preventable and care-intensive. As age increases, however, social welfare tends to absorb more of the costs.

Audits of spending efficiency will be crucial to enhancing the spending power of each euro. “The OECD estimates that one fifth of health expenditure makes little or no contribution to improving people's health.”

Inequalities in health status and inequity in healthcare finance and delivery continue to plague the system in many EU nations.

COVID-19 responses

While many countries had set up smoothly functioning mechanisms to deal with the pandemic, the EU was, generally, unprepared. The stockpiles of equipment, medicines and ventilators were inadequate in many places.

This hampered these countries from buying testing kits and setting up contact tracing, for example, early in the pandemic, which further slowed down virus containment efforts.
Crisis management plans fell short of reality, forcing healthcare staff to improvise and innovate, as well as overwork, to compensate. The need to share resources, and hospital capacity, internationally, could also be significant.

Thus, logistics, preparedness, coordination, and continuing with routine healthcare, are areas that need future improvement.

Healthcare in Asia

Asian healthcare systems are a mélange of public and privately managed programs

Singapore

Singapore uses the 3Ms system: a public statutory insurance system, MediShield Life for large hospital bills, and some high-end outpatient treatments as well, but not primary care, or specialist care at the outpatient level.

The premiums are subsidized to help even low-earning people to pay them, and working-age people pay more to allow older people to enjoy lower premiums.

A compulsory national health savings account called MediSave helps pay for hospital care and some outpatient treatments. MediFund is a social welfare program for poor citizens who cannot pay for out-of-pocket expenses even with MediSave.

Thus, the government, healthcare providers, and patients all share the responsibility for healthcare coverage – a multi-payer financing system. While competition and market forces enhance the quality of healthcare, the government strictly regulates the costs when they begin to rise beyond affordable rates.

The Ministry of Health also plans for workforce strength, training and land allotment for healthcare facilities, along with preventive health interventions. The system's centralized nature keeps administrative costs low and simplifies procedures.

Singapore spends about 4.5% of its GDP on healthcare, about 40% by the government, with 30% being out-of-pocket expenses.

China

China has almost universal publicly funded medical insurance, with urban employees enrolled in employment-based programs. Others enroll voluntarily, for basic subsidized medical insurance.

Comprehensive healthcare is covered, but deductibles and copayments apply. There is also a ceiling on reimbursement.

For-profit private insurance is also available for services not covered by public insurance. Patients share costs for physician visits, inpatient care and prescription drugs, which are uncapped.

China spends about 6.6% of its GDP on healthcare, with 28% being funded by central and local governments, 28% out-of-pocket, and 44% by public or private insurance, and social health donations. These form part of a medical assistance program for the poor.

Wide inequalities in public health services have been reported. Most residents feel that their insurance is as helpful, at least, as the basic public health services.

India

India provides universal free outpatient and inpatient care at government clinics and hospitals. States are in charge of organizing their healthcare services.

However, government facilities are notoriously understaffed and ill-equipped, so that most people pay out-of-pocket for private healthcare. The National Health Protection Scheme (Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana, or PM-JAY) was recently launched to attempt to address this: it supersedes the earlier under-performing National Health Insurance Program (Rashtriya Swasthya Bima Yojana, or RSBY).

The PM-JAY program is financed by taxes and enables free secondary and tertiary care at private hospitals. PM-JAY envisages grassroots Health and Wellness Centres while providing cashless hospital care for the 40% of people (approximately 100 million) who live below the poverty line.

Government workers and most formal employees have their own health insurance schemes. A few private health insurance providers also exist, with limited uptake. Less than 40% of Indians are insured.

The situation is worsened by the poor quality of public healthcare services and the shortage of doctors and equipment. Corruption, as in many developing countries, along with accessibility issues, exacerbates these drawbacks.

India spends less than 4% of its GDP on healthcare, with a quarter being funded by the public sector. Out-of-pocket payments at private hospitals make up 75% of the total expenditure, in stark contrast to other poor countries.

COVID-19 response

The overall strategy in east Asia's advanced economies was to suppress the spread of the virus using conventional containment measures.

Careful case tracking, contact tracing, and quarantine helped contain the virus in Singapore, Hong Kong and South Korea, for instance.

Even in less economically advanced countries like India, the Philippines, and Vietnam, public health education and preexisting community values proved useful.

These commonly shared values allowed people to take more easily to non-pharmaceutical interventions (NPIs) such as masking up, staying at home, and social distancing.

In India, the lockdown was a key weapon against the spread of the virus. This was coupled with a ramping up of production of personal protective equipment, ventilators and testing kits.

Yet, extreme and widespread poverty, weak healthcare systems and the high population density make tracking and countering the pandemic a difficult task in India, as in other developing Asian countries.

Healthcare systems in Australia

Australia has a tax-funded universal free public health insurance program, called Medicare. All citizens get free care for public and many physician services and drugs at public hospitals.

About 50% of Australian citizens also take out private insurance to pay for private hospital care or dental care. This is encouraged by the government, and high-income families pay a tax penalty for not buying private insurance.

The total expenditure on healthcare is about 10% of GDP, with 67% being from the public sector. It is jointly run by federal, state and territorial governments, and is among the best in the world.

The good and the bad

While free universal care is an undoubted advantage, funding may be challenging as the population ages, reducing tax inflow. Meanwhile, medical technology costs go up, making it difficult to keep up.

There is a disparity in access and care quality between the non-indigenous and the aboriginal population. Research is not well-aligned with national priorities. Urbanization continues to pose an obstacle to healthy living.

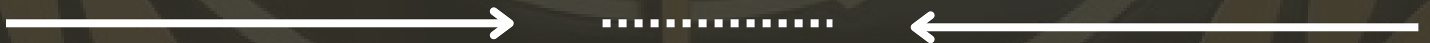
COVID-19 response

The Australian response to the pandemic included building transparency between the government and citizens, to ensure public trust. This in turn resulted in a high level of compliance to lockdowns, masking up and quarantine, as well as rapid testing.

Secondly, the decision-making process was driven by reliable data interpreted by experts and performed in an agile and iterative manner. Both political and public health leaders were seen to be cooperating and trustworthy.

Thirdly, the pandemic response was based on a collaboration across health and economic boundaries. The public health response was both willing and strong, which certainly helped to achieve the goal of virus containment.

This resulted in low mortality and infection rates, as well as a rapidly rebounding economy. Localized outbreaks still occur, and are handled on a crisis level. This has come at the cost of many stranded Australians abroad who cannot return home due to the cap on the number of returning passengers.



Healthcare systems in South America

While medical services tend to be cheaper here, they are also universal and publicly funded in countries like Chile and Columbia. As a result, medical tourism has boomed in these places.

Healthcare systems have progressed since the time when only employees in the formal labour market received public health insurance, to which employers, employees and government contributed.

The rest of the people relied on fragmentary services by the Ministry of Health, the church, and charitable or philanthropic organizations. The rich had private health care. The poor had almost nothing.

Colombia

Colombia is a success story in South American healthcare. It covers almost 97% of its population by mandatory universal health insurance. All citizens have access to the same healthcare services, with only 14% out-of-pocket spending. This is lower than that in many OECD countries.

The health system is financed through taxes and employment insurance and fully subsidizes the poor. Both public and private insurers are involved, and providers also belong to both public and private sectors, with a healthy competition between the two.

The FOSYGA; Solidarity and Guarantee Fund, is based on cross-subsidies between rich and poor, young and old, and healthy vs sick.

Participants may choose their provider within their network, and receive a package of primary care, some inpatient care, and emergency care, as well as inpatient care at tertiary level public hospitals. Eventually, the government hopes to eliminate supply-side subsidies and provide uniform coverage for all.

Performance management, accountability and efficiency need to be improved to build on these gains.

Chile

Chile has statutory health insurance for workers, with no employer or government contribution. The health funds are managed by ISAPREs (Social Security Health Institutions).

The rest of the population is covered by a public fund manager, the National Health Fund (FONASA). These cover healthcare payments.

Brazil

Brazil has a government-run universal comprehensive public health system, funded by taxes at federal, state and municipality level. While the federal contribution is about 43% of total public health expenditure, municipalities contribute almost a third.

The system covers all types of healthcare for all citizens and visitors. However, wait times are unreasonably long at all stages, leading to out-of-pocket spending for basic care, while the delays push up treatment costs.

Drug unavailability leads to out-of-pocket spending. About a quarter of people have private health insurance, typically as an employment benefit.

National health expenditure is about 9% of the GDP. Most hospitals are public.

Costa Rica

Costa Rica also has a successful healthcare system, under a single-payer model that combines social security with the medical services offered by the Ministry of Health. About 86% of the population has access to high-quality comprehensive care, which is delivered free. The rest are able to pay for care.

Argentina

Argentina has a healthcare system whereby insurance is provided and managed chiefly by workers' unions, while over a third of the population is uninsured and depend on public healthcare.

The good and the bad

South American healthcare systems suffer from poor resources, which are badly distributed to cover some areas. The capacity of the systems is low, and drug shortages are common. Corruption vitiates the process of official appointment and hampers reforms.

Response to COVID-19

The year of COVID-19 had seen over 21 million cases, and 560,000 deaths in South America, along with severe economic stress. Argentina, with a test positivity rate of 60 percent in October 2020 – the highest in the world - reflects both low testing and poor enforcement of non-pharmaceutical interventions.

Brazil had reported 13 million cases with over 330,000 deaths, with intensely divided political and public health messaging leading to it being one of the hardest-hit countries in the world. It was followed by Colombia, with a steadily increasing infection rate. Chile, meanwhile, had among the worst outbreaks in the world, with 1,500 deaths per million inhabitants.

The health response had been marked by its wide variation, with some countries instituting strict lockdowns, closing borders and eventually rolling out millions of vaccinations, while others have done almost nothing meaningful to prevent border crossing.

Limited resources, non-unified health systems, and poor social care, along with pre-existing unemployment and inequities, have led to a less than desirable response to the pandemic in most of Latin America, impacting the disadvantaged most severely, as expected.

Sample Position Paper

Country : Kingdom of Sweden
Committee : European Union
Topic Area : EUROZONE AND FINANCIAL SYSTEMIC CRISIS
Delegates : Lutfitasiwi

In 2009, 7 years after the euro introduction in 2002, Greece declared that its country has debt up to 300 billion euro, the highest in modem history. The crisis is spreading to Italy, Spain, Ireland, and Portugal. The Kingdom of Sweden recognizes the efforts that have been made by the Union, including bailout. Since the bailout is not enough to solve the debt, those countries are now being faced with the dilemma of whether or not they will stricter the austerity policy, resulting to more strikes and riots from the society or not cut the spending, which leads to financial collapse because other European governments may not have enough money to bail these countries out.

Even though Sweden is not in the eurozone, given the highly integrated economy of our union, Sweden cannot be an exception during this time of hardship. Not to mention, 50% of Sweden incomes come from foreign trade.

Cause

Kingdom of Sweden believes the the lack of discipline of several countries in ruling fiscal policies. Beside governments, it was the private sector who were taking out loans resulting to unprecedented low interest rates in southern European countries.

Current Policy

Even though Kingdom of Sweden is not in the eurozone because 80% of people disagree with euro, Kingdom of Sweden expresses its willingness to join the effort of the recovery of the eurozone.

Kingdom of Sweden agreed with European Financial Stability Facility establishment on 9 May 2010. Sweden also pledges $10bn to IMF bailout fund. On 9 December 2011, Sweden has agreed to sign the Fiscal Stability Treaty, a treaty that is able to coordinate the Union's fiscal budget.

Solution

Sweden has faced economic crisis in 1990, yet, Sweden has succeed to bounce back its debt less that 40% of its GDP. With those experiences, Sweden doesn't believe in more austerity policy and believes that EU should take these solutions into account:

(-) Kingdom os Sweden is **supporting the ratification on Fiscal Treaty**, believing that supervision towards countries fiscal budget in the integrated economy is necessary.

(-) **Conduct bank capitalization**: Finance Minister of Sweden, Anders Borg, said that giving the fund this flexibility would increase the eurozone's credibility and it will prevent the bank system from failing. The fund can either come from ECB or ESM. The same strategy was used when Sweden was going through its financial crisis in 1990.