UNGA

UN General Assembly

Chair: Justin Cabana
Vice Chair: Caroline Gee and Hunter Frommelt



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Letter From the Chair

Hello Honorable Delegates,

On March 1st, I will have the privilege of serving as your chair for UNGA in LYMUN XI. In addition to MUN, you may also recognize me from BPA, Science Olympiad, Scholastic Bowl, or Congressional Debate. In committee, we will explore current issues while navigating through tense politics. As we simulate these topics in our mock committee, remember that these issues affect millions in reality. Consider continuing your activism outside of our chamber, hopefully with improved skills from your gained experience at LYMUN. Tangents aside, here is some important information on preparation:

- The **timely submission of 2 original** (no plagiarism nor AI use) **position papers** is a requirement for award eligibility and must be formatted as follows:
    - header including name, school, position, and topic (any order is fine)
    - can be submitted electronically to cab513375@d204.lths.net or physically handed in at the start of committee

In committee, I expect to see diplomacy in collaboration, a solid understanding of the topics, and most importantly, fun! Make sure to follow the **no-tech policy** and **do not write working paper clauses before the conference starts**. Committee shall be kept equal by giving everyone a chance to speak, efficient by moving debate flow along at a steady pace, and most importantly– fun. After the 2nd session, I am available for chair feedback. Whether an experienced senior or an amateur freshman, I wish you all the best this upcoming conference.

Position List

Argentina
Australia
Bangladesh
Belgium
Brazil
Canada
China
Costa Rica
Cuba
Democratic Republic of the Congo (DRC)
Denmark
Egypt
France
Germany
India
Italy
Japan
Kenya
Liberia
Mexico
Netherlands
Nigeria
Peru
Philippines
Ukraine
United Arab Emirates
United Kingdom
United States of America
Qatar
Russia
Saudi Arabia
Singapore
Spain
South Africa
South Korea
Sudan
Sweden
Tunisia
Turkey
Vietnam

UNGA Background

After decades of violence at the end of two World Wars, 51 founding members convened at the June 1945 San Francisco Conference to adopt the UN Charter which laid the groundwork for global cooperation. Of the six organs the document devised, the UN General Assembly stood out as the central deliberative body where all member nations could cooperate on policy-making recommendations. Within the scope of the body are fiscal responsibilities, oversight over member admission, and supervisory powers over the six lower committees.

Within fiscal responsibilities is the formation of the UN budget. The General Assembly discusses and finalizes the level and distribution of funding across all agencies. These funds mainly originate through voluntary rather than obligatory contributions, though governments comprise the largest funding source through willing donation at ¾ of the budget. Other supranational organizations such as the EU and international financial institutions including the World Bank and International Monetary Fund generate 15% of funds. Private sector and non-governmental organization donations account for 5%, often marginal and irregular.

Often called the Main Committees, these six subsidiary bodies are designated specific areas of focus to delegate tasks to areas of expertise, while this Assembly, as in the name, covers general topics that span across several committees' focuses. When drafting working papers, be cognizant of the scope of committee power and budgetary limitations.



Topic A: **Urban Planning and Upgrading**

Just two years ago in 2022, the world population reached 8 billion people. The latest milestone before that was in 2011, at 7 billion. In those 11 years, humanity grew by 1 billion people at an astonishing rate, much quicker than the time it took to reach the first billion milestone in 1804. With rapid population growth comes rapid urbanization as people congregate in high density areas for collective and mutual economic benefit. If more people are around, there are more employment opportunities and more consumers for more start-ups. This pattern, generally observed in developing nations, is called **rural-to-urban migration** and occurs as jobs diminish in the agricultural sector due to mechanization and develop in the industrial sector due to innovation. Rapid industrialization and subsequent urbanization pose several challenges.

Subtopic: Urban Housing

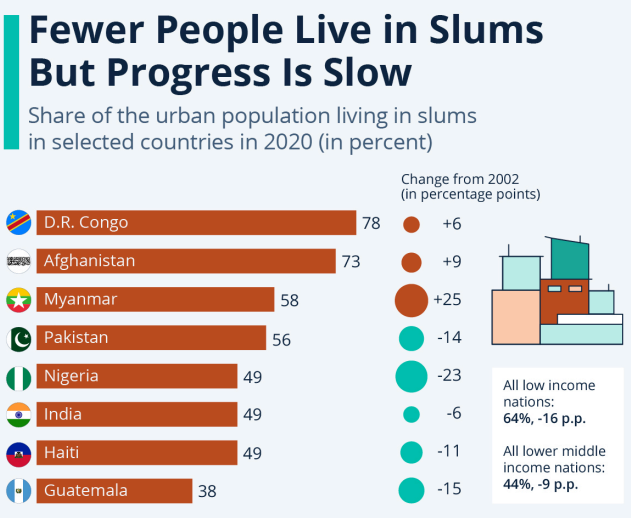
Housing crises are created as people move in quicker than buildings can be constructed. Consequently, either homelessness or slum creation arises– Sudan, the DRC, and Liberia all have more than half of their urban populations in slums coupled with a ≥3% urbanization rate, and the Sub-Saharan and South Asian regions also follow this trend. These squatter settlements, termed *favelas* in Brazil or *bidonvilles* in North Africa, house an estimated 10% of the world population in often unregulated, unsafe, and overcrowded neighborhoods. Lack of regulation creates health risks with unstable construction, which jeopardizes the safety of residents especially in areas prone to earthquakes or other disasters, improper ventilation, which worsens air


a Latin American favela

a North African bidonville

pollution, plus untreated sewage and poor filtration, which spread waterborne diseases such as cholera, dysentery, and polio, accounting for 1 million deaths annually.

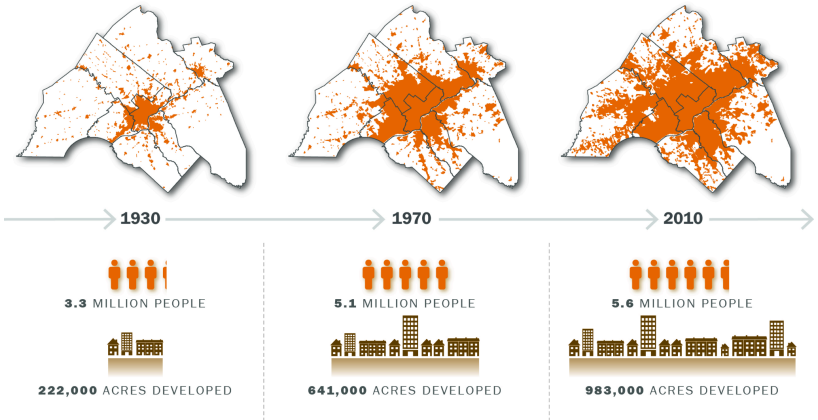
The intricacies of squatter settlements altogether have impelled some governments into **slum clearance**, the demolition of slums usually followed by construction of higher end property. The current examples in Urualla, Nigeria, or New Delhi, India display the motives of slum clearance in greater safety, higher property value, and political image, but expose the consequence of **gentrification**, the replacement of low value property with high value property that results in displacement of the original inhabitants whose lower income can't afford the higher rent, property tax, and overall cost of living. Though gentrification develops property value, it contributes to slum creation elsewhere through displacement, and has been further criticized for eroding the original culture of the neighborhoods in which it occurs. Urban developers must balance property improvement with ensuring affordability, often termed **slum integration**.



One response to gentrification is mass construction of affordable housing. Affordability is created in two ways: for one, affordable homes are strategically built to be cheaper. A smaller cost of construction from creating smaller, simpler homes, means less cost is carried over to the occupant. Secondly, mass creation of homes means greater supply which drives costs further down. However, especially after COVID-19 and supply chain backlog, construction slowed as expense and timeframe for projects rose, further complicating affordable housing programs. Some municipalities, or even entire countries like Germany and Sweden, have instituted **rent**

caps to limit property value inflation, but some report it has lowered the quality and quantity of rentals available as landlords adjust to lost revenue. Finally, another major response to housing crises is **zoning laws** that regulate what types of development (residential, industrial, commercial) can be built where.

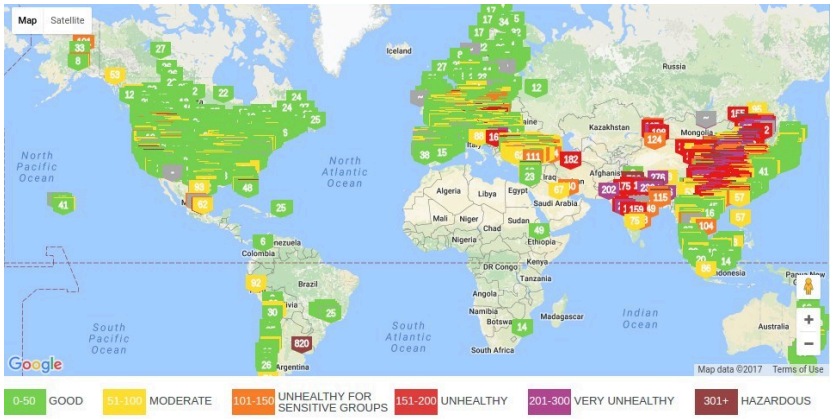
While developing areas see growing urban areas, developed areas witness expanding urban areas. As the core city is commercialized, residential areas relocate to the outskirts of cities. These suburbs are still connected to the city through railway, road, or other transport, and are usually still considered part of the greater metropolitan area. Developed areas experience urban to suburban migration among wealthy families who can afford the closer-knit communities and larger lawns of suburbs. When the expansion of urban and suburban land grows uncontrollably, it is known as **urban sprawl**. While the growth of suburban areas creates local economic growth and greater social cohesion, it has been criticized for unnecessary energy and water waste from larger properties, increased car dependency that creates more congestion and pollution, and habitat degradation. One general solution is to 'heighten' cities rather than 'widen' them by creating denser housing in the center to minimize waste, shift transport use from automobiles to public transit, and physically and socially bring communities closer together.

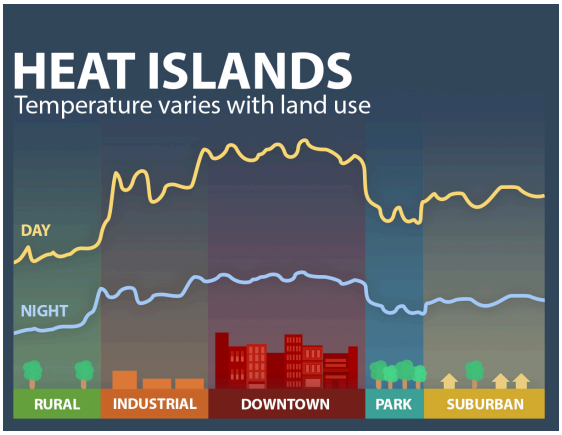


Subtopic: Urban Pollution

Another intricacy of population redistribution is the greater density within urban areas that follows movement into cities. It brings high density and the larger labor force, cultural diversity, and consumer market which enables cities to prosper. However, in areas with less resources, high density can pose challenges such as pollution.

Higher rates of consumption puts pressure on production whose waste is released as air and water pollution or improperly disposed of by consumers, explaining why 70% of the global carbon footprint is traceable back to urban areas according to the UNEP. Not only is density a factor in higher pollution, but so is flawed urban design that can result in urban heat islands and groundwater depletion, posing environmental and financial problems. Urban **heat islands** are caused by three main factors. First, city pavement with low albedo (solar reflectance) absorbs and emanates more heat, contributing to higher urban temperatures, which is further exacerbated by the second factor: impermeability of city pavement means less water can be held in the pavement to naturally cool it. Thirdly, the greenhouse gasses generated by industrial smog trap solar radiation and intensify temperatures. Then, urban heat islands burden civilians with discomfort, higher energy costs for more frequent and intense use of air conditions, and intensification

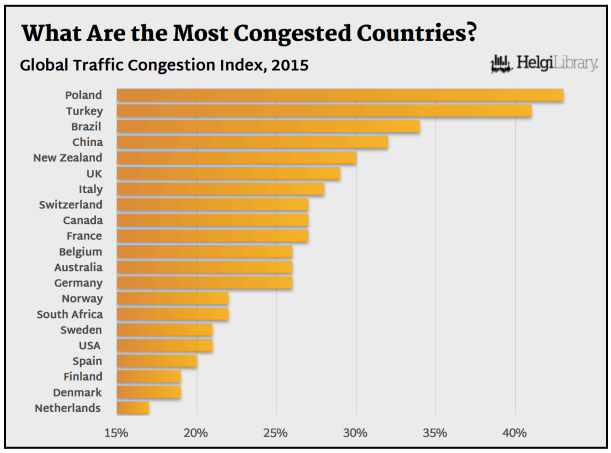




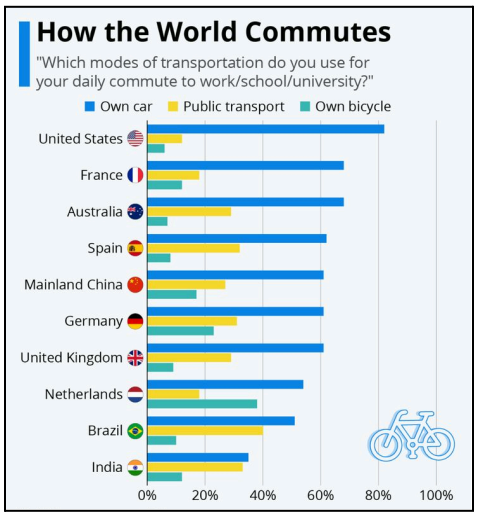
of **photochemical smog**. Heat catalyzes the reaction between industrial pollutants to form brown smog that inflames respiratory illness, decreases visibility which increases vehicle accidents, and hinders plant growth. Efforts to counter urban heat include limits on carbon emissions in urban areas, replacement of pavement with more reflective and permeable material, and creation of greenbelts or rooftop gardens which naturally cool the air with shade, transpiration, and provide people with recreational space and animals with habitat. Permeability also ties into groundwater depletion, as impermeable pavement does not allow rainfall to replenish underground reservoirs. Sometimes, in coastal cities, the problem is further exacerbated by **saltwater intrusion** when ocean water diffuses into emptied aquifers after urban overuse.

Subtopic: Urban Transport

Tying into pollution, traffic congestion is another important side effect of high density, which has financial implications in addition to its environmental ones. Traffic causes unnecessary losses of productivity, energy, and safety that could be avoided with smarter city planning. The most recent Global Traffic Scorecard report, which measures annual hours lost to congestion per driver, found that 58% of urban areas saw increases in traffic delays despite rising gas costs, adding more financial strain to civilians' spending. Combined, road incapacity and automobile overreliance both produce traffic. While increasing road capacity may seem to be the intuitive solution, road expansion is often impractical due to price and logistics, and poses ecological harm with more habitat destruction and engine emissions. Instead, many countries have pivoted towards shifting transport reliance from automobiles to safer, cleaner, faster and



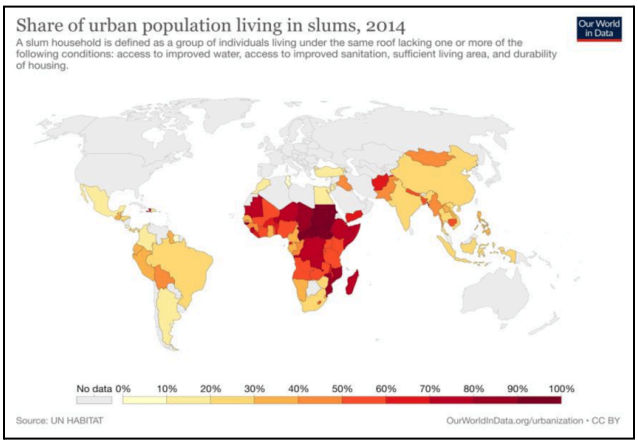
cheaper alternatives. One popular path for this goal, even enshrined in the UN Sustainable Development targets, is the use of **public transport** which "provides access to safe, sustainable, accessible and affordable transport systems for all." As for safety, public transport inherently has less accidents as drivers are more experienced or the vehicles are autonomous, and experiences less crime due to almost constant presence of people, surveillance, and staff. As for sustainability,



mass transit lowers emissions as it allows less vehicles to carry more people, which is only furthered by the fact that many public transport systems use cleaner vehicles such as electric buses, bikes, or high speed rail like in Japan or the coastal US. Some municipalities may forgo any transport altogether for maximal sustainability in **walkability**, the accessibility of all urban amenities by foot to eliminate pollution and increase social cohesion. Mass transit also addresses accessibility with greater interconnectivity that expands market size for local businesses and employment opportunities as people have greater physical mobility. Lastly, in regards to affordability, public transport fares can be made cheaper through investment and funding. However, some companies struggle to balance the fine line between charging travelers high enough to turn a profit and charging travelers low enough to maintain low income accessibility. Turning a profit is especially difficult for high speed rail, which has an immediate high upfront cost and slow payback with low train fares and a low number of travelers. The benefits of well thought-out transport showcase the importance of city planning. Developing areas must organize their current urbanization, while developed areas may have to retrofit outdated infrastructure to fit modern standards of affordable housing, environmental protection, and accessible transport.

Previous Solutions: Urban Housing

In partnership with the General Assembly, UN Habitat has spearheaded international action in the developing world's housing crisis. The 'Housing for All' campaign outlines several policy recommendations that 43 countries have implemented. One element to their strategic plan is citywide slum upgrading (CWSU) that has reached 190 cities and 5 million slum dwellers. The 2014 Practical Guide for CWSU outlines three key features of the program: street planning for greater connectivity, citizen participation for localization, and spatial analysis to map progress. The publication also includes outstanding examples, such as the Pamoja Trust in Kenya which convinced the Nairobi City Council to zone a special development area for denser affordable housing, or the Mumbai Urban Transport Program which constructed similar infrastructure except near railroads to allow slum dwellers more mobility. While general guidelines can be included in international solutions, as the program illustrates, personalization of housing programs to local communities' unique needs is pivotal. Inhabitants may backlash against urban planning done without their input, and landlords may challenge stringent rent caps or other market controls. Thus, UN Habitat reports community collaboration is essential to the success of housing programs. Similarly, the UNECE's 'Housing 2030' is a European centered campaign that also prioritizes 'good governance' in clear understanding of stakeholder roles, monitoring responsibilities, and implementation. In partnership with Euroconstruct, the Bank for International Settlements, and Housing Europe, the



regional action plan laid out four main goals: streamlined regulation, accessible funds, more land availability, and climate-neutral construction.

The developed world has also focused on their own challenges of suburbanization and urban sprawl. A study by Yale University summarized common traits in urban sprawl solutions, including private transport disincentives, zoning laws to limit horizontal urban expansion with greenbelts– natural recreational parks on the edge of a city– to fill space instead, and construction of affordable housing in the city center. The UN Urban Planning Lab with a budget of $3 million annually has worked with 17 countries to design 'compact, integrated, and socially inclusive cities.' A sister program, Urban Planning for City Leaders, is an organization of 400 planners to maximize land use and involve civil society in planning. Overall, though the UN has taken substantial steps toward solving the global housing crisis, there is still room for improvement in centralizing, streamlining and expanding efforts.

Table 1.

Top Hundred Countries in Terms of Constructed Impervious Surface Area

COUNTRY	ISA km^2	Population (Landscan 2004)	ISA per Person (m^2)
China	87,182	1,292,548,864	67.4
United States	83,881	282,575,328	296.8
India	81,221	1,058,349,824	76.7
Brazil	17,766	177,885,936	99.9
Russia	17,135	138,947,840	123.3
Indonesia	16,490	230,000,208	71.7
Japan	13,990	122,192,928	114.5
Mexico	11,854	103,608,488	114.4
Canada	11,295	32,022,750	352.7
Pakistan	10,666	150,465,168	70.9
France	9,537	59,497,124	160.3
Bangladesh	8,878	140,275,504	63.3
Germany	8,500	82,406,312	103.1
Italy	8,294	56,528,760	146.7
Nigeria	7,668	125,118,728	61.3
United Kingdom	7,576	58,926,004	128.6
Spain	7,037	39,481,976	178.2

Previous Solutions: Urban Pollution

The 11th Sustainable Development Goal (SDG11) encompasses the need for resilient, eco-conscious urban planning, which involves urban pollution mitigation. The UNECE has been particularly active for good urban air quality, setting an example for other regions to follow or tailor to their region. The 1979 Air Convention that cut back particulate matter emissions and 2017 Worldwide Light Vehicles Test which reports more accurate fuel efficiency to consumers helped reduce pollution by 30-80% since 1990, adding 1 additional year of life expectancy to the continent.

The first step towards creating policy and tracking its progress is data collection–something that many developing nations can't currently do with limited finances and resources. These 'overpolluted and underrepresented areas,' as described by a UNESCO report, are mainly concentrated in Central America, Africa, and South Asia. Data collection can help shine light on previously overlooked or even unknown issues; UN Water reported in 2021 that 3 billion people are at health risk due to scarce data on water quality. Nonetheless, despite limited resources, the developing world has made notable strides in urban pollution management such as Chile and South Africa's use of permeable pavement, or Argentina's 'green corridors.'

Previous Solutions: Urban Transport

UN Habitat's current mobility and transport campaign involves the expansion of public transit, spread of sustainable transport methods, and decrease of car dependency. The program recommends against road expansion to reduce urban sprawl, congestion, and emissions, instead offering high-capacity public transport systems such as metro, light rail, or bus rapid transit with 'last mile access' for greater availability as a more accessible long-term option. The characteristics and use of public transit vary region to region, from rising competition among US-based public electric scooter services to high speed rail in China.

Lastly, the idea of walkable cities has been formulated by UN Habitat, UNEP, and other environmental or housing organizations as an especially important solution for developing areas' urban planning and developed areas' urban upgrading. Amsterdam, Helsinki, and Zurich have all made significant progress in the creation of public transit, centralization of city services, and limitation of urban sprawl to form closer-knit communities. In many developing countries where integration of the outskirts into urban areas is just beginning, accessible transport and prevention

of sprawl is particularly important. Green corridors, zoning laws, and financial incentives are several examples of policies enacted by some nations to centralize the city and its transport.

Questions to Consider

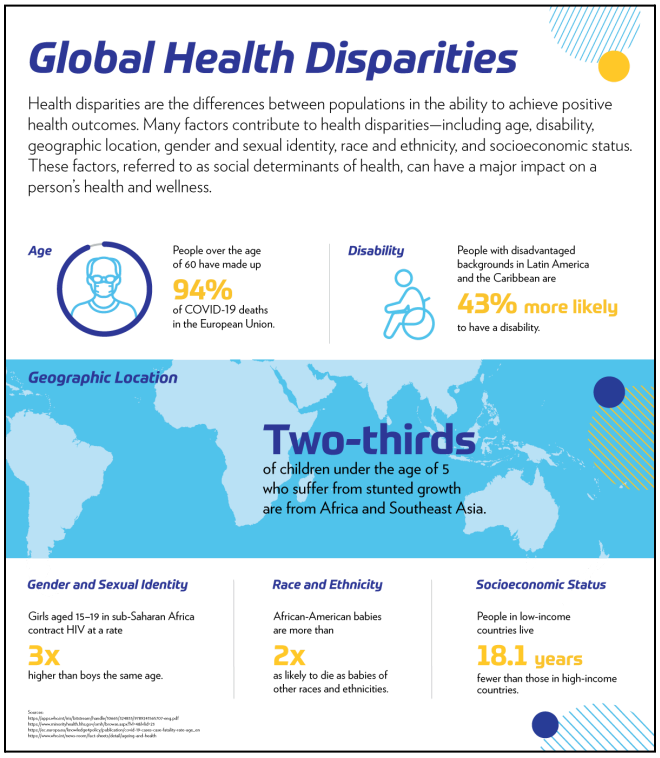
- Is your country developing and focused on urban planning or developed and focused on urban upgrading?
- How prevalent are informal (slum) settlements in your country?
- Are there local, national, or global initiatives your country is involved in to solve urban and industrial pollution?
- How sufficient is urban transportation in your country?

Glossary	
rural-to-urban migration	rural to urban migration trend in developing areas as employment shifts from agriculture to industry
slum clearance	removal of informal settlements and their inhabitants
gentrification	development of low value property into high value that inadvertently displaces the original poorer inhabitants
slum integration	slum upgrades intended to help the inhabitants
rent caps	limits on rent that landlords can charge on tenants
zoning	laws that dictate what types of buildings can be where
urban sprawl	horizontal expansion of urban or suburban areas
urban heat island	the higher temperatures in urban areas due to greater industrial pollution, pavement, and lack of green space
photochemical smog	mixture of pollutants formed by industrial emissions that limit visibility and inflict respiratory illness

saltwater intrusion	diffusion of saltwater into emptied aquifers due to overuse of groundwater, often in coastal cities
public transport	government ran system of vehicles to be used by all
walkability	accessibility of urban amenities by foot

Topic B: **Healthcare Accessibility**

Before the advent of modern medicine in the 18th century, humanity was plagued by frequent epidemics, ineffective treatment, and unsanitary practices. However, a series of innovations in the understanding of the human body, disease, and nutrition all culminated in a scientific revolution to permanently upgrade healthcare. Unfortunately, the benefits of medical advances are unevenly felt– disparities in health and access to treatment correlate with socioeconomic disparities between demographics, neighborhoods, or countries on the local and national scale. The World Health Organization quantifies this inequality into the 18 years longer a person from a high-income country will live than a genetically identical person born in a low-income country. Another empirical study conducted by WHO concluded zip code has a stronger influence on one's overall health than their genetics, as it correlates with their socioeconomic status, food availability, and level of education, all of which impact the quantity and quality of opportunities one has to improve their wellness. This health gap, illustrated by the study, manifests in the form of malnutrition, health



illiteracy, mortality, and other negative outcomes of inaccessibility. In order to bridge the medical gap, the underlying causes and possible remedies must be identified. The main factors behind the global health discrepancy, and their respective solutions, fit into two general categories: economic factors and social factors.

Subtopic: Economic Inaccessibility

Though healthcare has nearly always had a bad reputation of costliness, the price of these human services has only climbed, becoming more inaccessible to low-income people. Exorbitant fees pose a negative feedback loop that results in cyclical poverty. Poorer civilians are more likely to contract disease as lower socioeconomic background correlates with a lower quality of life and higher vulnerability to sickness, which then pushes people further into poverty due to healthcare debt. Then, as people are more impoverished, the affordability of sanitation, nutrition, or check-ins becomes even more unattainable, which leads to worse and costlier illness. The WHO estimates that 100 million people have been pushed into poverty because of health expenses, joining half of the world's population who cannot obtain essential services in the first place. This cycle has only exacerbated after the pandemic and supply chain backlog. During the COVID-19 pandemic, demand for medical supplies from masks to vaccines increased by 32%, to the point where hospitals had barely enough protection to ration to their workers, increasing costs by 20% as greater demand leads to greater prices. This trend was intensified by a pre-existent labor shortage in the healthcare workforce that worsened when many workers quit due to stress or tragically passed. In response, many clinics hiked costs to compensate for rising expenses, which hurt the poorest the

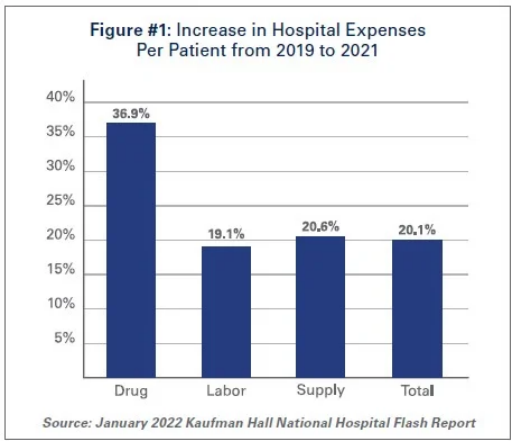


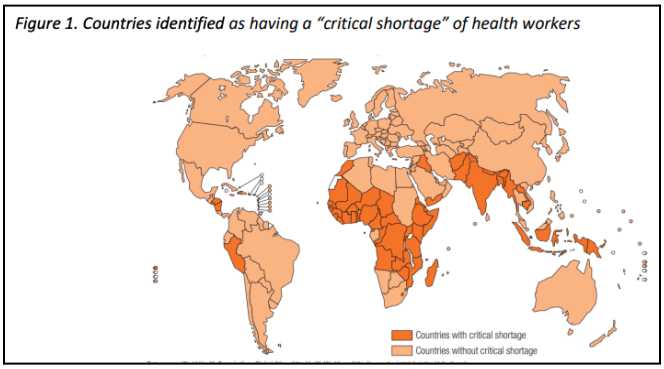
Figure #1: Increase in Hospital Expenses Per Patient from 2019 to 2021

Source: January 2022 Kaufman Hall National Hospital Flash Report

most. The UN Statistics Division documented that worldwide poverty rose 1 percentage point during the pandemic, reversing four years of progress. Of course, some governments attempted to dampen the destitution with hospital grants or increased welfare, but as budgets were tightened among a myriad of other issues with education, infrastructure, and the economy, financing these efforts was especially difficult with varied effectiveness. In all, the COVID-19 pandemic illustrated and intensified the financial barriers that separate people from quality healthcare, and revealed the need for stronger outbreak readiness.

Though the global health workforce shortage is predicted to rebound from 15 million workers short in 2020 to 10 million workers short in 2030, a lack of workers still remains prevalent, especially in poorer areas. These places lack educational opportunity, which contributes to a decrease in the quality of healthcare and the quantity of workers since less people are able to get interested in and get training for medicine. Poorer areas also correlate with more conflict due to scarcity of resources fostering competition or conflict causing costly destruction, which distracts from education and burdens hospital staff with greater demand. A bigger **patient to caretaker ratio** decreases quality of care as medical workers have less individual time with patients to form emotional connections and provide care, and usually is associated with higher healthcare costs for the patient as there is low supply and high demand. Large workloads, tremendous stress, and low salary all contributed to higher turnover, only worsening the inadequate amount of students who can enter the medical workforce in these areas.

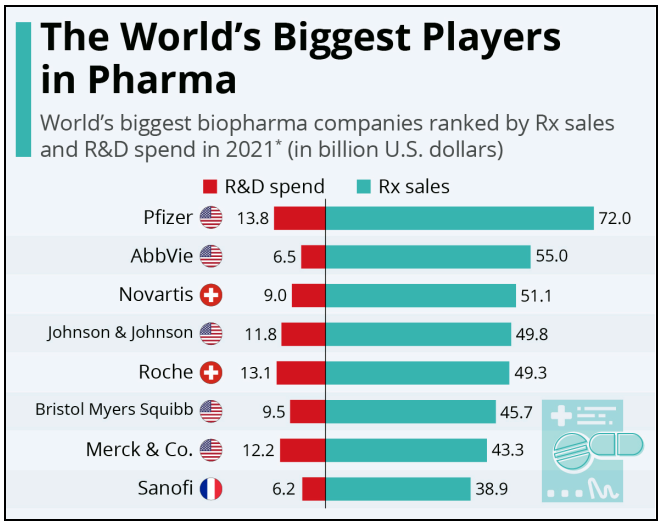
Figure 1. Countries identified as having a "critical shortage" of health workers



Another economic reason behind shortages in low income areas is decreased access to innovation. New, innovative drugs usually cost more. The high costs that hospitals incur in purchase means less money is leftover for workers salaries, contributing to labor shortages. Then, new medical technology may require costly and time consuming training for doctors, which further widens healthcare discrepancies between poorer and richer areas. Whether it's new drugs, advances in automation, or revolutionary vaccines, the pharmaceutical companies that are the center of innovation due to their massive profits often hike prices to garner even more revenue for more innovation to monopolize the industry. Less competition and higher prices for medicine disadvantage communities already struggling to provide healthcare even more. These monopolies, collectively called **Big Pharma**, dominate intellectual property rights with an average of 74 patents on top-selling drugs that garner a worldwide revenue of $1.5 trillion USD. While proponents of these companies argue large profit is needed to finance important innovation, opponents argue that a monopolized pharmaceutical industry dissuades competitive research, or even question the value of innovation. The Access to Medicine Foundation's 2018 Report found that out of the 139 urgently needed drugs as identified by WHO, 91 had yet to be developed, with 16 having no projects at all. The differences in budget and spending between Big Pharma companies, conflicting statistics or accounts, and the question of what qualifies as 'necessary spending' further complicates the trade-off between innovation and accessibility. Some report corporations mainly invest into research, while others document allocations mostly to lobbying or advertisements. Some fear monopolization doesn't just decrease innovation within



Big Pharma, but also prevents small upstarts from competing and spurring innovation. The argument posits that more competition between more companies would incentivize organizations to increase their quality better than their competitors to attract the most investment, driving innovation forward. The inaccessibility of the industry widens the global healthcare gap, and more broadly, the global wealth gap, since the medicine monopoly is almost completely based in the US and Western Europe. As a result, the countries excluded from this 'medical elite' feel underrepresented and underserved. Recently in February 2024, a group of African nations in WHO attempted to bring this problem to light and propose a solution in the form of financial compensation from pharmaceutical companies for pathogen access and benefit sharing (PABS) given to said companies. However, drug companies generally backed by the US and the EU opposed compensation and the creation of a centralized bureaucracy to manage that process, citing concerns with sovereignty infringements and sustainable profit.



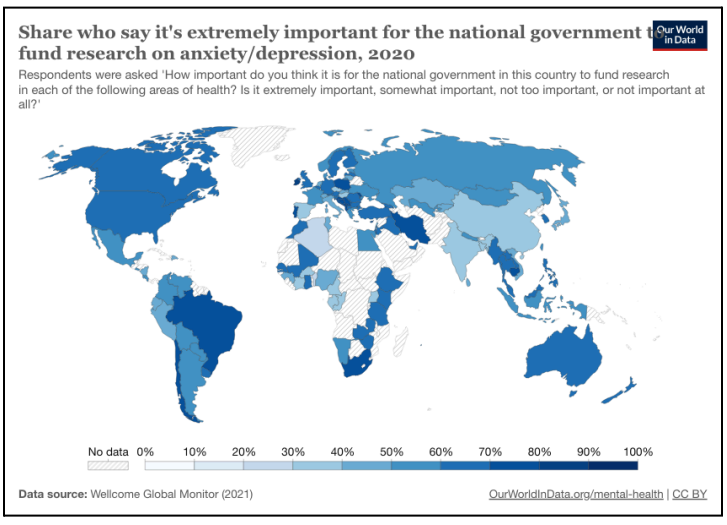
Lastly, another major barrier to healthcare is disconnectivity. Smaller, poorer communities lack the funds to construct and maintain transport infrastructure to larger settlements where healthcare services are more likely to be located, especially true for more specialized treatment. These regions are called **medical deserts**, and often span across impoverished rural



neighborhoods. Transport expansion is one response to physical inaccessibility, but often has high upfront and maintenance costs. Instead, to treat disadvantaged populations and displaced people, some have created **mobile health clinics** as a more flexible and viable alternative. These clinics can take a variety of forms from furnished ambulances to pop-up tents, but serve the same purpose in reaching disconnected people in need.

Subtopic: Social Inaccessibility

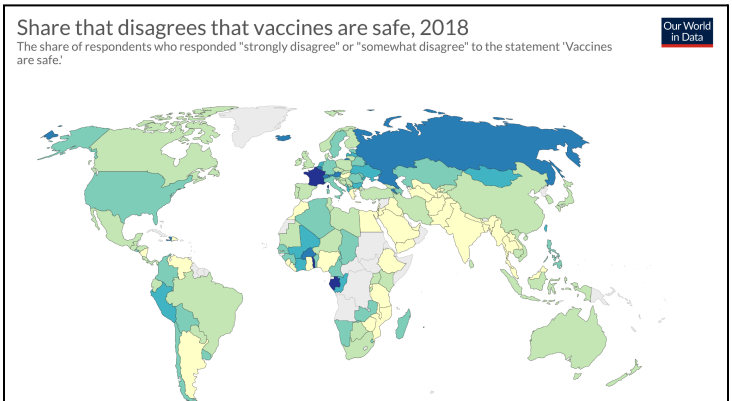
Not only do economic barriers of supply shortages, lack of education, and inadequate transport exist, but so do social barriers. Decades of discrimination based on sex, race, and other **protected characteristics** still persist as systemic divisions and social shame. Stigma is a particularly notable issue as according to a joint international study on 14 countries, depending on the country examined, 19-95% of healthcare workers reported stigma against health problems, especially for mental health. The American Journal of Public Health reported this stigma was one of the four causes behind why 70% of people worldwide suffering from mental illness don't receive treatment alongside lack of knowledge to identify features of mental illness, ignorance about how to access treatment, and an expectation of discrimination post-diagnosis. These factors encompass the three main categories of stigma: public stigma, negative attitudes against individuals with mental illness expressed by society at large; self-stigma, internal shame for one's own mental health conditions; and institutional stigma, government or organization policies that restrict the rights of those with mental health conditions. Public stigma often leads to self-stigma and institutional stigma, as societal shame and negative depictions of poor mental



health instill into one's own self-image and carry over into policymaking. Lower funding for mental illness research or cutbacks on mental health welfare are examples of institutional stigma that exacerbate the problem further, as less funding leads to lower quality care for patients and worsened mental health.

Not only is stigma a product of historical discrimination in healthcare, but so is systematic bias. Due to the aftermath of past discriminatory policies, people of color are less likely to receive services and be included in healthcare data collection. This data disparity became particularly problematic with the advent of **clinical algorithms** using AI. Artificial intelligence is machine learning algorithms that analyze trends across given data to make predictions about similar data. For instance, a clinical algorithm could be trained with past medical records to determine which patients, given their medical records, need urgent care the most. Such was the description of a widely used health algorithm reviewed by an international scientific journal which found out that Black patients had to be deemed much sicker than White patients with the same healthiness in order to be recommended for the same care. Another MIT publication found AI trained on incomplete and narrow data "consistently and selectively under-diagnosed under-served patient populations." These inherent biases are reflective of historical discrimination against minorities that has resulted in less data collected on, and lower clinical algorithim-supported healthcare quality for minorities.

Another emerging deterrent to healthcare is **disinformation**, intentional lies circulated throughout expanding social media platforms. The Journal of Medical Internet Research identified the most common health disinformation were anti-vax, anti-mask, and pro vaping. The rapid

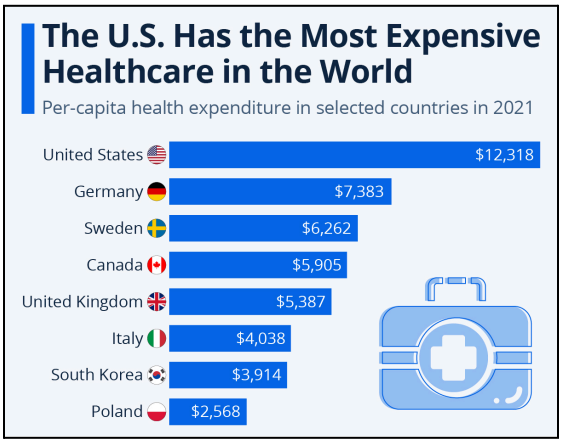


spread of this disinformation has led to real life consequences as it has dissuaded thousands from trusting or following healthcare professionals.

Previous Solutions: Economic Inaccessibility

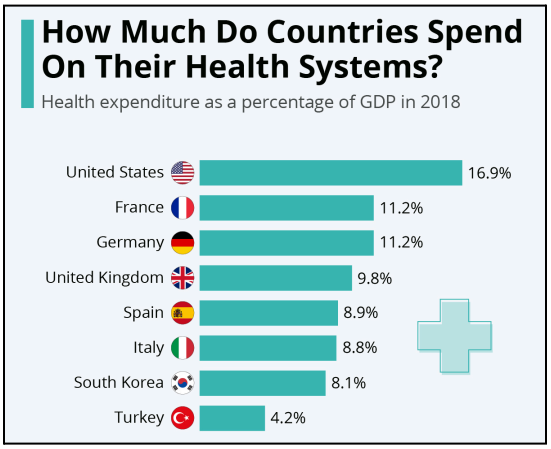
The main goal of all solutions to economic inaccessibility is **universal healthcare coverage (UHC)**. Described as the status of "all people having access to the full range of quality health services they need without financial hardship," by the WHO, numerous policies have been devised, implemented, and analyzed in effectiveness with varying degrees of success. There are no official recommendations for the specifics of UHC policies by the UN, possibly because the economic situation of countries and their healthcare differs regionally and locally, but general guidelines also have yet to be established.

As recovery from COVID-19 slowly finishes, prices are not decreasing back to pandemic levels, but leveling off at a new high. While some speculate that the new 'price plateau' is due to lingering supply chain backlog, others blame pharmaceutical companies for the supposed price hike. One attempt to lower prices that targets Big Pharma are **price caps** for medical products, usually life-saving ones like insulin or EpiPens. Australia, Canada, Greece, the UK and South Korea are all countries that enforce drug price controls. Proponents say price caps force companies to reallocate spending from advertising or lobbying to research and allow startups to innovatively compete. Opponents say price caps drive drug producers and retailers out of business. The Information Tech and Innovation Foundation reports if several nations reduced their price controls such that prices rose to 75% of US levels, pharmaceutical companies would have



increased revenue of $24 billion, which could be used to create 11 revolutionary drugs annually. The UN has no official statement on price caps for medicine.

Another solution that has been implemented nationally before is the **single-payer system**, which involves one entity, usually the national government, administering all the healthcare funding and payments. Brazil, South Africa, Cuba, Spain, and Saudi Arabia all have some form of this program. Meant to lessen healthcare costs for all, critics fear the system just shifts costs over into higher taxation to compensate for more government healthcare spending, lessens competition, and lengthens wait times due to the fact that only one entity manages all administration of funds and payments.



In response to labor shortages, some nations have formed visa programs to incentivize doctors, nurses, and physicians to relocate to their country to alleviate their shortages. The host countries are typically wealthier because they need stronger economies to attract workers. As a result, the already poorer countries of origin suffer from intensified shortages and weakened healthcare infrastructure, a symptom of **brain drain**. Some argue visa programs are beneficial for both, as migrants may return **remittances** to family members still in their country of origin to boost the domestic economy there.

Lastly, physical disconnectivity seen in medical deserts can be overcome with mobile health clinics. However, these programs need people willing to travel long distances possibly through unsafe areas and people educated enough to be medical experts, both of which make staffing difficult. One alternative that focuses on the community's self-sufficiency rather than

reliance on outside aid is to increase medical education funding and resource availability in medical deserts. Since quality education requires tons of spending for teachers, buildings, and supplies, this method has a high upfront cost but may be cheaper in the long term.

Previous Solutions: Social Inaccessibility

As most issues with social inaccessibility in healthcare, such as stigma and disinformation, are caused by oblivion, the main response usually involves public advocacy to inform the masses. For instance, the World Federation for Mental Health, a non profit closely tied to the UN, founded Mental Health Day to raise awareness about how to recognize and treat symptoms of mental disorders and raise funding. Similarly, many national governments allocate toward mental health in the form of information campaigns, covering therapy costs, and research investment. The UN formed a joint program in 2023 between UNICEF and WHO for children's mental health that is being piloted in six countries, with its main four goals being to strengthen government advocacy, formalize services, increase research, and garner publicity. Raising awareness helps people overcome stigma to get help, and challenges disinformation that may otherwise incentivize unhealthy behavior or dissuade people from proper treatment.

Biases within artificial intelligence, another social barrier, can be overcome with stricter requirements on AI quality enforced by governments. The EU has implemented a similar strategy by classifying clinical algorithms as high risk and subject to high scrutiny. Other countries have also adopted machine learning regulations to safeguard against inaccurate AI, especially those involved in medical decision-making. Some researchers have advocated for an 'AI pause,' or a moratorium on the development and use of advanced machine learning algorithms, but opponents disregard this as impractical and argue AI is better off being developed to further sort out biases rather than delay these advancements. Stricter regulation may also decrease competition as it

prevents smaller startups, who often can't afford the large amounts of data sometimes required for unbiased AI, from joining the market and spurring innovation with more competition.

Questions to Consider

- How intense is the medical worker shortage in your country? Is there national policy regarding this issue?
- Does your nation provide a single-payer system? What is the extent of government involvement in your country's healthcare industry?
- What are the most significant social barriers to healthcare in your nation, and what can be done or has been done to address it?

Glossary	
patient to caretaker ratio	amount of patients to amount of caretakers; the higher the ratio, the more overwhelmed a clinic is
Big Pharma	a group of drug companies that dominate the market
medical deserts	areas that lack access to healthcare
mobile health clinics	easily transportable furnished ambulances or pop-up tents that provide healthcare to medical deserts
protected characteristics	traits such as race, religion, or sex that, if used as a baseline for discrimination, violate human rights
clinical algorithms	computer programs that help medical decision-making
disinformation	intentionally deceptive information
universal health coverage (UHC)	the status of all people having cheap-to-free access to adequate healthcare resources
price cap	government created limits on prices of certain products
single payer system	a single entity, usually a government, pays for all healthcare services

brain drain	mass migration of educated people out of a country
remittance	money sent from migrants to their place of origin

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