CGS MUN

Committee: Economic and Social Council

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INTRODUCTION

"*Social and economic inequities perpetuate health disparities across regions and countries, as well as within countries*"

- Wafaa El-Sadr, Director of ICAP

Health is an inviolable and fundamental right of every human being, a product of biological, psychological, economic, social, political and environmental factors and ideally, it should not be subject to ethnicity, age, nationality, beliefs, economic and social status. If global health is, indeed, characterized by equality and equity, why are we still looking at a great difference in the life expectancy of different nations, which can even reach a difference of 35 years and why are there major health crises only in some parts of this world? The answer is clear and obvious. There are growing health disparities among nations and their health systems, fueling constant global instability, which will continue to exist and grow, if equality does not become the rule in global health.

All major public health crises seem to arise from the inequity among countries with different socioeconomic backgrounds and in some cases, even within regions of the same country. As this global health inequity is leading hundreds of thousands of people to death and millions of people to a life without a right to healthcare, the need to close the gap is becoming increasingly urgent. No matter how simplistic this task may sound, humanitarian aid is not enough and the complexity of global disparities in health is nothing less than a global challenge. International communication has illuminated the profound socioeconomic disparities that exist in global health and the link between a high social class and a high income with better access to health and better healthcare services.

Entering the 21st century, humanity has been faced with this challenge, which is not about interests and power, but concerns and affects the wellbeing and life of all. For the collective purpose of achieving the Sustainable Development Goals (SDGs), understanding and combating socioeconomic disparities in health is deemed necessary. Among the seventeen goals, SDG 3 states that we should ensure healthy lives for all people of all ages, while SDG 10 invites the global community to reduce inequality within and among countries. All in all, it is now the time to act responsibly and collectively against a crisis that affects all of us, since disparity does not only affect the one who experiences the injustice, but also the stability and unity of our world.

DEFINITION OF KEY TERMS

Disparity

While disparity describes the state of being unequal, a disparity is a great, noticeable and usually unfair difference. For example, while social disparities exist among different ethnic groups, there is a disparity between native citizens and immigrants in workplace. The opposite term is parity, which describes the state of being equal or same.

Global Health

"Area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide"[1]. Global health involves a number of sciences, apart from health-related ones, which take into account international determinants, factors, solutions and health issues, in order to apply population-based prevention, as a first goal and cure, rehabilitation and treatment to all, as secondary.

Health Inequality

A health-related disparity caused by non-remediable or non-controllable factor, which is not subject to human influence. An example of health inequality is

[1] https://publichealth.wustl.edu/public-health-and-global-health-definitions/

life expectancy between two different populations due to genetic differences/predispositions.

Health Inequity

A health-related disparity caused by a non-biological or non-genetic factor, which usually implies a kind of social injustice. An example of health inequity is lower life expectancy because of the absence of medications or clinicians.

Social Determinants of Health (SDH)

"The Social Determinants of health are the conditions in which people are born, grow, live, work and age, including the health system."[2] These determinants are influenced by the distribution of budget, power and resources at a regional, local, national and international level and are crucial when it comes to health inequities and socioeconomic disparities in the global health system.

Figure 1: The Social Determinants of Health

BACKGROUND INFORMATION

According to data provided by the World Health Organization (WHO), there is a 36-year gap in life expectancy among countries. It is more than evident that significant disparities exist among healthcare systems and there is no biological or genetic reason which could lead to such alarming differences in health indicators among countries, such life expectancy and child mortality. The disparities between Less Economically Developed Countries (LEDCs) and More Economically Developed

[2] http://www.wpro.who.int/topics/social_determinants_health/en/

Countries (MEDCs), as well as within healthcare institutions of the same country, depict equality in global health. Economic and social factors account for the largest part of this phenomenon, as social stability and economic growth favor the operation of healthcare providers, scientific and medicinal research and the access of all to health.

Economic disparities

Based on the Fact File of WHO on Health Inequalities, "women in the richest 20% of the global population are up to 20 times more likely to have a birth attended by a skilled health worker than a poor woman". Moreover, it is stated that low-income countries have ten times fewer physicians than countries who offer higher salaries for healthcare actors, citing the example of Nigeria and Myanmar which have about 4 physicians per 10.000, while Norway and Switzerland have 40 per 10.000. Hence, the lack of financial capital is directly linked to weaker and non-operating healthcare systems, with shortage of staff and equipment and to lower level of healthcare. On the contrary, great household wealth and assets account for greater health services and outcomes.

Figure 2: The factors which lead to economic inequality among nations

Globally, noticeable economic disparities exist between LEDCs and MEDCs. LEDCs lack funding and budget which could potentially be used to address shortages in hospitals and providing medications and treatment to all. Even when they are financially supported by organizations' donations, such as those provided by the World Bank and the United Nations, they are called to address other major problems, such as infrastructure, famine, war and education and health is rarely placed in the agenda. As a result, healthcare systems collapse, as in Libya, the right to health is inaccessible, medicinal research is non-existent and health indicators, such as child mortality and

illness rise. On the other side, MEDCs have thriving healthcare institutions and significant research action, since they possess the budget which is deemed necessary to deal with health crises and maintain good healthcare for all. Furthermore, living standards are much higher in the majority of MEDCs, as there is social insurance and public awareness on prevention of disease and illness.

Social disparities

Inequalities in global health are usually linked to poverty and social exclusion of certain groups from healthcare, which are both social phenomena. Difficulty of securing access of all to prevention and health, delay in acting on time during major health crises and lack of awareness of the specialized needs of children and the ageing population, as a result of non-effective governance are also creating disparities between the nations in which the abovementioned issues are present and the ones in which they are non-existent. Hence, the social background of a country is an indicator of the quality of healthcare provided to its citizens and major differences between societies automatically lead to great disparities in global health. In addition, even within the same country, social class and wealth can provide someone with easier access to better healthcare institutions and thus, creating a disparity among the citizens of the country, regardless of the general social background.

In the following table, there is the comparison between MEDCs and LEDCs, based on the general attitude LEDCs and MEDCs have.

Less Economically Developed Countries	More Economically Developed Countries
Priority is orientated towards: communicable diseases, maternal and child health, reproductive health, sanitation, clear and safe water, malnutrition, healthcare infrastructure and infectious diseases (ex. tuberculosis, EVD, malaria and HIV/AIDS).	**Priority** is mostly given to: non-communicable diseases, chronic diseases, health issues of the youth and of the ageing population.
Advances in technology are non-existent or at least, not enough to benefit patients and help prevention and treatment.	**Advances in medical technology** are a great benefit for patients, as they lead to effective and innovative management and prevention of disease for all.
The **ageing population** is treated equally to the others and receives the same amount of care.	Despite great medical and technological advances, the care of **older patients** is subject to

	discrimination and neglect, as they are being left behind because of their age.
There is great **need** to address major health crises and managing the already existing social and economic problems.	There is great **need** for prevention and awareness, especially in the youth, which presents various health issues because of its lifestyle (ex. alcohol, smoking, absence of physical exercise)
The state's **economic resources** are usually limited and not enough to cover health needs and build healthcare infrastructure and there is, thus, a need for **funding** from external factors.	In the majority of the MEDCs, the **states' resources** are used for healthcare infrastructure and for addressing health issues and there is **limited funding** from institutions as the UN and the EU.

In general terms, disparity in access to healthcare and health outcomes are closely associated with the wider disparities certain individuals and groups experience within the society and the different problems each society faces, based on its human capital, its location and its economic and social resources.

Social groups in disparity

Regardless of country and its socioeconomic characteristics, there are certain social groups which are found in disparity and are being prevented from healthcare, purposefully or not, in a large number of countries. On a global level, the needs of the ageing population are too often neglected or ignored, as they are no longer members of the human capital. When it comes to migration, a capital problem of our times, it is observed that migrants and refugees are being neglected and face great difficulty in accessing healthcare and in receiving proper care in their hosting countries. The hosting countries' budget is quite limited and health is placed on the bottom of the list with the needs that have to be covered. Health insurance is not always attainable by migrants and refugees. In fact, the migrants of an older age are rarely on the agenda of governments and humanitarian agencies, which is yet another sign that ageing populations are in disparity, regardless of the country they are in.

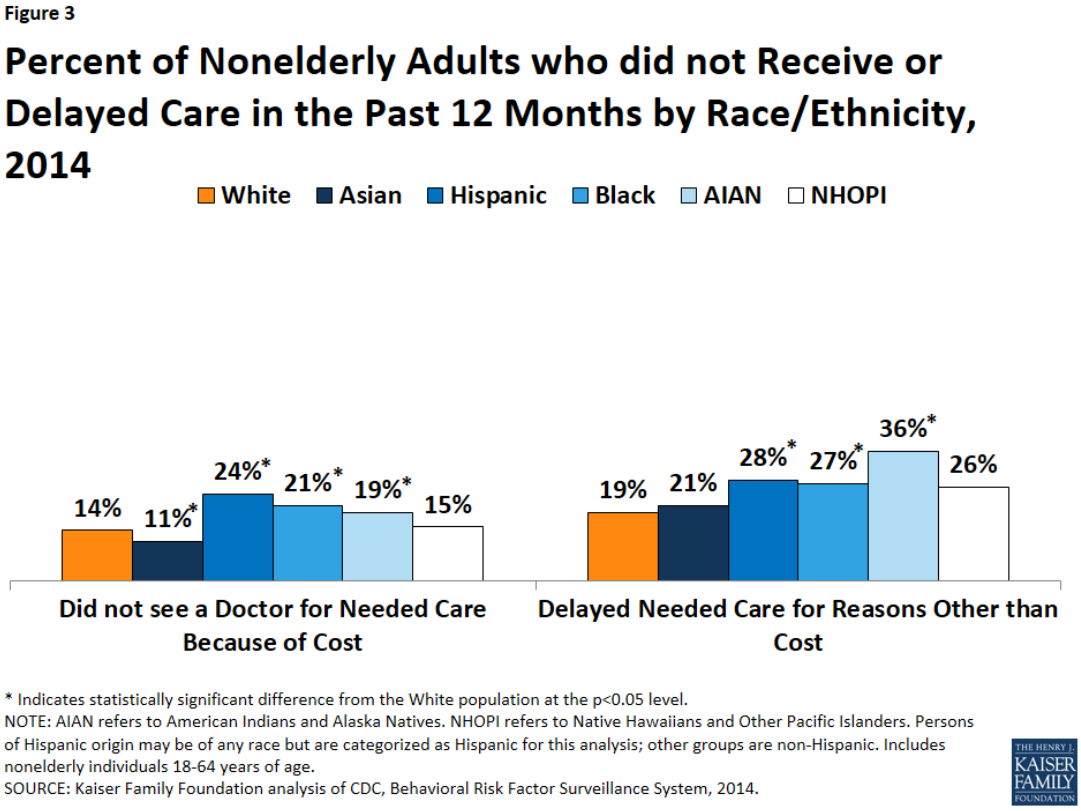

Figure 3: Graph that depicts the role of ethnicity to access to healthcare

Measure of socioeconomic disparities

For the purpose of detecting and measuring socioeconomic disparities in global health, health-related information is being gathered by comparing the living standards and the health outcomes among different groups and countries. While living standards data are being composed by the index of security, housing, famine and unemployment, health outcomes mainly derive from longevity, healthy life expectancy and rate of disease. In most of the cases, the comparison is being made based on socioeconomic status, in that the health outcomes of the lowest socioeconomic class are compared to the ones of the highest. The gap depicts the gap in access to health and healthcare . However, the social gradient is not easily measured by simple comparisons and thus, complex statistical indexes are used, such as:

- **child poverty**
- **premature mortality**

- teenage pregnancy
- low birth weight
- young people not in education, employment or training.
- deaths due to cardiovascular disease
- all-cause mortality among 15-44 year olds
- wellbeing

These indexes cover almost every activity of the social spectrum, which could possibly influence the health of an individual. The general rule is that the higher the social class, the higher the quality of health.

From all the indicators used, the most crucial and objective ones are longevity and infant mortality rate. Difference in longevity is a vital measure of socioeconomic disparities in health both among different nations and among different regions of the same country. The length of life of the average person reflect the sociopolitical and economic situation of the country, human security and well-being and the accessibility to healthcare. The infant mortality rate, the risk of an infant dying from birth until one year of age, depicts the equality of all in maternal and infant health and is generally easy to be measured. For example, the infant mortality rate in Iceland is 2 per 1000 births, while in Mozambique is 120 per 1000.

Miscellaneous health indicators of the global populations, such as premature mortality and sexually transmitted diseases, are also great markers that demonstrate the social conditions and the effect of social arrangements implemented by a state.

MAJOR COUNTRIES AND ORGANISATIONS INVOLVED

United States of America

Despite being one of the world's most powerful economies, there are great disparities in its healthcare system, mostly among different groups. The World Health Organization provides the following data, which depict a clear inequity of the African-American population and greater depression of men living in the USA: infants born to African-American women are 1,5-3 times more likely to die than infants born to women of other ethnicities, African-American men are the most likely ones, among all ethnic groups, to develop cancer – a rate of approximately 60% and

American male citizens are four times more likely to commit suicide than female citizens, regardless of ethnicity and age. However, the USA have taken action against socioeconomic disparities through the Health Inequity Index, which provides data for all the States and aids the government to form a proper policy.

United Kingdom

In the United Kingdom, overcrowding in households, hospitals, schools and public space is a major cause for health inequities and for the outbreak of certain diseases in the population, such as respiratory issues, meningitis, tuberculosis and even chronic conditions, such as heart disease. The lack of space and the sharing of rooms in healthcare institutions facilitate the spread of disease and does not facilitate the proper treatment of all patients. Crowding in hospitals of the NHS has been blamed for child mortality, while overcrowding has been associated to domestic injuries, child maltreatment and limited educational attainment, regarding doctors. In this case, a social dysfunction present both in healthcare institutions and in the UK, generally, puts the life of many in danger and depicts a clear social disparity caused by the lack of organization.

New Zealand

The National Housing Corporation has established a great collaboration with health authorities with the view of dealing with overcrowding in healthcare institutions. A number of infrastructure changes have been proposed, including renovations, additions or improvements to hospitals and clinics all over New Zealand. Up to date, the program has proved itself to be significantly successful as visits to primary health-care providers have been increased and acute hospitalization rates have been reduced.

Indonesia

Indonesia has been characterized a case study on the issue of socioeconomic disparities by WHO. The development report of Indonesia and the process of building its capacity monitored by WHO have been set as examples for other states regarding the integration of monitoring methods of health equality and equity into the national health information institutions. Ahmad Reza Hosseinpoor serves in WHO in health

equity monitoring and was responsible for the project in Indonesia, which faced great disparities both within its regions and in comparison to other countries.

Chad

Chad is one of the countries on which WHO has carried out case studies on the topic of socioeconomic disparities in healthcare, as healthcare rates in Chad are nowhere near the European ones. Characteristically, WHO reports that in Chad, every 5th child dies before the age of five, while the child mortality rate for European countries is set at 13 out of a 1000 children and the maternal mortality ration is over 1000 out of 100,000 births, in comparison to the 21 out of 100,000 in Europe. Those two figures depict severe dysfunctions in maternal and child health, caused by lack of equipment and lack of personal care by pregnant women living in deprived environments.

Ghana

In 2009, a WHO study in Ghana showed that rural hospitals received large numbers of trauma patients with road injuries, while the hospitals' workforce solely included practitioners with no trauma training. While Ghana's road fatality rates are 40 times greater than those of industrialized countries, the government has failed to provide all hospitals with trauma doctors, which were also needed for other health issues, as complicated delivery. With the view of addressing this major issue in hospitals, probably caused due to funding shortage, transport and law enforcement actors developed a strategy to increase the number of speed bumps to lower speeds to tackle the problem in its roots.

Commission on Social Determinants of Health (CSDH)

Established by the World Health Organization (WHO), the CSDH aims at providing support to UN-member states and other global health partners in order to address global health disparities due to social factors. Its action is worth mentioning, particularly in the field of public awareness, where the CSDH has created programs that alert society on the topic of the social determinants of health and health inequities. In addition, there has been great effort towards detecting the systematic and structural causes of weak healthcare systems. On the issue of combating global health disparities, the commission has suggested improving living standards,

fighting against the unequal and unfair distribution of budget, raising public awareness and objectively assessing the effectiveness of the implemented action.

European Union (EU)

Great disparities have been observed among the European healthcare systems and among the different social groups in European countries. The EU has funded a number of projects during the past decades with the view of ensuring that all EU citizens enjoy the same and best health possible. Most of the EU-funded actions were tackling the issue by raising public awareness, aiding states to develop effective policies and sharing the most effective practices implemented. In 2009, the EU run a program under the name "Solidarity in Health: Reducing health inequalities in the EU" which illuminated the social background of health disparities, criticized earlier efforts of the EU Health Strategy of 2007 and recommended a number of measures to be taken. Finally, the European Union set smart, sustainable and inclusive economic and social growth, as well as better health for all, as goals of the 2020 Strategy.

World Health Organization (WHO)

Beyond any doubt, WHO has been the most active organization on health disparities in global health, having established the Commission on Social Determinants of Health and the World Conference on Social Determinants of Health. During the preparation of the Conference, there have been a lot of case studies and research conducted on SDH among different countries, the Rio Political Declaration which was formed and a package of resources and tools to aid UN Member-States to manage health inequities, including the Health Equity Assessment Toolkit and the WHO Health Equity Monitor database. In addition, WHO's main suggestions include adopting different and international governance for health, promoting participation in policy-making and implementation, re-orienting the health field towards promoting healthcare and reducing health inequities and fostering dialogue and global co-operation.

TIMELINE OF EVENTS

Date	Description of Event

1872	The American Public Health Association (APHA) is established, the first national voluntary organization, dedicated to improving public health, but faces great resistance in building public health infrastructure.
1908	Countries and cities all around the globe start to administer public health and sanitation programs, as a way to reduce health inequalities.
1948	The World Health Organization (WHO) is established by the United Nations.
2006	The Health Equity Index is established in Connecticut and is used to measure the effect of social determinants of health in the USA.
	The European Union's Expert Group on Social Determinants and Health Inequalities describes and confirms the existence of health inequities in the European continent and the social roots of the phenomenon.
2010	The King-County Council, a legislative body in Washington D.C., establishes a plan for acting against health inequalities.
2011	The World Conference on Social Determinants of Health takes place in Rio de Janeiro, Brazil, under the auspices of WHO.
2018	A Symposium on Health Inequalities is hosted in Amsterdam by: - the Scientific Committee on Health Inequalities - the Royal Netherlands Academy of Arts and Sciences (KNAW)

UN INVOLVEMENT: RELEVANT RESOLUTIONS, TREATIES AND EVENTS

Resolutions

- **Outcome of the World Conference on Social Determinants of Health, 26 May 2012, WHA65.8: The Health Assembly endorses the Rio Political Declaration and suggests considering social determinants of health in the assessment of global needs of health, provide support to Member States in implementing the Rio Political Declaration on Social Determinants of Health and work with**

other subsidiary bodies of the UN on research, advocacy and capacity building.

- Global Health and Foreign Policy, 6 December 2012, A/67/L.36: The UN General Assembly calls upon Member States and the UN to accelerate the transition towards Universal Health Coverage, after global public health measures on health protection and on addressing the SDH are taken.
- Reducing health inequities through action on the social determinants of health, 21 May 2009, WHA62.14: The Health Assembly endorses the findings of the CSDH concerning effective policies for reducing health inequities and calls the Director-General to schedule a meeting, in order to discuss the trends of health inequalities and the SDH's effect on global health.

Treaties

Rio Political Declaration on Social Determinants of Health,21 October 2011

During the World Conference on Social Determinants of Health, UN Member-States adopted the Rio Political Declaration. The Rio Political Declaration is a global political commitment of UN Member-States to work collaboratively towards reducing health disparities and other international health-related issues, by acting in five action areas, set during the conference.

PREVIOUS ATTEMPTS TO SOLVE THE ISSUE

There is a satisfying number of actions and programs that have taken place, which partially helped UN member-states to detect the commonalities in social and economic variables which affect and determine health disparities and reduce them.

Global Plan of Action on Social Determinants of Health

Developed by the WHO Secretariat, the Global Plan guides the UN Secretariat on how to assist Member States and other partners in the implementation of the Rio Political Declaration and on achieving health equity in global health. Thanks to this plan, responsibilities of all UN bodies are now set.

Health Equity Assessment Toolkit

The Health Equity Assessment Toolkit is a software application which enables countries to access the WHO database and monitor health inequalities in their health systems and detect their roots a manual on how to set their own health information systems and database.

UN Platform on Social Determinants of health

Following the World Conference on Social Determinants of Health, the International Labor Organization (ILO) and various UN Bodies, the Joint UN Programme on HIV/AIDS (UNAIDS), the UN Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Children's Emergency Fund (UNICEF) and WHO have established a platform of dialogue on SDH, have agreed to collaborate on reducing health inequities and supporting countries to implement the Rio Political Declaration. The four fields of action have been set to be: advocacy, capacity strengthening, monitoring and country work, especially to the "One UN Countries" (Armenia, Cape Verde, Mozambique, Pakistan, Rwanda, Tanzania, Uruguay and Vietnam)

WHO European Review of Social Determinants and the Health Divide

After the collaboration of the EU and the WHO Regional Office for Europe, the WHO European Review was formed and includes guidance on policy making and on already existing WHO capacity-building actions. This Review links EU and WHO and establishes the full collaboration of Europe with the UN.

Equity Action

Implemented by EU, the Equity Action was a 36-month program which involved stakeholders and formed cross-sectoral policies and locally tailored strategies, in order to address the issue of socioeconomic disparities at a national, regional and local level. Action plans were developed for seven regions, while online tools have been used to identify health indicators in these regions.

Global Vaccine Action Plan (GVAP)

GVAP is an international framework approved by the World Health Assembly in May 2012, with the view of delivering universal immunization to all, regardless of ethnicity, age and socioeconomic position and reducing social and ethnic disparities in health. Overall, the plan was successful and served fully humanitarian goals.

POSSIBLE SOLUTIONS

As disparities in global health is an issue of the global agenda, there is need for action both in a local and in an international level.

On a local level, governments should step up their efforts to improve daily living conditions and health standards, tackle the discrimination and exclusion of certain social groups from healthcare and to structure and finance the public sector. It is of supreme importance to achieve policy coherence, in that the different departments of the governance and the government should collaborate. Local action is nowadays neglected, and it is imperative that governments take action for the own communities, since local stability helps governments move the needle on a large scale.

On a global level, establishing a collaboration among governments and international agencies and organizations is a first step towards a successful response to socioeconomic disparities in global health. The knowledge base on the issue of health inequities, with the help of scientists and sociologists, has to be expanded and a workforce which will be trained in social and economic determinants of health has to be developed. As the SDH are already known, there is need for the economic determinants of health to be set by an organization and to be acknowledged by the international community. In addition, we have to be in the position to be aware of the socioeconomic disparities, which could possibly be attained through the creation of a Global Health Equity Index, based on the Health Equity Index, which will compare and contrast data for all countries and nations. Finally, fostering humanitarian aid programs for all states and working towards universal health coverage and insurance for all could limit the disparities among nations and could help the nations which lack resources to face major crises on the sector of healthcare. It should be noted that emphasis has to be put on international action, as global action plans and campaigns are immediate and drastic solutions, which can help nations with weak or corrupted healthcare systems to be ameliorated and reach the international standards. In addition, a sensitized international community is necessary in order for aid programs and fundraising to take place.

In conclusion, the issue calls for action on multiple levels and for the involvement of multiple factors. It is important to note that every single aspect of the government and the economy is in the position to potentially affect health and health equity in global health, such as finance, education, employment, transport, awareness and housing. Up to date, there has been more focus on social disparities, but an effective policy should also include measures to tackle economic disparities and funding problems. As all nations will be benefited from the absence of socioeconomic disparities in health and from stability in global health, it is now the time to act for the benefit of all, to protect one of the fundamental rights of every human being, health.

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