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DPSR MUN

1st, 2nd And 3rd April

WHO

Re-Imagining And Restructuring Health Care Systems In View Of Upsurge Of Pathogens With Special Emphasis On Covid 19.

WHO
World Health Organization

Letter From Team Muniversiti,

Dear delegates,

Team MUNIVERSITI welcomes each one of you to DPSRMUN 2022. Several of you may be attending your first MUN conference, and we strongly urge you to review the study guide that has been compiled for you as a part of the conference to get a better understanding of the issue. We encourage all participants to be pragmatic in their outlook towards this conference. In order to reform policy and understand the mechanisms of global politics, it is imperative to comprehend the values and principles behind each agenda.

However, there is lot of content available beyond this study guide too. In order to get the most out of your intellectual energy, you will need to research, collate, write down possible points of discussion, questions, and possible responses. At the same time, it is not just about speaking and presenting, but also about the ability to listen, understand viewpoints and learn new perspectives from one another. Winning should not be your motive, but instead you should be motivated by learning, since learning something means that you are the real winner, directly and/or indirectly.

Wishing all of you a great learning experience. Looking forward to having you all with us.

Best wishes.
The Muniversiti Executive Board

Committee Overview
WHO

Introduction

The World Health Organization is a specialized agency of the United Nations that is concerned with world public health. It was established on 7 April 1948, and is headquartered in Geneva, Switzerland. The WHO is a member of the United Nations Development Group.

WHO Member States appoint delegations to the World Health Assembly, WHO's supreme decision-making body. All UN Member States are eligible for WHO membership, and, according to the WHO website, "other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly". The World Health Assembly is attended by delegations from all Member States, and determines the policies of the Organization.

Committee History

In 1945, diplomats from around the world met in San Francisco, California to negotiate the structure of a document that would eventually become the United Nations Charter. Further discussions by these diplomats led to the 1946 International Health Conference in New York City, where 61 states signed the Constitution of the World Health Organisation. This document, which took effect on 7 April 1948, serves as the foundation for the World Health Organisation (hereinafter “WHO”). WHO addresses the world’s international health priorities from within the United Nations by monitoring global health situations, directing the world health research agenda, setting international standards for health care, and providing policy recommendations for national health ministries and governments.

WHO is comprised of two main governance structures. The World Health Assembly is composed of representatives from 194 member states and sets international health policy. The Health Assembly also hires the Director General of WHO and supervises the Organisation's finances. WHO's Executive Board, made up
of 34 health professionals elected to three-year terms, handles the administrative responsibilities of the body and executes passed resolutions of the Health Assembly under the powers of the WHO.

In 2008, the WHO adopted Director General Margaret Chan's "Six Point Agenda." These points include: promoting health development, especially in areas facing dire poverty; fostering health security, especially in an urbanising world; strengthening health systems and health accessibility; harnessing research by setting the research agenda and setting international health standards; enhancing partnerships with civil society, governments, corporations, etc. to encourage strategic partners to improve health situations; and improving performance by reforming the WHO to be more effective and efficient in addressing international health situations. Besides the goals of WHO leadership, the genuine power of the Organisation lies in adopting resolutions on specific topics. Amongst the topics discussed at the 69th World Health Assembly in May 2016 were engagement with non-state actors (i.e.NGOs, private sector, etc.); tobacco use; HIV, hepatitis, sexually transmitted infections; and road traffic accidents and safety.

Committee Mandate

The Constitution of the WHO enumerates several responsibilities and goals for the body. Powerful tools belonging to the WHO include the Health Assembly's ability to adopt resolutions and make decisions for the Organization, setting international guidelines on topics from food and agriculture to the pharmaceutical industry, providing specialised and targeted aid to member states in need, and standardising medical and health-related practices. To function effectively as an Organisation, member states should always remain aware of the body's following objectives.

Most notably, the WHO Constitution contains a preamble that sets forth all of the principles for which the Organization seeks to progress. The preamble defines the term "health" as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This definition sets the foundation for the Organization's goals to achieve "the highest possible level" of health for all people. The WHO is motivated by the charge that health is a universal human right, because health provides a foundation for the peace and security of any state.
Therefore, all member states of the WHO are committed to promoting the protection and achievement of the health of all other peoples beyond their own. Furthermore, the WHO stresses that individual governments have the primary responsibility for the health of their people, but also recognizes that some countries are unable to come up with the resources to achieve the highest levels of health possible; therefore, the WHO adopts responsibilities like assisting member states, providing guidance by establishing international guidelines, or by joining the fight to eradicate diseases.

Agenda:

Re-imagining and restructuring health care systems in view of upsurge of pathogens with special emphasis on Covid 19.

Introduction:

When pandemics sweep through societies, they upend critical structures, such as health systems and medical treatments, economic life, socioeconomic class structures and race relations, fundamental institutional arrangements, communities and everyday family life. The COVID-19 pandemic is requiring all levels of government to act in a context of great uncertainty and under heavy economic, fiscal and social pressure. With the onset of new waves of infection in many countries since mid-2020 and the emergence of variants, governments are confronted with the limited ability to sequence policy action. National, regional, and local governments find they cannot count on following a straight or linear course of policy action to manage, exit and recover from the crisis. Instead, governments must act on all fronts simultaneously and in synchrony. This need for flexibility and adaptability is leading governments to reconsider their multi-level governance systems and reassess their regional development priorities.

The COVID-19 crisis has a strong territorial dimension, as regions have not been affected in the same way and the medium- and long-term impact will vary significantly across regions. The health crisis has markedly different outcomes across regions and municipalities within countries in terms of declared cases and related deaths. Regional disparities in mortality rates are high in some countries, reflecting heterogeneous access to health services, differing vulnerability to the disease (e.g. demographic criteria, different comorbidity rates, etc.) and the diversity of socio-economic conditions across places. In the early phase of the pandemic, densely populated urban areas were the hardest hit, but in the second half of 2020, and in 2021, COVID-19 spread towards less dense regions in some countries. There is growing evidence in many countries that regions at the bottom of the income distribution and deprived neighbourhoods have higher mortality rates.

Many countries moved from an approach that was applied nationally when the crisis hit in spring 2020, to a more territorial and differentiated approach across regions. In this way they adapt the crisis responses to local needs and limit the costs of national lockdowns. In many countries, specific measures regarding masks, school and restaurant closures, and full lockdowns have been adopted for specific localities or regions to limit their economic impact, e.g. in Australia, Canada, Colombia, Finland, France, Germany, Italy, Spain and the UK. While such a differentiated territorial approach is natural in federal countries, where health responsibilities are largely decentralised, it is also increasingly seen in a number of unitary countries. Since mid-2020, regional and local governments have also been more actively adjusting their response measures to the local context.

Beginning in December 2020, vaccination campaigns are being rolled out and implemented, with significant territorial and multi-level governance dimensions. For the most part, vaccination campaigns are led by national governments. Their implementation, however, is generally in coordination with subnational governments and health agencies to better address local needs and demographic differences (i.e. the share of the regional population falling into vaccination-priority groups). Challenges can arise when subnational governments were not sufficiently involved in the design of the vaccination delivery strategy. Some countries are currently exploring adopting a territorial approach to vaccination campaigns focused on communities or regions with higher risk level or a higher incidence of COVID-19 cases.

During the first quarter of 2021, significant challenges hindered vaccine deployment. Important challenges include limited vaccine supplies in some advanced economies and most developing countries due to constrained production capacity, and a highly inequitable and inefficient distribution of existing supply between countries. Varying capacity to plan and execute mass vaccination campaigns, in particular a lack of coordination across levels of governments and the effect of emerging viral variants of concern (VOCs) on the effectiveness of existing vaccines are also issues during the early phase of vaccination campaigns.

Within countries, regional disparities in accessing vaccines are generally limited, which indicates that there is an effort to make access universal across regions but also shows that regions with the highest incidence have not been prioritised. In countries where regional disparities are significant, they are often driven by factors relating to health or demographic factors and therefore differing shares of prioritised populations. Vaccine uptake rates may also differ across regions due to differences in local preferences or vaccine acceptance.

Statement of Issue:

The COVID-19 pandemic highlighted major flaws in the current healthcare system and flagged the dire need for reforms to increase efficiency of healthcare systems all over the world. This unprecedented public health emergency has demonstrated that health facilities, medical transport, patients as well as health care workers and their families can — and do — become targets everywhere. This alarming trend reinforces the need for improved measures to protect health care from acts of violence. During the COVID-19 pandemic more than ever, protecting the health and lives of health care providers on the frontline is critical to enabling a better global response.

In most OECD countries, all day care centres closed during the initial months at the national level. Closure of all day care centres and pausing the provision of LTC at home at the national level had a massive impact. For example, over 545000 older people did not receive community-based LTC in Colombia during the first wave, while closure of day care centres affected an estimated 21000 older people in the Czech Republic and 25000 older people in Greece. Moreover, home care decreased in 18 OECD countries. Care disruption also placed additional burdens on informal carers.

Many older people receiving home care had to forgo care for fear of infection, or were asked to postpone it during July-August 2020. One particular concern in terms of care continuity has been access to physiotherapy, rehabilitation and all types of physical activity among LTC recipients. Some countries undertook targeted efforts to prevent such concerns. For instance, in Navarre, Spain, 85% of nursing homes organised physical activity exercises and emotion management. In Chile, special isolation facilities for those infected by COVID-19 were coupled with an additional budget for rehabilitation and reablement.

Most of these issues can be summarised under the following headers:-

Severe Shortages of Testing Supplies and Extended Waits for Results: Hospitals reported that severe shortages of testing supplies and extended waits for test results limited hospitals' ability to monitor the health of patients and staff. Hospitals reported that they were unable to keep up with COVID-19 testing demands because they lacked complete kits and/or the individual components and supplies needed to complete tests. Additionally, hospitals reported frequently waiting 7 days or longer for test results. When patient stays were extended while awaiting test results, this strained bed availability, personal protective equipment (PPE) supplies, and staffing.

Widespread Shortages of PPE: Hospitals reported that widespread shortages of PPE put staff and patients at risk. Hospitals reported that heavier use of PPE than normal was contributing to the shortage and that the lack of a robust supply chain was delaying or preventing them from restocking PPE needed to protect staff. Hospitals also expressed uncertainty about availability of PPE from Federal and State sources and noted sharp increases in prices for PPE from some vendors.

Difficulty Maintaining Adequate Staffing and Supporting Staff: Hospitals reported that they were not always able to maintain adequate staffing levels or offer staff adequate support. Hospitals reported a shortage of specialised providers needed to meet the anticipated patient surge and raised concerns that staff exposure to the virus may exacerbate staffing shortages and overwork. Hospital administrators also expressed concern that fear and uncertainty were taking an emotional toll on staff, both professionally and personally.

Difficulty Maintaining and Expanding Hospital Capacity to Treat Patients: Capacity concerns emerged as hospitals anticipated being overwhelmed if they experienced a surge of patients, who may require special beds and rooms to treat and contain infection. Many hospitals reported that post-acute-care facilities were requiring negative COVID-19 tests before accepting patients discharged from hospitals, meaning that some patients who no longer required acute care were taking up valuable bed space while waiting to be discharged.

Shortages of Critical Supplies, Materials, and Logistic Support: Hospitals reported that shortages of critical supplies, materials, and logistic support that accompany more beds affected hospitals' ability to care for patients. Hospitals reported needing items that support a patient room, such as intravenous therapy (IV) poles, medical gas, linens, toilet paper, and food. Others reported shortages of no-touch infrared thermometers, disinfectants, and cleaning supplies. Isolated and smaller hospitals faced special challenges maintaining the supplies they needed and restocking quickly when they ran out of supplies.

Anticipated Shortages of Ventilators: Hospitals reported an uncertain supply of standard, full-feature ventilators and in some cases used alternatives to support patients, including adapting anaesthesia machines and using single-use emergency transport ventilators. Hospitals anticipated that ventilator shortages would pose difficult decisions about ethical allocation and liability, although at the time of our survey no hospital reported limiting ventilator use.

Increased Costs and Decreased Revenue: Hospitals described increasing costs and decreasing revenues as a threat to their financial viability. Hospitals reported that ceasing elective procedures and other services decreased revenues at the same time that their costs have increased as they prepare for a potential surge of patients. Many hospitals reported that their cash reserves were quickly depleting, which could disrupt ongoing hospital operations.

Changing and Sometimes Inconsistent Guidance: Hospitals reported that changing and sometimes inconsistent guidance from Federal, State, and local authorities posed challenges and confused hospitals and the public. Hospitals reported that it was sometimes difficult to remain current with Centres for Disease Control and Prevention (CDC) guidance and that they received conflicting guidance from different government and medical authorities, including criteria for testing, determining which elective procedures to delay, use of PPE, and getting supplies from the national stockpile. Hospitals also reported concerns that public misinformation has increased hospital workloads (e.g., patients showing up unnecessarily, hospitals needing to do public education) at a critical time.

History:

The COVID-19 pandemic has shown how vulnerabilities in health systems can have profound implications for health, economic progress, trust in governments, and social cohesion. Containing and mitigating the spread and infection rate of the virus continue to be essential. But so is strengthening the capacity of health systems to respond swiftly and effectively. This includes administering COVID-19 vaccines. After lightning speed development and testing, vaccine campaigns are rolling out in many countries. But questions about production, delivery and equitable access remain, not least for low and middle-income countries.

At the onset of the COVID-19 crisis, most OECD countries' overall pandemic preparedness and response systems were not fully prepared to face the pandemic. Where emergency preparedness systems existed, they often lacked follow-up to update existing measures, hampering an adequate and timely reaction. In most cases, the existing pandemic preparedness plans did not focus on or prioritise the LTC sector and in some instances, never mentioned LTC facilities. In eight countries (Australia, Austria, France, Germany, Iceland, Ireland, Italy and Slovenia), despite the existence of emergency preparedness systems for the health care sector in general, specific measures for LTC were missing prior to 2020.

Fifteen countries had issued guidelines for infection control in LTC facilities and seven countries had specific emergency preparedness plans for the LTC sector. For instance Estonia performed crisis management exercises prior to the pandemic to test the country's ability to react in case of emergency, while Japan had a Disaster Management bureau as well as a task force which could be activated when a large-scale disaster takes place. Similarly, other countries had specific institutes for the management of emergencies, like Australia, Finland, the Netherlands and Belgium.

History:

Since the start of the COVID-19 pandemic, the percentage of OECD countries with public national guidelines on infection control in LTC rose from 53% prior to 2020, to 84%. Seven OECD countries that did not include the LTC sector in their emergency preparedness systems prior to 2020 developed new LTC-specific measures like guidelines, webpages, task forces and rapid response teams.

At the early stage of the pandemic, a greater number of days between the first case and the first guidelines was related to a higher number of LTC deaths. Learning from the country's first hit by COVID-19 helped other countries to improve preparedness and buffer the impact of the pandemic. More stringent social distancing had a key role in reducing mortality in communities and hospitals and also affected community transmission into the LTC sector. In Austria the share of LTC deaths was dramatically lower in regions where regional governments applied more screening and stricter visit restrictions in LTC facilities.

Analysis:

Beyond containment efforts, what have health systems done thus far to manage this health crisis?

Some countries have strengthened access to health care, highlighting the importance of high quality universal health coverage. Today, in 23 OECD countries, 20% of people forgo care due to long waiting times or travel distance, and 17% because costs were too high. To offset this, specific measures have been introduced to cover diagnostic testing and regulate their prices, for example, in the United States, Germany and France.

To boost health workforce capacity, some countries have allowed medical students in their last year of training to start working now and have made efforts to mobilise pharmacists and care assistants. As part of a broader logistical strategy to boost efforts to diagnose people, Korea implemented a widely known drive-thru testing programme. All countries have made efforts to isolate suspected and confirmed cases, including encouraging home hospitalisation as in the United States.

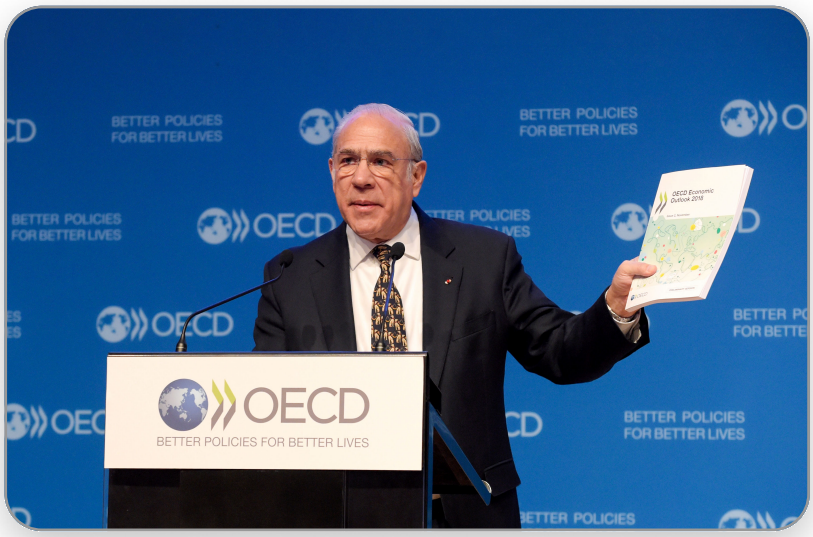
Innovative digital solutions are also emerging. Access to telemedicine has been made easier in France and the United States. Israel has introduced robotic devices and telemedicine use to monitor the health status of quarantined people. Korea is trialling smartphone applications to allow those in quarantine to report the evolution of their case as well as to monitor their quarantine compliance. Artificial intelligence initiatives to track the spread of the virus and predict where it may appear next have been developed in Canada.

The crisis has exposed the need for our health systems to be more resilient to crises of such gravity. While it is too early to draw conclusions, three aspects deserve consideration.

First, there is a need to strengthen disease surveillance mechanisms and health information infrastructures. Beyond early warning and response systems based on alerts and case notification, countries with standardised national electronic health records (EHRs) can extract routine data for real-time disease surveillance, clinical trials, and health system management. However, only Finland, Estonia, Israel, Denmark, Austria, Canada, Slovakia and the United Kingdom, as well as Singapore, have high technical and operational readiness to generate information from EHRs. This calls for more efforts to lift technical and data governance barriers that prevent the effective use of such data, while respecting data privacy, in line with the OECD Council Recommendation on Health Data Governance.

Second, the crisis has exposed the importance of having adaptable health systems. Lack of any sort of excess capacity can leave countries vulnerable to an unexpected demand surge. The availability of hospital beds and their occupancy rates vary greatly across OECD countries. For acute care beds, Japan has the highest number, at nearly 8 beds per 1,000 people, followed by Korea and Germany. For selected OECD countries, intensive care unit beds vary by a factor of 6. Equipping health systems with reserve capacity will require creative approaches, such as a “reserve army" of health professionals that can be quickly mobilised; storing a reserve capacity of supplies such as personal protection equipment; and maintaining care beds that could be quickly transformed into acute care beds.

Last, there is a need for strengthened coordination across countries. Besides efforts to coordinate an international response for rapid containment, we need to be able to accelerate the development of diagnostics, treatments and vaccines. It will currently take at least 18 months to make a new vaccine available for COVID-19. Beyond the initial spike in funding to support greater R&D efforts, there is also a need to sustain such developments should the epidemic eventually subside, so that we are better prepared for future ones. Once developed, fast-track procedures for new treatments and vaccines are important to encourage approval quickly. Commitments are also necessary to ensure that these products are made available at affordable prices where needs are the highest. As OECD Secretary-General Angel Gurría put it, we need renewed "joint actions to win the war".



Possible Solutions:

The urgent and global nature of the COVID-19 pandemic has forced countries to re-think, almost overnight, the governance arrangements that underpin their use of public communication. COVID-19 has thrown up extraordinary examples of resilience: the health workforce has absorbed phenomenal pressures and continued to function; new ways of working have been introduced, new facilities opened, new types of services delivered; several COVID-19 vaccines were developed and approved; and governments have found the money for health care and to protect their populations from the worst of the pandemic's economic effects. Nevertheless, all governments and all countries are aware of the very real failures: to sustain essential services; to protect health care workers; and to safeguard public health and, foremost, save lives.

Health systems, however well they managed during the crisis, were woefully underprepared and this points to, perhaps the most frustrating of all failings, the failure to learn from past crises. It was made abundantly clear during the financial crisis of 2008 that health systems, health, and wealth are inextricably linked to each other and that underinvesting in health systems has significant consequences not just for health but also for the economy itself and, ultimately, for our wellbeing. The COVID-19 pandemic offers lessons for how — this time — countries might build back better. There is a need to invest more in health systems and moreover for that investment to be appropriate. This implies putting funding into neglected areas and managing that funding efficiently. Areas that are critical to building back better and which require well managed investment include:

- Surveillance and monitoring systems that will allow health systems to respond and be better managed.
- Primary health care which is often the most appropriate and cost-effective setting for care.
- Public health which is best placed to handle threats of infectious and chronic diseases, including by influencing socioeconomic determinants of health and providing outreach to excluded communities.

- Skills and initiatives to promote better ways of working for individuals and teams, as well as across levels of health and social care.
- Remote health tools that complement more conventional patient clinician contact.
- New care pathways that draw on the investments in primary care, skills, and digital tools, and can be flexibly adapted in an emergency.
- Reimagine health systems governance, accounting for various contexts and the new multi-level and multi-stakeholder approaches that have surfaced during this pandemic.
- Ensure governance systems are more flexible, which allows changes and encourages innovation in an emergency, but which also insists on following the due process to protect health systems from abuse and a post hoc review.
- Develop stronger links beyond health systems, making health part of the wider discussion and planning of the economy and of social security.
- Improve two-way communications to build trust including through closer health system engagement with social networks and communities, with civil society, and with other stakeholders.
- Incorporate a clear international perspective that links governments with each other and with international bodies and which considers how to develop and distribute resources equitably.

Some key recommendations to ensure strengthening of the health care system are:

- **Ensure safe and fair access to vaccines across regions within countries through effective coordination mechanisms between national and subnational governments**, for example by sharing dose delivery projections. This is particularly important as all levels of governments must anticipate the surge in supply and ensure that the logistics and infrastructure is ready as vaccine deliveries accelerate. Involve subnational governments in vaccination campaigns to ensure faster and better territorial coverage. Involving local actors, who are better informed about the local population and infrastructure, is essential to successfully reach people that need vaccines first (e.g. the elderly, people with pre-existing illnesses and healthcare workers) and relieving the pressure on the healthcare system.

- **Consider adopting a "place-based" or territorially sensitive approach to recovery policies.** Introduce, activate or reorient existing multi-level coordination bodies in order to minimise the risk of a fragmented recovery response. Use such bodies to refine strategies, develop solutions, and agree on decisions with profound economic, social, and societal implications. Strengthen the quality of micro-level data within and between regions to improve understanding of the crisis and its impact.

- **Support cooperation across municipalities and regions to help minimise disjointed responses and competition for resources during a crisis.** Facilitate inter-municipal cooperation to support recovery strategies by ensuring coherent safety/mitigation guidelines, pooling resources, and strengthening investment opportunities, for example through joint borrowing. Actively pursue and promote cross-border cooperation in order to promote a coherent recovery approach across a broad territory (e.g. border closure and reopening, containment measures, exit strategies, migrant workers).

- **Strengthen national and subnational-level support to vulnerable groups to limit further deterioration in circumstances and to strengthen inclusiveness in the recovery phase.** Accomplishing this can include simplifying and facilitating access to support programmes, ensuring well-targeted services, introducing adequate and/or innovative fiscal support schemes, and identifying the needs for revising fiscal equalisation policies. Use digital opportunities (e.g. e-health, e-education) to help ensure continued service delivery, being sensitive to territorial, economic, and social disparities in access.
- **Avoid withdrawing abruptly fiscal support.** Continue helping subnational governments reduce the gap between decreasing revenues and increasing expenditures resulting from the COVID-19 crisis to avoid sharp cuts in subnational operating and capital expenditure, resulting in underfunded and unfunded mandates. Foster subnational governments' participation in recovery plans. Foster multi-level and multi-stakeholder dialogue and fiscal coordination, for example with national associations of subnational governments and other consultative bodies. Promote coordinated responses to the crisis' fiscal impact, using shared evidence and data, and a forward-looking perspective
- **Support subnational public investment over the medium-term** to avoid the massive cuts that occurred after the 2008 crisis. In addition to improving self-financing capacity, other possible avenues include those offered various classical fiscal instruments, such as temporarily relaxing budget rules for capital spending, increasing capital transfers and subsidies, easing the access to long-term projects on both credit and financial markets and supporting project preparation and implementation.
- **Reconsider regional development policy to build more resilient regions**, better able to address future shocks. This implies re-evaluating regional policy objectives, including with respect to their urban/rural equilibrium, the climate imperative, the digital divide, the balance between tangible and intangible assets

Conclusion:

Every health system had a different starting point when the pandemic struck, with different capacities of the key health systems functions — governance, financing, resource generation and service delivery. As highlighted by the Independent Panel on Pandemic Preparedness and Response (2021), countries, governments, and health systems were insufficiently prepared for COVID19. This reflected a legacy of reduced investment in resilient economies that left many health systems much weakened and with fewer resources to cope with the sudden surge in the demand for services.

While many health systems found ways to respond resiliently and maintain performance of the key health systems functions, those with stronger initial capacities have likely found it easier to manage the pandemic response. For example, while health sector financing could be increased relatively quickly, years of underinvestment in the health sector resulted in weakened health sector capacities that could not easily be overcome. This was particularly visible in public health and made implementation of effective FTTIS systems challenging (Chung et al., 2021). Despite massive investments, seemingly rapid solutions such as outsourcing of contact tracing to private call centres, or the use of digital apps could not replace the shoe-leather epidemiology conducted by experienced public health teams.

In 2008, in the Estonian capital Tallinn, 53 Member States from the WHO European Region agreed on an ambitious vision for the future of health systems, acknowledging that health systems, health and wealth are all interrelated, and committing to investing in strong health systems. The financial crisis struck in the same year causing many countries to retract their pledges, with many health systems subjected to austerity measures. Countries that made the biggest disinvestments in health and health care suffered the greatest declines in economic performance, proving the point made in Tallinn that there is no wealth without health (McKee & Kluge, 2018). In 2018, WHO Member States reconvened in the same location and reiterated the messages from a decade earlier, but with a renewed emphasis on inclusiveness and "leaving no one behind", recognizing that not everybody has benefited from gains in life expectancy and other health gains in the same way.

The COVID-19 pandemic made a clear case for addressing inequalities and protecting the poorest in society. It also proved again that there is no wealth without health and that the initial perception of a tradeoff between health and the economy was misguided. We should renew our commitment to the pledges made in Tallinn and invest in building strong health systems for prosperity, solidarity, and resilience in the face of any future health threats acting on the lessons learned during this devastating pandemic.

Rules of Procedure

- Opening of Debate

Roll call

established. A debate cannot begin without a quorum being established. A delegate may change his/her roll call in the next session. For example, if Delegate answers the Present in the First session, he can answer Present and vote in the next session when the roll call occurs.

During the roll call, the country names are recalled out of alphabetical order, and delegates can answer either by saying Present or Present or Present and Voting. Following are the ways a roll call can be responded in -

- Present - Delegates can vote Yes, No, or abstain for a Draft Resolution when they answer the Roll Call with Present.

- Present and Voting - An delegate is required to vote decisively, i.e., Yes/No only if they have answered the Roll Call with a Present and Voting. A Delegate cannot abstain in this case.

- Abstention - The Delegate may abstain from voting if they are in doubt, or if their country supports some points but opposes others. Abstention can also be used if a delegate believes that the passage of the resolution will harm the world, even though it is unlikely to be highly specific. A delegate who responded with present and voting is not allowed to abstain during a substantive vote. An abstention counts as neither “yes” nor “no vote”,and his or her vote is not included in the total vote tally.

Quorum

In order for the proceedings of a committee to proceed, quorum(also known as a minimum number of members) must be set which is one-third of the members of the committee must be present. Quorum will be assumed to be established unless a delegate's presence is specifically challenged and shown to be absent during the roll call. The Executive Board may suspend committee sessions if a quorum is not reached.

Setting The Agenda

In their opening meeting, delegates will have to set the agenda fortheir committee. A committee shall decide for the agenda in the following manner:

- The Chair will call for any points or motions on the floor, where a delegate may propose to set the agenda to a particular topic.

- The chair will call on those who are against the motion. In the event of opposition, one speech for and one speech against the topic area shall be limited to one and a half minutes each.

- The motion will be put to an informal vote by showing placards, a majority of 51% or more is required to pass. Upon failure, the second topic area is automatically set for discussion; if there is no second agenda item, then the council moves to an emergency meeting.

General Speaker's List

After the agenda for the session has been established, a motion israised to open the General Speaker's List or GSL. The GSL is where all types of debates take place throughout the conference, and the list remains open throughout the duration of the agenda's discussion. If a delegate wishes to speak in the GSL, he or she must notify the Executive Board by raising his or her placard when the Executive asks for Delegates desiring to speak in the GSL. Each country's name will be listed in the order in which it will deliver its speech.

A GSL can have an individual speaker time of anywhere from 60-120 seconds. Following their GSL speech, a Delegate has the option of yielding his/her time to a specific Delegate, Information Points (questions) or to the Executive Board.

Yields

Yield to another Delegate: When a delegate has some time left to speak, and he/she doesn't wish to utilize it, that delegate may elect to yield the remaining speaking time to another delegate.

This can only be done with the prior consent of another delegate (taken either verbally or through chits).The delegate who has been granted the other's time may use it to make a substantive speech, but cannot further yield it.

Yield to points of information: Delegates may also choose to yield to points of information. An Executive Board member will recognize a certain number of delegates who wish to ask questions regarding the agenda or the speech presented by the delegate. It is up to the Delegate to answer that question. Delegates have the option of answering the question then and there or refusing to answer it at the time. Ways of refusal include replying via chit at a later time or discussing the topic during an unmoderated caucus.

Yield to the Chair: When a delegate yields to the chair, any remaining time is deemed null and the board will move on to the next speaker in GSL. Some executive boards may also ask the delegate to answer substantive questions if necessary for debate. It usually happens when a country's position is crucial to the resolution of a problem.

Motions

During a moderated caucus, there will be no speakers' list. The moderator will call upon speakers in the order in which the signal their desire to speak. If you want to bring in a motion for a moderated caucus, you will have to specify the duration, a speakers' time, a moderator, and the purpose of the caucus. This motion is subject to seconds and objections but is not debatable.

In an unmoderated caucus, proceedings are not bound by the Rules of Procedure. Delegates may move around the room freely and converse with other delegates. This is also the time to create blocks, develop ideas, and formulate working papers, draft resolutions, and amendments. Remember that you are required to stay in your room unless given permission to leave by a Chair.

When raising a motion to suspend the meeting for an unmoderated caucus, the delegate must state the desired duration of the caucus. No topic needs to be specified. The Chair shall announce at what time the committee will reconvene. This motion is subject to seconds and objections but is not debatable. In case there are multiple motions for a caucus on the Floor, the vote will be casted first for the caucus with the longest duration.

At the end of the caucus, delegates may ask for an extension which does not exceed the original time of the motion.

During the course of debate, the following points are in order:

Point Of Personal Privilege

During the discussion of any matter, a delegate may raise a Point of Personal Privilege, and the Chair shall immediately address the point. A Point of Personal Privilege must refer to a matter of personal comfort, safety and/or well-being of the members of the committee.

Point Of Order

During the discussion of any matter, a delegate may raise a Point of Order and the Chair shall consider the request. A Point of Order must relate to the observance of the rules of the committee or to the way the Chair is exercising his or her power. A delegate raising a Point of Order may not speak on the substance of the matter under discussion. The Chair may refuse to recognize a Point of Order if the delegate has not shown proper restraint and decorum governing the use of such a right, or if the point is dilatory in nature.

Point Of Information (question to other delegates)

After a delegate gives a speech, and if the delegate yields their time to Points of Information, one Point of Information (a question) can be raised by delegates from the floor. The speaker will be allotted the remainder of his or her speaking time to address Points of Information. Points of Information are directed to the speaker and allow other delegations to ask questions in relation to speeches and resolutions.

Point Of Parliamentary Inquiry

If there is no discussion on the floor, a delegate may raise a Point of Inquiry to request clarification of the present procedural status of a meeting. A Point of Inquiry may never interrupt a speaker.

Working paper

These are the committee's views on a particular sub-topic of the main agenda at hand. They provide direction to the committee and indicate the way in which the committee is flowing. A working paper has no prescribed format and needs no signatories.

Before introduction to the committee, a working paper needs to be approved by the Chair. A working paper needs a simple majority to be introduced on the floor of the committee and voting can be carried out in an informal way. In case of multiple working papers, the Chair has the discretion to decide the order in which they are to be put to vote. If a working paper is passed it has to be incorporated in the resolution. The voting on a working paper can be done in an informal way by a show of placards.

Resolution and clauses

The solution to the entire agenda is called a resolution. A resolution requires a minimum of 1 author and 3 signatories to be introduced to the council. This minimum requirement holds true for every council irrespective of the council size. An author is one who formulates the resolution and cannot vote against the resolution, whereas a signatory is a person who simply consents to have the resolution being discussed in council and can exercise his/her vote in the way he/she pleases.

In case of multiple resolutions being brought to the Chair at the same time, the one with more number of signatories shall be put to the committee first for voting. A resolution before being introduced requires the prior approval and signature of the chair. The voting on introduction of a resolution for debate can be done in an informal manner however, the voting regarding the passing of the resolution must be done through formal voting procedure.

A resolution before being passed is always referred to as a Draft resolution and is prepared in two parts in the following format:

- Pre-ambulatory Clauses:

These are clauses which are an introduction to the resolution or solution and often refer to past resolutions, citations of speeches made and references to theUN charter. Every pre-ambulatory clause starts with any one of the following pre-ambulatory phrases and ends with a comma.

List of Pre-ambulatory Phrases:

Affirming, Alarmed By, Approving, Aware Of, Bearing In Mind, Believing, Confident, Contemplating, Convinced, Declaring, Deeply Concerned, Deeply Conscious, Deeply Convinced, Deeply Disturbed, Deeply Regretting, Desiring Emphasising,Expecting, Expressing Its Appreciation, Expressing Its Satisfaction, Fulfilling, Fully Alarmed, Fully Aware, Fully Believing, Further Deploring, Further Recalling, Guided By, Having Adopted, Having Considered, Having Considered Further, Having Devoted Attention, Having Examined, Having Heard, Having Received Having Studied, Keeping In Mind, Noting With Regret, Noting With Deep Concern, Noting With Satisfaction, Noting Further, Noting With Approval, Observing, Reaffirming, Realising, Recalling, Recognizing, Referring, Seeking, Taking Into Account, Taking Into Consideration, Taking Note, Viewing With Appreciation, Welcoming

- Operative Clauses:

These are the clauses which contain the actual solution to the agenda or crisis. They begin with an operative phrase and end in a semi-colon except for the last clause of the resolution which ends in a full stop.

List of Operative Phrases

Accepts, Affirms, Approves, Authorises, Calls, Calls Upon, Condemns, Confirms, Congratulates, Considers, Declares Accordingly, Deplores, Designates, Draws The Attention, Emphasises, Encourages, Endorses, Expresses Its Appreciation, Expresses Its Hope, Further Invites, Further Proclaims, Further Reminds, Further Recommends, Further Requests, Further Resolves, Has Resolved, Notes, Proclaims, Reaffirms, Recommends,Regrets, Reminds, Requests, Solemnly Affirms, Strongly Condemns, Supports, Takes Note Of, Transmits, Trusts.

Amendments

All amendments need to be written and submitted to the executive board. The format for this is authors, signatories and the clause with mentioning the add, delete and replace. There are two forms of amendment, which can be raised by raising a Motion for amendment and approval of the chair:

- FriendlyAmendments: Amendment,which isagreeduponby all the author/'s does not require any kind of voting.
- NormalAmendments: Amendments that are introduced by any other need not be voted upon by the council and are directly incorporated in the resolution. You need a simple majority in order to introduce a normal amendment.

Voting and types

Each member state of the meeting shall have one vote.
This is required only for passing a resolution or a declaration and takes place in 3 rounds. No observer, members of the press or administration staff are allowed to be present during voting. There are 3 rounds of voting:

Round 1: All delegates have an option between choosing:

- Yes
- No
- Yes with rights
- No withrights
- Abstain
- Pass.

Round 2: All delegates that have opted for rights get to justify their positions. This round is entered only if there is yes with rights or a no with rights and a pass.

Round 3: Delegates have to cast their final vote which cannot change between a yes, no and abstain.

A resolution passes if it has a 2/3rd majority: All delegates have an option between choosing:

- Yes
- No
- Yes withrights
- No withrights
- Abstain
- Pass.