Committee: Human Right Committee

Topic: The question of social and health care for the aged.

Chair: Sarah Elif Edwards

Introduction

In the past half century we have witnessed average life span increase all around the world as a result health and social care has adapted to fit the needs of the aged population. WHO reports that “Between 2000 and 2050, the proportion of the world's population over 60 years will double from about 11% to 22%. The number of people aged 60 years and over is expected to increase from 605 million to 2 billion over the same period”. This is not only a significant change in demographics and population but also a noteworthy societal change. Regardless whether the country is a developed country or a developing country, the new socio-economic dynamics effected the family structure. If it were a century ago a the aged members of the family would live with their sons and be taken care by them, nowadays this occurs less frequently and is only a part of a few cultures. So the care of the aged have shifted to medical staff from family members.

While there is improvement in all countries some are relatively more advanced than others due to several reasons such as economic capability, demographic and population size of the aged, availability and demand for social and health care services.

Definitions

First of all it is essential to define what is meant by aged. It is custom to define people that are 60-69 as young old, 70-79 is middle old and people that are 80 over as elderly old.

Health Care: the maintenance or improvement of health via the prevention, diagnosis and treatment of disease, injury, illness or any other physical or mental problems that relate to one’s health

Social Care: The provision by society of what is necessary for the health and welfare of a person or group of people; specifically any of various types of support or supervision provided by social workers and allied professionals, typically (especially opposed to health care) excluding the medical treatment of existing conditions.

History of the Problem

There has been a significant increase in the age demographics of a population. Although a small part of this global increase is due to the improved survival of aged people, most reflects improved survival at younger ages. In developing countries, death occurred most commonly in early childhood. Deaths are then evenly spread across the rest of life. As countries develop, better public health it means that more people survive childhood, and the pattern of deaths

changes to one in which people are more likely to die as adults. In high-income settings, the pattern of death shifts even more to old age, so that most deaths occur in people older than 70 years. As mentioned in the introduction, because families don't take care of the aged members the responsibility falls on the government.

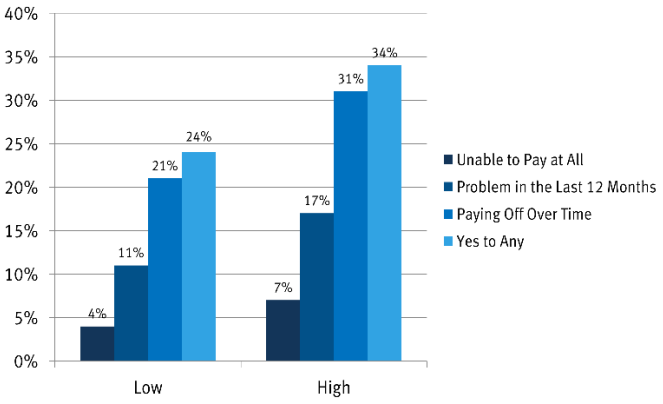
Current Situation

Currently countries have an increased demographic in aged people that they need to provide for, as this isn't a utopia countries can very rarely provide good health and social care for their citizens. It is only seen insignificantly economically developed countries such as UK and Japan where all of their citizens are allowed free public health care. While some developed countries such as USA haven't provided a health care system for their citizens it doesn't come as a surprise that developing countries such as Nigeria don't have adequate health and social care systems. Although an aging population is likely to be correlated with increasing health needs, particularly in low- and middle-income countries, the correlation with the demand for and utilization of, health services is less clear-cut. Furthermore, both among and within nations, it is likely that older people are caught between their greater need for health care and having less access to, or less use of, appropriate services.

Economic aspects

İt is crucial to talk about the economic aspects of this issue as the rising burden of chronic and acute disease, and the number of people with complex care needs in particular, require the development of systems that bring together a range of professionals and skills from both health-care and long-term and social-care sectors. It is commonly understood that population ageing and the growing numbers of older people will place additional strain on all parts of the health and social care system. Thus increasing government spending.

Percent of Privately Insured Adults with Difficulty Paying Medical Bills by Deductible, 2012

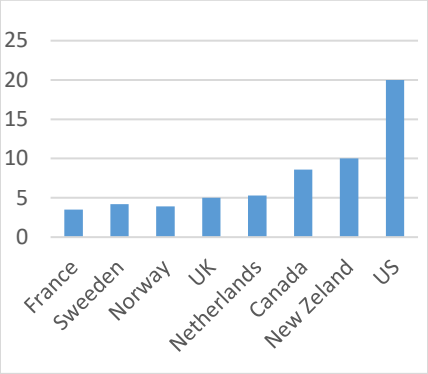


Source: Kaiser Family Foundation analysis of 2012 National Health Interview Survey (NHIS) data. Low deductible is defined as less than $1,200 for a single policy or less than $2,400 for a family policy. All differences between low and high deductible are statistically significant at the 0.05 level.

There are several programs in countries that have been adapted to fit their country's aged people's needs. Japan has the Kaigo Hoken insurance program, and the UK Government Office for Science has a report called Future of an Aged Population that has the impacts and trends of a country with an aging population, and identifies any related policy implications within the UK. However developing countries are severely lacking in this department.

It's not only governments that have a difficulty in providing for the aged. Individuals have stated several reasons for not accessing health care such as lack of transport, not being to afford treatment, denial of health care services, previous maltreatment, inadequate and equipment of the health care provider. All of these reasons lead to unavailability due to economic

circumstances. Here's a chart that gives the percentage of people aged over 65 that couldn't seek health care treatment due to the cost.



Country Policies

United Kingdom

In the UK Northern Ireland, Wales, Scotland and England each have different health and social care systems of publicly funded health care which is, funded by and accountable to separate governments and parliaments, together with smaller private sector and voluntary provision. Each common wealth state has its own National Health Service (NHS). Some of the differences are that in England and Wales the National Institute for Health and Clinical Excellence has guidelines for practitioners to treat some conditions and which particular condition should be funded, while the others don't have this and in Scotland the Scottish Medicine Consortium advises NHS Boards there about all newly licensed medicines and formulations of existing medicines as well as the use of antimicrobiotics but does not assess vaccines, branded generics, non-prescription-only medicines (POMs), blood products and substitutes or diagnostic drugs as a result some of the drugs got released earlier, this lead to complaints. Despite the differences all of the governments have developed an efficient system where by all of their citizens can seek and get free treatment, diagnosis and routine checkups from a general practitioner or other health care facilities. Depending on the situation of the patient they will get a community matron, it depends purely on the illness of the patient and not the age how often the community matron would visit. If the patient is over 60 they can get their prescribed medication for free (This is only applicable for England as Wales, Scotland and Northern Ireland already sell prescription drugs for free). A British citizen can either apply individually or a facility can contact social services if needed. Social services would make a package suitable for the patients' needs and price of it would be determined by their house-hold income.

United States of America

The U.S. health care system is unique among advanced industrialized countries. The U.S. doesn't have a uniform health system, has no universal health care coverage, and only recently enacted legislation mandating healthcare coverage for almost everyone. Rather than operating a national health service, a single-payer national health insurance system, or a multi-payer universal health insurance fund, it can best be described as a hybrid system. In 2014, 48 % of U.S. health care spending came from private funds, with 28 % coming from households and 20 %percent coming from private businesses. The federal government accounted for 28 % of spending while state and local governments accounted for 17 percent. Perhaps the biggest issue is the lack of health insurance coverage. The Center for American Progress estimated in 2009 that the lack of health insurance in the U.S. cost society between $124 billion and $248 billion per year.

In March, 2010, President Obama signed the ACA into law that made hundreds of significant changes to the U.S. healthcare system between 2011 and 2014. Provisions included in the ACA are intended to expand access to healthcare coverage, increase consumer protections, emphasizes prevention and wellness, and promote evidence- based treatment and administrative efficiency in an attempt to curb rising healthcare costs. However with the Trump administration, President Trump decided to scrap subsidies to health insurance companies that help pay out-of-pocket costs of low-income people. pull out of the insurance exchanges created under the Affordable Care Act if the subsidies were cut off. Known as cost-sharing reduction payments, the subsidies were expected to total $9 billion in the coming year and nearly $100 billion in the coming decade.

A country usually has three systems to decrease costs of health and social care:

A national health service, where medical services are delivered via government-salaried physicians, in hospitals and clinics that are publicly owned and operated—financed by the government through tax payments.

A national health insurance system, or single-payer system, in which a single government entity acts as the administrator to collect all health care fees, and pay out all health care costs. Medical services are publicly financed but not publically provided.

A multi-payer health insurance system, or all-payer system, which provides universal health insurance via sickness funds that are used to pay physicians and hospitals at uniform rates, thus eliminating the administrative costs for billing.

USA has neither of these.

Japan

The health care system of Japan is characterized by its universal coverage health insurance system Japanese government has been facing the dilemma of attaining both the reduction in the number of medical care facilities and the concurrent increase in the medical labor force. Due to the pressure of increasing health spending, the Japanese government had great effort to control excessive hospital resources. However, the increasing medical care needs due to the aging population have made the problem of insufficient medical staff more serious. As for the country's social care, a separate compulsory long-term care insurance (Kaigo Hoken) covers

the needs of the population aged 40 and over. Benefits are generous by international standards, designed to cover the costs of care less a 10 % co-payment (reduced on a mean-tested basis for lower income people), third of accommodation costs are covered, with the remainder subject to a means test and the assessment is career-blind which means that it doesn't take informal care provided by an individual's community into account.

India

India's constitution guarantees free healthcare for all its citizens. All state hospitals are required to provide free of cost healthcare facilities to the patients. Each district headquarters in most states have one or more Government hospitals where everything from diagnosis to medicine is given for free. Despite the fact that India has a guaranteed free healthcare system, the private healthcare sector is responsible for the majority of healthcare in India. Most healthcare expenses are paid out of pocket by patients and their families, rather than through insurance. According to National Family Health Survey-3, the private medical sector remains the primary source of health care for 70% of households in urban areas and 63% of households in rural areas. There's also limited health and social care in rural areas of India, only 2% of doctors are in rural areas - where 68% of the population live. It's one of the countries that need refining in their country policies and constitution considering the population and the availability of heath care. As for the countries social care, in Goa, as across India as a whole, formal long-term care services are generally lacking. Nursing homes don't admit people with dementia, and as of 2008, specialized dementia homes did not exist. The responsibility for people with dementia is placed mostly on family members. As a result a community based intervention has been developed to offer support and education to families of people with dementia by making use of locally available health and humanitarian resources. The intervention reduced improved care givers mental health and deceased aggressive behavior of people who have dementia. It's proved to be an effective solution that's easily applicable.

Past Solutions

Besides mentioning the country policies that work and are sustainable it's also good reference to mention past United Nations solutions.

In 1991, the United Nations General Assembly adopted resolution 46/91 entitled also as The United Nations Principles for Older Persons. This resolution rests very much on the findings and the recommendations of the Madrid Plan by encouraging government to include in their national action plan: independence of the elderly, participation of the elderly to the society, care, self-fulfillment and dignity. The Vienna Plan establishing the basis of recognition of the elderly, is followed twenty years later by the Madrid International Plan on Aging updating the last convention and emphasizing the importance of human rights as a reference, the two fundamental goals established are:

1. The full realization of fundamental rights and freedoms of older persons,

2. Ensuring the full enjoyment of the economic, social and cultural rights and the civil and politic rights of older persons and the elimination of discrimination against older persons.

In 2010, the resolution 68/182 of the General Assembly establishes an open ended working group on aging in order to evaluate the current international situation of the elderly, to identify the gaps and to establish the best way to address the problems the elderly are facing. This is followed in 2011 by a report of the Secretary General indicating that some good measures have been implemented since 2002, however these policies are inconsistent among member states.

NGO's

Here are a few NGO's to mention during debate and mention and refer to in your resolution papers. I have only put NGO's that work globally, in order for all member states to use them equally, but research your assigned delegations NGO's to get a better grasp on the matter.

World Health Organization (WHO): It's a specialized agency of the UN that is concerned with public health. Its objective "is the attainment by all people of the highest possible level of health" As of 2012 WHO has defined its role in public health as follows:

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;[19]
- setting norms and standards and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalyzing change, and building sustainable institutional capacity; and
- monitoring the health situation and assessing health trends.

What they've mainly done about aged people is gathering data.

Global Health Council (GHC): a United States-based non-profit leading networking organization "supporting and connecting advocates, implementers and stakeholders around global health priorities worldwide"

Questions a Resolution Must Answer:

How can countries provide their aged citizens with adequate health and social care system?

How can countries do this without having a significant amount of economic strain?

How can countries ensure that all of their citizens regardless of their economic background can have access to health and social care service?

How can countries have a sustainable health and social care system?

Sources:

Feel free to check any of them as reference for the main idea of the topic or specifics about your country policies. I highly recommend you read the first link, which is a PDF prepared by WHO.

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