

2026 STUDY GUIDE

WORLD HEALTH ASSEMBLY

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MUNLawS 2026

WORLD HEALTH ASSEMBLY

Study Guide

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EDITORS: ŽIVA SRŠE, ŽIVA ROZINA

From the Secretary General...

Dear Delegates,

It is my great pleasure to welcome you to this year's MUNLawS!

After ten months of planning, organising, and probably overthinking every possible detail, the day has finally come! We have put a lot of ourselves into making this conference happen, and we hope that you will enjoy it as much as we have enjoyed creating it.

Having been part of the MUN community for a few years now, organising a conference of your own is definitely a different experience, one filled with equal parts excitement, stress, and the occasional crisis. A big thank you goes to my team, Živa Srše, Živa Rozina, Vito Vidmar, and Maks Novak, for everything they have done along the way. I truly could not have asked for a better team!

*As a law student with a particular interest in human rights, I find myself increasingly concerned by the ongoing conflicts and divisions across different regions of the world. This is one of the reasons why, this year, we have chosen **Strengthening Regional Cooperation** as our overall theme.*

While that might sound like a very diplomatic way of saying “let's get along”, there is much more to it. In a world that often seems too divided, cooperation can sometimes feel difficult but that is exactly why it matters. And what better place to promote cooperation among young people than an MUN, where people from different countries and backgrounds come together, ready to listen to one another and, sometimes, even let go of their own ideas for the sake of finding common ground?

Throughout this conference, I encourage you to challenge one another, question your own assumptions, and defend your positions but most importantly, remember to listen to one another. The goal is not to be the loudest person in the room, but rather to see what we can achieve when all those voices are heard.

And of course, do not forget to have fun. At the end of the day, we are not real diplomats (yet)!

I hope you have an unforgettable few days filled with great debates, questionable amounts of caffeine, and, hopefully, many new friendships.

See you in the committee!

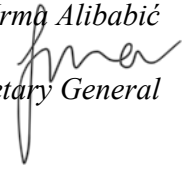
Irmā Alibabić

Secretary General



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INTRODUCTION TO THE COMMITTEE

Chairs' Welcome

Dear Delegates,

We are delighted to welcome you to the World Health Assembly and to have the opportunity to serve as your Chairs. We are looking forward to the discussions, negotiations, and ideas you will bring to the committee, and we hope that this conference will be both a challenging and rewarding experience for all of you.

This year, we will be addressing two highly relevant issues in global health. Our first topic, **Global Access Problem: GLP-1 Medicines**, will examine the growing importance of GLP-1 receptor agonists, while considering why access to these medicines remains so unequal around the world and what the international community can do about it. Our second topic, **Social Isolation as a Rising Health Risk**, will explore the consequences of increasing social isolation in the digital age and the role that governments and international institutions can play in addressing it.

As your Chairs, we want to create a committee in which everyone feels comfortable contributing, regardless of their previous Model UN experience. Alin is a fourth-year law student with experience in international moot court and MUN, with particular interests in the relationship between law, economics, and global governance. Abdul is completing his final year of a bachelor's degree in physics and has participated in numerous MUN conferences since high school, developing a strong interest in geopolitics and debate. We hope to bring these different perspectives to the committee and support you throughout the conference.

The Study Guide is intended to provide you with a starting point for your research and to introduce the main questions surrounding both topics. However, we strongly encourage you to go beyond it. Come prepared to understand the position of your assigned State, think critically about possible solutions, and engage with the arguments of other delegates.



Most importantly, we encourage you to be curious, respectful, and open-minded. Do not hesitate to ask questions, challenge ideas, or get involved in the debate. The best committees are not necessarily those with the most experienced delegates, but those where everyone is prepared to listen, negotiate, and work towards realistic solutions.

We look forward to meeting you and to seeing the ideas and solutions you bring to the floor.

Yours sincerely,

Alin & Abdul



About the World Health Organization

The World Health Organization is the United Nations **specialised agency** responsible for international public health. Established in 1948, it serves as the directing and coordinating authority on **global health matters within the UN system**, guiding international health policy, setting standards, and providing technical support to Member States.

History

The history of the World Health Organization traces back to the League of Nations Health Organization. The modern framework of global health governance was officially established on April 7, 1948, when the **Constitution of the World Health Organization (WHO)** came into force. This day is commemorated annually as **World Health Day**.¹

During the early decades, multiple WHO led programs and global initiatives including malaria control programs and child health campaigns, helped establish the organization as the central pillar of international health governance. The earliest celebrated achievement of the organization was the **eradication of smallpox in 1980**, which remains to this day the only human disease to be fully eradicated.²

The WHO's capacity to respond to a complex and heavily politicized global health crisis was tested during the **HIV/AIDS epidemic of the 1980s and 1990s**. Unfortunately, the response was slow and uneven, which ultimately led to the creation of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996.³

The **H1N1 outbreak** led to the first ever **declaration of a Public Health Emergency of International Concern (PHEIC)**, which allowed for the establishment of a legal framework for coordinating the global response that is still used to this day.⁴

¹ World Health Organization, "History of WHO." <https://www.who.int/about/history>.

² Centers for Disease Control and Prevention, "History of Smallpox," <https://www.cdc.gov/smallpox/about/history.html>.

³ UNAIDS, "About UNAIDS," <https://www.unaids.org/en/whoweare/about>.

⁴ World Health Organization, "Swine Influenza Situation in USA and Mexico," news release, April 26, 2009, <https://www.who.int/vietnam/news/detail/26-04-2009-swine-influenza-situation-in-usa-and-mexico>.

Critical gaps in the WHO's emergency response capacity were exposed during the **2014-2016 Ebola outbreak**. The delayed declaration of a PHEIC drew heavy criticism and led to major internal restructuring and the creation of the **WHO Health Emergencies Programme** to further strengthen the organization's ability to detect and respond to outbreaks rapidly.⁵

The recent **COVID-19 pandemic** was the most severe test in WHO's history. While the organization played a significant role in coordinating the global emergency response, it faced considerable political pressure, most notably from the United States. The WHO has been criticized over its handling of early information from China, and this has led to ongoing debates about the transparency of the WHO that continue to shape reform discussions to this day.⁶

Policies and objectives

The **13th General Programme of Work (GPW13)**, which covered the period from 2019 to 2023 and has been extended through 2025, introduced the **Triple Billion Targets**, which is an ambitious framework aiming to ensure 1 billion more people benefit from universal health coverage, 1 billion more are better protected from health emergencies, and 1 billion more enjoy better health and well-being.⁷

The **One Health Approach** is a framework that recognizes the **health of humans, animals, and ecosystems as interconnected**, making it a cornerstone of WHO policy. This reflects an understanding that health crises don't differentiate between a species or environment.⁸

The **14th General Programme of Work (GPW14)** covers the new cycle from 2025 to 2028 and sets the global health agenda guiding the WHO's work. Its vision is to save 40 million lives by promoting health, namely by addressing the root causes of diseases and strengthening health systems. The **Triple Billion Targets** have also been recalibrated to

⁵ "The Law of Responsibility and the World Health Organisation: A Case Study on the West African Ebola Outbreak," PMC, <https://pmc.ncbi.nlm.nih.gov/articles/PMC7226899>.

⁶ Think Global Health, "The World Health Organization and Pandemic Politics," <https://www.thinkglobalhealth.org/article/world-health-organization-and-pandemic-politics>.

⁷ World Health Organization, "Thirteenth General Programme of Work, 2019–2023," <https://www.who.int/about/general-programme-of-work/thirteenth>.

⁸ World Health Organization, "One Health," <https://www.who.int/health-topics/one-health>.

aim for 6 billion people with better health and 5 billion with universal healthcare, and 7 billion better protected from health emergencies by 2028.⁹

Structure and governance

Membership

WHO currently has **194 Member States**, belonging to 6 regions, making it one of the most universally represented bodies in the UN system.¹⁰ In addition to full members, certain territories without complete self-governance may participate as **associate members**, with **limited rights**.¹¹ Membership entails both **rights**, such as access to WHO technical assistance and participation in decision-making, **and obligations**, including financial contributions and reporting requirements. Membership has at times been wielded as a **political instrument**; the most prominent example is Taiwan, which, despite its significant public health capacity, has been excluded from WHO participation due to pressure from the People's Republic of China.¹²

World Health Assembly and Executive Board

The **World Health Assembly (WHA)** is WHO's **supreme decision-making body**, convening annually with representation from all Member States. It operates on the **principle of sovereign equality**, meaning one member gets one vote, with important decisions requiring a two-thirds majority. The WHA sets organisational policies, approves the programme budget, and determines the strategic direction of the organisation.¹³

⁹ World Health Organization, "Fourteenth General Programme of Work," <https://www.who.int/about/general-programme-of-work/fourteenth>.

¹⁰ Elizabeth Fee, Marcos Cueto, Theodore M. Brown, "At the Roots of The World Health Organization's Challenges: Politics and Regionalization," *American Journal of Public Health* 106, no. 11 (November 2016): 1912–1917, p. 1.

¹¹ World Health Organization, "Rights and Obligations of Associate Members and Other Territories," in *Basic Documents*, 47th ed. (Geneva: World Health Organization, 2009), pp. 19–22, <https://apps.who.int/gb/bd/PDF/bd47/EN/right-and-oblig-en.pdf>.

¹² Ping-Kuei Chen, "Universal Participation Without Taiwan? A Study of Taiwan's Participation in the Global Health Governance Sponsored by the World Health Organization," in *Asia-Pacific Security Challenges*, ed. Anthony J. Masys and Leo S.F. Lin (Cham: Springer International Publishing, 2018), 263–281.

¹³ World Health Organization, "World Health Assembly," <https://www.who.int/about/governance/world-health-assembly>.

The **Executive Board (EB)** functions as **WHO's operational governing body**, analogous to a board of directors. It is composed of **34 members** elected by the WHA for three-year terms, and is responsible for implementing WHA decisions, preparing the Assembly's agenda, and providing advice on urgent matters between sessions.¹⁴

The organisation is headed by a **Director-General** (currently, Dr. Tedros Adhanom Ghebreyesus), elected by the WHA on the recommendation of the EB.¹⁵

Mandate and powers¹⁶

WHO's mandate encompasses a broad but carefully defined set of powers.

- Its **normative powers** allow it to develop international health standards, guidelines, and classifications (such as the International Classification of Diseases).
- Its **treaty-making powers** enable it to negotiate binding international agreements, most notably the Framework Convention on Tobacco Control.
- Perhaps most consequentially, WHO holds **emergency powers**, including the authority to declare a Public Health Emergency of International Concern (PHEIC), which triggers heightened international coordination and response obligations under the International Health Regulations.
- WHO also provides extensive **technical assistance** to Member States, supporting health system strengthening, disease surveillance, and capacity building.¹⁷

A fundamental limitation, however, defines the boundaries of WHO's authority: **it cannot enforce compliance**. The organisation has no binding enforcement mechanism and must rely entirely on the cooperation of States. This structural constraint has been a persistent

¹⁴ World Health Organization, "Executive Board," On <https://www.who.int/about/governance/executive-board>.

¹⁵ World Health Organization, "Executive Board," On <https://www.who.int/about/governance/executive-board>.

¹⁶ Alison Lakin, "The Legal Powers of the World Health Organization," *Medical Law International* 3, no. 1 (September 1997): 23–49, pp. 29–30, 33, 38–41.

¹⁷ Alison Lakin, "The Legal Powers of the World Health Organization," *Medical Law International* 3, no. 1 (September 1997): 23–49, pp. 29–30, 33, 38–41.

source of criticism, particularly in the context of outbreak response, where timely and coordinated action is essential.¹⁸

Financing and partnerships

Mandatory payments by all WHO Member States are **assessed contributions**, which are calculated based on a nation's GDP and population size. This is the most stable and predictable form of funding for the organization, but it accounts for only up to 20 percent of the total budget of the organization, which leaves the organization heavily dependent on **voluntary contributions**.¹⁹

As stated in the previous paragraph, most of the WHO's budget comes from voluntary contributions made by Member States, private organizations and non-governmental organizations (NGOs). An important thing to note is that these **contributions often are earmarked**, which means their donors can specify where their money is spent. This creates a problem whereby the donors' priorities dictate the WHO's agenda rather than the global health needs.²⁰ Historically, the United States has been the largest single donor to the WHO, and this led to uncertainty following its threatened withdrawal in 2020.²¹

The Gates Foundation is consistently among the WHO's top donors and critics argue that the Foundation's influence skews WHO programming toward technological and market-based solutions at the expense of broader systemic and social determinants of health.²²

Gavi, the Vaccine Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria represent major multilateral financing mechanisms that work in close partnership with the

¹⁸ Alison Lakin, "The Legal Powers of the World Health Organization," *Medical Law International* 3, no. 1 (September 1997): 23–49, pp. 29–30, 33, 38–41.

¹⁹ World Health Organization, "How WHO Is Funded," <https://www.who.int/about/funding>.

²⁰ World Health Organization, "How WHO Is Funded," <https://www.who.int/about/funding>.

²¹ CBS News, "Trump Moves to Withdraw U.S. from the World Health Organization," <https://www.cbsnews.com/news/trump-withdraw-us-world-health-organization/>.

²² "The Gates Foundation, Global Health and Domination: A Republican Critique of Transnational Philanthropy," *International Affairs* (Oxford Academic), <https://academic.oup.com/ia/article/98/6/2039/6765178>.

WHO. Their existence also reflects a broader trend of health financing moving outside the WHO's direct control.²³

Key legal instruments

WHO's work is underpinned by several foundational legal instruments that define both its own authority and the obligations of Member States in the realm of global health governance.

WHO Constitution (1946)

The **WHO Constitution**, which entered into force in 1948, is the organisation's founding document. It establishes WHO's objective (the attainment by all peoples of the highest possible level of health) and enshrines health as a fundamental right. It also grants WHO its normative and treaty-making powers, **forming the legal basis for all subsequent instruments**.

International Health Regulations (IHR, 2005)

The **International Health Regulations** are the primary binding legal framework governing how States and WHO respond to public health risks with the potential to cross borders. Originally adopted in 1969 and significantly revised in 2005 following the SARS outbreak, the IHR require Member States to develop core surveillance and response capacities, notify WHO of events that may constitute a public health emergency, and implement measures to prevent unnecessary interference with international traffic and trade. Crucially, the IHR also provide the **legal basis for the Director-General to declare a Public Health Emergency of International Concern (PHEIC)**. Compliance, however, remains voluntary in practice, as the IHR contain no meaningful enforcement mechanism.

Framework Convention on Tobacco Control (FCTC, 2003)

²³ Malay Mail, "Trump Orders US Exit from the World Health Organization," January 21, 2025, <https://malaymail.com/news/world/2025/01/21/trump-orders-us-exit-from-the-world-health-organization/164053>.

The **Framework Convention on Tobacco Control** was WHO's first exercise of its treaty-making powers under **Article 19 of the Constitution**, and remains the **only global public health treaty negotiated under WHO's auspices**. It obligates Parties to implement measures on tobacco taxation, advertising bans, packaging requirements, and smoke-free environments. Although it is a binding instrument, implementation varies significantly across Member States.

Non-binding instruments

Beyond binding treaties, WHO produces a significant body of soft law, such as resolutions, codes, guidelines, and action plans, that shape State behaviour without creating strict legal obligations. Notable examples include the **Global Code of Practice on the International Recruitment of Health Personnel** and the **International Code of Marketing of Breast-milk Substitutes**. While not enforceable, these instruments carry considerable normative weight and **often serve as the foundation for domestic legislation**.

Current challenges and reform debates

The WHO's heavy **reliance on voluntary contributions that are earmarked** undermines its ability to set its own priorities, and when donors dictate spending the organization cannot respond to global health crises flexibly. Many reform advocates have called for a significant increase in the assessed contributions to better strengthen independence.²⁴

The current world is starting to become a heavily polarized geopolitical environment where decisions in regard to health are shaped by politics. The organization's ability to act swiftly has been heavily undermined by **rising tensions between Member States** and this is **slowly eroding the model that is based on consensus** on which it was founded.²⁵

On January 20, 2025, President Trump formally initiated the United States' withdrawal from the WHO. Following the required one-year notice period, the **United States formally**

²⁴ KFF, "The U.S. Government and the World Health Organization," <https://www.kff.org/global-health-policy/the-u-s-government-and-the-world-health-organization/>.

²⁵ "The United States Withdrawal From the World Health Organization: Implications and Challenges," PMC, <https://pmc.ncbi.nlm.nih.gov/articles/PMC12089832>.

exited the WHO on January 22, 2026. All US government funding to the WHO has been terminated, and US personnel assigned to or embedded with the WHO have been recalled from Geneva and WHO offices worldwide.²⁶

The consequences of this are severe and this has led to budget cuts across the organization. The US had contributed somewhere between 12–15% of WHO funding²⁷ and its withdrawal will likely lead to a diminished capacity to carry out the organization's core functions. No single Member State or private foundation can readily fill the gap left behind, making this the **most significant structural blow to the WHO since its founding.**

The pandemic also exposed a lot of structural weaknesses in the organization, and this led to the **loss of public trust in the WHO.** Ongoing reform debates center on increasing assessed contributions to reduce donor dependency and strengthen the WHO's emergency powers under the International Health Regulations.²⁸

²⁶ U.S. Department of Health and Human Services, "HHS Fact Sheet: U.S. Withdrawal from the World Health Organization," <https://cdc.gov/global-health/resources/us-withdrawal-who.html>.

²⁷ Statista, "Top Contributors to the World Health Organization," <https://statista.com/chart/33800/top-contributors-to-the-world-health-organization>.

²⁸ "The United States Withdrawal From the World Health Organization: Implications and Challenges," PMC, <https://pmc.ncbi.nlm.nih.gov/articles/PMC12089832>.

Topic A:

GLOBAL ACCESS PROBLEM: GLP-1 MEDICINES

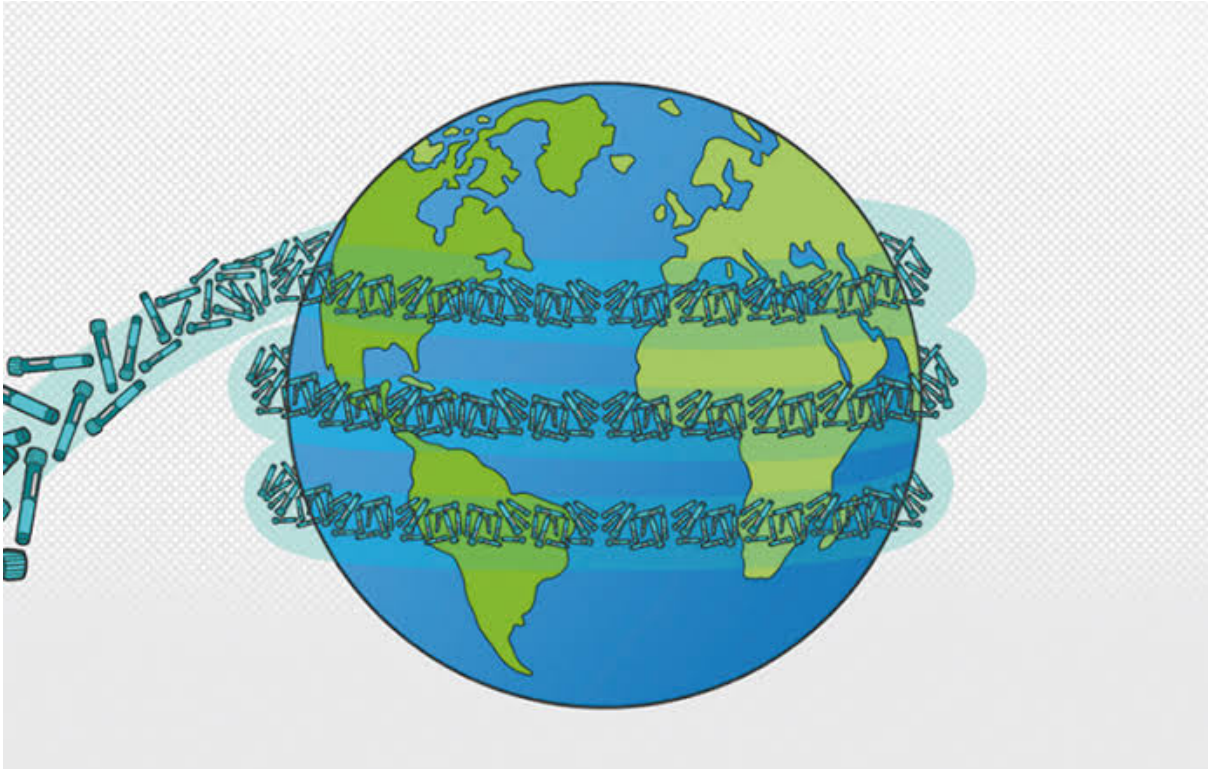


Figure 1: Global access problem²⁹

"Health is the foundation of sustainable development – shaped by governance, financing, rights, climate resilience and inclusion."³⁰

— Joseph Serutoke, at the World Health Assembly 2026

²⁹ Photograph retrieved from the ONdrugDelivery website.

³⁰ Joseph Serutoke, "UNDP Statement at the World Health Assembly 2026," United Nations Development Programme, June 1, 2026, <https://www.undp.org/geneva/speeches/undp-statement-world-health-assembly-2026>.

Introduction

Type 2 diabetes is one of the defining health crises of the twenty-first century. According to the International Diabetes Federation (IDF), approximately 537 million adults were living with diabetes in 2021, a number projected to reach 783 million by 2045.³¹ The burden is not evenly distributed: roughly three-quarters of people with diabetes live in low- and middle-income countries (LMICs), where healthcare infrastructure is strained and access to even basic medicines is unreliable.³²

Into this landscape arrived a class of drugs that many clinicians consider transformative: glucagon-like peptide-1 (GLP-1) receptor agonists. Originally developed for blood sugar management in type 2 diabetes, these drugs have demonstrated remarkable efficacy - reducing HbA1c (a key marker of long-term blood glucose), lowering cardiovascular risk, slowing kidney disease progression, and, yes, also producing significant weight loss.³³ The cardiovascular and renal benefits in particular are clinically significant for a disease that kills primarily through heart attacks, strokes, and organ failure.

The problem is access. GLP-1 receptor agonists cost between \$900 and \$1,000 per month in the United States without insurance.³⁴ Even in countries with public health systems, coverage is frequently restricted. In LMICs, these drugs are often entirely unavailable, or available only to a small wealthy minority.

This is not primarily a scientific failure - the drugs exist, they work, and manufacturing capacity is theoretically expandable. It is a structural failure: of intellectual property regimes, of market incentives, of supply chains, and of political will. This committee will

³¹ Hong Sun et al., "IDF Diabetes Atlas: Global, Regional and Country-Level Diabetes Prevalence Estimates for 2021 and Projections for 2045," *Diabetes Research and Clinical Practice* 183 (2022): p. 1, <https://doi.org/10.1016/j.diabres.2021.109119>.

³² Simiao Chen et al., "The Global Macroeconomic Burden of Diabetes Mellitus," *Nature Medicine* 32 (2026): p. 1, <https://doi.org/10.1038/s41591-025-04027-5>.

³³ Zhikai Zheng et al., "Glucagon-like Peptide-1 Receptor: Mechanisms and Advances in Therapy," *Signal Transduction and Targeted Therapy* 9, no. 1 (2024): pp. 1, 4, <https://doi.org/10.1038/s41392-024-01931-z>.

³⁴ Okifo, Oghenefejiro. "Cheapest GLP-1 Without Insurance: 2026 Price Guide." Doctronic, 2026. <https://www.doctronic.ai/blog/glp-1-cost-without-insurance-price-comparison-chart/>.

examine those structural failures and consider what international action is possible and appropriate.

Foundational concepts

OUTLINE OF THE TOPIC: At first glance, this topic appears to be about a new class of diabetes and obesity medicines. In reality, it is about:

- who gets access to those medicines,
- why many people struggle or cannot obtain them, and
- what role international organizations *can* play in addressing those barriers.

To follow the debate, it is helpful to think of the issue as a chain of interconnected questions - what GLP-1s are in the first place, why they remain important, what causes them to be inaccessible, international rules that shape them, who the major actors behind the issue are and what this committee, WHA, is able to do about it all.

Before examining the legal and political dimensions of this topic, delegates should become familiar with several scientific, economic, and legal concepts that appear throughout this guide. Understanding these definitions at the outset will make the subsequent sections considerably easier to follow.

NOTE FROM THE CHAIRS: Before proceeding to the key concepts and definitions, delegates are strongly encouraged to **watch the videos listed in the ‘Additional Preparation Materials’ section**. While this guide provides the necessary background, the videos offer a more accessible introduction to the scientific and economic foundations of the topic, making the subsequent discussion on policy questions easier to follow. Given the technical nature of GLP-1 medicines and the market structures surrounding them, spending a short amount of time with these resources will significantly improve delegates' understanding of the issues explored in this guide.

1. What are GLP-1 receptor antagonists?

Glucagon-like peptide-1 (GLP-1) receptor agonists are a class of medicines **originally developed to treat type 2 diabetes**. In recent years, GLP-1R (a member of the GPRC family) and its agonists have garnered widespread attention in the medical community. They mimic a gut hormone that stimulates insulin release, suppresses appetite, and slows gastric emptying.³⁵

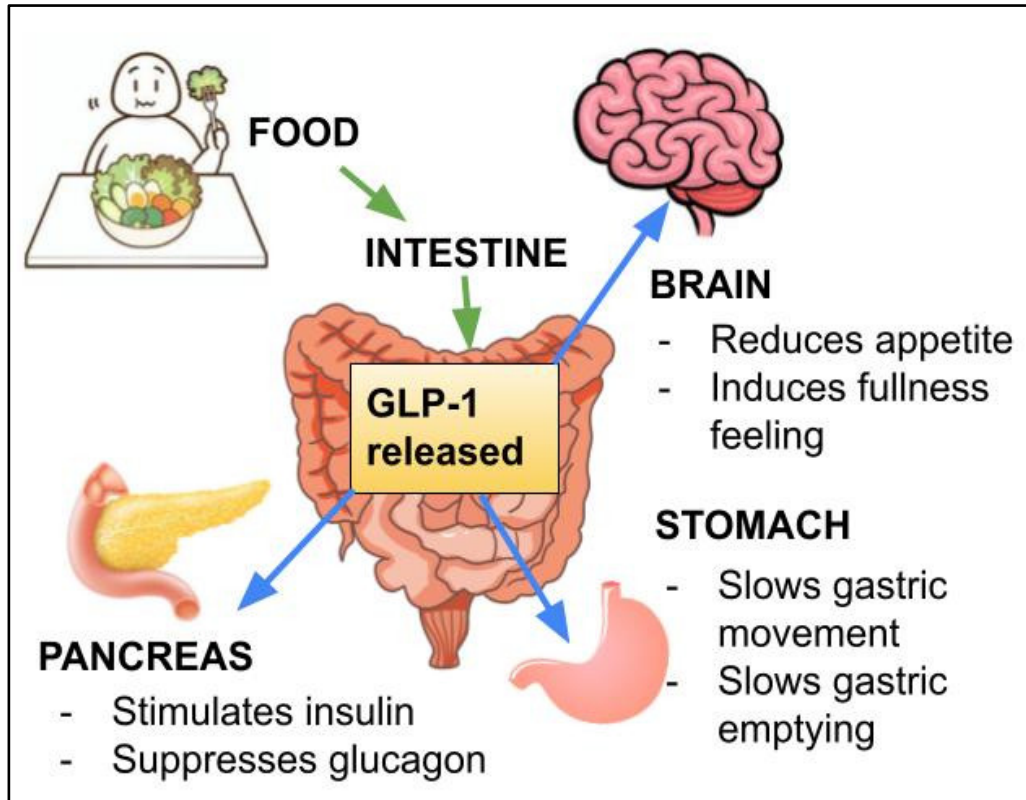


Figure 2: GLP-1³⁶

Clinical trials have demonstrated dramatic weight loss in patients with obesity, with some studies showing reductions of 15-25% of body weight on average after about a year - effects unprecedented in pharmacological treatment of obesity, previously achievable only through bariatric surgery.³⁷ Furthermore, the SELECT trial (2023) demonstrated that semaglutide significantly reduced major cardiovascular events (heart attack, stroke,

³⁵ Zhikai Zheng et al., "Glucagon-like Peptide-1 Receptor: Mechanisms and Advances in Therapy," *Signal Transduction and Targeted Therapy* 9, no. 1 (2024): pp. 1, 4, <https://doi.org/10.1038/s41392-024-01931-z>.

³⁶ Photograph retrieved from the WhatisBiotechnology.org. website.

³⁷ Allison B. Reiss et al., "Weight Reduction with GLP-1 Agonists and Paths for Discontinuation While Maintaining Weight Loss," *Biomolecules* 15, no. 3 (2025): pp. 1, 10, <https://doi.org/10.3390/biom15030408>.

cardiovascular death) in patients with obesity but without diabetes, independent of weight loss. This reframed **GLP-1s not merely as metabolic drugs but as broad cardiovascular medicines, dramatically expanding the potential patient population and commercial market.**³⁸

ESSENTIAL: Key approved drugs include **semaglutide** (Ozempic for diabetes, Wegovy for obesity - both **by Novo Nordisk**) and **tirzepatide** (Mounjaro for diabetes, Zepbound for obesity - **by Eli Lilly**).

2. Pharmaceutical market structures

NOTE FROM THE CHAIRS: Understanding how pharmaceutical markets function is essential to understanding why access to GLP-1 medicines has become a global issue. The price and availability of medicines are determined not only by their medical value, but also **by the structure of the market in which they are sold**. When only a small number of companies control production, competition is limited, prices tend to remain high, and supply shortages can have global consequences. Many of the policy questions discussed in this guide therefore sit at the intersection of public health, intellectual property, and competition policy.

Monopoly – A monopoly exists when a single company is the sole supplier of a product or service. In pharmaceuticals, monopolies are often created temporarily through patent protection, which grants one company the exclusive right to produce and sell a medicine for a specified period.

Duopoly – A duopoly is a market dominated by two companies. Unlike a monopoly, competition exists, but it is limited. The **global GLP-1 market is currently dominated by Novo Nordisk and Eli Lilly**, whose combined market share gives them considerable influence over prices, production, and supply.

³⁸ A. Michael Lincoff et al., "Semaglutide and Cardiovascular Outcomes in Obesity without Diabetes," *New England Journal of Medicine* 389, no. 24 (2023): 2221, <https://doi.org/10.1056/NEJMoa2307563>.

Competition – Competition occurs when multiple companies offer similar products and compete on factors such as price, quality, innovation, and availability. In competitive pharmaceutical markets, manufacturers have incentives to reduce prices and improve products in order to attract consumers and healthcare providers.

Blockbuster drug – A blockbuster drug is a medicine that generates exceptionally high annual sales. Because blockbuster drugs represent enormous commercial value, companies have strong incentives to extend their market exclusivity through patents and other legal protections.

Biosimilars – Because GLP-1 receptor agonists are biological medicines rather than chemically synthesized drugs, their generic equivalents are known as biosimilars. A biosimilar is highly similar to an existing biological medicine but cannot be an identical copy due to the complexity of biological manufacturing.



Figure 3: Difference between perfect competition and monopoly³⁹

3. Intellectual property terminology

NOTE FROM THE CHAIRS: Much of this committee's debate revolves around intellectual property law. Patents are designed to encourage innovation by allowing inventors to

³⁹ Photograph retrieved from the KeyDifferences website.

recover research and development costs. At the same time, they can delay competition and keep medicine prices high. Delegates should therefore understand the following concepts before examining the legal framework governing pharmaceutical patents.

Patent – A patent is an exclusive legal right granted to an inventor that allows them to prevent others from making, using, selling, or importing their invention for a limited period, usually twenty years from the filing date.

Patent holder – The patent holder is the individual, company, or organization that owns these exclusive rights. **In the case of GLP-1 medicines, patent holders such as Novo Nordisk and Eli Lilly control who may manufacture their products while patent protection remains in force.**

Secondary patent – A secondary patent protects a modification of an existing invention rather than the original medicine itself. These patents may cover new formulations, injection devices, manufacturing methods, dosing schedules, or additional medical uses.

Evergreening – Evergreening refers to the practice of obtaining multiple secondary patents in order to extend effective market exclusivity beyond the expiry of the original patent. Critics argue that this delays competition from generic or biosimilar manufacturers, while supporters contend that genuine improvements should continue to receive patent protection.

Compulsory licence – A compulsory licence is a government authorization allowing another manufacturer to produce or import a patented medicine without the patent holder's consent, provided certain legal conditions are met. The patent holder still receives compensation, but cannot prevent production.

Voluntary licence – A voluntary licence is an agreement in which the patent holder voluntarily allows another company to manufacture or sell the medicine under agreed conditions.

4. Country classifications⁴⁰

NOTE FROM THE CHAIRS: The impact of limited access to GLP-1 medicines differs significantly between countries. Throughout this guide, several internationally recognized classifications are used to distinguish countries according to their level of economic development and capacity to provide healthcare.

CLASSIFICATION	DESCRIPTION
Low- and Middle-Income Countries (LMICs)	Countries classified by the World Bank as having low or lower-middle levels of national income. These countries often face greater challenges in financing healthcare systems and ensuring access to expensive medicines.
High-Income Countries (HICs)	Countries with high levels of national income. They generally possess stronger healthcare systems and greater purchasing power, although access to expensive medicines may still be limited by reimbursement policies.
Least Developed Countries (LDCs)⁴¹	A United Nations classification for countries facing severe structural obstacles to sustainable development, including low income, limited industrial capacity, and high vulnerability to economic and environmental shocks. LDCs benefit from special treatment under several international agreements, including extended exemptions from certain pharmaceutical patent obligations under the TRIPS Agreement.
Global North and Global South	These terms broadly describe patterns of economic and political development rather than geographical location. The <i>Global North</i>

⁴⁰ World Bank, "World Bank Classification of Low and Middle Income Countries (LMICs)" (European Public Health Association, 2022), <https://db.eupha.org/repository/conference/2022/LMICs%20classification%20World%20Bank%202022.pdf>.

⁴¹ United Nations Conference on Trade and Development, "UN List of Least Developed Countries," accessed August 7, 2026, <https://unctad.org/topic/least-developed-countries/list>.

generally refers to wealthier, industrialized countries with greater political and economic influence, while the *Global South* refers to countries that have historically faced lower levels of industrialization, development, and access to global resources. Although commonly used in discussions of global health and development, these are broad analytical categories rather than formal legal classifications.

The access problem and why it matters now

The access landscape for GLP-1 receptor agonists (GLP-1RAs) is currently defined by a **collision of clinical breakthroughs, commercial demand, and shifting legal frameworks**. These medications, which mimic the endogenous hormone GLP-1 to regulate blood glucose and satiety, have **moved from being specialized diabetes treatments to global blockbusters** with far-reaching implications for public health and drug market governance.⁴²

GLP-1RAs are at the **center of two distinct health crises** that compete for medical and political priority. These drugs are simultaneously **approved for both diabetes and obesity**, creating a politically sensitive competition for supply and attention.

The first barrier to access is **price**. In the United States, branded semaglutide (Ozempic) lists at approximately \$935 per month. In most LMICs, this is simply not accessible. Generic semaglutide, according to cost modeling studies, could theoretically be produced for as little as \$1–5 per month, figures consistent with the economics of other biologics that have gone off-patent.⁴³ The gap between these prices reflects the operation of patents, regulatory exclusivity, and market power rather than fundamental production costs.

⁴² Zhikai Zheng et al., "Glucagon-like Peptide-1 Receptor: Mechanisms and Advances in Therapy," *Signal Transduction and Targeted Therapy* 9, no. 1 (2024): pp. X, <https://doi.org/10.1038/s41392-024-01931-z>.

⁴³ Healthline, "How Affordable Could Generic Ozempic Be? As Low as \$5 a Month, Study Finds," March 27, 2024, <https://www.healthline.com/health-news/how-affordable-could-generic-ozempic-be-as-low-as-5-a-month-study-finds>.

Price variation across markets differs; GLP-1 drug prices are not uniformly high globally. Novo Nordisk has implemented tiered pricing in some markets. Lower prices *are* possible, the US price is in many ways an outlier driven by the unique structure of the American pharmaceutical market (the lack of direct price negotiation by Medicare until very recently, the role of pharmacy benefit managers, etc.).⁴⁴

Second barrier are **persistent supply shortages** that have been going on since 2022, driven primarily by explosive demand for their weight-loss indications in high-income markets.⁴⁵ The FDA and EMA have both listed various formulations as being in shortage at various points.⁴⁶ These shortages have displaced patients with diabetes in wealthy countries and effectively locked out patients in LMICs entirely, since manufacturers have prioritized the most lucrative markets.

The insulin access crisis provides both a precedent and a warning. Insulin was discovered in 1921 and the original patent was sold to the University of Toronto for \$1. Yet today, millions of people with Type 1 diabetes in LMICs cannot access adequate insulin. GLP-1 drugs risk following the same trajectory unless deliberate policy intervention occurs while the policy window is open.⁴⁷

GLP-1 agonists are at a critical juncture. The drugs are new enough that their patent cliffs are *mostly*⁴⁸ still in the future (core molecule composition patent expires in the early 2030s in many jurisdictions). Decisions made by governments and international bodies now will shape whether a competitive generic market develops, or whether the current duopoly

⁴⁴ Mason Lancellotti, "Peptide Pricing Power: The GLP-1 Duopoly," *Emory Economics Review*, March 7, 2026, <https://emoryeconomicsreview.org/articles/2026/3/3/peptide-pricing-power-the-glp-1-duopoly>.

⁴⁵ Mason Lancellotti, "Peptide Pricing Power: The GLP-1 Duopoly," *Emory Economics Review*, March 7, 2026, <https://emoryeconomicsreview.org/articles/2026/3/3/peptide-pricing-power-the-glp-1-duopoly>.

⁴⁶ Sood, Nikhil, and Rohini Garg. "Global Rise of Compounded Weight-Loss Medicines: A Worrisome Trend." *Journal of the Endocrine Society* 9, no. 8 (2025) <https://pmc.ncbi.nlm.nih.gov/articles/PMC12164287/>.

⁴⁷ Lewis, Gary F., and Patricia L. Brubaker. "The Discovery of Insulin Revisited: Lessons for the Modern Era." *Journal of Clinical Investigation* 131, no. 1 (2021) p. 2. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7773348/>.

⁴⁸ In some jurisdictions and for some core molecules, such as semaglutide in India, the patents have already expired in late March of 2026 and generics in those markets are already thriving.

entrenches itself through regulatory exclusivity, secondary patents, and supply chain lock-in.

Brazil's decision to flag compulsory licensing as a live policy option,⁴⁹ the first major economy to do so, signals that the debate has moved from theoretical to operational.

NOTE FROM THE CHAIRS: The committee must grapple not only with the gap between what the international legal architecture permits and what political constraints allow, but also with which crisis it is primarily addressing: the immediate diabetic access crisis in LMICs, or the longer-term structural reform of how blockbuster drug markets are governed.

Legal and institutional framework

1. The TRIPS Agreement and pharmaceutical patents

The **Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)** is a multilateral agreement **administered by the World Trade Organization (WTO)**, in force since 1995. All WTO members, which counts 166 countries as of 2026,⁵⁰ are required to provide **minimum standards of intellectual property protection**, including:

- a minimum patent term of 20 years from the filing date;⁵¹
- patent protection available for both products and processes in all fields of technology, including pharmaceuticals;⁵²
- rights for patent holders to prevent third parties from making, using, selling, or importing the patented product.⁵³

Article 27 sets out **standards for patentability**, requiring novelty, inventive step, and industrial applicability - but the precise meaning of "inventive step" is left to national law,

⁴⁹ Bill No. 68/2026.

⁵⁰ World Trade Organization, "Members and Observers," accessed August 7, 2026, https://www.wto.org/english/thewto_e/whatis_e/tif_e/org6_e.htm.

⁵¹ Article 33 (Term of Protection).

⁵² Article 27 (Patentable Subject Matter).

⁵³ Article 28 (Rights Conferred).

creating wide variance in how strictly, or loosely, it is applied to pharmaceutical modifications.

Furthermore, for pharmaceutical companies, TRIPS created a global baseline of protection that replaced the patchwork of national patent systems that previously existed (many LMICs had deliberately excluded medicines from patent protection before TRIPS).⁵⁴ The agreement **dramatically expanded the geographic scope of pharmaceutical patents** and was deeply controversial from the moment of its adoption.

As regards GLP-1 receptor agonists - they are **not small-molecule drugs but biological products**: large, complex molecules produced in living cell systems. The manufacturing of biologics is more complex than that of small molecules, and true "generics" of biologics are called biosimilars (similar but not chemically identical to the original). **TRIPS does not specifically address biosimilars**, and the regulatory pathway for biosimilar approval varies considerably across jurisdictions. This creates additional barriers to generic competition beyond patents alone.⁵⁵

Least Developed Countries (LDCs) have repeatedly received extensions to their TRIPS compliance deadlines for pharmaceutical patents. As of the mid-2020s, LDCs are not required to enforce pharmaceutical patents, though in practice many lack the manufacturing capacity to take advantage of this flexibility.⁵⁶

⁵⁴ Urias, Eduardo, and Shyama V. Ramani. "Access to Medicines after TRIPS: Is Compulsory Licensing an Effective Mechanism to Lower Drug Prices? A Review of the Existing Evidence." *Journal of International Business Policy* 3, no. 4 (2020): 367–384. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7468182/>.

⁵⁵ Bas, Tomas Gabriel. "Innovative Formulation Strategies for Biosimilars: Trends Focused on Buffer-Free Systems, Safety, Regulatory Alignment, and Intellectual Property Challenges." *Pharmaceuticals* 18, no. 6 (2025): 908. <https://www.mdpi.com/1424-8247/18/6/908>.

⁵⁶ Dunn, Montgomery, and Ellen 't Hoen. "TRIPS Flexibilities Help Change Policy and Practice to Increase Access to Medicines: Evidence from 2001 to 2024." *BMJ Global Health* 11, no. 1 (2026): e021481. <https://gh.bmj.com/content/11/1/e021481>.

2. The Doha Declaration (2001)

The **Doha Declaration on the TRIPS Agreement and Public Health** was adopted by WTO members in November 2001, at the height of the HIV/AIDS crisis.⁵⁷

It was a landmark political statement affirming that TRIPS "does not and should not prevent members from taking measures to protect public health." It clarified that **States have the right to grant compulsory licences and to determine the grounds on which such licences are granted**. The **Paragraph 6 mechanism** allows least-developed countries (LDCs) to import generics produced under compulsory licence in other countries.⁵⁸

Key elements of the Doha Declaration include:

- WTO members have the right to determine **what constitutes a national emergency** for the purposes of TRIPS flexibilities;
- **public health crises** including HIV/AIDS, tuberculosis, malaria, and other epidemics can constitute national emergencies;
- members have the right to use TRIPS flexibilities to the fullest extent.

The phrase "other epidemics" is significant: it is broad enough to encompass diabetes (and obesity), which now affects over half a billion people globally, and kills more people annually than HIV, tuberculosis, and malaria combined.⁵⁹

Whether the political will exists to treat chronic non-communicable diseases with the same urgency as infectious disease epidemics remains a contested question.

One of the **former limitations of the original TRIPS was that compulsory licenses could only authorize production for the domestic market of the country issuing the license**.

This was problematic for countries with no pharmaceutical manufacturing capacity, who

⁵⁷ George, Erika. "The Human Right to Health and HIV/AIDS: South Africa and South-South Cooperation to Reframe Global Intellectual Property Principles and Promote Access to Essential Medicines." *Indiana Journal of Global Legal Studies* 18, no. 1 (Winter 2011): 167, p. 4.

⁵⁸ *Ibid.*

⁵⁹ Fisher-Hoch, Susan P. "Worldwide Increase in Diabetes: Implications for Tuberculosis Control." *Research and Reports in Tropical Medicine* 5 (July 3, 2014): 35–44, p. 1. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7337143/>.

needed to import generics.⁶⁰ The 2003 **waiver** (made permanent as **Article 31bis** in 2017) **allows countries to issue compulsory licenses specifically for export to countries with insufficient manufacturing capacity**.⁶¹ However, uptake has been extremely limited in practice, partly due to administrative complexity.

3. Compulsory licensing and other TRIPS flexibilities

A **compulsory license** is an authorization by a government that allows a third party (typically a domestic manufacturer or importer) to produce or import a patented medicine without the consent of the patent holder. The patent holder receives compensation (typically a royalty), but cannot block the production.⁶²

TRIPS Article 31 permits **compulsory licensing under specific conditions**:

1. the proposed user must **first attempt to obtain a voluntary license** from the patent holder on reasonable commercial terms (this requirement **can be waived in national emergencies**);
2. the compulsory license must be **non-exclusive** and **primarily for the domestic market**;
3. **adequate remuneration** must be paid to the patent holder (typically royalties).

In practice, countries invoking compulsory licensing **risk pressure from the United States Trade Representative's "Special 301" watch list** and **TRIPS-plus provisions in bilateral trade agreements with the EU**. This has created a significant gap between rights on paper and rights in practice, particularly for middle-income countries that do not qualify for LDC exemptions.

⁶⁰ Urias, Eduardo, and Shyama V. Ramani. "Access to Medicines after TRIPS: Is Compulsory Licensing an Effective Mechanism to Lower Drug Prices? A Review of the Existing Evidence." *Journal of International Business Policy* 3, no. 4 (2020), p. 2. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7468182/>.

⁶¹ McGivern, Lauren. "Trade-Related Aspects of Intellectual Property Rights Flexibilities and Public Health: Implementation of Compulsory Licensing Provisions into National Patent Legislation." *The Milbank Quarterly* 101, no. 4 (2023), p. 19. <https://pubmed.ncbi.nlm.nih.gov/37646392/>.

⁶² Carlos M. Correa, "Compulsory Licenses and Government Use: Challenges and Opportunities," p. 313, https://www.researchgate.net/publication/367808964_Compulsory_Licenses_and_Government_Use_Challenges_and_Opportunities.

EXAMPLES:

Real-world example of when a country invoked this was **Brazil** in 2007, when it issued a compulsory license for efavirenz, an antiretroviral drug, citing the high price charged by Merck. Brazil subsequently imported the drug from India at a fraction of the cost.⁶³

Similarly, **Thailand** issued compulsory licenses for several drugs including antiretrovirals and clopidogrel (a heart drug) in 2006-2008, triggering significant diplomatic pressure from the US government.⁶⁴

A further example is **India**,⁶⁵ which amended its patent law (Section 3(d)) to prevent the granting of new patents for new forms of existing substances that do not demonstrate significantly enhanced efficacy - a direct limit on evergreening.

Multiple countries also explored compulsory licensing for COVID-19 tools - the TRIPS waiver debate consumed years of WTO negotiations, eventually resulting in a limited 2022 agreement.⁶⁶

Other TRIPS flexibilities include:

- **Parallel imports**, which means that countries can import patented drugs from markets where they are sold more cheaply, without the patent holder's permission. TRIPS allows each country to set its own policy on this (**Article 6** enshrines the principle of exhaustion of rights).⁶⁷

⁶³ Wagner C. Rodrigues and Orenzio Soler, "Compulsory Licensing of Efavirenz in Brazil in 2007: Contextualization," *Pan American Journal of Public Health* 26, no. 6 (2009), <https://pubmed.ncbi.nlm.nih.gov/20107711/>.

⁶⁴ Suwit Wibulpolprasert, Vichai Choekvivat, Cecilia Oh, and Inthira Yamabhai, "Government Use Licenses in Thailand: The Power of Evidence, Civil Movement and Political Leadership," *Globalization and Health* 7, no. 32 (2011); Amy Glaser, "Patients Versus Patents: Thailand and the Politics of Access to Pharmaceutical Products," <https://pmc.ncbi.nlm.nih.gov/articles/PMC3180369/>.

⁶⁵ Bhaven N. Sampat, Kenneth C. Shadlen, "Indian Pharmaceutical Patent Prosecution: The Changing Role of Section 3(d)," *PLOS ONE* 13, no. 4 (2018), <https://pmc.ncbi.nlm.nih.gov/articles/PMC5880378/>.

⁶⁶ Nirmalya Syam and Muhammad Zaheer Abbas, "From Proposal to Compromise: The TRIPS Waiver Debate and the Crisis of WTO Decision-Making," pp. 9–10, <https://pmc.ncbi.nlm.nih.gov/articles/PMC12821828/>.

⁶⁷ Correa, Mity, *Access to Medicines and Vaccines*, p. 308.

- **Bolar exemption**, which means that countries can allow generic manufacturers to conduct research and regulatory work needed for drug approval before a patent expires, enabling faster market entry of generics post-patent.⁶⁸
- **Patentability criteria**, as countries have flexibility in how strictly they define what is patentable. Requiring genuine novelty and inventive step can prevent the granting of weak secondary patents.⁶⁹

4. WHO Essential Medicines List

The **WHO Model List of Essential Medicines (EML)** has been published since 1977 and is updated every two years by an Expert Committee. Inclusion on the EML is intended to **signal that a medicine is a priority for health systems globally**, serving as a guide for national formularies, procurement, and donor funding.⁷⁰

The **Expert Committee reviewed a proposal to add semaglutide in 2023 and declined**, citing primarily the absence of generic competition and the unacceptably high cost. This decision was controversial. Critics argued that the committee was penalizing the drugs for their price rather than their clinical value, while supporters argued that listing an unaffordable medicine creates false hope and distorts health system priorities.⁷¹

However, as of September 2025, there are multiple GLP-1 receptor agonists added to the EML. The **24th edition of the list** now **includes semaglutide, tirzepatide, liraglutide, and dulaglutide**.⁷²

⁶⁸ Li, "Bolar Exemption of the TRIPS Flexibilities: A Comparative Analysis between the US, Finland and China, of Patenting Pharmaceuticals and Access to Vaccines during COVID-19," p. 30, <https://su.diva-portal.org/smash/record.jsf?pid=diva2%3A1772840>.

⁶⁹ Sisule F. Musungu, "The Use of Flexibilities in TRIPS by Developing Countries: Can They Promote Access to Medicines?," p. 152, https://www.southcentre.int/wp-content/uploads/2022/11/Bk_2005_Use-of-Flexibilities-in-TRIPS_EN.pdf.

⁷⁰ Marianna Purgato, Corrado Barbui, "What Is the WHO Essential Medicines List?," *Epidemiology and Psychiatric Sciences* 21, no. 4 (2012): 343–345, <https://pmc.ncbi.nlm.nih.gov/articles/PMC6998134/>.

⁷¹ WHO. Report of the Expert Committee on the Selection and Use of Essential Medicines, 2023.

⁷² WHO. Report of the Expert Committee on the Selection and Use of Essential Medicines, 2025.

Metformin (a cheap, off-patent oral diabetes drug) is also on the EML and remains the first-line treatment for Type 2 diabetes globally. GLP-1 agonists are typically second or third-line treatments in clinical guidelines, used when metformin alone is insufficient, which applies to a very large share of the diabetic population over time.⁷³

5. Medicines Patent Pool (MPP)

The **Medicines Patent Pool (MPP)** is a United Nations backed public health organization established in 2010. Its model is straightforward: **it negotiates voluntary licenses** with patent-holding pharmaceutical companies, **under which the MPP receives the rights to sublicense** the technology to generic manufacturers, particularly in LMICs.⁷⁴

ESSENTIAL: A pharmaceutical company **voluntarily licenses** its patents and know-how **to the MPP** (often under political and civil society pressure). The MPP then **sublicenses** these rights **to multiple generic manufacturers**, creating competition that drives down prices. The patent holder receives royalties and gains some reputational benefit while retaining control over high-income markets.⁷⁵

The MPP has been most active in HIV treatment (licensing antiretrovirals including dolutegravir, tenofovir, and others), hepatitis C (sofosbuvir), and COVID-19 tools (nirmatrelvir/ritonavir, molnupiravir). Generic production under MPP licenses has reduced the price of key HIV drugs from thousands of dollars to just a few dollars per patient per year.⁷⁶

⁷³ Chelsea Baker, Cimmaron Retzik-Stahr, Vatsala Singh, Renee Plomondon, Victoria Anderson, and Neda Rasouli, "Should Metformin Remain the First-Line Therapy for Treatment of Type 2 Diabetes?," *Therapeutic Advances in Endocrinology and Metabolism* 12 (2021): 2042018820980225, <https://pmc.ncbi.nlm.nih.gov/articles/PMC7809522/>.

⁷⁴ Alfonso Galasso, Mark Schankerman, "Licensing Life-Saving Drugs for Developing Countries: Evidence from the Medicines Patent Pool," *Review of Economics and Statistics* 106, no. 6 (2024), <https://direct.mit.edu/rest/article-abstract/106/6/1529/113169/Licensing-Life-Saving-Drugs-for-Developing>.

⁷⁵ Charles Gore, Sébastien Morin, John-Arne Røttingen, Marie Paule Kieny, "Negotiating Public-Health Intellectual Property Licensing Agreements to Increase Access to Health Technologies: An Insider's Story," *BMJ Global Health* 8, no. 9 (2023), <https://pmc.ncbi.nlm.nih.gov/articles/PMC10496684/>.

⁷⁶ Ibid.

Novo Nordisk and Eli Lilly have not entered into any voluntary licenses with the MPP for their GLP-1 products. Civil society organizations have called for MPP negotiation, however, the companies have not engaged. The MPP itself has indicated interest in expanding into diabetes medicines.⁷⁷

NOTE FROM THE CHAIRS: Its application to GLP-1s is an open question: voluntary licensing would be less politically fraught than compulsory licensing, but requires the cooperation of Novo Nordisk and Eli Lilly, companies with limited incentive to reduce their own revenue.

Whether political pressure, compulsory licensing threats, or other mechanisms can bring companies to the negotiating table is a central policy question for this committee.

The GLP-1 duopoly: market structure and its causes

1. Novo Nordisk and Eli Lilly

The GLP-1 market is currently dominated by two companies to an unusual degree even by pharmaceutical industry standards.

Novo Nordisk (Danish) and Eli Lilly (American) together account for the near-totality of the commercially traded GLP-1 market - meaning all markets where patents are currently enforced and where regulatory approval has been obtained.

Their **dominance is global in legal terms:** generics cannot legally enter any major market without their consent or a compulsory licence, regardless of where they are manufactured.

The dominance of North America in global sales figures is itself **a symptom of the access problem:** LMICs generate almost no revenue precisely because the patent system and

⁷⁷ Medicines Patent Pool. "MPP and International Diabetes Federation Join Forces to Improve Access to Diabetes Medicines." 2020. <https://medicinespatentpool.org/news-publications-post/mpp-and-international-diabetes-federation-join-forces-to-improve-access-to-diabetes-medicines>.

pricing structures prevent them from participating in the market at all. The duopoly's commercial presence is therefore largest where the access crisis is most severe.⁷⁸

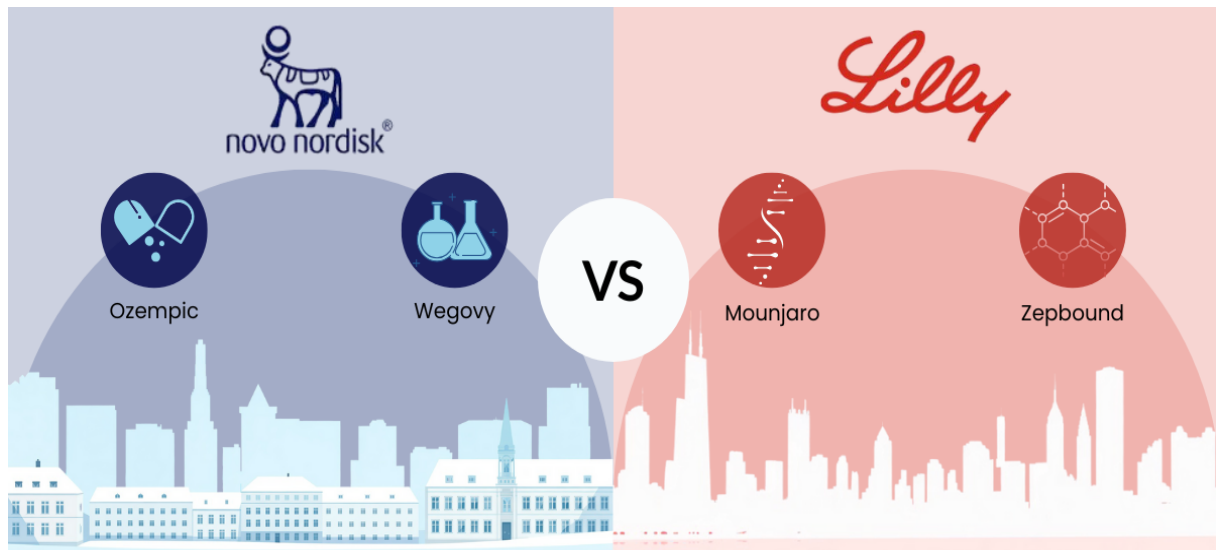


Figure 4: Novo Nordisk vs Eli Lilly in 2025⁷⁹

Novo Nordisk is a **Danish company** founded in 1923, originally focused on insulin (Denmark played a central role in the commercialization of insulin after its discovery in Canada). Novo Nordisk **holds approximately 50-55% of the global GLP-1 market by value**.⁸⁰ Its key GLP-1 products are **liraglutide** (Victoza/Saxenda) and **semaglutide** (Ozempic/Wegovy/Rybelsus).

Semaglutide has been transformative for the company's revenues: Novo Nordisk's market capitalization briefly exceeded Denmark's entire GDP in 2023, an extraordinary milestone reflecting the scale of GLP-1 demand.⁸¹

⁷⁸Diependaele, Lisa, Julian Cockbain, Sigrid Sterckx. "Raising the Barriers to Access to Medicines in the Developing World – The Relentless Push for Data Exclusivity." 2017. <https://pmc.ncbi.nlm.nih.gov/articles/PMC5347964/>.

⁷⁹ Photograph retrieved from the Skilling website.

⁸⁰ Alfred Marcus, "Novo Nordisk: A Comeback Story in the World's Fastest-Growing Drug Market," Seeking Alpha, March 27, 2026, <https://seekingalpha.com/article/4886523-novo-nordisk-a-comeback-story-in-the-worlds-fastest-growing-drug-market>.

⁸¹ Isaac Hanson, "Signal: Novo Nordisk Market Cap Higher Than Danish GDP Due to Obesity Drugs," Pharmaceutical Technology, September 1, 2023, <https://www.pharmaceutical-technology.com/news/novo-nordisk-market-cap-higher-than-danish-gdp-obesity-drugs/>.

The Danish government holds a significant indirect stake in Novo Nordisk through the Novo Nordisk Foundation, which owns the majority of Novo Nordisk's voting shares.⁸² This gives the GLP-1 debate a direct geopolitical dimension: EU positions on patent reform or compulsory licensing are complicated by Danish national interest in Novo Nordisk's profitability.

Eli Lilly is a **US-based company** founded in 1876. It **holds approximately 35-45% of the GLP-1 market**.⁸³ Its flagship product is **tirzepatide** (Mounjaro/Zepbound), a dual agonist that activates both GLP-1 receptors and GIP (glucose-dependent insulintropic polypeptide) receptors, showing even greater efficacy in trials than semaglutide alone.⁸⁴

The internal balance between the two is shifting rapidly. Novo Nordisk made GLP-1s mainstream through Ozempic, but Eli Lilly's tirzepatide (Mounjaro/Zepbound) has proven more effective on weight loss endpoints and has been gaining market share sharply. By Q2 2025, Lilly held approximately 57% of the US obesity market, having overtaken Novo Nordisk both domestically and, more recently, outside the US. This competition at the top does not, however, create access benefits for LMICs. Both companies maintain equivalent patent positions globally. Together, these two companies control approximately 90% or more of the global GLP-1 market by revenue.⁸⁵

This type of concentration is not coincidental. The history of GLP-1 drug development reflects decades of focused research investment, multiple patent filings at each stage of development, and a regulatory approval process that strongly advantages large established players. The scientific work underlying GLP-1 drugs, including Nobel Prize-

⁸² Novo Nordisk, "Share and Ownership Structure," accessed August 7, 2026, <https://www.novonordisk.com/investors/stock-information/share-and-ownership-structure.html>.

⁸³ Caroline Kovacs, *The Skinny: GLP-1/Obesity Drug Class History & Outlook to 2030* (Harvest Portfolios Group, August 2025), https://harvestportfolios.com/wp-content/uploads/2025/08/WhitePaper_GLP-1-Drug-Commercialization-2030-Report.pdf.

⁸⁴ Thinzar Min and Steve Bain, "The Role of Tirzepatide, Dual GIP and GLP-1 Receptor Agonist, in the Management of Type 2 Diabetes: The SURPASS Clinical Trials," *Diabetes Therapy* 12, no. 1 (2021), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7843845/>.

⁸⁵ Caroline Kovacs, *The Skinny: GLP-1/Obesity Drug Class History & Outlook to 2030* (Harvest Portfolios Group, August 2025), https://harvestportfolios.com/wp-content/uploads/2025/08/WhitePaper_GLP-1-Drug-Commercialization-2030-Report.pdf.

winning research on the incretine system, was often publicly funded, but the commercialization has been captured by private entities.⁸⁶

However, there have been recent shifts on the market. From **Indian generics** entering their market to other market participants such as **AstraZeneca**, which markets exenatide (a GLP-1 agonist derived from the Gila monster lizard's saliva, the original discovery that launched the field).⁸⁷ Several other companies, including **Sanofi** and **Pfizer**, have **GLP-1 programs in development**. Chinese companies, including **Hengrui Pharmaceutical**, have **GLP-1 candidates** and are moving toward global markets. These competitors are not likely to meaningfully disrupt the duopoly in the short term, but they represent the longer-term pressure that will eventually bring prices down.

2. Evergreening and secondary patents

Evergreening refers to filing secondary patents on minor modifications to an existing drug (new formulations, delivery devices, dosing regimens, or new indications) to extend effective market exclusivity beyond the initial 20-year patent term.⁸⁸

For GLP-1 drugs, evergreening is extensive, from core composition patents on the active molecule (e.g., the specific amino acid sequence of semaglutide) to device patents on the auto-injector pens used to administer the drugs, as well as the method-of-treatment patents on the specific dosing regimens, titration schedules, or patient populations.⁸⁹

ESSENTIAL: A generic or biosimilar manufacturer seeking to enter the market must either wait for all relevant patents to expire, design around them, or challenge them in court. Patent challenges are expensive and uncertain, designing around formulation and device

⁸⁶ Jeffrey M. Friedman, "The Discovery and Development of GLP-1 Based Drugs That Have Revolutionized the Treatment of Obesity," *Proceedings of the National Academy of Sciences* (2024), <https://pmc.ncbi.nlm.nih.gov/articles/PMC11441540/>.

⁸⁷ Zhikai Zheng et al., "Glucagon-like Peptide-1 Receptor: Mechanisms and Advances in Therapy," *Signal Transduction and Targeted Therapy* 9, no. 1 (2024): pp. 1, 4, <https://doi.org/10.1038/s41392-024-01931-z>.

⁸⁸ Reed F. Beall, et al., "Patent 'Evergreening' of Medicine-Device Combination Products: A Global Perspective," *Healthcare Policy* 18, no. 2 (2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9764446/>.

⁸⁹ Jessica C. Lai, "Blockbuster Drugs, Women Inventors and the Manufactured Patient: A Tale of Patents, Extraction and Exploitation," *IIC – International Review of Intellectual Property and Competition Law* 57, no. 2 (2026): 260–295, <https://link.springer.com/article/10.1007/s40319-026-01692-y>.

patents may require new regulatory approval. **The result is that even after the core composition patent expires, a new entrant faces a wall of secondary patents, creating a wall that can extend market exclusivity by many additional years.**⁹⁰

The core patent on semaglutide is estimated to expire in the United States around 2032 and in the EU around 2031 (with some variation considering the jurisdiction). However, the full patent estate for Ozempic/Wegovy includes hundreds of patents across many jurisdictions, with expirations extending well beyond the core. Generic entry before the early 2030s in major markets is unlikely absent successful patent challenges.

Critics argue that many do not meet a “meaningful inventive step” standard and serve primarily to delay entry of its generic counterparts. Defenders argue incremental improvements represent genuine therapeutic value and are necessary to recoup investment in post-approval development.

Evergreening is legal under current TRIPS rules. Addressing it requires either changes to patentability standards (allowing countries to reject secondary patents that do not represent true innovation), opposition proceedings (challenging weak patents before they are granted), or post-grant challenges (invalidating already-granted patents).⁹¹

EXAMPLE: India's Section 3(d) approach

It bars patents on new forms of known substances unless they demonstrate significantly enhanced efficacy, is the most prominent national example of addressing evergreening through patentability criteria and a model for stricter standards.⁹²

⁹⁰Jessica C. Lai, "Blockbuster Drugs, Women Inventors and the Manufactured Patient: A Tale of Patents, Extraction and Exploitation," *IIC – International Review of Intellectual Property and Competition Law* 57, no. 2 (2026): 260–295, <https://link.springer.com/article/10.1007/s40319-026-01692-y>.

⁹¹ DrugPatentWatch, "The Evergreening Playbook: How Pharma Extends Drug Exclusivity — and What It Actually Costs," March 8, 2026, <https://www.drugpatentwatch.com/blog/the-evergreening-playbook-how-pharma-extends-drug-exclusivity-and-what-it-actually-costs/>.

⁹² DrugPatentWatch. "India's Section 3(d): The Definitive IP Strategy Guide for Pharmaceutical and Biotech Companies." 2026. <https://www.drugpatentwatch.com/blog/indian-pharmaceutical-patent-prosecution-the-changing-role-of-section-3d/>

3. Industry consolidation

The broader pharmaceutical landscape has undergone significant consolidation over the past two decades, which has reduced competition at multiple levels.

Mergers and acquisitions have eliminated many independent pharmaceutical companies that might have developed competing products or pursued different pricing strategies. Platform consolidation means that the complex biologics manufacturing infrastructure (cell culture, fermentation, purification) is concentrated among a small number of contract manufacturers, reducing independent manufacturing capacity. Research & development consolidation has reduced the number of entities doing early-stage drug discovery, with large companies increasingly acquiring promising compounds from biotech startups rather than discovering them internally.⁹³

ESSENTIAL: For GLP-1 specifically, the decades of foundational research were concentrated at relatively few academic and commercial centers, and the early commercial development was dominated by two companies that moved faster than the rest of the industry. By the time competitors recognized the scale of GLP-1's potential, Novo Nordisk and Eli Lilly had substantial first-mover advantages in patents, manufacturing, regulatory approvals, and market relationships.

Smaller competitors are typically acquired before they can scale, and generic manufacturers find it economically impossible to challenge a patent thicket through litigation as the total cost of doing so routinely exceeds the expected value of the generic market.⁹⁴ This structural dynamic reproduces concentration even when individual patents already expire.

4. Supply chain fragility

⁹³ DrugPatentWatch. "M&A in Generic Drug Development: IP Valuation, Patent Strategy, and Dealmaking Intelligence." 2026. <https://www.drugpatentwatch.com/blog/mergers-and-acquisitions-opportunities-and-challenges-in-generic-drug-development/>.

⁹⁴ For example, in 2025 and 2026, both Novo Nordisk and Eli Lilly have both filed a dozen lawsuits against pharmacies and telehealth platforms to shut down the compounded alternative market.

Even in markets where GLP-1s are covered by insurance or national health systems, persistent shortages have been reported. This raises a question distinct from legal access: is the access problem primarily a patent issue, or also a manufacturing capacity constraint?

GLP-1 drugs are biologics, and their production is genuinely complex. Producing peptide-based biologics requires specialized fermentation facilities, highly controlled cell culture conditions, and sophisticated purification processes. The active pharmaceutical ingredient (API) must then be formulated into the final drug product and filled into injection devices, each step requiring separate specialized facilities.⁹⁵

ESSENTIAL: The API manufacturing for leading GLP-1 products is heavily concentrated. Novo Nordisk has invested in expanding its manufacturing base (including significant investments in Denmark, the US, and France), but it operates relatively few production sites globally.⁹⁶ Eli Lilly is similarly concentrated. **This geographic concentration creates systemic risk: disruption at a key facility (due to contamination, natural disaster, or regulatory action) can cause global shortages.**

In the United States, drug shortages created a specific policy situation: when branded drugs are on **FDA shortage lists**, **compounding pharmacies are permitted to produce copies without infringing patents**.⁹⁷ This resulted in a significant compounding pharmacy industry producing semaglutide, a situation Novo Nordisk has vigorously opposed legally.⁹⁸ The FDA began removing semaglutide from shortage lists in 2024-2025, triggering legal

⁹⁵ Sampathkumar, Krishnan, Bruce A. Kerwin. "Roadmap for Drug Product Development and Manufacturing of Biologics." 2024. <https://www.sciencedirect.com/science/article/pii/S002235492300477X>.

⁹⁶ Kansteiner, Fraiser. "Novo Nordisk Keeps GLP-1 Expansion Spree Rolling with \$2.3B Manufacturing Upgrade in France." 2023. <https://www.fiercepharma.com/pharma/novo-keeps-glp-1-expansion-spree-rolling-23b-manufacturing-upgrade-france>.

⁹⁷ U.S. Food and Drug Administration. "FDA Clarifies Policies for Compounders as National GLP-1 Supply Begins to Stabilize." 2026. <https://www.fda.gov/drugs/drug-alerts-and-statements/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize>.

⁹⁸ Santhosh, Christy, Kamal Choudhury, Mariam Sunny. "Novo Nordisk Expands Lawsuits Against Weight-Loss Drug Compounders." Reuters, 2025. <https://www.reuters.com/legal/litigation/novo-nordisk-expands-weight-loss-drug-compounders-2025-08-05/>.

battles with compounding pharmacies. This episode illustrates how supply fragility creates policy contradictions.

ESSENTIAL: Most current GLP-1 formulations require refrigeration, creating a "cold chain" requirement that is logistically challenging in LMICs with limited refrigeration infrastructure. Oral semaglutide does not require refrigeration but has lower bioavailability. The **development of thermostable formulations** is an active area of research and **would significantly affect LMIC access**. The 2026 launch of oral GLP-1 pills is thus expected to reduce supply chain fragility by removing the cold-chain requirement and enabling more scalable manufacturing processes.⁹⁹

NOTE FROM THE CHAIRS: Any access reform will need to address whether legal changes alone, without parallel investment in manufacturing, can deliver meaningful results on the ground.

Positions of key actors

NOTE FROM THE CHAIRS: Understanding how different States and blocs approach this issue is essential for effective MUN participation. Delegates should therefore research their assigned country's specific positions beyond this summary.

European Union

The EU occupies a **complex position**: it is home to Novo Nordisk (headquartered in Denmark) and has a strong pharmaceutical industry, but also has universal healthcare systems that have strong interests in controlling drug costs.

The European Medicines Agency (EMA) has approved semaglutide and other GLP-1 agonists for diabetes.¹⁰⁰ EU Member States negotiate drug prices through national health technology

⁹⁹ Peri, Ravi Vamsi, et al. "Designing GLP-1 Delivery: Structural Perspectives and Formulation Approaches for Optimized Therapy." 2025. <https://pmc.ncbi.nlm.nih.gov/articles/PMC12644520/>.

¹⁰⁰ Meglio, Marco. "EMA Approves Semaglutide as First GLP-1 RA for Cardiovascular, Stroke-Related Benefits." 2025. <https://www.neurologylive.com/view/ema-approves-semaglutide-first-glp-1-ra-cardiovascular-stroke-related-benefits>.

assessment (HTA) processes.¹⁰¹ Prices in the EU are generally significantly lower than those in the US (often 70-80% lower) due to centralized or coordinated negotiation. The **EU's Joint Clinical Assessment framework**, coming into fuller effect in the mid-2020s, is intended to **further harmonize HTA across Member States**.

The EU has a **strong interest in maintaining robust pharmaceutical patent protections**, reflecting the interests of its pharmaceutical industry. Since 2018, the **European Commission** has published a **report on intellectual property rights in third countries**, analogous to the United States' annual "Special 301" report, which is often used to pressure States seen as offering insufficient protection for intellectual property rights.¹⁰²

Historically, compulsory licensing in the EU operated mainly at the national level under WTO TRIPS flexibilities. At the EU level, **Regulation (EC) 816/2006** allowed **compulsory licensing for the manufacture and export of pharmaceuticals to low- and middle-income countries**, but it was rarely used in practice.

This changed with **Regulation (EU) 2025/2645**, which entered into force in January 2026 and created the **first EU-wide compulsory licensing mechanism for formally declared crises or emergencies**. Developed partly in response to COVID-19 supply-chain disruptions, the Regulation **allows the European Commission to grant a "Union compulsory licence" for crisis-relevant products** when voluntary licensing cannot ensure sufficient and timely access. The mechanism applies to patents, patent applications, utility models, and supplementary protection certificates (SPCs), while excluding trade secret disclosure. **Rights holders must receive appropriate remuneration**. Although the framework strengthens EU-level coordination during emergencies and facilitates cross-

¹⁰¹ Fernandez, Judith, et al. "Health Technology Assessment in Europe: A Comparison of Organizations and Introduction to the European Regulation." 2025. <https://www.sciencedirect.com/science/article/abs/pii/S0755498225000156>.

¹⁰² Medicines Law & Policy. "Pressure from European Countries Related to the Use of TRIPS Flexibilities." 2024. <https://medicineslawandpolicy.org/2024/05/pressure-from-european-countries-related-to-the-use-of-trips-flexibilities/> , European Commission, Directorate-General for Trade and Economic Security. "Commission Releases Its Report on Intellectual Property Rights in Third Countries." 2023. https://policy.trade.ec.europa.eu/news/commission-releases-its-report-intellectual-property-rights-third-countries-2023-05-17_en.

border supply, it remains **narrowly limited to crisis situations** and does not establish a broad mechanism for overriding pharmaceutical patents on affordability grounds.¹⁰³

The EU has been an active supporter of global health initiatives and has provided significant funding for COVAX and other access programs. However, its **actual use of TRIPS flexibilities or pressure on European companies to license in LMICs has been limited**.¹⁰⁴

Access to GLP-1 drugs for diabetes varies considerably across EU Member States.

Richer Member States with more generous national formularies have better coverage, while Eastern European Member States may have more restricted access. This internal inequity complicates a unified EU position.¹⁰⁵

United States

The United States is the world's largest pharmaceutical market by revenue and the primary profit center for GLP-1 manufacturers. Its position on global access is deeply shaped by domestic politics and the pharmaceutical industry's lobbying power.

US GLP-1 prices are the highest in the world by a large margin, reflecting the absence (until very recently) of any government price negotiation for Medicare drugs. The **Inflation Reduction Act (2022)** empowered Medicare to negotiate prices for a limited number of high-cost drugs. **Semaglutide was selected for negotiation in 2024**. This represents a significant domestic policy shift, though its global implications are debated.¹⁰⁶

¹⁰³ Eversheds Sutherland. "New EU Framework for Compulsory Licensing of Patents in Crisis Situations." 2026. <https://www.lexology.com/library/detail.aspx?g=b722c53d-7c4b-441b-8cff-30a2a076b839>.

¹⁰⁴ Dunn, Montgomery, and Ellen 't Hoen. "TRIPS Flexibilities Help Change Policy and Practice to Increase Access to Medicines: Evidence from 2001 to 2024." *BMJ Global Health* 11, no. 1 (2026): e021481. <https://gh.bmj.com/content/11/1/e021481>.

¹⁰⁵ Car, Mate, et al. "National Utilization and Expenditure Trends of GLP-1 Receptor Agonists and Dual GLP-1/GIP Agonist in Croatia, 2017–2024." *Medicina* 61, no. 12 (2025): 2210. <https://pmc.ncbi.nlm.nih.gov/articles/PMC12734843/>.

¹⁰⁶ Sadeghi, Abolfazl, Tyler J. Varisco. "Medicare Drug Price Negotiation Under the Inflation Reduction Act: Ensuring the Continuity of Critical Real-World Pharmaceutical Studies." *Value in Health* 28, no. 12 (2025): 1927–28. <https://www.sciencedirect.com/science/article/abs/pii/S1098301525024660>.

The US government has historically been the world's most aggressive defender of strong pharmaceutical patent rights in trade negotiations. The **US Trade Representative (USTR)** maintains a **"Special 301 Report"** that **identifies countries with "inadequate" IP protections and can threaten trade sanctions**.¹⁰⁷ Countries like India and Thailand that have used TRIPS flexibilities have faced significant US diplomatic pressure.¹⁰⁸

The US is a major funder of PEPFAR (HIV/AIDS treatment), the Global Fund, and other global health programs.¹⁰⁹ These programs have often relied on generic medicines produced in India, a somewhat contradictory position given US IP maximalism.¹¹⁰

There is growing bipartisan concern in the US about drug prices domestically. Some legislators and civil society groups have supported international access to medicine; the pharmaceutical industry argues that high prices fund research and development (R&D) which benefits everyone.¹¹¹

The US has not taken any specific international action on GLP-1 access for diabetes. Domestic insurance coverage for GLP-1s for diabetes is variable, coverage for obesity indication is even more restricted (Medicare did not cover GLP-1s for obesity until legislation in 2025, and even that coverage remains contested).¹¹²

¹⁰⁷ United States Trade Representative. "Special 301." Accessed August 28, 2026. <https://ustr.gov/issue-areas/intellectual-property/special-301>.

¹⁰⁸ Zhanpeng Li, Peng Guo, "Compulsory Licensing of Pharmaceuticals during Public Health Crisis: A TRIPS Framework Analysis," *Frontiers in Public Health* 13 (September 2025), p. 4, <https://pmc.ncbi.nlm.nih.gov/articles/PMC12463931/>.

¹⁰⁹ Institute of Medicine. "U.S. Funding for the PEPFAR Initiative." Chap. 4 in *Evaluation of PEPFAR*. Washington, DC: National Academies Press, 2013. <https://www.ncbi.nlm.nih.gov/books/NBK207014/>.

¹¹⁰ Doctors Without Borders/Médecins Sans Frontières. "Why India's Generic Medicines Industry Is So Important." 2010. <https://www.doctorswithoutborders.org/latest/why-indias-generic-medicines-industry-so-important>. Dionisio, D., Daniela M., "Impending Flop for Brand Antiretrovirals in the Emerging Markets?" *The Open AIDS Journal* 2 (2008). <https://doi.org/10.2174/1874613600802010068>.

¹¹¹ Major, Ajay, Blase N. Polite. "Bending Versus Transforming the Drug Cost Curve: A Matter of Political Will." *The Cancer Journal* 26, no. 4 (2020): 304–310. <https://doi.org/10.1097/PPO.0000000000000458>.

¹¹² American College of Gastroenterology. "Anti-Obesity Drugs Will Not Be Covered by Medicare and Medicaid in 2026." 2025. <https://gi.org/journals-publications/acg-blog/anti-obesity-drugs-will-not-be-covered-by-medicare-and-medicaid-in-2026/>.

Brazil

Brazil is a significant middle-income country with a large and diverse population, a substantial pharmaceutical manufacturing sector, and a track record of assertive use of TRIPS flexibilities.

Brazil's Unified Health System (SUS) provides universal healthcare to all citizens and has a strong mandate to procure medicines at low cost. Diabetes prevalence in Brazil is high, roughly around 15–16% of adults.

Brazil's **2007 compulsory license for efavirenz** (antiretroviral) remains the most prominent use of compulsory licensing by a major middle-income country.¹¹³ This created a precedent and demonstrated political will to use TRIPS flexibilities against pharmaceutical company resistance.

GLP-1 drugs are available in Brazil but primarily through private purchase. SUS coverage is extremely limited. Brazilian civil society and some government actors have **explored whether compulsory licensing could be applied to GLP-1 drugs for diabetes**. As a result of this action, a **Bill regarding compulsory licensing of Mounjaro patents** has been fast-tracked.¹¹⁴

Brazil has domestic pharmaceutical manufacturing capacity through Fiocruz (a public health research and production institution) and private companies. However, **biological manufacturing for complex GLP-1 peptides would require significant investment in new capacity**.

¹¹³ Wagner C. Rodrigues, Orenzio Soler, "Compulsory Licensing of Efavirenz in Brazil in 2007: Contextualization," *Pan American Journal of Public Health* 26, no. 6 (2009), <https://pubmed.ncbi.nlm.nih.gov/20107711/>.

¹¹⁴ Tavares Office. "Brazil's Congress Fast-Tracks Bill on Compulsory Licensing of Mounjaro Patents." 2026. <https://www.tavaresoffice.com.br/brazils-congress-fast-tracks-bill-on-compulsory-licensing-of-mounjaro-patents/>.

China

China presents a uniquely complex picture: it is simultaneously a major pharmaceutical manufacturer, an increasingly significant R&D player, and a country with a very large population bearing a heavy diabetes burden, as China has the world's largest absolute number of people with diabetes (approximately 148 million adults, roughly a quarter of the global total). This creates enormous domestic demand and political pressure for affordable treatment.

Chinese pharmaceutical companies have developed **domestic GLP-1 drugs**. Berberitriene-based approaches and various peptide drugs are in use or development. Several Chinese companies (including Hengrui, Innovent, and others) have GLP-1 drugs in clinical development or early approval, some of which may reach global markets. **China represents a credible emerging competitor to the Novo Nordisk/Eli Lilly duopoly.**¹¹⁵

China has been a target of US IP complaints but has also strengthened its patent system. Its approach to pharmaceutical patents is evolving. China has used compulsory licensing provisions domestically in certain contexts.¹¹⁶

China positions itself as a champion of the Global South on many issues, including access to medicines, while simultaneously having commercial interests in expanding its own pharmaceutical companies' global reach. This dual positioning creates some tensions.

India

India is arguably the most consequential single country for global access to medicines, as the world's largest producer of generic pharmaceuticals. India also has the second-largest

¹¹⁵ Zhang, Julie. "China's Weight-Loss Drug Makers Take on Global Giants as Novo Nordisk Patent Expires." *South China Morning Post*, 2026. <https://www.scmp.com/business/china-business/article/3347869/chinas-weight-loss-drug-makers-take-global-giants-novo-nordisk-patent-expires>.

¹¹⁶ Yin, Qian. "Compulsory Licenses for Pharmaceutical Patents in China in Light of the TRIPS Agreement." *Asian Journal of WTO & International Health Law and Policy* 18, no. 1 (2023): 131–180. <https://ssrn.com/abstract=4410986>.

number of people with diabetes globally, approximately 77–80 million adults. Affordable access to GLP-1 drugs is a domestic health imperative as well as a global one.

Indian generic manufacturers, including companies like Sun Pharma, Cipla, Dr. Reddy's, Aurobindo, and dozens of others, **produce the majority of generic medicines used in low-income countries globally**, including the antiretroviral drugs that have saved millions of lives through PEPFAR and the Global Fund. This manufacturing base is **India's most important contribution to global medicine access**.¹¹⁷

India's **Patents Act** includes **Section 3(d)**, which **prevents the grant of patents** for new forms, uses, or combinations of known substances **unless they demonstrate significantly enhanced efficacy**. This **provision directly targets evergreening** and has been used to reject secondary patents on several drugs. It is one of the most important pieces of national pharmaceutical patent law globally.¹¹⁸

Indian generic manufacturers have been actively working on GLP-1 biosimilar and generic development. **Some domestic GLP-1 biosimilar products exist in India**, though global regulatory approval (from FDA, EMA) is a separate problem. India has consistently faced US pressure over its patent law and its support for generic manufacturing. **Section 3(d) has been repeatedly cited in USTR Special 301 reports**.

Indian pharmaceutical companies are actively launching generic and biosimilar versions of GLP-1 drugs like semaglutide following domestic patent challenges, aiming to significantly reduce costs. While these products are available in India as of March 2026, gaining approval

¹¹⁷ Waning, Brenda, Ellen Diedrichsen, and Suerie Moon. "A Lifeline to Treatment: The Role of Indian Generic Manufacturers in Supplying Antiretroviral Medicines to Developing Countries." *Journal of the International AIDS Society* 13 (2010): 35. <https://doi.org/10.1186/1758-2652-13-35>.

¹¹⁸ DrugPatentWatch. "India's Section 3(d): The Definitive IP Strategy Guide for Pharmaceutical and Biotech Companies." 2026. <https://www.drugpatentwatch.com/blog/indian-pharmaceutical-patent-prosecution-the-changing-role-of-section-3d/>.

from stringent regulatory bodies like the US FDA or EMA remains a complex hurdle due to differing standards.¹¹⁹

Overview of blocs

BLOC	LIKELY MEMBERS	PRIMARY POSITION
IP Protection States	US, Denmark, Switzerland, Japa, South Korea	Prioritize strong patent protection and innovation incentives; favour voluntary licensing and market-based solutions over weakening IP rights.
Advocates for Access	India, Brazil, South Africa, Bangladesh, Cuba, Kenya, Nigeria, Thailand, Indonesia, Mexico	Prioritize affordable access through TRIPS flexibilities, compulsory licensing, local manufacturing, and technology transfer.
Emerging Pharmaceutical Powers	China, India, UAE, Brazil	Seek to expand domestic pharmaceutical industries while balancing innovation incentives with affordable access and technology transfer.
Multilateral Public Health	France, Italy, Germany, Sweden, Iceland, UK, Canada, Australia	Support international cooperation, voluntary licensing, stronger global health mechanisms, and expanded access while broadly preserving the existing patent framework.

¹¹⁹ The Pharma Letter, "Indian Generics Shake Up GLP-1 Market as Eli Lilly Loses Ground," 2026, <https://www.thepharmaletter.com/generics-news/indian-generics-shake-up-glp-1-market-as-eli-lilly-loses-ground>.

Points a resolution should address

NOTE FROM THE CHAIRS: The aim of this committee is to **adopt a resolution on GLP-1 access that Member States can act on.**

In the WHO, resolutions are adopted by the World Health Assembly (or, in a simulated committee, by your body acting in that capacity). Decisions are normally reached by **consensus** wherever possible. However, when consensus fails, resolutions go to a vote and require a **simple majority of members present and voting** to pass.

As with most UN bodies, WHO resolutions are **not binding** in the way domestic law is, but they carry significant **normative and political weight**, and can direct the Secretariat, set global health policy, or call on member states to take specific domestic action.

The committee should approach these issues not in isolation but as an **interconnected system**. Addressing patents without addressing manufacturing capacity, for example, may produce paper victories without real access improvements.

1. Patent reform and evergreening

The current international patent system, as implemented under TRIPS, allows pharmaceutical companies to maintain market exclusivity well beyond the 20-year nominal patent term through the filing of secondary patents on incremental modifications. This is particularly acute for complex biologics like **GLP-1 agonists, where the number of potential secondary patents is large.**

Reform could look like a lot of things.

One option is **harmonization of patentability standards upward**. Encouraging or requiring WTO/TRIPS members to adopt stricter patentability criteria, such as genuine novelty and a *real* inventive step, would screen out weak secondary patents.

It could also be achieved through encouraging countries to develop **robust pre-grant and post-grant patent opposition systems** that allow generic manufacturers and civil society to challenge weak patents. India's system could be a model.

Requiring **disclosure of all patents covering a drug product** (similar to the US "Orange Book" and "Purple Book" systems, but globally) would allow generic manufacturers to understand the full patent landscape and identify viable challenges.

NOTE FROM THE CHAIRS: Any patent reform discussion will involve tension between countries with large pharmaceutical industries that want strong patent protection, and LMICs that want maximum flexibility. The **framing of this debate, innovation vs. access, is artificial:** strong evidence exists that the current system does not optimally fund innovation (it over rewards incremental improvements and underinvests in neglected diseases). Delegates should engage with this empirical evidence.

GUIDING QUESTIONS:

- What standard of "inventive step" should qualify a pharmaceutical modification for independent patent protection? Should a new formulation or delivery device automatically qualify?
- What multilateral mechanisms can enforce more stringent evergreening standards, and what role, if any, does WHO have in setting norms here?
- Should a new international body be created to review pharmaceutical patent applications for public health impact?

2. Access and compulsory licensing

Currently existing options are **TRIPS flexibilities, the Doha Declaration, and Article 31bis of TRIPS**. They **already provide legal mechanisms for compulsory licensing**. The **problem is that these mechanisms are underused** due to political pressure, administrative complexity, and manufacturing capacity constraints.

There is a credible argument that the **global diabetes epidemic** could be understood **as** the kind of **public health emergency** that justifies **TRIPS flexibilities** under the Doha Declaration, as the phrase "other epidemics" in the Doha text is broad, and diabetes meets any reasonable threshold of severity, after all it does affect hundreds of millions of people, it kills millions annually, and imposes enormous economic costs on LMICs.

The committee could **clarify which diseases are eligible through a WHA resolution**, affirming that non-communicable diseases including diabetes are covered by Doha Declaration flexibilities. This would reduce political risk for countries considering compulsory licensing.

Groups of countries acting together to issue compulsory licenses or jointly negotiate with manufacturers have more leverage than individual countries. **Regional approaches could be encouraged.**

The committee could also **call on manufacturers to enter voluntary license negotiations with the MPP**, specifying the policy context (Doha Declaration applicability to diabetes, as mentioned above) that could make refusal politically costly.

The manufacturing know-how to produce a GLP-1 biosimilar is not fully encoded in the patent documents and companies hold significant trade secrets in their manufacturing processes. **Technology transfer** (not just patent licensing) **may be necessary.**

GUIDING QUESTIONS:

- Under what conditions should TRIPS flexibilities be available to Member States without triggering bilateral trade retaliation?
- Should the WHO formally evaluate GLP-1s for EML designation, and what criteria should apply?
- How should the EML framework be strengthened to provide greater legal and political cover for States invoking compulsory licensing?

3. Market concentration

ESSENTIAL: A market dominated by two companies is inherently fragile and has limited competitive pressure to reduce prices or expand access. Addressing the GLP-1 duopoly requires **thinking about competition at multiple levels: R&D, manufacturing, and distribution.**

Dominant pharmaceutical companies may engage in anti-competitive behaviors (predatory pricing, exclusionary contracts with distributors, pay-for-delay agreements with would-be generics). International coordination of competition law enforcement, or development of international competition rules applicable to pharmaceutical markets, is a long-term project but worth discussion and encouragement!

Advance market commitments, prizes, or other alternative innovation financing mechanisms could encourage new entrants into the GLP-1 market, particularly manufacturers oriented toward LMIC markets.

GUIDING QUESTIONS:

- Should WHO convene or support a multilateral mechanism for pharmaceutical antitrust coordination?
- What role should public R&D investment and procurement pooling play in reducing market concentration?
- Should there be WHO guidance on market conduct standards for essential medicines, including pricing transparency obligations?

4. Supply chain and manufacturing

The COVID-19 pandemic dramatically illustrated the dangers of over-reliance on a small number of manufacturers in a few countries. The same lesson applies to GLP-1 drugs. Building regional manufacturing hubs, in Africa, Southeast Asia, and Latin America, would create resilience and reduce dependence on Northern manufacturers.



Figure 5: Supply chain¹²⁰

Access to patents alone is insufficient for biologics. Companies hold trade secrets in cell lines, fermentation conditions, purification methods, and quality control processes. **Meaningful access for LMIC manufacturers requires technology transfer**, which means sharing of the actual manufacturing know-how, not just licensing of the patent rights. This can be politically and commercially sensitive but has precedent (the WHO's mRNA vaccine technology transfer initiative).

Another thing which could help is the WHO prequalification, which certifies that generic and biosimilar medicines meet international quality standards, enabling procurement by UN agencies and donor programs. **Expanding prequalification capacity for GLP-1 biosimilars** would facilitate LMIC market entry.

Moreover, **investment in refrigeration infrastructure and development of thermostable GLP-1 formulations** are parallel tracks for improving LMIC access. Cold chain requirements are a practical barrier even when drugs are otherwise available and affordable.

Obtaining regulatory approval for a biosimilar in each country is expensive and time-consuming. **Regional regulatory harmonization** would reduce barriers to market entry for generic manufacturers. **WHO's collaborative registration procedures** can also reduce approval timelines.

¹²⁰ Photograph retrieved from the Sourcemap website.

GUIDING QUESTIONS:

- Is the access problem primarily a legal barrier or a manufacturing capacity constraint – or both?
- Should the WHO coordinate international investment in expanding GLP-1 manufacturing capacity, particularly in LMICs?
- What lessons from COVID-19 vaccine supply failures should inform any new coordination mechanism?

Further guiding questions for delegates

As you prepare your position papers and draft resolutions, consider the following:

- Does your country's domestic situation (diabetes burden, pharmaceutical industry, manufacturing capacity, trade relationships) align with or create tension with what is ethically ideal in global health terms?
- What is the most appropriate UN body to address GLP-1 access - the WHA, the WTO, UN Economic and Social Council (ECOSOC), or a combination? How do the mandates of these bodies affect what kinds of solutions are possible?
- The Doha Declaration's reference to "other epidemics" opens a potential door for compulsory licensing for diabetes medicines. What political, legal, and practical steps would be needed to walk through that door?
- Technology transfer is at least as important as patent licensing for complex biologics. What mechanisms exist or could be created to compel or incentivize technology transfer from Novo Nordisk and Eli Lilly?
- How should the committee balance the genuine innovation value of pharmaceutical patents, which do fund real R&D, against the access imperative? What reforms would preserve incentives for innovation while reducing the access barriers created by evergreening?
- What role should public pharmaceutical manufacturing play? Is it realistic? What would it require?

- How does the framing of GLP-1 access for diabetes (versus obesity) affect the political economy of this debate? Does focusing on diabetes change who the natural allies and opponents are?

Additional preparation materials

NOTE FROM THE CHAIRS: The following sources will deepen your understanding of the issues covered in this guide. Delegates are strongly encouraged to consult primary sources (resolutions, treaty texts, company disclosures) in addition to secondary analysis.

VIDEO RESOURCES:

We recommend that you watch the following helpful YouTube videos which explain relevant topics in a simple manner:

- Drug Chug, **How do GLP-1 Agonists Work?**. Available at YouTube:
<https://www.youtube.com/watch?v=wQVDdcOQBdu>.
- Patrick Kelly, **How Pharmaceutical Patents Make Drugs Expensive**. Available at YouTube:
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Topic B:

SOCIAL ISOLATION AS A RISING HEALTH RISK



Figure 6: Social isolation¹²¹

¹²¹ Photograph retrieved from the iStock by Getty Images website, credited to DrAfter123.

Introduction

In an era where connections are but a click away, it seems we are growing ever so lonelier. Social isolation has transitioned from a private concern to a global public health crisis as recognized by the World Health Organization in 2023, leading to the establishment of the Commission on Social Connection to address this matter.¹²²

“Even in a digitally connected world, many young people feel alone. As technology reshapes our lives, we must ensure it strengthens—not weakens—human connection.” said Chido Mpemba, Co-chair of the WHO Commission on Social Connection. The numbers back this statement, with studies showing that loneliness affects people of all ages, especially youth and people living in low- and middle-income countries (LMIC). Between 17–21% of individuals aged 13–29 reported feeling lonely, with the highest rates among teenagers. About 24% of people in low-income countries reported feeling lonely, which is twice the rate of that in high-income countries (about 11%).¹²³

Despite such jarring evidence, international policy responses remain underfunded and inconsistent among different regions and income groups. As stated by WHO Director General Dr Tedros Adhanom Ghebreyesus, “In this age when the possibilities to connect are endless, more and more people are finding themselves isolated and lonely”.¹²⁴ Technology was meant to bring the world closer, instead it deepened human disconnection and it is precisely this stark paradox that this committee must address.

Social isolation isn’t just a consequence of the pandemic that ravaged the world in 2020. Eroding traditional community-based institutions and family structures were already silently eating away at the social fabric long before the COVID-19 outbreak forced the world into lockdown. Accelerating urbanization has fundamentally changed the human habitat.

¹²² World Health Organization, "WHO Launches Commission to Foster Social Connection," November 15, 2023, <https://www.who.int/news/item/15-11-2023-who-launches-commission-to-foster-social-connection>.

¹²³ World Health Organization, "Social Connection Linked to Improved Health and Reduced Risk of Early Death," June 30, 2025, <https://www.who.int/news/item/30-06-2025-social-connection-linked-to-improved-health-and-reduced-risk-of-early-death>.

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Although cities do offer economic opportunities, this has come at the cost of social cohesion, with the lack of “Third Places” where social interactions flourished.

What the pandemic did, though, was unveil the system that had been concealing this crisis and show the world its scale and urgency. Between 2009 and 2024, the global percentage of people who cited social isolation increased by 13.4%. The majority of this increase occurred in 2019, which shows that the pandemic didn’t create this issue but accelerated it.¹²⁵

Key issues

1. Commercialization of “Third Places”

The prime driver of the above-mentioned pre-pandemic rise in social isolation is the **transformation of the modern human environment**. Historically, social interactions depended on the availability of accessible gathering points outside the home and workspace. These so-called “**Third Places**”, such as parks and community centers, functioned as neutral grounds for people to meet and engage in interactions and build social ties.¹²⁶



Figure 7: Characteristics of "Third Spaces"¹²⁷

¹²⁵ Thomas E. Fuller-Rowell, Samia Sultana, and Ichiro Kawachi, "Global Trends and Disparities in Social Isolation," *JAMA Network Open* 8, no. 9 (2025): e2532008, <https://pmc.ncbi.nlm.nih.gov/articles/PMC12439063/>.

¹²⁶ The Hood. "What Is Third Space? – Theory & Why It Matters for Community Life." <https://thehood.ae/blog/what-is-third-space-concept-theory/>.

¹²⁷ Photograph retrieved from the Hood website.

However, over the recent decades, heavy urbanisation and commercial real estate development have all but **eliminated these “Third Places” in favour of privatised spaces**. Open spaces are increasingly being designed to prevent gathering. Commercialised places require continuous financial spending, which prices out young and the elderly.

This has consequently led to modern high-density cities that are an environment where millions live in close proximity yet remain unknown to each other.

2. Household fragmentation and demographic shifts

Over the past 50 years, **average household sizes have shrunk exponentially**, with single-person households currently representing about 30% to 40% of residential units all across urban centers in Europe and Asia.¹²⁸ These altered household structures are the result of deep demographic transitions across both the high-income and developing regions. These trends are **due to three primary socioeconomic shifts**:

- **Aging Population:** Longer life expectancies paired with decreasing fertility rates have yielded a disproportionate number of elderly citizens living alone following the loss of their spouse.
- **Growth in Nuclear Families:** Multi-generational households where extended families all lived together and provided built in social care have largely dissolved in favour of nuclear living arrangements.
- **Labor Mobility:** Shifting economic demands increasingly force young adults to move away from their home regions in favour of better opportunities, and this severs established childhood and family networks in exchange for temporary workforce integration.¹²⁹

¹²⁸ United Nations Department of Economic and Social Affairs, Population Division, *Household Size and Composition Around the World 2017 – Data Booklet* (ST/ESA/SER.A/405), 2017, https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/aging_theme_household_size_and_composition_around_the_world_2017_data_booklet.pdf.

¹²⁹ OECD, "SF1.1: Family Size and Composition," OECD Family Database, https://webfs.oecd.org/els-com/Family_Database/SF_1_1_Family_size_and_composition.pdf.

While solitary living doesn't necessarily induce loneliness, the absence of regular contact with other individuals removes a buffer against social distress, which leaves individuals far more vulnerable to isolation when health or economic shocks occur.

3. Labor displacement

Social isolation and economic inequality go hand in hand. Poverty limits an individual's ability to afford public transport, participate in recreational activities, or engage in social gatherings. Financial strain also creates chronic distress, which can lead individuals to withdraw from social life due to social anxiety.¹³⁰

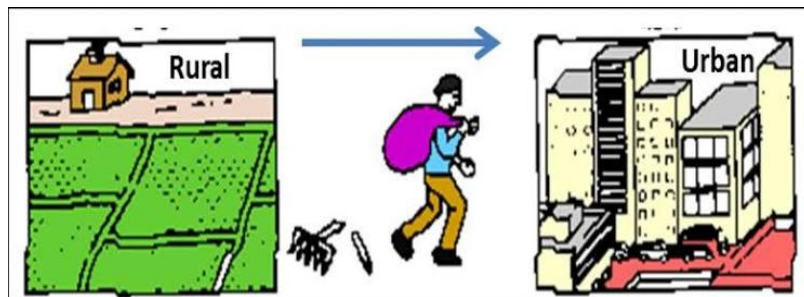


Figure 8: Labor displacement¹³¹

In LMICs, rapid and unplanned **migration from rural villages to urban areas** cuts traditional community safety nets. Migrants tend to inhabit overcrowded settlements that lack basic infrastructure, which generates a form of socioeconomic isolation where economic survival comes at the cost of social cohesion.¹³²

4. Public policy gaps

While the social and technological drivers are quite evident, social isolation is also the product of governance failures. Over the course of history, public health frameworks have always operated in a model that allocates resources to physical disease and clinical

¹³⁰ World Health Organization, *From Loneliness to Social Connection: Charting a Path to Healthier Societies* (Geneva: World Health Organization, 2025), <https://iris.who.int/bitstream/handle/10665/381746/9789240112360-eng.pdf?sequence=1>.

¹³¹ Photograph retrieved from ResearchGate.

¹³² UN-Habitat, *World Cities Report 2022: Envisaging the Future of Cities* (Nairobi: United Nations Human Settlements Programme, 2022), https://unhabitat.org/sites/default/files/2022/06/wcr_2022.pdf.

intervention. This would mean that social infrastructure such as public transit and municipal community programs have **rarely been seen as a health necessity**.

Also, economic metrics such as Gross Domestic Product (GDP) do not price in social connection as an external factor. **Workplace policies** in many industrializing economies prioritize maximum labor output and offer minimum protections for work-life balance.¹³³

When States treat **social infrastructure** as an optional luxury rather than a public necessity, they leave local non-governmental organisations (NGOs) and underfunded civil society groups to absorb the burden of social isolation.

5. Fragmentation of governmental ministries

The addressing of social isolation at a State level has a critical barrier, which is the extreme **fragmentation of government ministries**. Without coordinated action across multiple ministries such as the public health, urban planning, digital regulation, transportation, and social welfare ministries, the issue of social isolation cannot be properly solved. However, national governance structures operate with isolated budgets and competing strategic mandates. Without a central ministry with statutory frameworks, national interventions remain incapable of addressing the root cause of this social disconnection.¹³⁴

6. Advances in human connection technology and social isolation: the paradox

Ironically, this crisis has been deepened alongside the greatest advancements in human connection technology. The rise of social media, instant messaging, and video calls all promised a world without distance, yet the evidence tells a different story. Primarily among adolescents, heavy use of digital platforms has been shown to be linked to increased

¹³³ World Health Organization, *From Loneliness to Social Connection: Charting a Path to Healthier Societies* (Geneva: World Health Organization, 2025), <https://iris.who.int/bitstream/handle/10665/381746/9789240112360-eng.pdf?sequence=1>.

¹³⁴ UK Government (Department for Digital, Culture, Media and Sport), *A Connected Society: A Strategy for Tackling Loneliness* (London: HM Government, October 2018), https://assets.publishing.service.gov.uk/media/5fb66cf98fa8f54aafb3c333/6.4882_DCMS_Loneliness_Strategy_web_Update_V2.pdf.

feelings of loneliness. This abundance of technology has **replaced high-quality social interactions with low effort digital micro interactions**.

Major technological platforms are all built on models that **prioritize engagement rather than social connection**. These social media algorithms often create echo chambers that isolate individuals and generate social anxiety. Social media content that provokes reactions is rewarded rather than content that fosters real relationships. A generation that is the most digitally active in history yet one of the loneliest ever recorded is the result of such technological frameworks.¹³⁵

NOTE FROM THE CHAIRS: This committee must question what responsibility States and the international community bear to address this issue of technology becoming a substitute for human connection rather than a catalyst for it.

7. Health impacts

Social isolation doesn't just mean sadness or the feeling of being left out. The health consequences of social isolation are severe and widespread. Social isolation and loneliness have been linked to **impacts on physical health** such as **cardiovascular disease** and **type 2 diabetes, and mental health**, such as **depression** and anxiety. The health risks have been compared to smoking 15 cigarettes a day. Estimates suggest that loneliness accounts for approximately 870,000 deaths each year. That is around 100 deaths every single hour.¹³⁶

Studies also show that people who are lonely are twice as likely to develop depression, and prolonged social isolation has been linked to **increased dementia risk**. Older adults bear compounded consequences due to mobility issues and the loss of peers. Isolated individuals have been shown to have a **weaker immune response to vaccines** and a **decreased ability to fight off viral infections**. This is also a systemic crisis, as socially

¹³⁵Office of the U.S. Surgeon General, *Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community* (Washington, DC: U.S. Department of Health and Human Services, 2023), <https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf>.

¹³⁶Stefan Anderson, "Loneliness, Social Isolation Linked to 871,000 Annual Deaths, WHO Finds," Health Policy Watch, July 4, 2025, <https://healthpolicy-watch.news/loneliness-social-isolation-linked-to-871000-annual-deaths-who-finds/>.

isolated patients are more **likely to be re-admitted to hospitals and stay longer** during their visits, which places immense strain on national healthcare infrastructure, particularly in nations with ageing populations.¹³⁷

8. Vulnerable communities

While this crisis affects people of all age groups and backgrounds, certain groups face a disproportionate burden. According to the WHO, one in four **older people** and 5–15% of **adolescents** experience isolation and loneliness, and these figures are said to be underestimates.¹³⁸

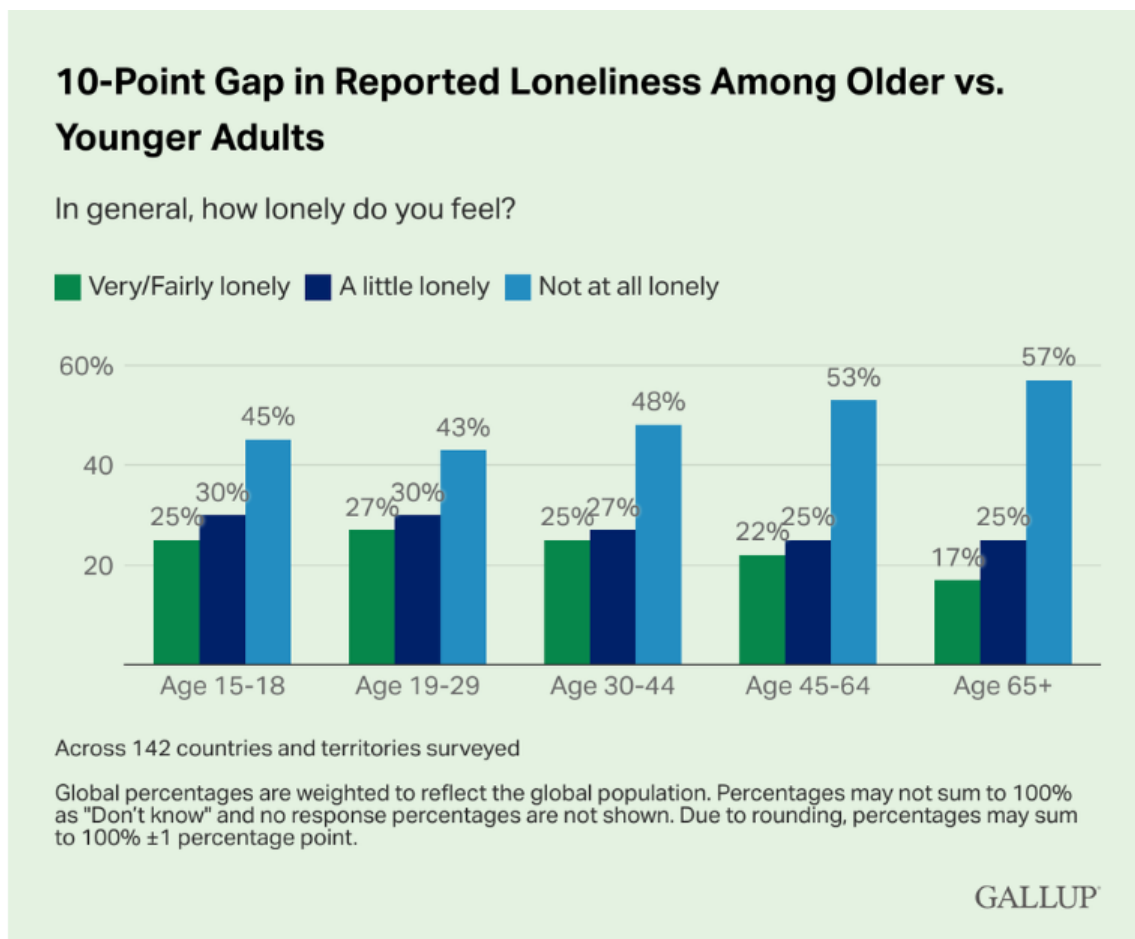


Figure 9: Loneliness among older vs. younger adults¹³⁹

¹³⁷ Centers for Disease Control and Prevention, "Health Effects of Social Isolation and Loneliness," *Social Connectedness*, updated May 15, 2024, <https://www.cdc.gov/social-connectedness/risk-factors/index.html>.

¹³⁸ World Health Organization, "Social Connection," *Questions and Answers*, June 30, 2025, <https://www.who.int/news-room/questions-and-answers/item/social-connection>.

¹³⁹ Photograph retrieved from the Gallup blog.

Refugees face isolation brought forth through language barriers and cultural displacement.

People with disabilities encounter physical and social barriers that can lead to less meaningful participation in the community.

Also, **LGBTQ+ individuals** often experience chronic isolation due to deep-rooted stigma and rejection.

Furthermore, the disparity in social isolation between high-income and **low-income groups** peaked during the pandemic in 2020, which reflects how poverty and limited infrastructure compound the risk of social isolation in low-income nations and communities. It has been shown that poverty may account for elevated rates of loneliness in low-income nations due to the limited economic opportunities that lead to social exclusion and encourage migration, which severs existing social ties. Hence, addressing social isolation cannot be separated from addressing inequality, which are deeply intertwined.¹⁴⁰

International response so far

Even though the scale of this crisis is large, the international response is quite slow and fragmented. However, multiple significant developments have signalled a growing recognition of the social isolation crisis.

1. World Health Organization (WHO)

The most significant development towards this issue came in 2023, when the WHO established the **Commission on Social Connection**. The Commission's mission is to define a global agenda on social connection and raise awareness of the issue by building collaborations that drive solutions for countries and individuals. The Commission

¹⁴⁰ World Health Organization, *From Loneliness to Social Connection: Charting a Path to Healthier Societies* (Geneva: World Health Organization, 2025), <https://iris.who.int/bitstream/handle/10665/381746/9789240112360-eng.pdf?sequence=1>.

represents the **first coordinated effort to treat social isolation as a public health emergency** that deserves policy attention.¹⁴¹

2. United Kingdom

The United Kingdom remains the global pioneer in national loneliness policy. In January 2018, the prime minister led the creation of a **ministerial lead for loneliness** following the recommendations of the Jo Cox Commission on Loneliness, with the intention that the new role would ensure loneliness reduction remains an enduring parliamentary priority. Later that year, the UK government became the first in the world to publish a **loneliness reduction strategy**. This strategy included the commitments of multiple government departments to encourage the **practice of “social prescribing”** where patients with loneliness are referred to local community centers and befriending schemes. As of 2020, the UK government had **distributed over £20 million to various initiatives** to reduce loneliness.¹⁴²

3. Japan

Japan in 2021 followed the path of the UK, appointing its **Minister of Loneliness** after the country saw a surge in suicide rates for the first time in over a decade, with shocking estimates stating that more people were dying from suicide in a single month than from COVID-19 across the entire year. *Hikikomori*, an acute social withdrawal in which individuals retreat entirely from society for months or years, and *kodokushi*, the phenomenon of elderly individuals dying alone and remaining undiscovered for extended periods due to isolation, are two phenomena that have been compounding the crisis in the country.¹⁴³

¹⁴¹ World Health Organization, "WHO Launches Commission to Foster Social Connection," 15 November 2023, <https://www.who.int/news/item/15-11-2023-who-launches-commission-to-foster-social-connection>.

¹⁴² UK Department for Digital, Culture, Media & Sport, *A Connected Society: A Strategy for Tackling Loneliness — Laying the Foundations for Change* (London: HM Government, October 2018), <https://www.gov.uk/government/publications/a-connected-society-a-strategy-for-tackling-loneliness>.

¹⁴³ "Japan Now Has a 'Minister of Loneliness' to Tackle Mental Health Issues," *Time Out Tokyo*, 25 February 2021, <https://www.timeout.com/tokyo/news/japan-now-has-a-minister-of-loneliness-to-tackle-mental-health-issues-022521>.

4. United States of America



Figure 10: Six pillars of the US Strategy for Human Connection¹⁴⁴

The United States has taken a different path. Rather than appointing a minister dedicated to addressing loneliness, the United States issued an **advisory that declared an “Epidemic**

¹⁴⁴ Photograph retrieved from Our Epidemic of Loneliness and Isolation 2023 - The U.S. Surgeon General’s Advisory on the Healing Effects of Social Connection and Community, p. 47.

of Loneliness and Isolation”,¹⁴⁵ which brought the issue into mainstream public view at the highest federal health authority. The advisory called for systematic changes across healthcare and technology regulation, which **framed social connection as a national health imperative**. Additionally, the federal government published a **National Strategy for Human Connection**, which was structured around **six pillars** displayed above.

5. Low- and Middle-Income Countries

In developing regions across Africa, South Asia, and Latin America, **formal loneliness strategies are largely non-existent** due to strict budget constraints and competing health crises which have taken higher precedence. Rather than establish new specialised ministries, LMICs **tend to utilise existing Community Health Worker (CHW) networks**, such as India’s Accredited Social Health Activist (ASHA) workers or Ethiopia’s Health Extension program. CHW’s that are conducting home visits for infectious disease monitoring or maternal healthcare are trained to perform basic social health screenings and help integrate local isolated individuals into local faith-based or other community based local networks, which presents a highly cost effective model for States with constrained resources.¹⁴⁶

6. Gaps in the current response

While some of the above-mentioned national responses are encouraging, they remain an exception rather than the rule. Most nations, particularly low- and middle-income countries, have **no dedicated policy or funding frameworks** to address social isolation. There is **no internationally standardized tool for measuring loneliness** across populations, which makes cross-country comparisons difficult and global resource allocation inconsistent. The economic costs of isolation are only beginning to be estimated,

¹⁴⁵Office of the U.S. Surgeon General, *Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community* (Washington, DC: U.S. Department of Health and Human Services, 2023), <https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf>.

¹⁴⁶ World Health Organization, *From Loneliness to Social Connection: Charting a Path to Healthier Societies* (Geneva: World Health Organization, 2025), <https://iris.who.int/bitstream/handle/10665/381746/9789240112360-eng.pdf?sequence=1>.

which means that policymakers are often making decisions without the full picture of what inaction could cost. Bridging these gaps is central to the work of this committee.¹⁴⁷

Overview of bloc positions

NOTE FROM THE CHAIRS: Understanding where different groups of nations stand on social isolation is paramount for productive debate. While every delegation will bring its own national perspective, the following blocs represent the broad coalition that is likely to emerge in the committee.

BLOC	LIKELY MEMBERS	PRIMARY POSITION
Pioneer Nations	United Kingdom, Japan, United States, Norway, Denmark, Sweden, Australia	Advocates for a globally standardized measurement tool for loneliness, the expansion of social prescribing into national healthcare systems and the increased WHO funding dedicated to social connection research and programming.
Tech-Forward Nations	South Korea, Japan, China, Gulf States, Singapore	Promote investments in digital connectivity to combat social isolation via the form of AI companions or digital community options and oppose resolutions that call for heavy regulation of social media platforms.
Low- and Middle-Income Nations	African Union member states, South Asia,	Sceptical of solutions designed in high-income nations without accounting for resource constraints in their own countries. Likely to

¹⁴⁷ World Health Organization, *From Loneliness to Social Connection: Charting a Path to Healthier Societies* (Geneva: World Health Organization, 2025), <https://iris.who.int/bitstream/handle/10665/381746/9789240112360-eng.pdf?sequence=1>.

	Southeast Asia, Latin America	prioritize debt relief and development funding for any isolation policy.
Sovereignty and Family Centric Nations	Russia, Saudi Arabia, Central Asia, certain Eastern European states	Argue that strong family structures and religious community networks are the most effective buffers against isolation. Fearful that international frameworks risk undermining national sovereignty over social policy and will be unlikely to support WHO oversight mechanisms and will prefer their national governments to address social connections within their borders.

Points a resolution should address

NOTE FROM THE CHAIRS: Delegates should **not simply acknowledge social isolation as a public health crisis** when drafting their working papers and draft resolutions, but should move beyond acknowledgment and **work towards formulating actionable multilateral policy mechanisms**. Resolutions should address the following challenges.

1. Global standardisation of data collection

Member States currently lack a unified framework for measuring social isolation and disconnection. Diagnostic tools vary by region, which prevents accurate country comparisons and hinders efficient WHO resource allocation.

GUIDING QUESTIONS:

- How could the global community standardize the measurement of social isolation across various cultural and economic contexts?
- How can the WHO establish an index that accounts for all the cultural differences between multiple urban societies while safeguarding an individual's health data privacy?

2. Urban planning

The issue is the elimination of free and accessible gathering spaces (“Third Places”) due to the expansion of commercial real estate and automobile-centered urban planning.

GUIDING QUESTIONS:

- How can urban planning and public infrastructure be redesigned to foster social connection?
- What laws or incentives can Member States introduce to mandate public spaces in modern urban developments?
- What role should schools and educational institutions play in building social skills and preventing isolation from an early age?

3. Technological governance and social media

Algorithms in social media apps are engineered to prioritize engagement over meaningful connections, and the rapid rise in generative AI companions risks causing social collapse.

GUIDING QUESTIONS:

- How should the international community balance the promotion of digital connectivity with the growing evidence that excessive screen time deepens rather than alleviates loneliness?
- How can the WHO work with international bodies to establish guardrails for digital platforms?
- What regulations should apply to allow for anti-dependency protocols?
- What obligations, if any, do technology companies bear in addressing the isolation their platforms may be contributing to?

4. Resource conscious frameworks for developing nations

LMICs cannot afford to create standalone ministries or expensive programs while addressing economic hardships or urgent infectious diseases.

GUIDING QUESTIONS:

- How can LMICs address social isolation without diverting resources from other urgent health priorities?
- How can LMICs adapt existing networks of health workers to perform social health checks?
- What multilateral funding or frameworks can support these transitions in LMICs?

Additional preparation materials

VIDEO RESOURCES:

We recommend that you watch the following helpful videos.

On social isolation as a mental health issue (12 mins):

- Dr Syl, **Social Isolation: The Hidden Mental Health Trap**. Available at YouTube:
<https://www.youtube.com/watch?v=X9fkB0gLKhQ>.

TED Talk on the topic (10 mins):

- Jonny Sun, **You are not alone in your loneliness**. Available at YouTube:
https://www.youtube.com/watch?v=gi6rMXu_veE.

Documentary outlining the entire topic (34 Mins):

- ColdFusion, **How We Became the Loneliest Generation**. Available at YouTube:
<https://www.youtube.com/watch?v=I19btmIBhx0>.

Short video on social isolation (1 min):

- CNN, **Dr. Molly Maloof explains how social isolation affects the cell**. Available at CNN:
<https://edition.cnn.com/2026/05/28/health/video/molly-maloof-social-isolation-spark-factor-wellness-digvid>.

On the “Loneliness Epidemic” (10 mins):

- CNN, **Is there really a ‘loneliness epidemic’?**. Available at CNN:
<https://edition.cnn.com/2026/08/28/tv/video/amanpour-horowitz-loneliness>.

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FURTHER READING:

Sources listed below are additional recommended readings.

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