SPC2: Special Conference on Health and Family Welfare

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Issue: Measures to prevent neglect of patient wellbeing in primary healthcare

TIMUN '22

Turkish International Model United Nations

TIMUN Affiliated Conference

Committee: Special Conference on Health and Family Welfare (SPC2)

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I. Introduction

Primary health care includes physical, mental, and social well-being and it is people-centered rather than disease-centered. PHC is a whole-of-society approach that includes health promotion, disease prevention, treatment, rehabilitation and palliative care. By providing care in the community as well as through the community, PHC addresses not only individual and family health needs, but also the broader issue of public health and the needs of defined populations. Primary health care emerged in the early 1970s as WHO's response to the failure of its basic health services approach. The Soviet Union succeeded in getting WHO's governing bodies to agree to hold an international conference on PHC, a conference that was held in Alma-Ata, the capital of the Soviet Republic of Kazakhstan, in September 1978.

Patient neglect is an issue of increasing public concern, yet remains poorly understood. The perceived frequency of neglectful behavior varies by the observer. Patients and their family members are more likely to report neglect than healthcare staff, and nurses are more likely to report on the neglectful behaviors of other nurses than on their own behavior. The causes of patient neglect frequently relate to organizational factors such as high workloads that constrain the behaviors of healthcare staff, burnout due to high intensity of work, insufficient salary for the healthcare employees, and the relationship between carers and patients.

Medical education is the most fundamental flaw that causes neglect of patient wellbeing in primary healthcare. Despite some positive curricular changes in a few countries which are directed at orienting medical education towards community, few countries have scarcely succeeded in inculcating a social perspective that can allow people to sympathize and relate to the health needs of the community. Topics under community medicine, such as maternal and child health and sanitation have been inadequately integrated with clinical subjects in Member States. With medical education failing to hold the torch for primary care, an affiliation for specialty- and super-specialty medicine has grown largely unchecked in a setting which has perennially failed to prioritize primary care over hospital care. As a result, while medical education was supposed to foster the conviction that the real indicators of development are an improvement in things as fundamental as nutrition and sanitation, it has ended up instilling a strong adoration for sophisticated tertiary care systems of relevance to only an affluent few.

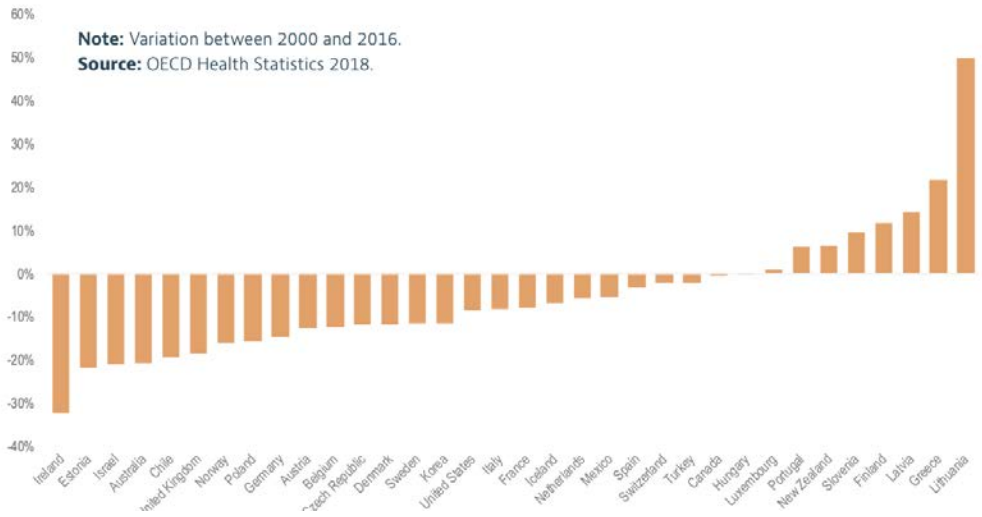

Image 1: The share of general practitioners continues to drop across two-thirds of OECD countries

Throughout the world, the price of healthcare is drastically increasing. Universal trends such as urbanization, demographic aging, and the marketing of unhealthy lifestyles have caused a sharp rise in chronic diseases. These diseases now impose around 80 percent of their burden on low and middle income countries. The demands of life-long treatment further damage already weak primary healthcare systems and increase the costs. In addition, soaring numbers of the frail elderly further surge the demands on health systems, the health workforce, and for social welfare. Endeavors to prevent diseases have also become more complicated. For instance, chronic diseases are largely triggered by a limited number of lifestyle related factors, however, these factors lie beyond the control of the health sector. Considered together, these trends help explain recent calls from leaders in all regions of the world for a renewal of primary healthcare to especially prevent patient neglect. Healthcare systems will not spontaneously gravitate towards greater efficiency or greater equity in access to care.

II. Involved Countries and Organizations

The United States of America (USA)

The United States is a Member State that has faced problems with its primary care workforce, but dysfunctional financing schemes and inability to compete for the hearts and minds of the next generation of young doctors severely threaten its future. Most issues in the country are a direct consequence of the market approach to healthcare. Primary care in the USA consists of three aspects; family medicine, general internal medicine and general pediatrics. Numerous problems and concerns have been voiced in the previous years have remained– primarily dissatisfaction, long hours, high stress, poor reimbursement, and erosion of scope practice. The healthcare system in the USA functions as a marketplace, consuming nearly

%16 of the overall economy and nearly %25 of its annual growth. Its role as a reliable economic engine yields incredible technology and pharmaceutical development, however also causes uninsurance and underinsurance, poor population health compared with other developed countries, and unethical disparities in both health and primary health care. The lower salaries of doctors in primary care compared with hospital specialists dissuade medical students, half of whom now graduate $115.000 or more in debt, from pursuing primary care careers. The services of primary care doctors have long been undervalued by the Medicare programme, which often cuts its annual payments to cope with overspending on procedures in secondary and tertiary care.

During the Covid-19 pandemic, the patient neglect in the USA has increased. Human Rights Watch has stated that potential neglect and prolonged isolation may have caused serious harm to many people in nursing homes in the United States during the Covid-19 pandemic. Throughout the USA, many people in nursing homes suffer from extreme weight loss, dehydration, untreated bedsores, inadequate hygiene, mental and physical decline, and inappropriate use of psychotropic medications among nursing home residents. Staffing shortages, which is a longstanding issue that was a significant problem during the pandemic, and the absence of family visitors, many of whom nursing homes rely on to help staff with essential tasks, may have contributed to possible neglect and decline. In addition to nursing homes, hospitals in the USA are also very prone to patient neglect. It is estimated that more than 250,000 deaths per year in the USA are due to medical errors in the hospitals.

Image 2: The Strategic Framework of the Global Patient Safety Challenge

World Health Organization (WHO)

The World Health Organization (WHO) plays an essential role improving local health systems and coordinating the global response to health threats. WHO is actively involved in the issue of patient neglect in primary healthcare and has published various documents regarding the topic.

According to WHO, a comprehensive primary health care approach includes three components which are: meeting people's health needs throughout their lives, addressing the broader determinants of health through multisectoral policy and action; and empowering individuals, families and communities to take charge of their own health. In WHO's Eastern Mediterranean region existing indicators have been adapted to regional

realities to create the PHCMI (Primary Health Care Measurement and Improvement) initiative, which enables countries in the region to evaluate existing health systems and approaches. PHCPI, the Primary Health Care Performance Initiative, through its Vital Signs Profiles, also provides a great deal of data to assist countries in evaluation and decision-making. Once the data is available, and the decisions are made, it is time for implementation. To that end, WHO has, with the support of partners, created the PHC Operational Framework. This document outlines a number of PHC levers which countries can use to guide the move to a PHC model. And to assist countries in judging the results of their efforts and determining whether or not they are on track to meet their goals, a Monitoring and Evaluation Framework. Additionally, to assist countries and health professionals to understand how the numerous areas and aspects are implicated in primary health care, WHO has launched the Technical Series on Primary Healthcare.

WHO is also focusing global attention on the issue of patient safety and began a campaign in solidarity with patients on the World Patient Safety Day on 17 September. “No one should be harmed while receiving health care. And yet globally, at least 5 patients die every minute because of unsafe care,” said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. “We need a patient safety culture that promotes partnership with patients, encourages reporting and learning from errors, and creates a blame-free environment where health workers are empowered and trained to reduce errors."

Middle East and North Africa (MENA) Region

A combination of chronic underfunding of public health services and long-term socio-economic trends resulted in a tenuous and uneven recovery for the Middle East and North Africa region as it emerged from the COVID-19 pandemic. The limited fiscal space caused by the truncated economic transition to market economies, particularly in developing MENA, has two key consequences on health financing. First, the lack of budget flexibility prevents governments from assuming the costs of providing healthcare and shifts health spending to patients, who must pay out of pocket. Out-of-pocket spending (OOPS) accounts for a major portion of health spending in many middle-income and low-income MENA countries. For example, the share of OOPS in total health spending is around 60 percent in Egypt and 80 percent in Yemen. By contrast OOPS is 6 percent in Oman, where the government pays for most health services. A good health financing system should spread the cost of paying for health care by providing prepaid health services— from pools funded by either taxes or commercial insurance—to those in need of services. The MENA reliance on OOPS, however, shifts the cost burden to patients and can drain household incomes.

This low reliance on health insurance pools reduces financial leverage on providers, which constrains a country’s ability to direct funds to critical public health functions like disease prevention and surveillance. That is the second consequence of underfunding public health because of limited fiscal space due to fiscal myopia. Individuals, not governments, are the de facto purchasers of services. This mechanism shifts

purchasing power away from large population pools that demand upstream health measures, like prevention and disease surveillance, to those in need of downstream, often costlier, individual services. The pandemic has demonstrated the need for prevention, detection, and response. But that need extends to longer-term,

Table 5.1. Overconfident MENA: Public Health System Preparedness versus Self-Assessments

	A. Objective Preparedness Relative to Benchmarks				B. Self-Reported Preparedness Relative to Benchmarks				C. Overconfidence: Objective Minus Self-Reported Preparedness Relative to Benchmarks			
Country	Surveillance capabilities	Information sharing	Health system capacity	Regular planning & readiness exercises	Surveillance capabilities	Information sharing	Health system capacity	Regular planning & readiness exercises	Surveillance capabilities	Information sharing	Health system capacity	Regular planning & readiness exercises
QAT	-1.47	-2.02	-0.66	-2.47	-0.30	0.32	0.42	0.60	1.17	2.33	1.08	3.07
UAE	-2.20	-1.36	-0.44	-0.94	0.72	0.64	-0.15	0.76	2.92	2.00	0.29	1.70
KWT	-0.39	0.15	-0.48	-1.19	-0.46	-0.49	-0.59	-0.77	-0.07	-0.64	-0.11	0.42
SAU	0.56	0.04	0.67	-0.80	-0.03	-0.43	-0.39	0.12	-0.59	-0.47	-1.06	0.91
BHR	-0.34	-1.08	-1.13	-1.83	0.37	-0.06	0.23	0.99	0.72	1.01	1.36	2.83
OMN	-1.32	-0.39	0.27	-0.58	1.19	0.43	0.84	0.42	2.52	0.82	0.57	1.00
LBY	-1.26	-0.08	-0.23	-1.40	-1.30	-0.81	-0.30	-1.81	-0.04	-0.73	-0.07	-0.41
LBN	-0.30	0.56	1.15	-0.70	0.58	0.84	-0.26	-0.08	0.88	0.28	-1.41	0.63
IRN	0.93	-0.60	0.66	-1.32								
EGY	-1.15	-0.07	-0.25	0.69	0.74	0.86	1.52	1.76	1.88	0.93	1.77	1.06
DZA	-0.86	-1.14	-0.91	-1.66	1.86	0.88	1.53	0.06	2.72	2.02	2.45	1.72
TUN	-1.08	-0.74	-0.25	-1.64	1.17	0.61	0.85	-0.76	2.25	1.35	1.10	0.88
IRQ	-0.91	0.41	-1.24	-1.63	-2.89	0.95	1.60	0.96	-1.98	0.54	2.83	2.59
JOR	1.42	-0.10	0.56	1.26	-1.38	-1.27	-1.16	-1.58	-2.80	-1.17	-1.73	-2.84
MAR	0.79	1.34	1.24	-1.12	1.40	0.89	1.39	1.15	0.62	-0.44	0.15	2.27
DJI	-0.87	-0.62	-1.08	-1.37	-0.26	-1.13	-1.50	-1.24	0.61	-0.51	-0.41	0.13

Image 3: Public Health System Preparedness versus Self-Assessments

pervasive health stresses, such as NCDs. Strategic purchases of health services, which use purchasing power as leverage to make providers cooperate with health system objectives -- are a powerful way to ensure funds for health priorities like NCDs. But the strategy is weakly pursued in middle-income MENA.

To further emphasize the severe issue of patient neglect and underfunding in primary healthcare MENA countries' Global Health Security Index (GHSI) data can be observed. MENA countries' GHSI data consistently underperformed their income-level benchmarks. Additionally, the table shows that wealthier countries in MENA underperformed relative to income peers in the objective score system.

III. Focused Overview of the Issue

Primary healthcare has been a growing issue, however, it hasn't received sufficient attention in many member states. Due to lack of funding from government and interest, patient neglect deemed itself the most pressing repercussion of flawed primary healthcare. Patient neglect spans nursing homes, special treatment facilities to hospitals throughout the world, especially in low and middle income countries.

1. Different Types of Patient Neglect

Nursing home neglect is an issue of worldwide significance. Nursing home neglect occurs in nursing homes as can be inferred from its title and it occurs when nursing home residents do not get proper care and suffer physical and mental health problems as a result. 15.3% of elder abuse complaints are from patient neglect in nursing homes. Nursing homes neglect consists of failure to attend to residents, giving them inaccurate doses of their medication, and overlooking their needs intentionally. Such cases are usually a consequence of inadequate staffing that leaves the employees burnt out. %20 of nursing homes throughout the world were understaffed as of December 2020. Another reason for patient neglect in nursing homes is negligent hiring processes. Nursing homes that do not conduct thorough interviews, and don't check backgrounds during the hiring of staff and practitioners suffer from patient neglect and elder abuse as well.

Medical neglect is also a common form of neglect in many member states. Medical neglect occurs when a medical staff member or licensed physician fails to meet a patient's healthcare needs. Medical neglect includes: failing to administer medication when needed, improper medical care for existing health problems like diabetes or dementia, not regularly moving patients with mobility issues, putting them at risk for bedsores; and not reporting signs of illnesses.

Although neglect is frequently used to refer to physical cases, there is an emotional level of neglect that is just as dangerous. Social and emotional neglect is an overlooked form of neglect which refers to a patient deprived of their needs of socialization and friends. This type of neglect is mostly observed in patients in nursing homes or special treatment facilities. Social and emotional neglect includes isolating vulnerable patients, not providing patients with mental issues with their needs, and preventing patients from seeing their families and friends.

Neglect of personal hygiene has also been a fundamental issue in many member states especially Least Economically Developed Countries (LEDCs). Poor hygiene in hospitals, medical places includes failing to change the clothes of a patient, not regularly checking in on patients, not changing the clothing or bedding of a patient who has soiled themselves, not feeding or bathing the patients.

2. Requirements for Proper Primary Healthcare

Good primary health care has the potential to improve health, reduce socioeconomic inequalities in health, and make health care systems people-centered while making better use of health care resources. For primary healthcare to serve and fulfill the needs of its citizens, it should be comprehensive, funded and be composed of numerous aspects. Proper medical education is essential for the base of primary health care. Proper medical education should teach future doctors and practitioners to put the community's needs

ahead of anything else and shouldn't solely focus on diseases and hospitals but care and health. Investing in primary health care generates good returns for society but this requires adequate resources. Yet only 14% of total health spending is currently devoted to primary health care across OECD countries, while the share of general practitioners as a share of all doctors has dropped from 32% in 2000 to 29% in 2016 across OECD countries. (Realizing the Full Potential of Primary Health Care | OECD) There is an urgent need to shift from the reactive solo-practice primary health care model to a proactive, preventive and participatory approach. In 2018, only 15 OECD countries had primary health care services based on teams or networks. Robust and portable Electronic Health Record (EHR) across the care continuum is also key for proactive, people centered primary health care.

IV. Key Vocabulary

Primary Health Care (PHC): PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment.

Tertiary Medicine: Tertiary medicine can be defined as highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Secondary Medicine: Secondary care is used to refer to the care of a specialist or a personalized doctor. These specialists may include oncologists, cardiologists, and endocrinologists.

Procedure Neglect: Procedure neglect is used to refer to occurences when a treating medical professional performs a procedure below the recognized standard of care.

Caring Neglect: Caring neglect is failings in care that are below the threshold of being proceduralized, yet lead patients, family and the public to believe that staff are unconcerned about the emotional and physical wellbeing of patients.

V. Important Events & Chronology

Date (Day/Month/Year)	Event
1967	The American Academy of Pediatrics (AAP) introduces the term "medical home" to describe primary care that is

	accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective.
1978	The Declaration of Alma-Ata was introduced at the International Conference on Primary Health Care, and is the first international declaration of primary health care's key role in promoting the health of all people.
1978	The World Health Organization (WHO) lends its support of primary care in their Primary Health Care report.
1996	The Institute of Medicine (IOM) publishes Primary Care: America's Health in a New Era and redefines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community." The publication also mentions medical homes.
2002	The seven national family medicine organizations launch The Future of Family Medicine (FFM) project and produce the Future of Family Medicine: A Collaborative Project of the Family Medicine Community.
2002	The Chronic Care Model is born and emphasizes the critical role of primary care to prevent, manage, and treat chronic illness.
2005	Renowned researcher and primary care champion Dr. Barbara Starfield publishes Contribution of primary care to health systems and health, a seminal work that acknowledges the six primary care mechanisms that benefit health.
October 2018	The Declaration of Astana was ratified at the Global Conference on Primary Health Care which took place in Astana, Kazakhstan.

VI. Past Resolutions and Treaties

- Declaration of Alma-Ata International Conference on Primary Health Care

  https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2

  This conference identified primary health care as the key to the attainment of the goal of Health for All. The Conference and the declaration state that primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

- A/RES/72/139

  https://undocs.org/Home/Mobile?FinalSymbol=A%2FRES%2F72%2F139&Language=E&DeviceType=Desktop&LangRequested=False

  The resolution stresses the importance of accelerating progress toward universal health coverage (UHC), including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

- A/75/L.41

  https://undocs.org/en/A/75/L.41

  Through this resolution, the Assembly urged Member States to strengthen national systems through ensuring affordable health care for all and called upon them to strengthen their resilience as an integral part of their preparedness for related emergencies. It also stressed the importance of monitoring the indirect impacts of the pandemic on health service delivery, acknowledged the efforts of health workers and care workers during the pandemic and called upon Member States and others to support funding for the Access to COVID-19 Tools Accelerator (ACT-Accelerator), as well as the equitable distribution of diagnostics, therapeutics and vaccines.

- Declaration of Astana

  https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

Countries around the globe signed the Declaration of Astana, vowing to strengthen their primary health care systems as an essential step toward achieving universal health coverage. The Global Conference on Primary Health Care in Astana, Kazakhstan in October 2018 endorsed a new declaration emphasizing the critical role of primary health care around the world. The declaration aims to refocus efforts on primary health care to ensure that everyone everywhere is able to enjoy the highest possible attainable standard of health.

VII. Failed Solution Attempts

Patient neglect is still an essential issue which indicates that there aren't any drastic solutions that yield success. A useless solution to the issue would be directly blaming and punishing medical staff, practitioners and physicians, because there are many underlying causes of patient neglect that are not under the control of the medical staff. For instance, in many countries doctors and medical staff suffer from high and intense work hours which leaves them burnout, therefore, unintentional and unwanted cases of patient neglect occurs, however, it isn't productive or reasonable to blame the medical staff for such cases as they are not at complete fault.

It is also not possible to solve the issues and flaws in primary healthcare without proper staffing and funding. As the Covid-19 pandemic proved, numerous member states were ill-prepared for the pandemic, struggled to import vaccines and suffered from contamination of the disease. However, member states still persist in not providing sufficient funding for their primary healthcare systems and continue to pass ineffectual laws that don't improve their healthcare systems especially LEDCs. Without funding, understaffing occurs which paves the way for further patient neglect incidents.

VIII. Possible Solutions

Education is the cornerstone of preventing patient neglect. Media coverage of neglect in nursing homes, hospitals and special treatment facilities has made the public knowledgeable about — and outraged by — negligent treatment in those settings. There needs to be a concerted effort to educate the public about the such cases of patient neglect and the ramifications of these cases. Education isn't restricted by public education, but medical education is also incredibly essential. Medical education's goal should be to create not only a competent primary-care physician but also one that is oriented to "health and community" rather than "disease and hospital". There should be positive curricular changes directed at orienting medical education towards the community, and medical education should inculcate a "social perspective" that can allow doctors and medical staff to sympathize and relate to the health needs of the community. Topics under

community medicine, such as maternal and child health and sanitation, have been inadequately integrated with clinical subjects and should be incorporated into medical curriculums. Unless the motivation of the medical workforce is aligned with the community's healthcare needs, no measure shall succeed in effecting a solution to the problem. A medical curriculum that is adequately oriented to primary care and community health, and a healthcare system and policy environment that gives the community their due is long overdue. Member states can no longer continue to adhere to an "overflow principle" of sorts whereby simply manufacturing more doctors would automatically pump more of them into the hospitals. The kind of training imparted largely decides the kind of motivation carried into service.

There should be repercussions of patient neglect which would prevent medical workers from acting negligently. The lack of consequence generates a sense of irresponsibility that enables the medical staff from behaving in negligence. Unfortunately, in some member states patient neglect is not a punishable crime, which increases the case of patient neglect and endangers the people's lives. The existence of penalties refrain people in the health industry from behaving irresponsibly and diminishes the possibility of patient neglect. Additionally, spontaneous inspections should be conducted to hospitals and nursing homes to inspect the quality of service given to patients. Spontaneous inspections would improve the chances of detecting patient neglect and remeding the situations.

Most importantly, countries should create a healthcare plan that they should abide by. Lack of organization has put many countries in severe situations during the COVID-19 pandemic. The underfunding in many countries continues to be a pressing issue, thus, there should be an appropriate budget allocated for health and for health emergencies such as epidemics and pandemics. Medical staff and workers as well as health experts should be consulted while creating a robust plan for the primary healthcare system. Readiness and organization are prominent solutions to primary healthcare systems of member states.

IX. Useful Links

- History | Primary Care Collaborative

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- Patient neglect in healthcare institutions: a systematic review and conceptual model | BMC Health Services Research

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