Houston Area Model United Nations
Standard Committee

WHO



Chair | Aiza Dada
Topic A: Regulating Access to GLP-1 Medicines
Houston Area Model United Nations 52
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Chair Letter

Welcome delegates,

Welcome to HAMUN 52! My name is Aiza Dada, and I am incredibly excited to be your chair for WHO this year.

I am currently a sophomore biology major in the honors college here at UH, and I plan to study politics and ethics with a minor in Phronesis. I first joined Model UN as a junior in high school, when I saw how much of a blast my friends were having. Since then, I've joined the collegiate Model Debate circuit and had the amazing opportunity to travel to New York, Washington D.C., and Philadelphia for conferences. Last year, I had the pleasure of serving as vice chair for CSW at HAMUN. Model UN has given me the opportunity to meet some incredible people, challenge the way I think, and become much more comfortable defending ideas under pressure.

I am especially excited to chair WHO because public health is one of those subjects that affects literally everyone, whether or not we spend much time thinking about it (and as a bio major, I'm always thinking about it). Both topics this year will force us to question: what happens when medical solutions exist, but the resources needed to provide them are not equally available? There will be no shortage of things for you all to disagree about, which, conveniently, is the entire point of committee.

My biggest piece of advice is to research your country, not just the topic. Think about funding, feasibility, and implementation. Also, please do not feel like you need to walk into committee knowing the entire global healthcare system by heart. Come prepared, speak even when you are nervous, listen to other delegates, and be willing to change your approach when somebody raises a point you had not considered. Some of the best moments in Model UN happen when a debate goes somewhere you never expected. Have fun with it, take risks, and enjoy the occasional chaos!

Best of luck, and please reach out with any questions!

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Committee Background

Two WHO functions are central to this topic. First, WHO maintains the Model List of Essential Medicines (EML), first published in 1977 and updated every two years by an independent Expert Committee. The EML identifies the medicines WHO considers most important to a functioning basic health system. More than 150 countries use it to guide national acquisition, insurance coverage, and drug registration decisions. Second, WHO develops evidence-based clinical guidelines (such as its December 2025 guideline on GLP-1 therapies for obesity) that shape how governments and clinicians around the world use a given treatment.

WHO does not manufacture, patent, price, or distribute medicines itself; its influence operates through standard guidance, technical assistance, procurement pooling mechanisms, and diplomatic pressure on Member States and industry.

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) and the newer dual GLP-1/GIP agonists are, by most measures, the most commercially and clinically significant new drug class of the 2020s.

Originally developed to manage type 2 diabetes, these medicines were found to produce dramatic, sustained weight loss and to meaningfully reduce cardiovascular and kidney complications. Demand exploded far beyond diabetes care: by late 2025, roughly one in eight U.S. adults reported having taken a GLP-1 medicine for weight loss, and global sales of the leading products are projected to exceed $80 billion in 2026, making this drug class larger than any single cancer or autoimmune therapy on the market.

Topic Relevance

This committee is being convened at a pivotal moment. In September 2025, the WHO Expert Committee added GLP-1 receptor agonists (semaglutide, dulaglutide, liraglutide) and the dual agonist tirzepatide to its Essential Medicines List for adults with type 2 diabetes who also have cardiovascular disease, chronic kidney disease, or obesity.

In December 2025, WHO went further, issuing its first-ever clinical guideline conditionally recommending GLP-1 therapies for the long-term treatment of obesity itself, a disease WHO estimates affects more than one billion people worldwide and was linked to 3.7 million deaths in 2024 alone. Both actions were explicitly framed as tools to "unlock access," yet WHO itself acknowledged in the same announcements that current prices, weak health-system readiness, and a near-total manufacturing duopoly make genuinely equitable global access unlikely without further international action.

At the same time, 2026 has brought the first wave of patent expirations on semaglutide in India, China, Canada, Brazil, and Turkey, triggering a rapid entry of lower-cost generics in those markets, while the U.S. composition-of-matter patent does not expire until 2031–2032.

This creates a fast-widening "two-speed" world. Countries with generic manufacturing capacity and expiring patents are seeing prices fall 70–90%, while most low- and middle-income countries without such capacity remain locked out entirely, and high-income countries with strong patent protection continue to pay the highest prices in the world. Layered on top of this are serious concerns about counterfeit and unregulated compounded products entering the market to fill the affordability gap, which WHO has flagged as an active patient-safety crisis.

In short: the science has outpaced the policy. This committee's task is to design the international approach, spanning pricing, licensing, manufacturing, regulation, and health-system support, that can close the gap between what GLP-1 medicines can do and who is actually able to access them.

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Topic Background

What Are GLP-1 Medicines?

GLP-1 (glucagon-like peptide-1) is a naturally occurring gut hormone released after eating that stimulates insulin secretion, slows gastric emptying, and signals satiety to the brain. GLP-1 receptor agonists are synthetic compounds that mimic this hormone, and were first approved for type 2 diabetes in the mid-2000s (exenatide, then liraglutide). The current generation, semaglutide (Novo Nordisk's Ozempic for diabetes and Wegovy for weight management) and tirzepatide (Eli Lilly's Mounjaro for diabetes and Zepbound for weight management), produces substantially greater and more durable weight loss than earlier formulations, alongside reductions in major cardiovascular events, kidney disease progression, and, per emerging evidence, overall mortality.

A Market Unlike Any Other

The GLP-1 market today is effectively a duopoly: Novo Nordisk (Denmark) and Eli Lilly (United States) control the overwhelming majority of global supply and revenue, with Sanofi and a handful of other firms pursuing smaller or differently positioned products. This concentration, combined with overwhelming demand, produced repeated supply shortages in high-income markets through 2023–2025 even as many low- and middle-income countries had little to no legal supply at all. Novo Nordisk and Eli Lilly have each launched limited global-access initiatives, including Lilly's "30x30" program targeting 30 million people in resource-limited settings. However, independent analyses, including from Médecins Sans Frontières (MSF), find that these medicines remain effectively unavailable in most low-income countries, and unaffordable even where nominally on sale.

The Scale of the Health Burden

WHO's obesity guideline notes that obesity affects more than one billion people globally and, without intervention, is projected to double by 2030; it estimates the associated global economic cost could reach $3 trillion annually by that year. Both diseases are increasingly understood not as conditions of affluence but as global phenomena, with obesity prevalence rising sharply across urbanizing regions of Africa, Latin America, and Asia even as undernutrition persists in the same countries. This causes a "double burden" that complicates any uniform international policy response.

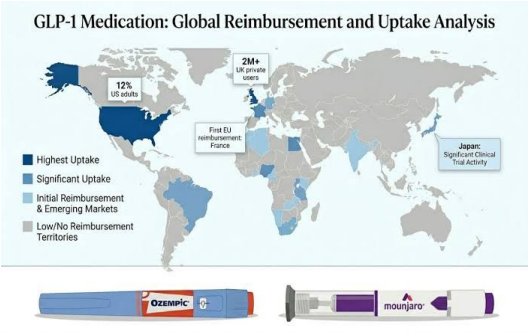


The Access Gap

The clearest way to understand this topic is through price. The same molecule, produced by the same manufacturer, is sold at radically different prices depending on the country, a pattern common in pharmaceuticals but unusually extreme for GLP-1s given the intensity of global demand. The table below illustrates approximate monthly costs across a range of markets and payment contexts (figures are illustrative list prices compiled from multiple 2025–2026 sources and vary by dose, formulation, and negotiated rebates). Several patterns are worth highlighting for debate. First, the United States pays substantially more than other high-income countries for the identical product, a disparity that has drawn sustained scrutiny from the U.S. Congress and prompted a 2026 "Medicare Bridge" arrangement lowering the government price to roughly $245 per month for eligible beneficiaries.

Second, price is a poor proxy for access in absentia: Novo Nordisk's Wegovy, for example, is registered in only a small number of countries across Europe, the Middle East, and Africa combined, meaning most patients in those regions cannot legally obtain it at any price. See Table 1: Illustrative monthly GLP-1 medicine costs by country/payer, 2025–2026 (approximate, USD).

Third, an MSF-commissioned study published in 2024–2025 estimated that GLP-1 diabetes medicines could be profitably manufactured and sold for under one dollar per month if patent holders licensed production to generic manufacturers, another disputed point of debate for access advocates.



Country / Payer	Approx. Monthly List Price (USD)	Country / Payer	Approx. Monthly List Price (USD)
United States (list price)	$950 – $1,350	United States (Medicare Bridge, 2026)	$245
United Kingdom (NHS)	~$90 – $230	Germany	~$100 – $170
Japan	~$280	Denmark	~$185
Brazil	~$95 (diabetes indication)	South Africa	~$115 (diabetes indication)
India (post-patent generic, 2026)	~$45 – $70 (70–90% below originator)	MSF-estimated generic cost floor	~$0.89 – $1.00

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Counterfeiting, Compounding, and Patient Safety

The affordability gap has fueled a parallel crisis in unregulated supply. Since 2022, WHO's Global Surveillance and Monitoring System has tracked a rising number of falsified semaglutide products. In 2024 WHO issued a first-ever global medical product alert after confirming counterfeit Ozempic pens, some of which contained unverified ingredients or non-sterile needles, in Brazil, the United Kingdom, and the United States. Similar alerts followed in Nigeria and elsewhere.

Separately, unregulated "compounded" versions of semaglutide and tirzepatide, produced by compounding pharmacies to fill legitimate drug shortages, have generated over a thousand adverse-event reports to the U.S. FDA alone, including dosing errors and hospitalizations, and have drawn legal action from Novo Nordisk over product purity. This dimension of the issue means that any resolution addressing legitimate access must also grapple with the incentives that push desperate patients toward dangerous, unregulated alternatives.



The 2026 patent expirations in India, China, Brazil, Canada, and Turkey are the single biggest near-term shift in this landscape. Within days of the Indian composition-of-matter patent lapsing in March 2026, more than a dozen domestic manufacturers (including Dr. Reddy's, Torrent, Sun Pharma, Cipla, Natco, and Zydus) launched generic semaglutide at prices reported to be 70–90% below the originator price, with dozens more products following within months.



However, because semaglutide is a complex peptide rather than a simple small-molecule drug, replicating it at scale requires significant manufacturing sophistication. This means that many countries with weaker pharmaceutical sectors cannot simply "go generic" even once patents lapse elsewhere, and cannot legally import Indian or Chinese generics into markets where the patent, or an import restriction, still applies.



Key Stakeholders

Originator Pharmaceutical Manufacturers

Novo Nordisk (Denmark) and Eli Lilly (United States) hold the dominant patent portfolios and manufacturing capacity for the leading GLP-1 products. Both companies argue that high prices in wealthy markets fund the extensive R&D risk behind these medicines (including years of costly trials) and that patent protection is essential to sustaining future innovation. Both have also launched limited access and tiered-pricing programs in response to public pressure, while resisting calls for compulsory or broad voluntary licensing that they argue would undercut incentives for future drug development.

WHO and Multilateral Bodies

Beyond WHO itself, the World Trade Organization (WTO) administers the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement, which sets the international patent rules at the center of this debate, including flexibilities such as compulsory licensing that some countries have used for other essential medicines. The World Bank, Gavi, the Global Fund, and regional development banks are potential vehicles for pooled procurement or financing mechanisms, following models used for vaccines and HIV medicines. UNITAID and the Medicines Patent Pool (MPP), the same mechanism that helped expand generic access to HIV and hepatitis C treatments, are frequently cited as templates that could be adapted to GLP-1s.

Civil Society and Global Health NGOs

Organizations like MSF (Médecins Sans Frontières), the People's Vaccine Alliance-like access coalitions, and the International Diabetes Federation have emerged as strong proponents of licensing and pricing transparency and the need to consider access to GLP-1 drugs as a global issue similar to access to antiretroviral drugs for HIV infection in the early 2000s. They often refer to the Doha Declaration on TRIPS and Public Health as the precedent setting how to prioritize access during health emergencies. In turn, drug manufacturers and some high-income countries argue that while obesity and diabetes can be serious problems, they do not constitute an emergency.



TOPIC A: QUESTIONS TO CONSIDER

- What role, if any, should compulsory licensing or other TRIPS flexibilities play in expanding access to GLP-1 medicines, and under what conditions should the international community consider this justified?
- Should WHO or another multilateral body establish a dedicated mechanism (similar to the Medicines Patent Pool) for voluntary licensing of GLP-1 medicines, and how would participation be incentivized for originator manufacturers?
- How should the committee balance protecting pharmaceutical innovation incentives against the urgent, growing burden of diabetes and obesity in low- and middle-income countries?
- How should the international community respond to the growing danger of counterfeit and unregulated compounded GLP-1 products, without simply criminalizing patients seeking affordable alternatives?
- Should tiered or differential pricing be formalized as an international norm for essential medicines, and if so, who should determine which tier a given country falls into?
- How should the committee address the fact that patent timelines vary drastically by country, creating a fragmented, multi-speed global market for the same medicines?

This topic sits at the intersection of public health, trade law, and industrial policy, and there is no single "correct" solution. I encourage you to research your country's actual voting record and statements on related issues (such as the Doha Declaration, the COVID-19 TRIPS waiver debate, and prior WHO Essential Medicines List decisions) as a guide to a defensible, realistic position.

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