BRIEFING PAPER
The WHO Pandemic Treaty and IHR Amendments

1. HEADLINES

The World Health Organization (the **WHO**) is currently developing two international legal instruments intended to increase significantly its authority in managing public health emergencies, including pandemics:

(1) Amendments to the 2005 International Health Regulations (the **IHR Amendment**s); and

(2) A pandemic treaty, termed 'ÇA+' by the WHO (the **Treaty**).

The current draft of the IHR Amendments proposes significant new supra-national powers to be exercised exclusively by the WHO during public health emergencies, and broadens and brings forward in time the circumstances in which those powers could be triggered.

The draft Treaty is intended to support the bureaucracy, financing and governance that would be needed to underpin the expanded IHR and is thus predominantly (albeit not exclusively) practical in nature.

The IHR Amendments, if adopted, will fundamentally change the relationship between national governments and the WHO and would hardwire into international law a top-down supranational approach to public health — in particular as relating to public health emergencies of international concern — including pandemic preparedness and pandemic response policies. It would place the WHO at the helm of that approach, giving an unelected and democratically unaccountable organisation sweeping national- and international-level powers to control, direct and interfere in the affairs of its member States and to override fundamental rights of individual citizens.

Whereas to date the WHO has been empowered to issue recommendations, the proposed updates would empower the WHO to give legally-binding directions effective at the level of individual States, regions or globally, for example, to:

- mandate financial contributions to fund pandemic response activities
- require the surrender of intellectual property and technologies
- mandate the manufacture and international sharing of vaccines and other health products capable of "improv[ing] quality of life"
- override national safety approval processes for vaccines, gene-based therapies, medical devices and diagnostics
- require citizens to disclose their medical status

- forcibly quarantine or prevent citizens from travelling
- medically examine, inject or otherwise medicate citizens

These proposals, if adopted, will also greatly expand the WHO's public health surveillance mechanism with a global workforce whose continuing employment will depend on the need (actual or perceived) to identify more viruses and variants of concern. This global workforce will be subsidised by taxpayer funds but can also expect to receive substantial funding from private and corporate interests that stand to gain from the vaccine-based responses envisioned for infectious disease outbreaks.

The WHO's aim is to have both the Treaty text and the IHR Amendments ready for adoption at the 77th meeting of the World Health Assembly (the **WHA**) in May 2024[1].

2. PROCESS AND TIMING

Both draft instruments are currently passing through a standard WHO process of open and closed committee meetings and internal and external reviews, after submission of proposals by interested States.

The IHR is an existing legal instrument, so to pass these amendments the WHA, the decision-making body of the WHO, will only need a simple majority of member States. All existing signatories to the IHR (including the UK) will then have 10 months in which to opt out, or otherwise be considered to have accepted the amendments.[2]

The Treaty will be a new legal agreement. As a new treaty, adoption by the WHA requires a two-thirds majority of member States. Each State will then need to comply with its own national treaty ratification procedures.

Scholars have noted[3] that both processes appear rushed and that negotiating a new multilateral treaty in less than three years is highly unusual as is the fact that States were given only four months to table amendments to the IHR.

To date, such public commentary as there has been has been largely centred on the Treaty. However, and while the two complementary sets of proposals need to be assessed together, in many respects it is the IHR Amendments which contain the more concerning proposals from the perspective of national sovereignty and individual human rights.

To appreciate their significance, these two documents need to be assessed in the context of an evolving (and increasingly privatised) funding structure for the WHO, which according to WHO insiders is impacting the ethos and self-perceived purpose of that organisation. Also significantly relevant has been the corporatisation of public health, and in particular in the field of pandemic preparedness where public health officials can rapidly build reputations and careers and where many of the most significant financial opportunities lie for private investors.

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[1] https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75(9)-en.pdf

[2] This opt-out period was originally 18 months but was reduced to 6 months at a meeting of the WHA in 2022.

[3] https://opiniojuris.org/2023/02/27/the-proposed-amendments-to-the-international-health-regulations-an-analysis/

More on this context is included in the Annex at the end of this briefing paper.

3. THE PROPOSALS

3.1 A supra-national land grab

While positioned as a necessary next step for achieving global public health coordination and cooperation, and an equitable allocation of resources and expertise during health emergencies — ostensibly an agreeable response to health threats that know no borders — the proposed IHR Amendments would, if adopted, materially expand the WHO's health emergency and bio-surveillance powers, and in particular those granted to its director general (**DG**), whose appointment is determined by a non-democratic process among member States of the WHA (in practice heavily influenced by the preferences of the global superpower States).

Though not officially acknowledged, it is well noted by commentators and affirmed by WHO insiders that the nature of the appointment of the DG and of the senior officials who report to and support the DG, exposes those individuals to the soft power influence of influential States and public officials, and to the investor and corporate interests associated with and supported by those States.[4]

The Covid pandemic experience has clearly evidenced that pandemic preparedness and response is not only a dynamic and cutting edge area of public health where public health organisations and officials can earn distinction and advancement, and can have (or at least be perceived to have) rapid impact relative to traditional areas of global health focus such as the alleviation of malnutrition, the eradication of polio and malaria and the development of local health systems providing primary health care; but is also the area for which the market for pharmaceutical interventions (particularly vaccines) is likely to be the largest and most profitable.

It appears from the nature of the Treaty and the IHR Amendments that the WHO, encouraged and aided by interested States and major global corporations, is now seeking to cement itself as the exclusive global controller not just of the identification of pandemics or potential pandemics (see next paragraphs) but of the design and execution of pandemic responses, including pharmaceutical interventions. If unchecked, this could prove to be a public health land grab of remarkable proportions and at odds with the paradigms of personal autonomy and accountable sovereign government to which those of us living in the UK and other so-called liberal democracies have become accustomed.

3.2 Giving the WHO and its DG global binding health emergency powers

As a binding multilateral legal instrument, the International Health Regulations currently have force under international law. While they are, therefore, legally binding on WHO member States (and while many states have incorporated the IHR into their domestic laws), currently the recommendations that the WHO's DG (with the support of an emergency committee) issues once he has declared a public health emergency of international concern (**PHEIC**), are non-binding under international law.

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[4] See, e.g. Thomas Fazi, 'How the WHO was captured' and David Bell, Amendments to WHO's International Health Regulations.

This would change under the proposed amendments, which specifically state that member States will recognise the WHO as the guiding and coordinating authority of the international public health response during PHEICs[5], amend the definition of 'recommendations' from its current form of non-binding temporary recommendations to seemingly binding recommendations which WHO member States would "undertake to follow…in their international public health response".

Moreover, as explained more fully below, the IHR Amendments materially expand the scope of situations in which the WHO's DG could declare a PHEIC to have arisen.

The effect of these amendments would be to elevate the WHO above national ministries of health, and effectively to upgrade the status of the WHO from a public health advisory organisation to a supra-national public health executive. It gives the WHO, its executive committees and its DG rule-making powers which, with the exception of the UN Security Council acting under chapter VII of the UN Charter, no other UN organ or specialised UN agency possesses, let alone the individual DG of one of those specialised agencies.

Consistent with the surrender of national sovereignty implicit in this new arrangement, each member State will be required to appoint an 'authorised responsible authority' with which the WHO — an unelected international body requiring compliance by national governments with its rules; no longer 'suggesting' or 'supporting' — will be entitled to liaise to achieve national-level compliance and coordinated action[6].

3.3 Removing the requirement for an actual health emergency

Currently, the DG advised by an emergency committee has the power to declare a public health emergency of international concern – a decision with vast health, social and economic implications triggering numerous legal and practical consequences. Clearly, much hinges on the definition of a PHEIC, and who identifies it.

The IHR Amendments will remove the requirement for there to be a confirmed health emergency in which people are undergoing measurable harm or risk of harm, instead allowing those consequences to flow from the identification of the mere "potential" for a public health emergency. The amendments will also remove the requirement for the impacted state(s) to agree that an emergency has occurred, and although the DG would seek the views of an emergency committee before declaring a PHEIC the ultimate discretion in declaring such an event is the DG's alone.[7]

The combined effect of these handful of updates to the IHR would be to expand vastly the powers of the WHO to identify and declare a PHEIC[8] and to enable the DG in effect to bypass current WHO processes that ensure, on paper at least, a range of expertise to be sought and documented, and a range of evidence weighed for reliability, before triggering public health emergency powers.

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[5] IHR, new Art. 13A

[6] IHR, Art. 4

[7] IHR, Art. 12

[8] IHR,Art. 12

As discussed below, such broad rights to interfere and take control have huge potential not only for State-based rule-making and decision-making, but also for the integrity of human rights and norms that we regard as fundamental and inalienable. It allows the WHO and its DG to insert itself and give binding recommendations in relation to almost anything pertaining to societal life (health, in the WHO's definition, is construed broadly to include physical, mental and social well-being). There is no mechanism for oversight of WHO decision-making by an elected parliament or equivalent body, and no effectively-enforced legal jurisdiction with whose norms and standards the WHO must comply when exercising its broad discretionary powers.

3.4 Extending the scope of the WHO's emergency powers

Other proposals in the IHR Amendments seek to expand considerably the WHO's institutional capacities (during a PHEIC) and its bio-surveillance capacities (at all times); and relatedly, also the scope and content of the binding recommendations it would be able to issue to its member States during a PHEIC.

It is proposed that the WHO be given control over certain key national resources, including binding requirements for financial contributions from member States; and the surrender of intellectual property, know-how and technologies including diagnostics and other devices, PPE, vaccines[9] and the supply of health products — the definition of which would include include any commodity or process that may impact on a public health response or which would "improve quality of life" (it seems likely that these latter draconian IP-related provisions will not be agreed by States such as the US which take an aggressive line on IP protection).

Notably, the WHO would also be required to give binding directions to require member States with production facilities to scale up their production of specified health products to aid the WHO's response to PHEICs.[10]

3.5 Human rights becoming a relative concept

In its current form he IHR provide that:

"The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons".

This is consistent with the Universal Declaration on Human Rights, agreed by the UN in the aftermath of the Second World War, the provisions of which form a basis for modern international human rights law.

When addressing individual rights, however, the IHR Amendments would abandon the WHO's anchoring to the Universal Declaration of Human Rights, altering the above foundational provision to read "The implementation of these Regulations shall be based on on the principles of equity, inclusivity, coherence and in accordance with their common but differentiated responsibilities of the [member States], taking into consideration their social

[9] IHR, Art. 13(5)

[10] IHR, new Art. 13A

and economic development".[11]

This signals a fundamental shift in the human rights approach underpinning the WHO and to which all UN countries have signed up. It implies that the wealthy and the poor have different rights, and that there is a hierarchy of 'development' that defines one's rights.

Of great concern, the IHR Amendments then go on to propose that existing powers for the WHO to make recommendations concerning the executive response to a pandemic situation that could impact profoundly on individual rights should be upgraded from non-binding to binding recommendations. These include powers for the WHO to order border closures, travel restrictions, tracing of contacts, refusal of entry, implementation of exit screening, quarantining, medical examinations (including requirements for proof of vaccination) and even the forced medication of individuals.

Thus, if agreed, these amendments would at their broadest enable the WHO to order member States to require their citizens to disclose their medical status, to forcibly quarantine or prevent citizens from travelling, to medically examine them and even to inject or otherwise medicate them.[12] And the powers to do so could be triggered potentially by the determination of a single official (the DG) that a "potential" public health emergency had arisen following surveillance activities controlled by the WHO.

As jurists Silvia Behrendt and Amrei Müller[13] note, "there is a general lack of engagement with the implications that many of the proposed amendments may, if adopted, have on the enjoyment of human rights."[14]

3.6 Surveillance capabilities greatly expanded

The Treaty and the IHR Amendments, as proposed, would establish a huge surveillance infrastructure and bureaucratic mechanism requiring member States to look for emerging, re-emerging or new pathogens that could potentially have pandemic/PHEIC potential and to respond in accordance with the WHO's directions. Together they aim to reinforce existing duties and create new duties for WHO member States to build bio-medical surveillance capacities to detect, assess, notify and report events that could constitute a PHEIC, and require so-called "developed" member States to offer assistance in this regard to "developing" member States.

As is discussed more fully in the Annex at the end of this briefing paper, much of the funding for this surveillance network will originate from private and corporate interests that stand to gain financially from the mass testing and vaccine-based responses envisioned for (real or potential) infectious disease outbreaks.

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[11] IHR, Art. 3

[12] IHR, Art. 19 and Art. 13A.

[13]http://opiniojuris.org/2023/02/27/the-proposed-amendments-to-the-international-health-regulations-an-analysis/#:~:text=Amendments%20to%20the%20International%20Health%20Regulations%20(2005)%20(IHR),(AbAC)%20in%20November%202022.

[14] https://opiniojuris.org/2023/02/27/the-proposed-amendments-to-the-international-health-regulations-an-analysis/

As Bell notes, "even a DG uninterested in wielding such power will face the reality that they put themselves at risk of being the one who did not 'try to 'stop' the next pandemic, pressured by corporate interests with hundreds of billions of dollars at stake, and huge media sway. As well as questions of national sovereignty in health this raises questions of rational and appropriate use of resources. WHO is not assessing the country's health needs here, it is assessing one small aspect and dictating the resources spent on it, irrespective of other health burdens."

3.7 Mandatory provision and sharing of resources by WHO member States

After self-declaring an emergency, the IHR Amendments propose that the DG of the WHO would have powers to instruct member State governments to provide WHO and other countries with "resources" – both funds and health and other commodities. As already noted above, this could include the WHO giving directions for intervention in manufacturing processes to increase the production of specified health commodities.

In provisions which seem unlikely to survive scrutiny by States which are typically conservative on IP protection (such as the US) the amendments suggest that States could be required to cede power to the WHO over patent law and intellectual property, including control of manufacturing know-how, of commodities deemed by the DG to be relevant to the potential or actual health problem that is deemed of interest. This IP and manufacturing know-how may be then passed to other States or to private interests (i.e. commercial rivals) at the DG's discretion. Though it may not survive the negotiation process, this would be a highly controversial intrusion into international commerce.

3.8 Mandatory data sharing

Under significantly broadened data sharing provisions, WHO member States would be required to make information available to the WHO at the WHO's request, and to permit the WHO to make this available not only to other member States and relevant intergovernmental organisations, but to relevant international and regional organisations.[15] This includes organisations with private and corporate representation on their boards including those with direct financial conflicts of interest such as CEPI, Gavi and Unitaid.[16]

Presently, in sharing data at all, the WHO is required to take into account the views of the member State concerned. However, under the IHR Amendments the new duty to share data is mandatory — "the WHO shall, when justified by the magnitude of the public health risk, immediately share with other states the information available to it" - and is no longer subject to the requirement to consider the views of the impacted member State.[17]

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[15] IHR, Art. 11

[16] For an overview of the relationship between these institutions, the Bill and Melinda Gates Foundation and the WHO, see 'The Covid Consensus', Toby Green and Thomas Fazi, p. 155-6.

[17] IHR, Art. 10

3.9 Censorship

The proposals would hardwire into law the promotion of censorship activities by the WHO[18] by requiring it to build institutional capacity to globally coordinate infodemic management and to prevent the spread of misinformation and disinformation.

While in practice the WHO does this already through its so-called 'Infodemic unit', through which it enlightens states about what, in its opinion, amounts to health 'mis- or disinformation' concerning PHEICs, tracking social media posts in real time in 30 countries and 9 different languages, the proposals would place this activity — currently undertaken on a voluntary basis — onto a mandatory footing. Quite aside from free speech concerns, this radical change in approach raises pressing questions about the wisdom of ordaining the WHO as the single source of pandemic truth especially given that in the early days of the pandemic the WHO itself was already spreading what can only be described as misinformation – such as the WHO's claim that Covid was zoonotic in origin or the erroneous discounting of post-infection immunity as a source of effective protection.[19]

3.10 Medical safety

Following a declaration of a PHEIC the IHR amendments would require the WHO to develop appropriate regulatory guidelines for the rapid approval of health products (including vaccines, gene-based therapies, medical devices and diagnostics). While it is easy to understand the underlying assumption here – that in a public health emergency the accelerated manufacture and support of these technologies, alongside expedited regulatory approval, is a good thing – the issue of course is that this (real or alleged) emergency is declared unilaterally by the DG based on an incredibly broad definition of an emergency. As scholars point out, there is significant potential for this to threaten "long fought-for standards of medical law aiming to ensure safety and efficacy of medical products".[20]

For example, the proposals will, if adopted, likely result in the extension and legal entrenchment of the WHO's 'Emergency Use Listing Procedure' through which unlicensed, investigational medical products are 'emergency listed'; in other words, de facto 'emergency approved' for global production and administration once the DG has declared a PHEIC.

3.11 International travel conditional on medical status

New provisions included in the IHR Amendments would also expand the requirements for vaccination and test certificates for travel, and would make routine the operation of a global "interoperable system" for digital health certificates for verification of vaccine status

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[18] IHR, Annex 1, Part A, para 7.

[19] The lack of scientific basis for this claim, which was subsequently rebutted by the WHO itself, is discussed further in The Covid Consensus, Green and Fazi, p. 74.

[20] https://opiniojuris.org/2023/02/27/the-proposed-amendments-to-the-international-health-regulations-an-analysis/

or test results, which will likely become a pre-condition for any cross-border travelling during a PHEIC, or potentially even outside PHEICs (that is, at all times).[21]

In so laying the groundwork for routine international vaccine passport checks as a precondition for travel, we would be taken further away from the basic right to leave and return to a country enshrined in the Universal Declaration of Human Rights.

3.12 The proposed amendments to the ÇA Treaty

Broadly, the draft ÇA+ treaty outlines the infrastructure, logistics and funding mechanisms required to implement the changes prescribed by the IHR Amendments.

It would establish an international supply and logistics network overseen by the WHO[22] — to be sustained during inter-pandemic times, and scaled up during any pandemic; it reinforces the duty of WHO member States to relinquish IP rights during public health emergencies;[23] and bolsters requirements discussed above to accelerate and potentially reduce regulatory oversight in relation to the approval and licensing of pandemic-related products for emergency use.[24]

Critically, in what appears to be another deep interference with member States' right to determine independently the priorities of their own health policies, the amended Treaty would also require each WHO member State to commit a minimum of 5% of its national health budget and an as yet unspecified percentage of GDP towards pandemic prevention and response.

A 'Governing Body' is to be set up under WHO auspices, to oversee the implementation of the Treaty.[25]

4. CONCLUSION

While international cooperation and coordination is undoubtedly sensible in public health, it is not alarmist to acknowledge the significance of the surrender of sovereignty and individual rights and freedoms (to the WHO and its key proponents) that would be effected by these proposals, nor to feel concerned by the absence of public knowledge or debate of these proposals, certainly in the UK, and not least given the known significance for UK voters of issues of national legal sovereignty and individual rights and freedoms in the context of the UK's recent referendum and general election.

As Thomas Fazi recently noted:

"It would be concerning even if the organisation had maintained its original funding model, institutional structure and underlying philosophy. But it's particularly concerning if we

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[21] See proposed changes to IHR, Art. 23.

[22] Treaty, Art. 6

[23] Treaty, Art. 7

[24] Treaty, Art. 8.

[25] Treaty, Art. 20.

consider that the WHO has fallen largely under the control of private capital and other vested interests. It would mark the definitive transformation of global health into an authoritarian, corporate-driven, techno-centric affair — and risk making the Covid response a blueprint for the future rather than a disaster which should never be repeated."[26]

As well as the debatable wisdom of hardwiring into international law many of the aggressive and disputed features of the Covid pandemic response — features which many commentators have argued, through disruptions to health systems, education and increased poverty, will cause far higher mortality, at a far younger age, than would have been expected from Covid-19 itself — there is a question as to whether this supra-nationalisation of health policies with the WHO at its core could ever be consistent with fundamental principles of national sovereignty and the democratic, community-based approach to public health originally championed by the WHO.

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[26] https://unherd.com/2023/03/how-the-who-was-captured/ Thomas Fazi is a leading commentator on the international pandemic response and co-author with KCL History Professor, Toby Green, of The Covid Consensus, The Global Assault on Democracy and the Poor – A Critique From the Left, C. Hurst & Co, Jan 2023

ANNEX: THE CONTEXTUAL CIRCUMSTANCES OF THE WHO AND ITS ACTIVITIES[27]

Foundations of the WHO

The WHO was created, after World War II, as the health arm of the United Nations with the aim of promoting "the enjoyment of the highest attainable standard of health" across the globe with health being understood, crucially, as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

As a reaction to the brutality of 20th-century totalitarian and colonial regimes — both of which had involved horrendous cases of medical abuse — the WHO was firmly grounded in human rights principles and emphasised the importance of community participation and 'horizontal' approaches to healthcare - improved living conditions, nutrition and sanitation. In line with other founding documents of the UN and the UN Declaration of HRs, its constitution was premised on the concept that all people were equal and born with basic inviolable rights.

WHO funding structure

Until the 1980s, the organisation had relied on the contributions of its member states for its regular budget. However, in recent decades the emphasis of the WHO changed, associated with underlying changes in funding: its support base of core funding allocated by countries, based on GDP, evolved to a model where most funding is provided by private and corporate interests, including pharmaceutical giants, and as such is directed to specified uses.

The priorities of the WHO have evolved accordingly, moving away from community-centered care to a more vertical, commodity-based approach which — because the donors are able to direct the use of the funds they contribute — inevitably follows the interests and self-interests of these funders. As Bell explains, "This is reflected in an apparent move from priorities based on disease burden to priorities based on commodities, particularly vaccines, that generate profit for its private and corporate sponsors."

Indeed, over 80% of the WHO's budget is now 'specified' funding by way of voluntary contributions typically earmarked for specific projects or diseases in a way that the funder specifies.[28] Over the years, among the private extra-budgetary donors to the WHO, the Bill & Melinda Gates Foundation has risen above the rest: by the 2010s, it had become the WHO's second-largest donor, accounting for around 10% of all funds.

It is no secret[29] that Gates exerts a huge influence over the organisation, nor is the fact that Gates has aimed to make vaccination a major focus of WHO policy. In 2011, Gates spoke at the WHO, and declared: "All 193 member states [must] make vaccines a central focus of their health systems". The following year, the World Health Assembly adopted a "Global

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[27] This section draws heavily on 'The Covid Consensus', Toby Green and Thomas Fazi (Hurst, 2023), and articles written by Thomas Fazi and published in Unherd, "How the WHO was captured", and David Bell, a public health physician and former WHO staffer specialising in epidemic policy.

[28] https://www.euronews.com/next/2023/02/03/how-is-the-world-health-organization-funded-and-why-does-it-rely-so-much-on-bill-gates

[29] https://www.swissinfo.ch/eng/politics/does-bill-gates-have-too-much-influence-in-the-who-/46570526

Vaccine Plan" that the Gates Foundation co-authored, and it has been suggested that over half of the WHO's total budget is now devoted to vaccines.[30]

It is also no secret that the Gates Foundation has significant ties to the pharmaceutical industry, and since its creation it has owned material stakes in several pharmaceutical companies. The foundation's website candidly declares a mission to pursue "mutually beneficial opportunities" with vaccine manufacturers.

In parallel, other 'public-private partnerships' have arisen, including Gavi, the vaccine alliance, and CEPI (dedicated solely to pandemics). These organisations include private interests on their governing boards, and promote a narrow, vaccine-driven response, to matters of public health which one must assume also reflect the business priorities of private sponsors.

Whether or not such a preoccupation with vaccines to the exclusion of other health initiatives is a positive approach is a matter of debate[31], but it is a statement of fact that private organisations are in a position to influence the WHO through direct funding and through funding within WHO member States. Indeed, in 2012 the WHO's then DG, Margaret Chan, complained that because the WHO's budget is highly earmarked, it is "driven by what [she calls] donor interests".[32]

These concerns have been re-articulated by Linsey McGoey, professor of sociology at the University of Essex, who notes: "According to its charter, the WHO is meant to be accountable to member governments. The Gates Foundation, on the other hand, is accountable to no one other than its board of trustees. Many civil society organisations fear the WHO's independence is compromised when a significant portion of its budget comes from a private philanthropic organisation with the power to stipulate exactly where and how the UN institution spends its money."[33]

The escalation of pandemic threats

Although the WHO has acknowledged that pandemics have historically occurred just once per generation over the past century and killed a fraction of those who died from endemic infectious diseases, pandemics seem nonetheless to attract much of the corporate and financial interest discussed above.[34]

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[30] 'The Covid Consensus', Green and Fazi, page 157

[31] Commentators argue that this new central focus on vaccines has diverted the WHO away from 'poverty alleviation, nutrition and clean water'.

[32] https://thegrayzone.com/2020/07/08/bill-gates-global-health-policy/

[33] Linsey McGoey, No Such Thing as a Free Gift: The Gates Foundation and the Price of Philanthropy (London/ New York: Verso, 2016)

[34]In the years leading up to the pandemic, Gates' activities had been focused on the topic of pandemic preparedness in particular. Speaking at an event hosted by Massachusetts Medical Society and the New England Journal of Medicine (NEJM) on April 27, 2018, Gates said he believed "the world needs to prepare for pandemics in the same serious way it prepares for war."

"This preparation includes staging simulations, war games and preparedness exercises so that we can better understand how diseases will spread and how to deal with responses such as quarantine and communications to minimize panic." https://www.cnbc.com/2020/01/27/bill-gates-in-2018-world-needs-to-prepare-for-pandemics-just-like-war.html

In reality, as David Bell writes,[35] "the WHO lists just 3 pandemics in the past century, prior to Covid-19; the influenza outbreaks of 1957-58 and 1968-69, and the 2009 Swine flu outbreak. The formers killed 1.1 million and 1 million people respectively, while the latter killed 150,000 or less. For context, 290,000 to 650,000 people die of influenza every year, and 1.6 million people die of tuberculosis (at a much younger average age). In Western countries, Covid-19 was associated with deaths at an average age of about 80 years, and global estimates suggest an overall infection mortality rate of about 0.15 percent, which is similar to that for influenza (0.3-0.4% with Covid in older Western populations). Thus, pandemics in the past century have killed far fewer people and at an older age than most other major infectious diseases."

Set against this, however, the Treaty and IHR Amendments would together create an international bureaucracy with vast funding — envisioned at up to $31 billion per year, including $10 billion in new funding.[36] For context, the entire current WHO annual budget is about $3.6 billion. This same bureaucracy will surveil for new and variant viruses, identify them, determine their 'threat' and then mandate a pharmaceutical response.

[35] https://brownstone.org/articles/what-the-who-is-actually-proposing/

[36]https://thedocs.worldbank.org/en/doc/018ab1c6b6d8305933661168af757737-0290032022/original/PPR-FIF-WB-White-Paper.pdf