Doing Good by Hammering the Poor

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“Doing good” on a global scale has never been so popular, and never more profitable. The public-private partnerships that now dominate the global public health industry have generously overperformed since early 2020, enriching private and corporate donors alike.

The World Health Organization’s (WHO) ongoing pandemic treaty negotiations hold promise to lock in this edifying upwards shift of wealth, enabling a repetitive regime of lockdowns, border closures and coerced vaccination to continue the impoverishment and subjugation of those less fortunate.

This new paradigm is made possible because those who work for the WHO, international agencies and private foundations, who formerly advocated for the betterment of the world’s disadvantaged billions, no longer do. Core principles of public health policy – community empowerment, equality, and poverty reduction – have been exchanged for public health-for-profit. No heroic fight or defense, just complicity and rapidly expanding career opportunities.

Impoverishment is more profitable than empowerment

The past two years have been particularly demoralizing for anyone still adhering to the principles of the WHO constitution and the human rights conventions that aimed to prevent the return of public health fascism after World War II.

The displacement of the Alma Ata model of *community empowerment* by a new model of commodity-based health *delivery* required the compliance and active collaboration of the 'global health community' – those staff and consultants of the WHO and other international health agencies, foundations and non-government organizations who were once assumed to stand against colonialism and exploitation.

These same people had reaffirmed the principles of community control in Astana as recently as 2018. Some helped publish the 2019 WHO guidelines for pandemic influenza that rejected lockdowns and border closures due to their discriminatory nature in harming lower-income people. Quite a volte-face to now agree to a near-uniform regime of coercion, mandated poverty and vertical control. Welcome to the new era of stunningly profitable, rhetoric-heavy global health colonialism.

Global health gets hijacked

International public health, or 'global health' as wealthy Westerners rebranded it, grew over the past two decades to become a celebrity cause. Increasing flows of public money, through the Global Fund in particular, rejuvenated struggling endemic disease programs of low-income countries. But the promise of rising private and corporate finance brought with it a centralized approach that emphasized the commodities those corporations and private interests were invested in, particularly vaccines.

The Bill & Melinda Gates Foundation sponsored the Gavi organization exclusively for delivery of vaccines. Unitaid was formed to focus on building markets for commodities, and Cepi was launched at Davos in 2017 solely to promote vaccines and biologicals for pandemics.

A traditional abhorrence of conflict of interest was overcome by this allure of new money. The Gates's in particular, a couple who made their money from software development, now had direct influence at a board level over major health organizations determining health policy and funding for billions of people. This seems extraordinary, but to prevent it, staff of these organizations would have to oppose the sponsors of their own salaries, their pension funds and children's education, and accept reduced operational budgets. They didn't.

Corporate CEOs and investors became the new public health gurus, funding 'global health' colleges that turned out disciples to work in the organizations they sponsor, responding to modeling and pharma development their sponsors have funded and/or directed. This moral decay of global public health was laid bare through the Covid-19 response.

A virus overwhelmingly targeting the elderly became a reason to block the education and socialization of hundreds of millions of children, and promote mass malnutrition, while a vaccine (not immunity) was 'awaited.' It was considered sufficient reason to break supply lines, healthcare access and employment for low-income populations, reversing decades of progress on poverty reduction, child marriage, women's rights and infectious diseases such as HIV/AIDS and malaria.

This willingness to promote 'stay home, submit, comply' medical fascism seems almost ubiquitous in the Global Health Community, at least for those residing in wealthier countries. Even the World Bank recognizes it is killing vulnerable people far faster than Covid-19. To halt and fix this mess, we need to understand why these people comply.

What we all know (knew)

Public health had previously embraced certain principles and well-evidenced knowledge. Health was defined broadly in the 1946 WHO constitution as *"…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*' Recognizing this complexity, good public health practice therefore requires any recommended intervention to take into account risk and benefit across these various categories of health.

The 'public,' as free beings, are then supposed to weigh these recommendations against competing priorities and values, including cultural and religious beliefs and customs, to make decisions without force or coercion. These requirements are not radical; they form the basis of more than 75 years of public health practice, anchored in human rights conventions and the principles of informed consent.

Fundamental areas of evidence inform these public health recommendations. Of particular relevance:

1. Reducing social capital (increasing poverty and reducing personal autonomy) reduces average life expectancy independent of other risk factors.
2. Economic decline on a national scale reduces life expectancy, particularly in low-income countries where poverty has a large impact on infant mortality. The converse is true: improving education and economic well-being improves life expectancy.
3. Most historic improvement in life expectancy in high-income countries, including specifically in vaccine-preventable diseases, occurred before mass vaccination (excluding smallpox), associated with better living standards including diet, clean water and housing, with antibiotics playing a later but important role.

These realities are standard teaching in public health schools. The staff of global health organizations knew how lockdowns and border closures would play out. For many populations, this is and will be dead children, dead babies – far more, far younger, than Covid-19 will kill.

The age-association of Covid-19 was clear in early 2020. The age-structure of populations in Asia and Africa is young – half the population of sub-Saharan Africa are under 19 years – predicted to die from Covid-19 at a similar or lower rate than influenza.

So why hammer the poor?

The WHO itself had warned of the harms of lockdown-style approaches in its 2019 pandemic influenza guidelines. The 'global health community' espoused these core principles when they were 'normative' and consistent with career advancement.

Now, many have even joined the vilification of the few who continued to proclaim them. The Great Barrington Declaration was orthodox public health. Advocacy for human rights and personal autonomy was not previously a fringe movement.

This raises questions that get to the root of the crisis of truth and morality in global health:

- Why did people, who in 2019 would debate fine points of costs and benefits in order to allocate resources for maximal impact, abandon these practices so readily?
- Why are they now comfortable supporting programs that employ coercion and blatant disregard for human rights?
- Why are they supporting actions that they know, from training and experience, will increase preventable disease, reduce life expectancy, and lock generations into poverty?

In essence, how did thousands of people in a 'humanitarian' industry agree to participate in what they know, or previously knew, was wrong and harmful on a massive scale?

Was humanitarianism always an empty shell?

All of us are flawed human beings, subject to similar faults, and drives. So no less those who get paid to redistribute aid money. Here are six plausible explanations:

1. Job security is a stronger driver than ethics. Organizations such as the WHO and BMGF pay well, and health, education and pension benefits are difficult to abandon. Business class seats and 5-star hotels are a seductive work environment. Standing against your employer, when you stand to lose all, does not bring obvious personal rewards.
2. Propaganda and mass psychosis don't recognize vocations. Fear and panic are universal attributes. Propaganda can impact people irrespective of intelligence, education and training. An irrational fear of a virus can cloud rational thought.
3. Claims of support for human agency and equality were merely expedient for career prospects pre-2020. Historically, health personnel have been widely accepting of mass abuse, while the eugenics movement gained wide consensus in the medical community. There is no good historical precedent for the health professions following higher ethical standards than the general population.

4. Many people are simply weak-willed. They may recognize harm but lack the courage to stand against it. Peer pressure and fear of being ostracized are powerful drivers. It is easier to wait for others to speak first, or for a protest movement to grow large enough to be safe.
5. In hierarchical organizations, people just follow orders. If they did not, someone else would. This was dealt with in the late 1940s and is essentially just cowardice.
6. There can be a genuine excitement in finally 'managing' a pandemic. We are all prone to seek and prolong moments of self-importance. Being enabled to pretend one is saving the world trumps another routine day in the office.

However, two years into the Covid-19 event, there are no excuses left for perpetuating these harms, no possibility of denying their existence. It is past time that the staff, and staff associations, of international organizations found the spine to stand for the populations they claimed to serve, and demand that their organizations adhere to basic public health principles.

Time for those in the WHO to demand compliance with the WHO constitution. Time to insist that health equity is the guiding principle rather than equitable distribution of a commodity that can now do little but enrich their sponsors. Not because profit is evil, but because letting people die in the name of profit is.

What future for Global Health?

In the long term, the major international public health institutions, post-Covid, will be devoid of credibility to anyone serious about improving global health. Any pretense of standing for the world's poor and disadvantaged is surely over. Private foundations in Western countries never had such a mandate and should never have been able to accrue such influence.

The world needs a non-colonialist approach. Countries and communities must determine their own health priorities, own their own disease responses. There is a place for agencies to promote dialogue between countries, collate data and support those that are poorly resourced. The WHO, for example, once did this. But this must be divorced from the profiteers who throughout history have gathered like pigs at such a trough.

The constitution of the WHO, drawn up in the era of decolonization, failed to stop its recurrence. A new model for international health institutions is needed to ensure that ultimate decision-making in health lies with populations. The global public health community can choose to continue to be part of the crime, or support those within low-income countries who must be its remedy.

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