Four Myths about Pandemic Preparedness

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We are assured by the World Health Organization (WHO), the World Bank, the G20, and their friends that pandemics pose an existential threat to our survival and well-being. Pandemics are becoming more common, and if we don't move urgently we will have ourselves to blame for more mass death of the 'next pandemic.'

The proof of this is the catastrophic harm done to the world by COVID-19, a repeat of which can only be prevented by transferring unprecedented funds and decision-making power to the care of public health institutions and their corporate partners. They have the resources, experience, knowledge and technical know-how to keep us safe.

This is a no-brainer, all of it, and only a fool who desires mass death would oppose it. But there are still people who claim that the link between the public health establishment and large corporations appears to be the only part of this narrative that withstands scrutiny.

If true, this would imply that we are being systematically deceived by our leaders, the health establishment, and most of our media; a ludicrous allegation in a free and democratic society. Only a fascist or otherwise totalitarian regime could run such a broad and inclusive deception, and only people with truly bad intent could nurture it.

So let's hope such 'appearances' are deceptive. To believe that the premise behind our leaders' Pandemic Preparedness and Response agenda is knowingly based on a set of complete fabrications would be a conspiracy theory too far. It would be too uncomfortable to accept that we are being deliberately misled by people we elected and the health establishment we trust; that the assurances of inclusivity, equity and tolerance are mere facades hiding fascists. We should examine the key claims supporting the pandemic agenda carefully and hope to find them credible.

Myth #1: Pandemics are becoming more common

In its 2019 pandemic influenza guidelines, the WHO listed 3 pandemics in the century between the 1918-20 Spanish flu and COVID-19. The Spanish flu killed mainly through secondary bacterial infections at a time before modern antibiotics. Today we would expect most of these people, many relatively young and fit, to survive.

The WHO subsequently recorded pandemic flu outbreaks in 1957-58 ('Asian flu') and 1968-69 ('Hong Kong flu'). The Swine flu outbreak that occurred in 2009 was classed by WHO as a 'pandemic' but caused just 125,000 to 250,000 deaths. This is far less than a normal flu year and so hardly deserving of the pandemic label. Then we had COVID-19. That's it for a whole century; one outbreak the WHO classifies as a pandemic per generation. Rare, or at least highly unusual, events.

Myth #2: Pandemics are a major cause of death

The Black Death, the Bubonic Plague that swept Europe in the 1300s, killed perhaps a third of the entire population. Repeat outbreaks over the following centuries caused similar harm, as had plagues known from Greek and Roman times. Even the Spanish flu did not compare with these. Life changed prior to antibiotics – including nutrition, accommodation, ventilation and sanitation – and these mass-mortality events subsided.

Since the Spanish flu we have developed an array of antibiotics that remain extremely effective against community-acquired pneumonia. Fit young people still die from influenza through secondary bacterial infection, but this is rare.

The WHO tells us there were 1.1 million deaths from the 1957-58 'Asian flu,' and a million from the 1968-69 Hong Kong flu. In context, seasonal influenza kills between 250,000 and 650,000 people every year. As the global population was 3 to 3.5 billion when these two

pandemics occurred, they classify as bad flu years killing about 1 in 700 mostly elderly people, with little influence on total deaths. They were treated as such, with the Woodstock Festival proceeding without super-spreader panic (regarding the virus, at least…).

COVID-19 has a higher associated mortality, but at an old average age equivalent to that of all-cause mortality, and is nearly always associated with comorbidities. Much mortality also occurred in the presence of the withdrawal of normal supportive care such as close nursing and physiotherapy, and intubation practices may have played a role.

Of the 6.5 million that the WHO records as dying from COVID-19, we don't know how many would have died anyway from cancer, heart disease or the complications of diabetes mellitus and just happening to have a positive SARS-CoV-2 PCR result. We don't know because most authorities decided not to check, but recorded such deaths as being due to COVID-19. The WHO records about 15 million excess deaths throughout the COVID-19 pandemic, but this includes lockdown deaths (malnutrition, rising infectious disease, neonatal death etc).

If we take the 6.5 million toll as likely, we can understand its context by comparing it with tuberculosis, a globally endemic respiratory disease that few worry about in their day-to-day lives. Tuberculosis kills about 1.5 million people every year, which is almost half the annual COVID-19 toll in 2020 and 2021. Tuberculosis kills far younger on average than COVID, removing more potential life-years with each death.

So based on normal metrics for disease burden, we could say they are roughly equivalent – COVID-19 has had an impact on life expectancy overall fairly similar to TB – worse in older populations in Western countries, far less in low-income countries. Even in the US COVID-19 was associated with less (and older) deaths in 2020-21 than normally occur from cancer and cardiovascular disease.

COVID-19 has not therefore been an existential threat to the life of many people. The infection mortality rate globally is probably around 0.15%, higher in the elderly, much lower in healthy young adults and children. It is not unreasonable to think that if standard medical knowledge had been followed, such as physiotherapy and mobility for frail elderly people and micronutrient supplementation for those at risk, the mortality rate may have been even lower.

Whatever one's views on COVID-19 death definitions and management, it is unavoidable that death is rare in healthy younger people. Over the past century all pandemic deaths have been very low. Averaging less than 100,000 people per year inclusive of COVID-19, they are a small fraction of that caused by seasonal flu.

Myth #3: Diversion of resource to pandemic preparedness makes public health sense

The G20 has just agreed with the World Bank to allocate $10.5 billion annually to its pandemic prevention and response Financial Intermediary Fund (FIF). There is, in their view, about $50 billion needed in total per year. This is the annual, holding budget for pandemic preparedness. As an example of their preferred response when an outbreak occurs, Yale University modelers estimate that to vaccinate people in low and middle income countries with just 2 doses of COVID-19 vaccine would cost about $35 billion. Adding one booster would total $61 billion. Over $7 billion has thus far been committed to COVAX, the WHO's Covid vaccine financing facility, vaccinating most who are already immune to the virus.

To put these sums in context, the annual budget of the WHO is normally below $4 billion. The entire world spends about $3 billion annually on malaria – a disease that kills well over half a million young children each year. The largest financing facility for tuberculosis, HIV/AIDS and malaria, the Global Fund, spends less than $4 billion per year on these three diseases combined. Other and larger preventable killers of children, – such as pneumonia and diarrhea, receive still less attention.

Malaria, HIV, tuberculosis and diseases of malnutrition are all increasing, while economies globally – the main long-term determinant of life expectancy in lower-income countries – decline. Taxpayers are being asked, by institutions that themselves will benefit, to spend vast resources on this problem rather than on diseases that kill more and younger people. The people pushing this agenda do not appear to be dedicated to reducing annual mortality or improving overall health. Alternatively, they either cannot manage data or have a window on the future that they are keeping to themselves.

Myth #4: COVID-19 caused massive harm to health and the global economy

The age-skewing of COVID mortality has been unmistakable since early 2020, when data from China demonstrated almost no mortality in healthy young to middle-aged adults and children. This has not changed. Those contributing to economic activity, working in factories, farms and transport, were never at great risk.

The economic and personal harm arising from the restrictions on these people, unemployment, destruction of small businesses and supply-line disruption, was a choice made against orthodox policy of the WHO and public health in general. The prolonged school closures, locking in generational poverty and inequality on both a sub-national and international level, was a choice to perhaps buy months for the elderly.

The 2019 WHO pandemic guidelines advised against lockdowns due to the inevitability that they would increase poverty, and poverty drives illness and reduces life expectancy. The WHO noted this disproportionately harms poorer people. This is not complicated – even those at the center of the lockdown and future digital ID agenda such as the Bank of International Settlements (BIS) acknowledge this reality. If the aim of poverty-promoting measures had been to reduce elderly death, the evidence for success is poor.

There seems little reasonable doubt that growing malnutrition and long-term poverty, rising endemic infectious disease, and the impacts of education loss, increased child marriage and increased inequality will far outweigh any possible mortality reduction achieved. UNICEF's estimation of a quarter-million child deaths from lockdowns in South Asia in 2020 provides a window into the enormity of the harm lockdowns wrought. It was the novel public health response that caused the massive harm associated with this historically mild pandemic, not the virus.

Facing truth

It seems unavoidable that those advocating for the current pandemic and preparedness agenda are intentionally misleading the public in order to achieve their aims. This explains why, in the background documents of the WHO, the World Bank, G20 and others, detailed cost-benefit analyses are avoided. The same absence of this basic requirement characterized the introduction of Covid lockdowns.

Cost-benefit analyses are essential for any large-scale intervention, and their absence reflects either incompetence or malfeasance. Prior to 2019, the resource diversion being contemplated for pandemic preparedness would have been unthinkable without such analysis. We can therefore reasonably assume that their continued absence is based on fear or certainty that their outcomes would scupper the program.

A lot of people who should know better are going along with this deceit. Their motives can be surmised elsewhere. Many may feel they need a good salary, and the resultant dead and impoverished will be far enough away to be considered abstract. The media, owned by the same investment houses who own the Pharma and software companies sponsoring public health, are mostly silent. It is hardly a conspiracy to believe that investment houses such as BlackRock and Vanguard work to maximize return for their investors, using their various assets to do so.

A few decades of our elected leaders trooping off for closed-door sessions at Davos, together with a steady concentration of wealth with the individuals they were meeting, could not really have landed us anywhere else.

We knew this 20 years ago, when the media still warned of the harm that increasing inequality would bring. When individuals and corporations richer than medium-sized countries control major international health organizations such as Gavi and CEPI, the real question is why so many people struggle to acknowledge that conflicts of interest define international health policy.

The subversion of health for profit runs contrary to the entire ethos of the post-World War Two anti-fascist, anti-colonialist movement. When people across politics can acknowledge this reality, they can put aside the false divisions that this corruption has sown.

We are being deceived for a reason. Whatever that is, going along with a deception is a poor choice. Denial of truth never leads to a good place. When public health policy is based on a demonstrably false narrative, it is the role of public health workers, and the public, to oppose it.

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