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Pandemic preparedness and the road to international fascism

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Abstract

The World Health Organization's broad definition of health embraces physical, mental and social well-being. Expressed in its 1946 constitution alongside concepts of community participation and national sovereignty, it reflected an understanding of a world emerging from centuries of colonialist oppression and the public health industry's shameful facilitation of fascism. Health policy would be people-centered, closely tied to human rights and self-determination. The COVID-19 response has demonstrated how these ideals have been undone. Decades of increasing funding within public-private partnerships have corroded the basis of global public health. The COVID-19 response, intended for a virus that overwhelmingly targeted the elderly, ignored norms of epidemic management and human rights to institute a regime of suppression, censorship, and coercion reminiscent of the power systems and governance that were previously condemned. Without pausing to examine the costs, the public health industry is developing international instruments and processes that will entrench these destructive practices in international law. Public health, presented as a series of health emergencies, is being used once again to facilitate a fascist approach to societal management. The beneficiaries will be the corporations and investors whom the COVID-19 response served well. Human rights and individual freedom, as under previous fascist regimes, will

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lose. The public health industry must urgently awaken to the changing world in which it works, if it is to adopt a role in saving public health rather than contributing to its degradation.

INTRODUCTION

The era of European imperialism was justified through claims of altruism, with mega-corporations managing the pillaging of colonies and dispersing responsibility from governments (Kipling, 1899; Roos, 2020). The incomes and career paths of an army of bureaucrat adventurers served the East India Companies that formed quasi-government entities, allowing individuals to shift responsibility to a faceless business imperative (Roos, 2020; Salomons, 2021).

After centuries of colonial invasion and control, the Second World War's aftermath precipitated several decades of emphasis on human rights, national independence, and open exchange of information. Although democratic institutions in the post-war period were not universal and were frequently flawed, there was at least a common understanding that values reflecting individual freedom were "right". The Universal Declaration of Human Rights (United Nations, 1948) and the Nuremberg Code (1947) articulated those values. The United Nations, World Health Organization (WHO) and sister organizations growing out of this worldview formed under a general understanding that each country should be independent, each person equal, and that human agency or autonomy was fundamental to a good society (WHO, 1946; WMA, 2014).

In parallel to this human rights emphasis, the growth of capitalism and technology in the West drove an increasing inequality of wealth and so inevitably of power (Stone et al., 2020). Those living through the 1980s and 1990s would recall discussion on how this could undermine society and should be addressed. But fears of future political tyranny or social conformity, as in Orwell's (1949) *1984* or Huxley's (1932) *Brave New World*, are abstract. In our daily lives, we move within timescales that fit poorly with the needs of future generations.

Nevertheless, many powerful people were anxious that individual freedom had grown beyond acceptable bounds. They longed for the settled patterns of the old order that still had traces of feudalism. This mindset can be found in Schwab and Malleret's (2020) book *COVID-19: The Great Reset*. Reflecting this desire to return to old certainties, the public health response to COVID-19 can be construed as a tool to restore the old order in which a pliant public accepts official information as true without question and obeys leaders who impose top-down controls. This renewal of past ideals now also requires public obedience to mega-corporations that are concentrating wealth, as with past aristocracies, at the expense of freedom. The only option that remains to dissenting individuals is to remove ourselves from this cycle and head for somewhere unknown. Much will depend on whether we can learn from history. To heed history's lessons, we need to ensure we are basing our view in reality.

THE HISTORY OF THE WHO

In 1851, European nations met in Paris for the world's first International Sanitary Conference (Howard-Jones, 1975). The European powers represented also controlled large areas of Asia and

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Africa. They wished to impose their version of civilization on others while extracting their riches but this came at a price: ships returned with pestilence, particularly cholera, that ravaged the populations back home. The conference was convened to agree on standards and practices for controlling people at borders in times of outbreaks. Human rights were not a great concern, with some participants such as Portugal and the Netherlands still practicing slavery, but healthy workforces were important to economies, and pestilence sometimes failed to respect social hierarchies (Reuters, 2007). An aristocracy knew what was best for their own people and for those in distant lands whose health, welfare, and rights, they also owned. Their burden was to manage the lives of others (Kipling, 1899).

Several conferences later, a convention was finally signed in Venice in 1892, concerning cholera and, later, bubonic plague (Howard-Jones, 1975). A permanent office, the Office Internationale d'Hygiene Publique was inaugurated in Paris in 1907 (preceded by 5 years by the International Sanitary Bureau in the Americas), and the international health bureaucracy was born (Howard-Jones, 1975; McCarthy, 2002). The Paris office was tasked with finding and managing outbreaks and pandemics. It was Western-centered and, through its governments and their corporate implementers, empowered to tell the rest of humanity what to do.

These international health experts reflected the international order of the time, where Europeans and North Americans imposed an imperialist model of public health. In their confidence of having better knowledge, better science, more money, and better breeding than those they oversaw, they had no reason to doubt the righteousness of their cause. They could ply their pandemic trade through the human rights abuses, mass famine, and comfortable fallacies of their colonial world (Siddiqui, 2020; History Guild, 2022; Horan, 2010).

With the forming of the League of Nations after World War I, a spirit of inclusiveness among hegemonic colonial powers allowed the addition of one Asian colonial power, Japan (though the Japanese would later claim this was not on equal terms) (Howard-Jones, 1975). The International Health Organization of the League of Nations supported this world order, concentrating on infectious disease outbreaks that continued to define mortality throughout Europe and beyond (CMA, 1924; Weindling, 1995). Against a background of the influential technocracy and eugenics movements of the 1920s and 1930s, public health concerned the imposition of control to force improvement in society, or at least to transform it according to their definition of this (Allen, 2011; Corbett, 2017). The role of public health in promoting those deemed superior over those deemed inferior reached its zenith in the attempted elimination of whole ethnic groups by Nazi Germany before the collapse of the Nazis made overt expressions of eugenics and technocracy unpopular (Nuremberg Code, 1947).

The World Health Organization was formed in 1946 amidst the aftermath of this fascist approach, at a time when much of the world's population was engaged in throwing off the yoke of its colonial masters or openly aspiring to do so. The WHO is ostensibly egalitarian when it comes to member states; each state has one vote in the World Health Assembly (WHA) and in one of six regional assemblies (WHO, 1946). The WHA was the primary decision-making body. It was funded by "core" contributions based on a country's gross domestic product (GDP) (WHO, 1946, 2022a). Implementation followed the technical decisions guided by the Assembly (WHO, 1946).

The WHO based its definition of health broadly; "Health is a state of physical, mental and social well-being, not merely the absence of disease or infirmity" (WHO, 1946). Social well-being parallels the requirements of the Universal Declaration of Human Rights developed during the same period, abhorring slavery and servitude and recognizing individual human agency (UN, 1948). Slavery, coercion, and restrictions on individual freedom were not healthy. The WHO charter emphasizes the importance of community involvement in decision-making (WHO, 1946).

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The WHO and other UN agencies restated this approach in 1978 in the Declaration of Alma Ata, emphasizing community control of health (WHO, 1978). While the Whitehall studies emphasized the importance of social capital to good health in high-income societies, links between local control and community health are even stronger in those of low income (Doerr et al., 2020; Marmot et al., 1978, 1991; World Bank, 2014). Public health graduates could make a living off the philosophy of human rights and "horizontal" delivery of health care. It was the standard, orthodox approach to public health.

GLOBAL HEALTH AND THE TRANSFORMATION OF WHO

The anniversary of Alma Ata was recognized through the Astana meeting of 2018 (WHO, 1978, 2018). Comparing the Alma Ata and Almaty declarations is telling. The latter is high on rhetoric but light on actionable, definitive statements (WHO, 2018). Something had fundamentally changed in the intervening years that allowed empty rhetoric to replace substance.

Private philanthropy had always been present in global public health. However, apart from the Wellcome Trust in the UK, contributions were relatively small (Wellcome Trust, 2022). Wellcome grew from an endowment of the drug entrepreneur Henry Wellcome in the 1930s, funding research in tropical medicine and supporting a network of research institutions based in, and allied with, low-income countries. While dominated by British researchers, it did display some effort to base itself among those it sought to support.

The rapid growth of the computing and software industry brought unprecedented wealth to a few individuals, concentrating much global commerce in the hands of a small number of corporations. As wealth begat more wealth and monopolistic practice, individuals amassed greater assets than some medium-sized countries. Directing part of this wealth to health through "philanthropy," particularly public-private partnerships, subtly but rapidly changed the entire ethos of global health.

The Bill and Melinda Gates Foundation began involving itself with WHO from its inception in 2000, soon surpassing Wellcome Trust in funding, and becoming a major direct donor to the WHO (BMGF, 2022; WHO, 2022b). The Gates Foundation worked particularly through funding to other organizations including WHO and organizations that it helped inaugurate such as GAVI (originally the Global Alliance for Vaccines and Immunization) and CEPI (originally Coalition for Epidemic Preparedness Innovations). Gates funding of WHO has overwhelmingly been noncore or "specified" funding, directed to an area of work or specific projects of interest to the funder (CEPI, 2022; Gavi, 2022a).

A relative decline in country-based core funding to the WHO has also occurred, thereby diverting the organization from its traditional public health functions. Specified (and thematic) contributions now comprise approximately $6.4 billion of just under $8 billion expenditure in 2020–2021 (WHO, 2022b). This means that most WHO work is based on what funders, including private individuals such as Mr. William (Bill) Gates Jr, agree to and are willing to fund—not necessarily what the WHO technical staff or the WHA deem of primary concern for the populations they serve. This situation is unavoidable if WHO wants the money but reliance on private funding is an obvious threat to the whole idea of community-based, and nation-based, health policy.

Whereas the influence of directed funding from private and corporate donors has undoubtedly influenced WHO implementation, it is still limited by the role of the WHA and its ultimate role in approving overall policy, and by the WHO board which is restricted to rotating members nominated from WHA countries (WHO, 1946). Since the year 2000, there has been a

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growth of international bodies parallel to the WHO that are even less retrained in partnering with private influence. The Global Fund to fight AIDS, Tuberculosis and Malaria was inaugurated in 2002 as a financing mechanism to consolidate funds for health and transfer them to low- and middle-income countries (LMICs), prioritizing these three endemic infectious diseases (Global Fund, 2022a). Registered as an international organization in Switzerland, its board includes a mix of private, government and non-government organization (NGO) interests, including the Gates Foundation. The Gavi alliance (concentrating on vaccination support) and Unitaid (supporting market-shaping for health commodities in LMICs) were formed as "public-private partnerships" after 2002 (Gavi, 2022a; Unitaid, 2022). Lastly, CEPI, was formed at the World Economic Forum's Davos meeting in 2017 by the Gates Foundation, the Norwegian Government, and others specifically to develop responses for pandemics, concentrating again on vaccines (CEPI, 2022). Gavi, Unitaid, and The Global Fund all include Gates Foundation or other private representation on their boards (Gavi, 2022a; The Global Fund, 2022a; Unitaid, 2022). These members bring not only voting rights but the weight of a considerable chunk of the organizational budgets. The Gates Foundation has given $4.1 billion to Gavi, and is among the top 7 donors to CEPI (the private UK Wellcome Trust is another) (CEPI, 2022; Gavi, 2022b).

Funding global health is not intrinsically a bad thing, and it is understandable that donors will want influence on how their funds are spent. As further funding is dependent on the funder being pleased with previous outcomes (unlike the assessed core budget of the WHO), the staff of these organizations, including the WHO, are obviously under pressure, overt or otherwise, to please their funders. A reduction in future support can mean a loss of salary and of staff in their team. Where donor influence includes board membership, the potential to direct policy in favor of the donor is obvious. If this was about supporting art exhibitions or running private airlines, there would be little cause for concern. However, when the lives and well-being of several billion people are involved, including their freedom to make their own health choices, the relationship between donor and public is quite different.

The major international health organizations require thousands of staff to run them. Many of these staff now learn their trade in schools dedicated to "global health," funded by foundations such as Gates, Bloomberg, and Rockefeller that are supporting the health institutions themselves (Cape Partnership, 2020; Doughton, 2017; Johns Hopkins, 2022). Concentrated in wealthy countries, they train young well-off people in the areas in which the donors wish to work. Eponymous foundations such as those of the Clintons' and Gates' can then use their family name to give young graduates remarkable access to the ministries of health of low-income countries (BMGF, 2022; CHAI, 2022). Staffers with minimal background in the cultures and experiences of low-income populations are inserted into positions of considerable influence. Having been trained in schools such as the University of Washington, Harvard, Johns Hopkins, and Imperial College that are supported by the same sources, it is reasonable that they would maintain a significant sympathy for these sponsors' priorities.

Health policy depends heavily on data, collated from countries or derived from research. Once more the same names—Gates, Wellcome, Clinton—feature heavily in this process. The modeling that defined the COVID-19 response was predominantly from Gates-funded groups at Imperial College and the University of Washington (BMGF, 2017, 2020; Czyzewski, 2022). The Global Burden of Disease report, on which the WHO heavily relies, is funded by the Bill and Melinda Gates Foundation. Research programs in malaria, tuberculosis, and HIV are strongly vaccine oriented (GBD 2019 Diseases and Injuries Collaborators, 2020). The data available to guide health policy are the data that donors are interested in collecting.

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Over the two decades prior to 2020, the field of global health was thus transformed from a backwater of traditional tropical health schools and little-known research institutes into a well-resourced industry that linked training, research and implementation arms. The digital-technology revolution produced a set of extremely wealthy philanthro-capitalists who oversaw the transformation of the global institutions managing this industry from relatively independent technical agencies owned by countries and concentrated on horizontal community-centered health to a far more centralized approach heavily dependent on the technology and pharmaceuticals in which the new class of funders were invested (Comparebrokers, 2023; Gavi, 2022a; Unitaid, 2022; WHO, 2022b). These public-private partnerships brought more funds and undoubtedly saved many lives. They also put in place a mechanism where the people whose health was at stake would have inevitably decreasing influence on how the funding was used.

The Second World War led to the closure of a colonialist chapter in which the corporations of rich countries managed the welfare of vast numbers for profit. The 21st century has seen this model return, with the same claims of "for the good of the many" that were traditionally used by the rich and the entitled to justify their practice of dictating to the masses.

A SOCIETY FIT FOR FEAR

While international public health was being re-oriented towards a private-interest model, its dictates still had to be broadly acceptable to the public to be implemented, at least in democratic countries. As long as personal freedom and democratic decision-making were considered sacrosanct, public health professionals had limited ability to impose their will on others. Medical fascism can succeed only when a large section of the public is sympathetic to its message.

Most people in wealthier countries grow up with little close experience with death until they reach old age, as life expectancy has increased markedly over the past two centuries (Our World in Data, 2022). Childhood mortality in particular has declined. This has been primarily driven by improved living conditions and nutrition but also significantly by medical interventions, particularly antibiotics. In contrast, the 1.3 billion people of sub-Saharan Africa have far closer experience of death. While under-5 mortality has dropped from 170/1000 live births to just above 70 in the 30 years to 2020, children growing up in these populations still experience the deaths of over 1 in 15 of their peers (World Bank, 2022a).

A further contrast between low- and high-income countries is the evolution of religious belief, with the past few decades witnessing a major decline in formal religious observance in many higher-income countries, particularly in Europe and North America. It seems reasonable to assume a belief in life after death, implying that current time on earth is just a chapter in a far greater story of one's existence, would make death less of a thing to be feared. Conversely, a belief that death was the end of oneself, an unmitigated disaster for anyone who wishes for continued existence, would make death something to be avoided even at great cost to self or others.

In this context, the push in recent years to highlight vaccination seems important. While vaccination has played a significant role in reducing mortality, it played a significantly smaller role than living conditions, nutrition, and antibiotics. Its wide introduction came after the bulk of the gains in wealthier countries had been achieved (Our World in Data, 2022). This was standard teaching in public health a few decades ago but a belief that vaccines have been pivotal to increased life expectancy seems common now in society (Keenan, 2020). There has been a dramatic increase in childhood vaccination in the past 40 years (CDC, 2023). But life-expectancy in North America actually reversed its increase in the several years before COVID-19, declining by

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0.03 percent per year in 2015, 2016, and 2017 (Harper et al., 2021). The reversal in life-expectancy contrasts with the expansion of vaccination (CDC, 2022), This reduced life expectancy is widely attributed to metabolic disease, particularly rising obesity, driven by consumption of large quantities of sugar and processed foods (Hales et al., 2020; Kim et al., 2021). The resultant need for chronic medications ironically supports the same corporate profit motives that some would claim are driving the prominence of vaccines.

COVID-19 AND THE ABANDONMENT OF PRIOR KNOWLEDGE

From early 2020, the world witnessed a major shift in the way public health was implemented. Prior knowledge and the consensus on fundamental principles ceased in many countries, and a new approach substituted (De Larochelambert et al., 2020; WHO, 2019). This happened with little protest from the global health community—those working in the industry as it grew though the preceding two decades. Three of these abandoned areas of practice particularly stand out.

First, public health is based on weighing costs and benefits. All interventions will have costs, whether financial alone, costs in diversion of resources (human and financial) from other health priorities, or costs from direct harm accruing from an intervention. The latter includes both short- and long-term harms. Obvious examples include canceling cancer screening or chest pain reviews. Medical screening is conducted because it is believed to reduce death, and therefore we can assume that canceling such screening will increase mortality. It is not possible to determine the value of a public health intervention without weighing such harms against expected benefits.

Second, assessment of disease burden relies on estimates of life-years lost or impaired. Mortality is an easy number to follow, but nearly everyone on earth would agree that the impact of the death of a five-year-old will be greater than that of an 85 year old. One loses about 70 years of life, the other perhaps two, particularly if they are already unwell. Public health has previously coped with this by including life-years lost or impaired (by disability) in metrics such as disability-adjusted life years (DALYs) or quality-adjusted life years (QALYs) (WHO, 2020). The child dying of malaria will lose far more DALYs than the 85-year-old with pneumonia, so investment to save the child is commonly seen as more appropriate than saving the pneumonia patient (at the resource allocation level where such decision must be made). This is not a reflection on the value of a life but of the value of the years lost by dying. This is a critical distinction.

Third, broad evidence has accrued linking poverty and loss of social capital to reduced life expectancy. The Whitehall studies in the United Kingdom demonstrated a link between lower life expectancy and lower socio-economic status (Marmot et al., 1978, 1991). People who earn less and who lack locus of control and self-determination die at a lower average age, which means that bosses live longer than workers. At a macro level, reducing gross domestic product is associated with increased mortality, particularly in low-income countries where food reserves tend to be lower and the prevalence of endemic infectious disease is greater (Doerr & Hofmann, 2020). This is why the WHO, in its 2019 recommendations on pandemic influenza management, strongly advised against measures such as border closures, or quarantine or restriction of healthy people (WHO, 2019).

These three factors were the previous basis for most international health policy. Although donor preferences played an increasing role within these areas, the rhetoric at least required that resources were seen to be allocated on the basis of life-years added per dollar spent.

From early 2020, the same institutions that had previously espoused these principles ignored them in the COVID-19 response. Either something happened to the mind-set of many thousands

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of people working in these institutions, or most had only paid lip-service to these concepts and were willing to abandon them when it was convenient. Structures that ensure direct private and for-profit influence on decision-making and spending must have an influence on this, as financial return on investment may now be weighed against disease burden reduced. Public health staff from societies with an increasing distance from death and greater fear of it, coupled with a misunderstanding of the importance of vaccine-based responses, were primed to succumb to fear and believe in a pharmacological "fix".

Whatever the relative importance of these influences, reducing death from a single respiratory virus became the primary function of public health. Disease burden was restricted to mortality alone, which included, incongruously, anyone who died from any cause but who had recently tested COVID-positive with a PCR test (CDC, 2020). (Statistics on disease-related mortality were expanded from "died *of* COVID" to "died *with* COVID".) Though the average age of death from COVID-19 was similar to the age of all-cause death in most countries, and life-years lost is so fundamental to understanding disease burden, age was seldom mentioned in media reports of COVID-19 mortality and does not feature on WHO dashboards (WHO, 2022c). Impoverishment and economic decline became an acceptable cost to stop a virus (World Bank, 2022b), ignoring the inevitable future burden and greater inequality that this would bring. The basic tenets of public health could not have been "forgotten". Something changed in public health leadership and the way in which staff worked that permitted this knowledge to be ignored and deliberate mass harm to be wrought.

The outcomes of this include measures that pushed economies in most African countries into recession, denied hundreds of millions of children formal education, pushed millions of girls into child marriage over the next decade, and forced up to 130 million people into severe food insecurity (Cousins, 2020; UNICEF, 2021a, 2021b, 2022a; WFP, 2022; World Bank, 2022b). The context of COVID-19 to these populations is important. More than 50 percent of the 1.3 billion people in sub-Saharan Africa are under 20 years of age and so at very low risk from COVID-19 (Bell & Schultz Hansen, 2021; UN, 2022a). Other infectious diseases, the control of which is highly dependent on healthcare access and strong economies, are a far larger threat to these populations (Bell & Schultz Hansen, 2021). COVID-19 mortality has remained accordingly low as age distribution predicted, while lockdowns and other response measures have had a huge impact on health and future well-being.

The advent of mass COVID-19 vaccination has exacerbated this trend, as WHO and other organizations continue to push for population-wide vaccination while their own studies show most are already immune (WHO, 2022d). This program is unprecedentedly expensive to international public health, absorbing over $4.5 billion and estimated by CDC to require over $10 billion for initial vaccination in sub-Saharan Africa, and by Yale to require $35 billion globally (Meldrum, 2021; Mustafa Diab et al., 2021; Savinkina et al., 2022; WHO, 2022d, 2022e). In contrast, global malaria and tuberculosis expenditures are about $3.5 billion and $6 billion programs, respectively (WHO, 2021a, 2021b). Current knowledge of the waning efficacy of these vaccines and the financial and health costs of resource diversion on malaria, HIV, tuberculosis, and other endemic problems has failed to reduce the priority this program is given. We are seeing the largest public health program for low-income countries in history being rolled out in the face of irrefutable evidence that it can have minimal clinical benefit and will inevitably have a high indirect cost. This is implemented by a workforce of thousands across international organizations who once knew the harm this would cause. Whether a result of the behavioral psychology deployed to promote fear early in the COVID-19 response, or driven by fear of job-loss having been trapped by funder-driven health policy, this mute acceptance is significant when thinking of the future

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agenda for international public health now being pushed by those who promoted the unorthodox response to COVID-19.

The COVID-19 response has broken down the barriers to a new and authoritarian approach to international public health. The concept of forcing mass behavioral change, suspending basic human rights, and coercing mass vaccination has been moved into the mainstream, while populations have become accustomed to censorship and public vilification of dissenters and noncompliers (Mello et al., 2022; Miller, 2020). False claims by public officials, such as assuring the public of transmission-blocking through vaccination, have become common. Moreover, the major media have simply reported statements made by officials rather than questioning their veracity (Bell, 2022a). People have become accustomed to what would previously have been considered an authoritarian or fascist approach to health and society. All this for a virus to which children and the working-age population are at very low risk (Ioannidis, 2021; Levin et al., 2020; Pezzullo et al., 2023; Verity et al., 2020). Future responses to outbreaks can now use this response as a precedent, imposing draconian measures for moderate- to low-intensity threats.

International health agencies are shifting emphasis to a pandemic preparedness and response (PPR) agenda, tying the cost of the COVID-19 response to a need to identify future threats earlier or respond more rapidly (Gavi, 2022c; Global Fund, 2022b; UNICEF, 2022b; WHO, 2022f). In terms of international health, the US$10.5 billion annual price tag in additional resource to be allocated to this effort is far higher than annual spending on tuberculosis or malaria, a major cause of child death (WHO, 2021a; WorldBank). Pandemics are historically rare, with WHO listing only three in the 100 years prior to COVID-19, killing fewer than 2.5 million people (Tuberculosis currently kills roughly 1.5 million annually.) (WHO, 2019, 2021b). The "Spanish" flu of 1918–1919 killed an estimated 20 to 50 million but most probably due to secondary bacterial infection in this period prior to antibiotics and modern medical care (Morens et al., 2008; WHO, 2019).

It appears highly likely, however, that the frequency of declared pandemics and health emergencies will increase. While "pandemic" has always been loosely defined, the current WHO definition requires only a new variant pathogen to spread across borders—irrespective of severity of disease or mortality caused (WHO, 2009). A large part of the investment in the new pandemic agenda, funded initially through a new financial intermediary fund instrument of the World Bank and through expansion of The Global Fund to fight AIDS, Tuberculosis, and Malaria, will address surveillance and detection of new and variant viruses (Global Fund, 2022b; World Bank, 2022c).

As viruses mutate frequently, particularly RNA viruses such as the coronaviridae, widespread sequencing will inevitably demonstrate new variants. As severity is not a requirement to declare an emergency, and any variant could be presented as a potential threat, the bar for instituting a response can now be very low (WHO, 2009). That response, based on precedent, can now broadly restrict behavior and human rights to an extent unthinkable in the 60 years prior to 2020. and The Global Fund set up in the past two decades to support pandemic preparedness and vaccination, ensures that a large international workforce, with little or no public oversight, will be dependent on identifying and responding to threats and emergencies—whether real or imagined—in order to justify their salaries. The relatively massive funding being allocated to this effort—and the involvement of institutions such as CEPI, the Gavi Alliance, and The Global Fund that were set up in the past two decades to support pandemic preparedness and vaccination—will create perverse incentives to classify minor disease outbreaks as global threats that require draconian measures.

The monkeypox outbreak in 2022 served as an example of the ease with which this new public health paradigm can be brought into place (UN, 2022b). Despite the outbreak being confined almost exclusively to a small section of the population (homosexual men with multiple

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sexual partners) and occurring in this group with low prevalence with only 5 deaths recorded globally, the Director General of WHO was able to declare an international emergency against even the advice of his own advisory committee. The new international pandemic instrument (treaty) and changes to the International Health Regulations currently under negotiation within the WHO are designed to further increase the Director-General's power to proclaim emergencies and bring force of international law to back his pronouncements (WHO, 2021c, 2022g, 2022h).

CONCLUSION: A DISRUPTED FUTURE

The drive of fascism in the 1930s was heavily supported by the health professions. While this was most obvious in Germany, where doctors were over-represented in the Nazi party and the SS, the eugenics and technocracy movements of North America had aspects in common with fascism and operated in the mainstream of public health (Allen, 2011; Corbett, 2017; Haque et al., 2012). The fascist thinking behind such movements relies heavily on the concept of combining corporate and political authority as defined by Mussolini, with the welfare of the masses being placed in the hands of political tyrants and closely allied corporatists. They were characterized by the identification and vilification of minorities, by intense propaganda backed by heavy censorship, and by the use of health professions to enforce aspects of population control, including management of dissenters and those considered of less worth.

While the COVID-19 response gave hints of how aspects of this could return, the pandemic preparedness and response (PPR) agenda appears designed to lock this in for the long term. Against a background of easing of restrictions on killing fellow humans through euthanasia legislation in Western countries, we have had three years of restrictions on travel and public gatherings, censorship in media and public discourse, and open vilification of minorities on the basis of choice of medical status (Government of the Netherlands, 2022; Health Canada, 2021). The PPR agenda aims for more funding than any other international public health program. Rather than being a subject of discussion within the democratic structures of individual countries, it is being negotiated by poorly accountable international bodies such as the WHO, the G20 and World Bank, in concert with private bodies, such as the World Economic Forum, that, in turn, have heavy direct involvement from the pharmaceutical and software companies that stand to gain financially from mass vaccination, surveillance, and social credit programs (WEF, 2022; WHO, 2022f, 2022g, 2022h; World Bank, 2022c). While the scale is broader than the nationalist fascism of 80 years ago, the similarities in the structure and the corporate-authoritarian model for decision-making have clear echoes.

If the agenda of pandemic threat and response continues along the lines established by the COVID-19 response, we are likely to see Western societies transfer decisions on such issues from open, transparent, democratic processes to privately controlled bodies. The promotion of fear and active use of behavioral psychology in the COVID-19 response was successful in achieving broad public acceptance of, or at least acquiescence to, the removal of what had been considered fundamental rights (Dodsworth, 2021). Pandemics are a rare event but the PPR agenda is being successfully promoted on the demonstrably false premise that they are becoming more frequent and have increasing severity (Bell, 2022b; WHO, 2019). The public's acquiescence to increasing and institutionalizing of restrictions seems likely, as the German public acquiesced to similar measures in the 1930s. An underlying fear of death, fed by a false but very broadly supported narrative, worked in the

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1930s, worked from 2020 to 2022, and seems likely to work again. Keeping "us" safe in the context of a threat that causes individuals to feel powerless is a difficult paradigm to oppose.

Previously, fascist regimes were overthrown through warfare with external powers. In this new incarnation, the private and international institutions involved work above or outside of national sovereignty and appear to have broad support among the higher levels of national governments. There is no external power that can march across the border and overthrow the dictator. While it is unclear how non-Western populations such as those of Africa will react, with their widely differing societal experience of colonialism and direct oppression, the way out for Western societies, with their reliance on democratic institutions that appear to be captured by the broader agenda, is unclear. Mass acquiescence to COVID-19 response measures suggests that the ability or desire of citizens in Western societies to defend basic human rights and norms is low. There has also been an increase in the ability of those in control to silently censor websites that might have activated stronger public dissent. Incompetence within this leadership may be necessary to bring this episode to an end or a loss of the apparent consensus that this leadership currently exhibits. Either way, it is hard to see democratically based Western society persisting in its current form. We should be thinking through alternative structures that undermine the influence of fear on populations and that expose the lies of propagandists, while laying bare the fascism they espouse. If most continue to acquiesce, they should at least be clear on what they are acquiescing to.

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