Britain would have to hand over 20pc of vaccines under pandemic treaty

Fears voiced that agreement could mean vaccines being taken from where they are most needed and sent to areas not at risk

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The World Health Organisation (WHO) will have the power to legally demand that Britain hands over 20 per cent of its vaccines and drugs in a pandemic under a treaty due to be ratified next month.

In March 2021, leaders including Boris Johnson announced plans for a new agreement that would bind countries in tackling global health emergencies.

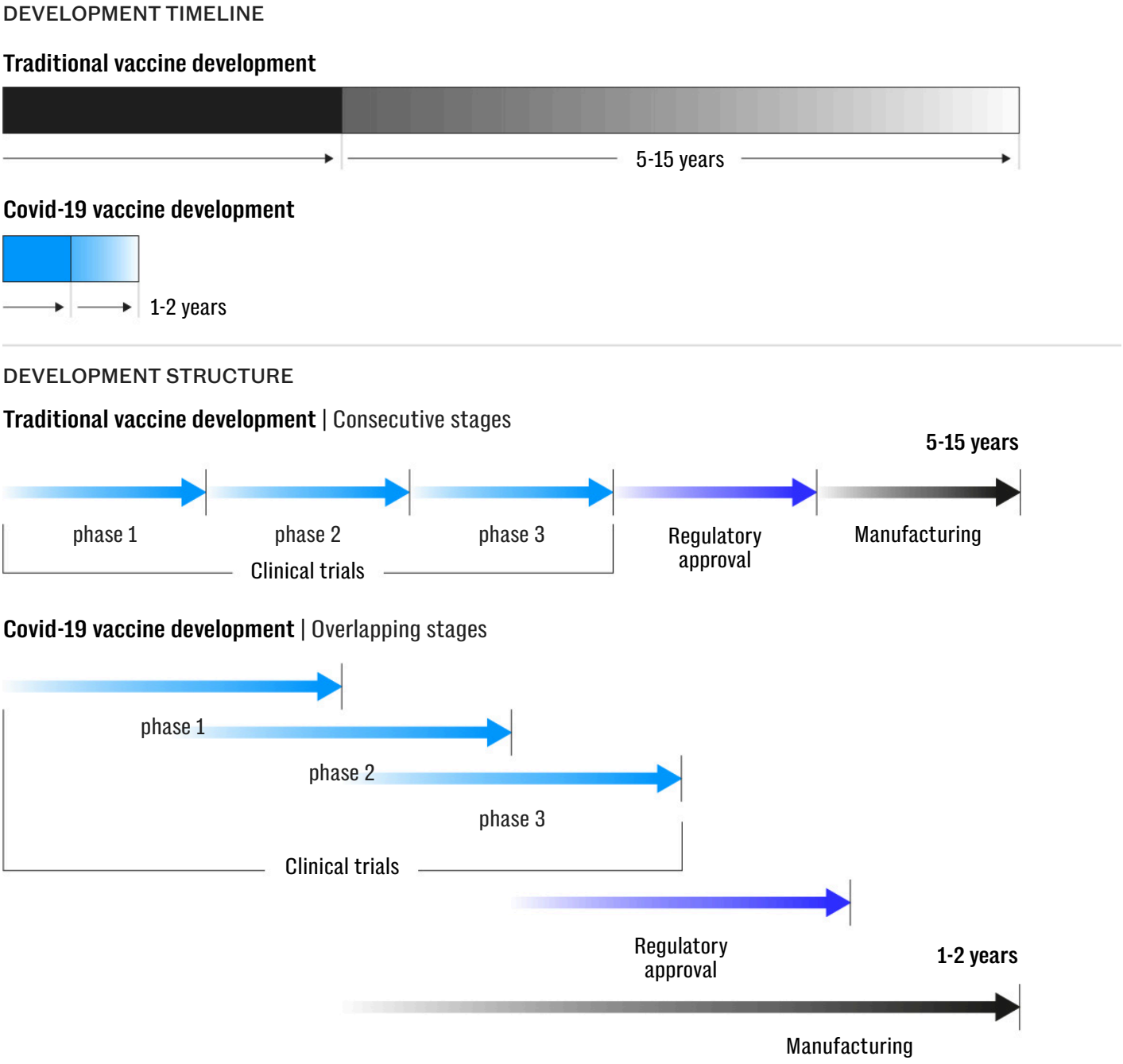
The treaty was criticised for removing sovereign powers, raising fears that Britain would risk signing away its control over pandemic policy to unelected health officials. It has been substantially watered down in the final draft, released this month.

However, under the terms of the new agreement Britain would be obliged to give up 20 per cent of "pandemic-related health products" and prevented from stockpiling supplies.

The updated document says countries must grant "at a minimum… in the event of a pandemic, real-time access by WHO to 20 per cent (10 percent as a donation and 10 percent at affordable prices to WHO) of the production of safe, efficacious and effective pandemic-related health products".

It states that parties should "set aside a portion of its total procurement of relevant diagnostics, therapeutics or vaccines in a timely manner for use in countries facing challenges… and avoid having national stockpiles of pandemic-related health products".

How quickly Covid-19 vaccines were developed compared with traditional timeframes



SOURCE: OUR WORLD IN DATA

But the scheme was criticised as "token" and there were fears it could mean vaccines being taken from where they are most needed and sent to areas not at risk, with foreign populations eligible to receive UK-manufactured vaccines before the British public.

Dr David Bell, a global health expert and former WHO medical officer said: "The problem is that it bears no relationship to need. It seems token. As an example, Covid-19 was barely a problem in sub-Saharan Africa other than South Africa, as there is less than one per cent of the population over 75, half are below 20 and metabolic disease rates are low.

“These things are best worked out in the context of the specific disease and population. I am unclear why this is in a treaty, as it is a general principle that is already followed and best addressed on a case-by-case basis. Otherwise, it forces an inappropriate allocation of resources. It seems arbitrary, which is not a good basis for a treaty.”

Britain was among the first countries to develop and roll out a Covid vaccine, the AstraZeneca jab, made at Oxford University, but was criticised by the global health community for holding on to its supply of jabs until it had a healthy surplus and offering a second dose before some poorer countries had been given a first.

The UK did eventually give away 100 million jabs, but under the terms of the new treaty it could be forced to relinquish more of its supplies and give them away earlier in a pandemic.

More than 12,000 people have now signed an open letter calling for the ratifying of the treaty to be postponed until the full implications have been established.

Member states will meet this week to discuss the latest draft, with nations having set a deadline of May for reaching an agreement. Disagreement among countries over the access to vaccines could mean parts of the agreement are pushed back to 2026.

‘So many variables remain’

Some experts are expecting an initial “vanilla” version to be ratified in May, with more controversial aspects kicked down the road in order to try to gain consensus at a later date.

Dr Clare Wenham, an associate professor of global health policy at the London School of Economics, said: “The current state of negotiations is anyone’s guess. So many variables remain – it will depend on next week and whether member states decide to get some parts across the line and have an agreement, or agree to delay for the future.

“If I were a betting person, I would think a very high level ‘vanilla’ treaty will be agreed, with anything controversial removed or kicked down the line for future protocols.

“What will have to happen bilaterally to get that outcome is yet to be seen, but I wouldn’t be surprised if deals were being done behind the scenes for low and middle-income countries to acquiesce.”

Last week, at the inaugural meeting of the Pan-European Network for Disease Control, held in London, Dr Hans Kluge, the WHO regional director for Europe, told The Telegraph he hoped countries would share data on diseases but also on stock of healthcare products such as vaccines.

“There was a lack of coherence in policy-making [during the Covid pandemic]. Masks, no masks, and other measures,” he said. “That means there was no platform to coordinate and to work towards the same standards and the same policies.

“There were countries which were in a shortage, and there were quite a few countries which had to throw away quite a number of vaccines.”

The World Health Organisation was approached for comment.

Why this treaty could do more harm than good

Next month, 194 member states of the World Health Organisation (will vote on acceptance of two documents that are intended to transform international public health and the way countries interact when the WHO’s director general declares an emergency, ***writes David Bell***.

If formalised, these changes will be legally binding and govern the relationship between countries and the WHO.

Although this “pandemic treaty” contains significant health, economic and human rights implications, negotiations are still actively under way in various committees, with only weeks left until the intended vote. They have been developed with unusual haste on the premise that there is a rapidly increasing urgency to mitigate pandemic risk.

The sense of urgency is fuelled by a misrepresentation of data and citations on which the WHO and other agencies have relied, justifying the projected cost of at least £25 billion per year.

In claiming an “existential threat” of increasing outbreaks of infectious disease, these agencies are ignoring the very revolution in diagnostic technologies that they have been promoting for the past few decades. Most outbreaks reported now could not even have been distinguished from routine diseases several decades ago. They also ignore an actual downturn in reports in the past decade.

Moreover, many of the points in the proposed treaty are based on the precedents from the Covid pandemic. It is an understatement to say the WHO’s policy recommendations were not always correct. Some caused tremendous damage. And there has been no serious effort to understand how countries like Sweden fared so well during Covid while ignoring virtually every piece of the WHO’s advice.

Must be proportionate to the threat

We should certainly devote time and attention to preventing and managing disease outbreaks. But it must be proportionate to the threat, and the fact is there are many other

more pressing and consequential public health concerns to address.

As usual, it will be the low-income countries with the highest health burdens, like malaria and tuberculosis, who will suffer most with this diversion of funding. A growing international public health bureaucracy and their pharmaceutical and private sponsors, intentionally or not, will benefit.

I was a scientist and medical officer at the WHO for nearly nine years. There are many dedicated people working there who believe it is a force for good. In many ways, they're right. But large organisations become self-serving when they forget their purpose. For the WHO, this was fighting high burden diseases in poor countries.

The requirements for specific review times for member states have been put aside, inevitably undermining equity between countries. States with less resources will have time to fully assess the implications for their own populations prior to voting. This is an extremely poor and dangerous way to develop a legally binding international agreement or treaty, and the opposite of the WHO's mandate.

Time to decelerate

Completing a global directive by the WHO is not just a matter of gaining rapid agreement, but rather giving countries the needed time to go through a deliberate process that understands their strengths and limitations. A more careful process on the front end will help ensure that lower income countries are fully understanding and able to implement actions in the future to benefit the populations of each nation.

Short of that, countries may feel obligated to vote in favour and diminish the concerns being voiced by leaders at home. A global system is only as good as the capacities of countries to implement goals in real time. The current speed to agreement has given this important process short shrift. This portends a more powerful WHO alongside weaker nations that are most important for responding to the next crisis.

My colleagues and I have penned an open letter calling upon the WHO and member states to extend the deadline for the adoption of the amendments to the International Health Regulations and a new Pandemic Agreement next month at the 77th World Health Assembly to safeguard the rule of law and equity. We have garnered more than 12,000 signatories thus far.

It is time to decelerate for the purpose of designing a coherent legal pandemic package, based on a sober assessment of what worked during Covid and what did not.

The alternative – rapidly institutionalising a confusing set of different legal regimes, overriding authorities, and proliferation of competing global actors – will surely do more

harm than good.

David Bell is a public health physician and former scientist and medical officer at the World Health Organisation

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