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Philanthrocapitalism. The Gates Foundation
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Editor's note

This commentary on philanthrocapitalism and the Gates Foundation is a shortened and edited version of a paper by Anne-Emanuelle Birn published in *Hypothesis.* The paper, *accessed above and here,* is fully referenced. It also includes a detailed account of the Rockefeller Foundation and its shaping of global public health policy and practice before, during and after the creation of the United Nations, the World Health Organization and the Pan American Health Organization. Readers with scholarly interest or who want to check statements in this briefer commentary should rely on the full paper and access it now. It is also accessible as a lecture at the University of Washington, given by Anne-Emanuelle Birn.

We publish the commentary here, and the commentary that follows by Claudio Schuftan, in the month of the WHO World Health Assembly. At the WHA, basic issues concerning the funding and governance of WHO, and its relationship with 'the private sector', will be discussed. World Health Organization member state representatives present at the WHA need to know the nature, purposes and policies of the Gates Foundation. So do their colleagues in international and national governments everywhere.

The Bill and Melinda Gates Foundation is after the US, far the biggest funder of the World Health Organization, and with the UK contributes roughly one-third of the entire annual income of WHO. Gates funding is not freely given to WHO. It is reserved for projects devised or approved by Gates. These projects typically take little or no account of the underlying and basic causes of disease, health and well-being. Further, the current troublesome WHO policy of 'public-private partnerships' in which the private partners in the field of food and nutrition are transnational corporations whose profits depend on ultra-processed products, has from the start been largely driven by Gates and associated organisations.

Leaders in global health

He's got the whole world in his hands. In this satire, Bill Gates seems to be holding Asia and scrutinising Europe. His Foundation is 'driven by the interests and passions of the Gates family'

International health philanthropy, American-style, is back. Almost exactly a century after the Rockefeller Foundation began to use John D. Rockefeller's colossal oil profits to stake a pre-eminent role in shaping the institutions, ideologies, and practices of international health, as well as of medicine, education, social sciences, agriculture, and science, the Bill and Melinda Gates Foundation has emerged as the current era's most influential global health, and also to an important extent education, development, and agriculture, agenda-setter. The high profile of the Foundation's computer software magnate founder Bill Gates and his wife Melinda, coupled with the Foundation's big-stakes approach to grant-making and partnering, has made it a *de facto* leader in the global health field.

So it is in recent years that the Gates Foundation has emerged as this era's most renowned, and arguably its most influential, global health player. A century ago, the Rockefeller Foundation, likewise founded by the richest, most ruthless and innovative capitalist of his day, was an even more powerful international health actor.

This commentary reflects critically on the roots, needs, and reach of global health philanthropy, comparing the goals, paradigms, principles, methods and agenda-setting roles of the Rockefeller and Gates Foundations in their historical contexts.

It proposes that the Rockefeller Foundation's early 20th century initiatives had a greater bearing on international health when the field was wide open – in a world order characterised by forceful European and ascendant US imperialism – than do the Gates Foundation's current global health efforts amidst neoliberal globalisation and fading US hegemony. It concludes in the following commentary that the Gates Foundation's pervasive influence is nonetheless of grave concern both to democratic global health governance and to scientific independence, and urges all those professionally and otherwise concerned to play a role in contesting and identifying alternatives to global health philanthrocapitalism.

The nature of modern philanthropy

The Rockefeller Foundation and the Gates Foundation both emerged at a critical juncture in the history of international/global health. Each alike fended off public opprobrium for their cut-throat monopolistic business practices, and both have been subject to adulation and scepticism regarding their philanthropic motives.

Both foundations have focused on generating and applying new knowledge. One appeared when the international health field was in gestation; the other as it faced midlife crisis. One sought to establish health cooperation as a legitimate sphere for (inter)governmental action, creating principles, practices, and key institutions of the international health field; the other challenges the leadership and capacity of public multilateral agencies, pushing ahead an overlapping global health governance arrangement with a huge role allotted for the private sector. Both foundations, and their founders, were/are deeply political animals, all the while claiming the technical and purportedly neutral scientific bases of their effort. Given the confluence of largesse and leadership at distinct historical moments, various questions arise:

- How and why have US philanthropies played such an important role in the production and shaping of international/global health knowledge, organisations, and strategies?
- What are the ideological, institutional, and human welfare implications? Have these foundations marked a singular, unimpeachable path in this field, or are there meaningful alternative approaches towards achieving global health equity?
- What are the continuities and what has changed in the philanthropists' prerogatives?

Such questions are particularly salient in an era in which 'philanthrocapitalism' has been cited not as a venal endeavour – through which profits amassed by way of the exploitation of workers and natural resources are then harnessed through the very same exploitative business approaches in the name of improving human welfare – but hailed unabashedly as a means 'to save the world' according to 'big business-style strategy'. The Gates Foundation efforts are emblematic of an overall trend towards for-profit style management, leadership training, and goal-setting, as well as the privatising of public health activities. They are also tax-efficient: see Box 1.

Box 1

Philanthrotax

Unlike government entities, which are subject to public scrutiny, private philanthropies are accountable only to their own self-selected boards, and decision-making is usually in the hands of just a few executives. In North America and certain other settings, philanthropic foundations are exempt from paying most taxes, and contributions to philanthropies benefit from tax deductions. Both individual and corporate donations are tax-deductible, a practice that itself removes billions from the public coffers. Up to one third or more, depending on the tax rate, of the endowment monies of private philanthropies are thus subsidised by the public, which has no role in how priorities are set or how monies are spent.

The beginnings of philanthrocapitalism

Box 2

The Rockefeller Foundation

Editor's note. The fully referenced paper in Hypothesis pays roughly equal attention to the Rockefeller Foundation. Here is a digest. Readers are encouraged to access the full paper, which includes further discussion to be published in *WN* next month.

The Rockefeller Foundation was established in 1913 by oil mogul John D. Rockefeller 'to promote the well-being of mankind throughout the world.' The Foundation virtually single-handedly popularised the concept of international health. It was also the major influence upon the field's 20th century agenda, approaches, and actions.

Rockefeller's efforts were part of a new American movement – 'scientific philanthropy.' Launched by Scottish-born, rags-to-riches steel magnate Andrew Carnegie in an 1889 essay, 'The Gospel of Wealth,' published in *The North American Review*, this approach called for the wealthy to channel their fortunes to the societal good by supporting systematic social investments rather than haphazard forms of charity. Carnegie left a legacy of thousands of public libraries and bath-houses along with donations to higher education, the arts, and peace studies, an example heeded by various fellow multi-millionaires.

The philanthropists-cum-'robber barons' of the day were reviled for the provenance of their philanthro-profits from the exploitation and repression of workers. Philanthropy was regarded by many contemporaries as a cynical way to counter working class unrest, growing political radicalism, and claims on the state, and as a means of tempering threats to business interests and to capitalism itself, in the tumultuous late 19th and early 20th century Progressive Era. Domestically in this period, philanthropy played an ambiguous role in struggles around government-guaranteed social protections, by promoting 'voluntary' efforts in place of citizen entitlements. Since then, compared with most European and many Latin American countries, the private and philanthropic sectors in the United States have played a large part in the provision of social services – both curbing the size and scope of the US welfare state, and giving private interests undemocratic purview over social welfare.

Public health was the ideal vehicle through which Rockefeller philanthropy could apply expert findings to public well-being. This was a prescient choice, for public health was a nascent field in the United States, beginning to professionalise but with limited government foothold, giving the Rockefeller interests considerable room to test out ideas and practices.

Through its international health work, Rockefeller courted politicians and civil servants across the globe, generated deep loyalty among health professionals (and connected local elites to prestigious international medical networks), instilled a belief in public health among local populations throughout the world, and helped to build and modernise dozens of public health institutions. Yet its efforts went well beyond health.

It stabilised colonies and emerging nation-states by helping them meet the social demands of their populations, encouraged internationalisation of scientific, bureaucratic, and cultural values, stimulated economic development and growth, expanded consumer markets, and prepared vast regions for foreign investment, increased productivity, and incorporation into the expanding system of global capitalism. It sought to generate goodwill, promising social advancement in place of gunboat diplomacy and colonial repression. It was a philanthropy and also a national, bilateral, multilateral, international, and transnational agency.

Box 3
The Rockefeller legacy

Editor's note. The [fully referenced paper in Hypothesis] pays detailed attention to the Rockefeller Foundation. Here is a digest. Readers are encouraged to access the full paper.

The principles that were largely invented by Rockefeller have left behind a powerful, if problematic, legacy for global health. These include:

1. Agenda-setting from above. International health initiatives are donor-driven, with the agenda of cooperation formulated and overseen by the international agency, whether through direct in-country activities or the awarding of grants.
2. Budget incentives. Activities are only partially funded by donor agencies; matching fund mechanisms require recipient entities to commit substantial financial, human, and material resources to the cooperative endeavour.
3. A technobiological paradigm. Activities are structured in disease control terms based upon: a) biological and individual behavioural understandings of disease etiology; and b) technical tools applied to a wide range of settings.
4. *A priori* parameters of success. Activities are bound geographically, through time constraints, by disease and intervention, and/or according to clear exit strategies, in order to demonstrate efficiency and ensure visible, positive outcomes.
5. Consensus by way of transnational professionals. Activities depend on professionals trained abroad (often alongside donor agency staff) who are involved in international networks, easing the domestic translation of donor initiatives and approaches.
6. Adaptation to local conditions. Activities are afforded limited flexibility, based on the local cultural and moral economy and political context.

While these principles evolved generically, rather than as part of a master scheme – and they certainly fed on alignments between Rockefeller and a variety of national interests – their durability reflects the marked asymmetries in political and medical power that characterise most international and global health interactions, then and now.

The Rockefeller legacy has borne in heavily on the WHO, founded in 1948. Lewis Hackett oversaw Rockefeller International Health Division (IHD) programmes in South America and Italy for over thirty years. He noted: 'To a greater or lesser degree, all the international organisations have adopted the policies and activities in which the IHD has pioneered,' through inheritance of personnel, fellows, practices, and equipment. Rockefeller's most direct imprint on the World Health Organization took place through Fred Soper, who spent almost two decades at the helm of the IHD large-scale campaigns against malaria and yellow fever in Brazil before becoming head from 1947 to 1958 of what became in 1949 WHO's regional office for the Americas, now the Pan American Health Organization.

The Rockefeller model of international health cooperation was further entrenched in WHO with the 1953 election of Marcolino Candau as its director-general, a post he held until 1973. He oversaw the establishment of WHO's global malaria and smallpox eradication campaigns, among others, as well as a massive effort to provide public health training fellowships to over 50,000 health personnel from across the world.

The longevity of Rockefeller's interlocking principles of international health was more than a matter of personal networks of influence. Each of the Rockefeller principles above has continued ideological salience and bureaucratic convenience, as witnessed in the structure, strategies, and tenets of the global health field today.

The time of the Cold War

In the decades following World War 2, a dizzying array of organisations connected to international health were founded or revamped, from bilateral aid and development agencies, to the World Bank and International Monetary Fund, to United Nations agencies including the UN Children's Fund (UNICEF), the UN Food and Agriculture Organization and the United Nations Development Programme, to numerous international and local nongovernmental organizations, humanitarian and advocacy movements, research institutes, private foundations and business groups.

The postwar liberation movements in Asia, Africa, and (later) the Caribbean transformed the prior purview of imperial powers over their colonial holdings into a more complex geopolitical dynamic, in which multiple actors operated in multiple settings, and dozens of newly independent nations gained a voice, at least nominally, at the international policy-making table.

From 1946 through the early 1990s, these actors, and the international health field writ large, were shaped by two main factors. These were the Cold War and the political and ideological rivalry between American (Western bloc) capitalism and Soviet (Eastern bloc) communism; and as a corollary to this, the paradigm of economic development and modernization, which was perceived by the Western powers as the sole path to progress for the decolonised Third World.

In this context, Eastern and Western blocs deployed international health initiatives. The former provided big ticket infrastructure including hospitals, pharmaceutical plants, and clinics. The latter offered some of the same plus disease campaigns. Both sponsored huge numbers of fellowships for advanced training in the respective blocs, as a means of forging alliances with, and seeking to politically to dominate, low-income countries.

By the 1950s it was clear that the reconfiguration of world power brought few benefits to the former colonies. In 1964 the G77 movement of non-aligned (with either the USSR or the USA) countries was founded to confront neocolonialism in development aid, demand respect for sovereignty in decision making, and denounce unfair international trade arrangements and the lack of democracy in UN agencies.

As international health became a pawn in the Soviet-American competition for power and influence (the Soviet bloc pulled out of the WHO in 1949, returning only in the mid 1950s), many countries also learned to play the rivals against one another, sometimes stimulating improved social conditions, other times exacerbating unequal power and control over resources. Under Indira Gandhi, for example, India received as much or more aid from Washington as from Moscow, with both superpowers eager to accede to New Delhi's requests for foreign development assistance.

The World Health Organization, largely controlled by Western bloc interests, continued to operate in the style set down by the Rockefeller Foundation. (For summaries of Rockefeller and its work, see Boxes 2 and 3, above). This was characterised by professionalisation and bureaucratic growth and flagship technically-oriented global disease campaigns. These were first against yaws (with penicillin) and TB (with BCG); then, fatefully and unsuccessfully, against malaria (based on the insecticide DDT, following its extensive use during World War 2), and culminating with an ambitious though divisive in some locations, technically feasible, vaccine-based smallpox campaigns resulting in a declaration of smallpox eradication in 1980.

But in the 1970s, the WHO's disease-focused, donor-driven approach began to be challenged, both by member countries, especially G-77 countries, which were seeking cooperative efforts that addressed health in an intersectoral fashion, and also from within headquarters, under the visionary leadership of its Danish Director-General Halfdan Mahler (first elected in 1973, holding this office until 1988). The primary health care movement, as enshrined in the seminal 1978 WHO-UNICEF Conference and *Declaration of Alma-Ata,* and WHO's accompanying 'Health for All' policy, called for health to be addressed as a fundamental human right, through integrated social and public health measures that recognise the economic, political, and social context of health, rather than through top-down, techno-biological campaigns.

Social medicine's resurrection in the 1970s in the guise of primary health care created bitter divisions in and between WHO and UNICEF. The Rockefeller Foundation played a small but instrumental role in promoting *selective* primary health care, which was a reduced, technical and highly contested counterpart to Alma-Ata's broad social justice agenda for primary health care. Selective primary health care's emphasis on 'cost-effective' approaches, for example immunisations and oral rehydration therapy, became the main driver of UNICEF's child survival campaigns of the 1980s, under its then director James Grant, the son of an eminent Rockefeller man.

The rise of the 'market' economy

Just as WHO was trying to escape the yoke of the Rockefeller Foundation's international health principles, it became mired in a set of political, financial, and bureaucratic crises that tested both its legitimacy and its budget. The oil shocks and economic crises of the late 1970s and 1980s impeded many member countries from paying their dues. As well, member countries accused WHO of having too many personnel at headquarters and not enough in the field.

Around the same time, the rise of neoliberal political ideology lauding the 'free market' and denigrating the role of government in redistributing wealth, providing for social welfare, and regulating industrial and economic activity resulted in a parting with Rockefeller's interwar model of strong, publicly-supported international healthinstitutions. The administration of conservative US President Ronald Reagan

froze the US's financial contribution, in order to reprimand WHO for its essential drugs Programme (which had established a generic drug formulary) and for the 1981 International Code of Marketing of Breast Milk Substitutes. Both of these WHO achievements were seen by business interests as deliberate anti-corporate strategies.

By the early 1990s less than half of WHO's budget came from annual dues subject to 'democratic' World Health Assembly decisions. Instead donors, who by now included a variety of private entities in addition to member countries, increasingly shifted WHO's budget away from dues-funded activities to *a priori* assignment of funds to particular programmes and approaches. As a result of this trend, today almost 80 per cent of WHO's budget other than for core funding is earmarked, whereby donors designate how their 'voluntary' contributions are to be spent.

Once the Cold War ended, the anti-Communist rationale for Western bloc support for WHO disappeared, leaving in its wake promotion of trade, commodification of health, disease surveillance, and health security, as justifications for international health. By this time, apart from its health security role addressing surveillance, notification, and control of resurgent infectious diseases such as TB, and pandemics such as of influenza, WHO was no longer at the heart of international health activities, as had been stipulated in its 1946 Constitution.

In this period, the World Bank, pushing for efficiency reforms and privatisation of health care services, had a far larger health budget than WHO. Many bilateral agencies bypassed WHO in their international health activities. The WHO hobbled along thanks to 'public-private partnerships', which provided business interests, such as pharmaceutical corporations, a major, arguably unjustified, role in international public health policymaking Throughout the 1990s, international health spending was stagnating, and the future of WHO and the entire field seemed to be in question.

As these events were unfolding, international health was renamed 'global health'. This new term has been adopted broadly over the past two decades, and is meant to transcend past ideological uses of international health as a handmaiden of colonialism or a pawn of Cold War rivalries and development politics. The term 'global health' implies a shared global susceptibility to, experience of, and responsibility for health. In its more collective guise, global health refers to health and disease patterns in terms of the interaction of global, national, and local forces, processes, and conditions in political, economic, social, and epidemiologic domains. This is in reality not so different from the meaning of 'international health'.

In sum, during the Cold War the Rockefeller Foundation was far overshadowed by bigger players in the ideological war of West versus East. International health philanthropy would return in a significant way, in a new guise, only after the huge infusion of resources seen as necessary to win the Cold War began to dry up. The fact that this reemergence coincided with the rise of neoliberalism was pivotal. International philanthropy would now operate in a context attacking the role of the state and favouring private sector, for-profit approaches.

Enter the Gates Foundation

Bill Gates announcing a new development to the world's media. He says 'once you get beyond the first million dollars, it's still the same hamburger'. The Gates Foundation gives him a new objective

In 2000, almost a century after the Rockefeller Foundation filled the previous era's vacuum, a new entity appeared that would once again mould the international/ global health agenda. The Bill and Melinda Gates Foundation was established by Bill Gates (Microsoft founder and its first, long-time, chief executive officer and the world's richest person from 1995–2007, and again in 2009 and 2013), together with his wife Melinda plus Bill Gates Senior. It is by far the largest philanthropic organisation involved in global health. The September 2013 endowment stood at US$ 40.2 billion, including 7 instalments ranging from US $1.25 to 2.0 billion of a US$ 31 billion donation made in 2006 by US. mega-investor Warren Buffett, who is also a trustee of and advisor to the foundation.

With total grants of US$ 28.3 billion through 2013 and recent annual spending around US $3 billion – approximately 60% of which has gone to global health efforts (the remainder to development, agriculture, global advocacy, education, libraries, and local initiatives in the US Pacific Northwest) – Gates' global health budget has surpassed the budget of the WHO in several recent years. Its sheer size, and the celebrity and active engagement of its founders, turned the Foundation into a leading global health player virtually overnight.

Publicly accessible sources of information about the Seattle, Washington-based Foundation are limited to its website, which does not cover documents related to internal decision-making and operating practices, such as meeting minutes, memos, and correspondence. According to its global health division, the Foundation's primary aim in this area is 'harnessing advances in science and technology to reduce health inequities' through the innovation and application of health technologies.

These encompass treatment (by way of diagnostic tools and drug development partnerships) and prevention (through, for example, vaccines and microbicides).

Initially, the foundation sought to avoid expanding its portfolio too quickly, focusing on a few disease-control programmes mostly as a grant-making agency. This has changed over the past few years, with efforts reaching over 100 countries, the establishment of offices in the United Kingdom, China, and India, and the growth of its staff to more than 1,100 people.

Saving the world

Bill Gates speaks in 2011 about European investments in global health and development that are saving many lives at a Living Proof campaign event held at the Museum Dapper. Paris, France

Gates, echoing Rockefeller, follows a technically-oriented approach, with programmes designed to achieve positive evaluations through narrowly-defined goals, and adheres to a business model emphasising short term achievements.

Many global health agencies are keen to join with the Gates Foundation. Indeed, it has an extraordinary capacity to marshal other donors to its efforts, including bilateral donors, which collectively contribute ten times more resources to global health each year than does the Foundation itself, but with considerably less recognition. This extends to some organisations that in the past took on social justice approaches, for instance Norway's NORAD development agency. Associations with successful, high-profile activities that show a 'big bang for the buck', potentially within a single political cycle, are pursued even if in the long term the technical bang may turn out to be far smaller than it could have been through combined social, political, and public health measures, such as improving neighbourhood and working conditions, abolishing the military, or building redistributive welfare states.

Money and the ability to mobilise it, grow it, and showcase its effectiveness, validated by Gates-funded research, based on the dominant techno-scientific biomedical model, together with founders Bill and Melinda Gates' high-visibility protagonism, are not the only factors enabling the reach of the Foundation. Its emergence on the scene came precisely at the apex of neoliberal globalisation. At that time, overall spending for global health (counting WHO and other multilateral as well as bilateral organisations) was stagnant. Suspicion by political and economic elites (and, by way of a hegemonic media, by voters in many countries) of public and overseas development assistance, was at a near all-time high. Many low- and middle-income countries were floundering under the multiple burdens of HIV/AIDS, re-emerging infectious diseases, and soaring chronic ailments, compounded by decades of World Bank and International Monetary Fund-imposed social expenditure cuts. All this has exaggerated the Gates Foundation renown as a saviour for global health.

Gates has been widely lauded for infusing cash and life into the global health field and encouraging participation of other players. But even those who recognise this role decry the Foundation's lack of accountability and real-time transparency (over what are, after all, taxpayer-subsidised dollars) and the undue power other private actors, including those encouraged under the Foundation's favoured model, over the public good

As the 'pied piper' of global health, Gates collaborates with and supports a range of public-private partnerships, the US National Institutes of Health, the World Bank, WHO, and other multilateral agencies, as well as universities, private businesses, advocacy groups, and non-government organisations. As with Rockefeller in the past, the vast majority of Gates global health monies go to or by way of entities in high-income countries. For example, since 1998, the Seattle-based PATH (Programme for Appropriate Technology in Health), together with PATH Drug Solutions, and PATH Vaccine Solutions, have together received over US$1.6 billion in grants from the Gates Global Health Program, approximately 15% of global health grants disbursed to date, including close to US$ 614 million in grants for malaria research; over US$ 177 million in grants for neglected and infectious diseases; and over US$ 305 million in grants for enteric diseases and diarrhoea

Overall, the Foundation's Global Health Program supports research on and development of diagnostics, preventives, treatments, and disease campaigns addressing HIV/AIDS, malaria, TB, pneumonia, diarrhoeal diseases, and 'neglected diseases' (all of which have existing technical tools for control, from medicines to vaccines and oral rehydration salts to insecticide-impregnated bed nets), in addition to financing translational sciences. The Foundation also provides funding for research on cervical cancer screening methods, recently generating significant ethical criticism for the studies it supports in India.

In a shift since 2011, the Global Development Program now oversees a number of global health-related activities in the areas of: family planning; 'integrated delivery';

maternal, neonatal, and child health; nutrition; polio; vaccine delivery; and water, sanitation, and hygiene (the latter already being part of the Global Development Program). As in the global health arena, these efforts focus on innovating and delivering tools, procedures, and other targeted interventions, often with private enterprise partners. The Foundation's growing attention to sanitation, for example, supports development of new sanitation technologies as well as markets for new sanitation products and services.

Quick fixes

Gates sets great store by vaccines and other immediate treatments of infectious diseases. These are of course life-savers, but Gates has much less interest in the basic social and economic causes of disease

Leading Gates grants in the global health arena have included US$ 1.5 billion to the public-private partnership the Global Alliance for Vaccines and Immunisation (GAVI, which Gates was instrumental in launching, and still has a heavy hand in overseeing) to increase access to childhood and other vaccines; US$ 456 million to the PATH Malaria Vaccine Initiative; over US$ 500 million in grants to the Aeras Global TB Vaccine Foundation, and US$ 355 million to Rotary International for polio eradication. Gates has also provided approximately US$ 3 billion for HIV/AIDS control, also covering topical microbicides and vaccine development).

The Foundation's most prominent global health efforts involve support for vaccine development. In 2010 it committed US$ 10 billion over 10 years to vaccine research, development, and delivery. To be sure, vaccines are important and effective public health tools, but it is essential to consider the nature of the Foundation's vaccine investments, as well as what is neglected by this approach, such as, and most fundamentally, adequate living and working conditions. The Gates approach is, like that of Rockefeller, reductionist, perhaps best exemplified in Bill Gates' keynote speech at the 58th World Health Assembly in May 2005. See Box 4 for an extract.

Box 4

Bill Gates tells the world what to do

Here is an extract of the keynote address Bill Gates gave to the WHO World Health Assembly in May 2005.

I believe we are on the verge of taking historic steps to reduce disease in the developing world. What will make it possible to do something in the 21st century that we've never done before? Science and technology. Never before have we had anything close to the tools we have today to both spread awareness of the problems and discover and deliver solutions. Global communications technology today can show us the suffering of human beings a world away. As the world becomes smaller, this technology will make it harder to ignore our neighbors, and harder to ignore the call of conscience to act...

But the desire to help means nothing without the capacity to help—and our capacity to help is increasing through the miracles of science. Again and again, over and over, scientists make the impossible possible... We have an historic chance to build a world where all people, no matter where they're born, can have the preventive care, vaccines, and treatments they need to live a healthy life.

To build this world I see four priorities. First, governments in both developed and developing countries must dramatically increase their efforts to fight disease. The wealthy world's governments must not be content to merely increase their commitment every year. They need to match their commitment to the scale of the crisis. Yet, this will not happen unless we see a dramatic increase in the efforts of developing countries to fight the diseases that affect their people. Countries in sub-Saharan Africa spend a smaller percentage of their gross domestic product on health than any other region of the world. A stronger commitment from developing countries will inspire a stronger commitment from the rest of the world.

Priority number 2. The world needs to direct far more scientific research to health issues that can save the greatest number of lives -- which means diseases that disproportionately affect the developing world. In the early 1900s, Nobel Prizes were awarded for discoveries about the causes of both tuberculosis and malaria. Yet, more than a hundred years later, we don't have effective vaccines for either one. It's not because the problem is unsolvable; it's because we haven't put our scientific intelligence to this task. The world can change this—for malaria, tuberculosis, and so many other diseases.

In order to get the world's top scientific minds to take on the world's deadliest diseases, in 2003 our foundation launched 'The Grand Challenges in Global Health.' We asked top researchers to tell us which breakthroughs could help solve the most critical health problems in the developing world....More than 10,000 scientists from over 70 countries submitted proposals for research. They included ideas such as vaccines that don't need refrigeration, handheld micro-devices that health workers can use with minimal training to detect life-threatening fevers, and drugs that can attack diseases that hide from the immune system. The quality of the ideas and the volume of the response showed us that when scientists are given a chance to study questions that could save millions of lives, they flock to it. We were so taken with the response that today we are announcing an increase of our commitment to these Grand Challenges from 200 million dollars to 450 million dollars.

I am optimistic. I'm convinced that we will see more groundbreaking scientific advances for health in the developing world in the next ten years than we have seen in the last fifty. We're already seeing it...

Having a private sector orator address this annual gathering, at which WHO member countries set policy and vote on key matters, was unprecedented. Bill Gates' bravura in invoking the model of smallpox eradication based on vaccination (sidestepping its non-patented status) to set the course of WHO into the future, was astounding. Thus, as well as the passage above (Box 4), he said:

> Some point to better health in the developed world and say that we can only improve health when we eliminate poverty. And eliminating poverty is an important goal. But the world didn't have to eliminate poverty in order to eliminate smallpox, and we don't have to eliminate poverty before we reduce malaria. We do need to produce and deliver a vaccine.

Strikingly, Gates appealed to his audience with a deceptively simple technological solution to an enormously complex problem just two months after WHO launched its Commission on Social Determinants of Health, established precisely to counter overly biomedical understandings of health, and to investigate and advocate for addressing the range of fundamental structural and political factors that influence health. Further, Gates' assertion directly contradicts an abundance of public health and demographic research that demonstrates that the modern mortality decline since the 19th century has been the consequence of improved living and working conditions, followed by a combination of these socio-political approaches with medico-technologies that emerged since World War 2. (And see Box 5, below).

Unlike the early 20th century Rockefeller Foundation, which was open to social medicine research that showed the importance of both anti-poverty, redistributive efforts and technical interventions, Bill Gates' stance now suggests that he sees that there is a sufficient critical mass of pro-business politicians and scientists, and that leftist alternatives can be ignored or summarily rejected.

In a similar vein, the Gates Grand Challenges in Global Health initiative, created in 2003 and enhanced in 2008 through Grand Challenges Explorations, funds scientists in several dozen countries to carry out 'bold', 'unorthodox' research projects, but only if they view health in circumscribed, technological terms, not through integrated technical and socio-political understandings. While the approximately US$ 1 billion dollars spent on the Grand Challenges in its first decade is hardly the Foundation's largest initiative, it offers a valuable means for publicising and validating its approach in the scientific community, with serious consequences. Even Challenge 16, to 'Discover New Ways to Achieve Healthy Birth, Growth, and Development' – a question inherently linked to an array of social factors – identifies 'molecular pathways' as the primary roadblock to understanding what underlies poor infant health, without reference to living conditions of newborns and their families

Disavowing the messy and complicated politics of addressing health in the context of social conditions is certainly seductive for those promoting technical and managerial solutions for ill health. Yet with or without addressing the underlying causes of premature death and disease, there is no scientifically sound quick fix.

Box 5

Securing universal health care

In the space of less than a decade, Venezuela's *Barrio Adentro* programme ('Inside/Within the Neighbourhood,' founded in 2003) – to provide just one illustration from the recent social policies of left-wing governments across Latin America – doubled access to primary health care, reaching near universality, with 3200 health clinics built in the country's poorest neighbourhoods, places that had never before enjoyed such local infrastructure or attention to human need. According to WHO figures and other appraisals, in the first decade of Venezuela's Bolivarian Revolution, infant mortality accelerated its decline, going from 19 to 13.9 deaths/1000 live births, with under-5 mortality dropping from 26.5 to 16.7 deaths/1000 births.

This initiative drew from Venezuela's 1999 Constitution, which declares health to be a human right guaranteed by the state, coupled with 'bottom-up' political demands for health and social services, nutrition, housing, education, and improved employment.

Undoubtedly the likely billions of dollars (including the exchange of Venezuelan oil for the service of thousands of Cuban doctors) invested in this effort are far greater than what the Gates Foundation or even all overseas development aid put together might spend on primary health care in a single country. One would never expect or desire such a role for donors. Yet the lack of interest on the part of the Gates Foundation and most mainstream donors, whose ideological agendas reject these kinds of redistributive measures, in supporting, highlighting, or even considering Venezuela's integrated approaches as a legitimate and effective though not flawless route to global health equity, speaks volumes. In the 1980s, by contrast, though most mainstream bilateral aid agencies and development banks pulled out of revolutionary Nicaragua, a handful, notably the Scandinavians, stayed on, to assist the country in implementation of primary health care and universal education.

According to Bill Gates himself, many of the Grand Challenges are not expected to yield results until 15 or more years out, far longer than he originally envisioned, a time-frame in which large-scale social and political investments in, for example, comprehensive primary health care-based systems and health equity – had these been supported – could have paid off, and on a far grander scale.

Societies fighting for social justice do not offer a politically palatable pathway in a neoliberal environment marked by extreme concentration of wealth and power. The Gates Foundation, emblematic of elite interests in contemporary society, disregards the underlying causes of ill-health in the first place. It overlooks what role the unprecedented accumulation of wealth in the hands of a few has played therein. It remains fiercely proud – staking out a moral high ground – of its generosity and technical know-how, while remaining under-scrutinised by scientists and the public.

Admittedly, Gates has also engaged in smaller-scale patronage of certain initiatives that are not narrowly techno-biomedical and that provide support to some governments aiming to ensure publicly-funded national health care systems. In 2006, for example, Gates gave a US$ 20 million startup grant to launch the International

Association of National Public Health Institutes, based at the Emory University Global Health Institute in Atlanta, US, the Mexican National Institute of Public Health, and France's Institute for Public Health Surveillance, which helps support numerous public health institutes in low- and middle-income countries, including Cuba. In 2007 Gates provided US$ 5 million to the WHO-based Global Health Workforce Alliance, which seeks to address the health personnel shortage across low-income regions. But such grants are at the margins of Gates' efforts, both in monetary and publicity terms, and do not in and are not an alternative to the Foundation's method of operation.

Box 6

Gates and 'public-private partnerships'

Among the key levers of Gates influence are 'public-private partnerships', a global health funding and operations modality enabled by the massive entry of private capital into the health and development arena at the end of the Cold War. Philanthropic and business interests have long been involved in international health, but it was not until the 1990s that PPPs were formalised as a central element of global health. Following the prescription of privatisation of public goods required by the World Bank and IMF, these consciously draw on profit-making principles as a driver of policies, product development, and other activities The Rockefeller Foundation had successfully pushed this approach in the mid 1990s, but the catalytic part it played was soon upstaged by Gates philanthropy, which by this time had far more resources than Rockefeller.

There are now dozens of major global health PPPs in existence, with budgets ranging from a few million to billions of dollars. These include Stop TB, Roll Back Malaria, the International AIDS Vaccine Initiative, and the Global Alliance for Improved Nutrition (GAIN), many of which were launched by Gates or were or are funded by Gates. Portrayed as opportunities to expand funding and visibility, these 'collaborations' between the private sector and public agencies, both multilateral and national, extend far beyond Gates to include a range of business interests such as pharmaceutical companies and their philanthropic spinoffs. They have granted the business sector and profit-oriented approaches an enormous and unprecedented role in international public health policymaking without accountability in return. They also show a marked difference from the Rockefeller early and mid 20th century goal of pushing for public health, at both national and international levels, to be an accountable public sector responsibility.

Gates is by no means the only player in the public-private partnership sphere, and PPPs are not exclusive to the health arena. But the prominent part it has played in the two most influential PPPs, the Global Fund to Fight Tuberculosis and Malaria (the Global Fund), and the Global Alliance for Vaccination and Inoculation (GAVI), underscores the power of Gates in shaping and enhancing the public-private partnership model. The Global Fund, inaugurated as a Swiss foundation in 2002 with a US$ 100 million grant from Gates, is the largest PPP. Aimed at bypassing the perceived bureaucratic encumbrances of the UN, (which also can be described as independent and accountable decision-making bodies and processes) in funding services and therapies to combat these three diseases, the Global Fund has further debilitated the WHO and any semblance of democratic global health governance.

A technology-focused, disease-by-disease approach to global health has manifold limitations. But this model prevails, abetted by Gates' sway within formal global health decision-making bodies. The Foundation's role has been magnified by the formation of the 'H8', which are WHO, UNICEF, UNFPA, UNAIDS, the World Bank, Gates, GAVI, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, the world's leading global health institutions. The H8 holds meetings, like the G8, at which the mainstream global health agenda is shaped behind closed doors. Organisations influenced by Gates constitute a plurality.

The establishment of the Global Fund has also served to weaken an important transnational movement for intellectual property reform. This surged in the late 1990s to address the grossly immoral profiteering of pharmaceutical companies that impeded access to HIV/AIDS drugs in low- and middle-income countries, notably Africa. For example, a case filed by the AIDS Law Project, a human rights advocacy organisation, in South Africa in 2002 against excessive pricing by foreign pharmaceutical companies found a sympathetic ear with the country's Competition Tribunal. Settling out of court, the companies agreed to issue voluntary generic licenses for AIDS drugs, an outcome that inspired activists in other countries to follow suit. Once the flow of philanthropic and bilateral donations made medicines more accessible in the absence of intellectual property reform, the deep tensions between pharmaceutical profiteering and the health of the global poor was, at least in a limited fashion, attenuated.

The voting members of the Global Fund's governing board are split 50/50 between representatives of donor governments (8 members), private philanthropy (1), and the private sector (1) on one hand; and, on the other, representatives of low- and middle-income countries (7), 'communities' (1), and non-government organizations from 'developed' (1) and 'developing' (1) countries. The Global Fund raises money, reviews proposals, and disburses grants and contracts, rather than implementing programmes directly. As of 2013, the Fund had distributed upwards of US$ 22.9 billion to some 1,000 programmes in over 140 countries, and in December 2013 donors pledged an unprecedented additional US$ 12 billion for the next 3 years.

Incredibly, WHO and UNAIDS have no vote on the board of the Global Fund. But the private sector, represented by the pharmaceutical corporation Merck/MSD, and private foundations, represented by Gate, which has given close to US$ 1.5 billion to the Fund, do have votes. The Fund, like many public-private partnerships, offers 'business opportunities', lucrative contracts, as a prime feature of its work.

Similarly, GAVI has been critiqued for placing too much emphasis on new and novel vaccines, often developed by its pharmaceutical partners, rather than ensuring that known effective basic vaccination is universally carried out, and for being largely 'top-down', paying scant attention to local needs and conditions. Critics have also faulted GAVI for the heavy representation of industry on its board, and for directly subsidising the profits of already mega-profitable Big Pharma corporations through dubious contracts and incentives, all in the name of 'saving children's lives'.

World Health Organization work has also become tethered to public-private partnerships.(See Box 6, above). In recent years, activities with various PPPs have constituted between US$ 700 million and US$ 864 million of WHO's biennial budgets of over US$ 4 billion. This approximately 20–25% of the total is likely an underestimate given that several major partnerships, including Roll Back Malaria, are not captured in this figure. PPPs have undermined WHO's authority and ability to function. It was only as late as 2007 that the WHO Executive Board recognised the numerous problems posed by PPPs, such as fragmentation of global health efforts and policy, low cost-effectiveness, and insufficient accountability.

Yet WHO has not attempted to present systematically data about its participation in PPPs, and since 2012–13 has stopped issuing a section on PPPs in the biennial budget, admitting it 'did not always have full control of the results and deliverables'. Further evidence of WHO's evasions and hesitations regarding the problems of private sector involvement in its work is a 2010 WHO World Health Assembly resolution that calls on countries to 'constructively engage the private sector in providing essential health-care services'.

Certainly some global health public-private partnerships have helped spur research and development and enabled better diffusion of pharmaceuticals. Product Development Partnerships in particular have raised hundreds of millions of dollars for medicines for 'neglected diseases'. But on the whole they bring most of the same insidious problems as mainstream health donors writ large: imposition of outside agendas, poor harmonisation with stakeholders and national governments, underfunding, and vilification of the public sector. Ultimately, narrowly targeted PPPs entrench vertical, top-down, single disease-focused programmes. There is no PPP for social justice in health! These jeopardise health systems and impede integrated approaches to national, international and global health.

These concerns are aggravated by the incongruity between the profit-making mandates of corporations, and WHO's commitment to health as a human right. Public-private partnerships have marshaled billions of dollars to global health, at the same time as opening the door to extensive commercialisation and private sector influence in policymaking, making global health a bigger business opportunity than ever before. According to one ex-pharmaceutical executive, public-private partnerships may provide incentive for academic researchers to do work of value to industry partners'. This suggests an underhand way for private industry to influence global health research and the way scientific results are reported. Bilateral donors have become increasingly invested in PPP activity. When benefits such as direct grant monies, tax subsidies, reduced market risk, reputation enhancement, expanded markets, and intellectual property rights are taken into account, the net result is that most PPPs channel public money into the private sector, not the other way around.

Public-private partnership as a concept and in practice has been heavily shaped by the Gates Foundation. It allows private interests to compromise the public health

agenda. It gives legitimacy to corporations' activities through association with UN agencies. It conflates corporate and public objectives. It raises a host of conflicts of interest, whereby private partners seek to commercialise their own products through involvement with public partners. Moreover, most global health public-private partnerships favour short term, vertical approaches to disease control, compounded by profit-making imperatives. They also promote profit-making at the front end of global health work, as opposed to strategic public health activities in the public interest (against yellow fever, for example, as carried out by Rockefeller) that benefited capitalist interests only after the public health work was carried out.

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The second commentary, in the June issue of *WN*, includes discussion of conflicts of interest, and the prospects of more equitable governance and funding of global and national public health policies and programmes, especially in the global South. As stated above, scholars and others who want to read Anne-Emanuelle Birn's full paper, which is complete with extensive referencing, *can do so now by accessing this link here.*

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