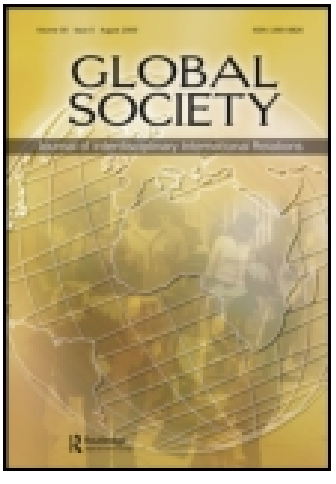

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The Rockefeller and Gates Foundations in Global Health Governance

JEREMY YOUDE

The Bill and Melinda Gates Foundation (BMGF) is the world's wealthiest philanthropic organisation and a major player in global health governance. While its emergence may be dramatic, BMGF's role in global health mirrors the experience of the Rockefeller Foundation's International Health Division nearly 100 years earlier. Both organisations provoked fear and consternation, but their supporters argued that both offered innovative techniques and filled niches governments could not or would not address. This article examines the parallels in arguments for and against the global health activities between the Bill and Melinda Gates Foundation and the Rockefeller Foundation. It also calls into question larger questions about the role of private actors in global governance and whether their activities in recent years are really all that unprecedented.

A wealthy private philanthropic organisation has taken a leading role in addressing international health concerns. The philanthropy's funds come almost entirely from its founder's pockets, a controversial and polarising businessman. The foundation's budget outstrips those of various international health organisations; indeed, the foundation actually contributes a significant amount of money to a number of those organisations. It raises questions about the role of existing international organisations dedicated to international health, with some observers fearing that it seeks to replace those organisations. Critics lambaste the philanthropy for running roughshod over international health structures, playing too dominant a role, ignoring the concerns of other actors, supporting inappropriate technologies and diverting attention from its founder's ethical lapses and economic inequalities. In essence, this private, unaccountable and non-transparent organisation is displacing state-based structures to advance its own interests in an unprecedented manner. To its advocates, however, this private organisation is able to augment existing international health structures and inject additional resources and attention into addressing infectious disease control and eradication.

To the modern observer, the above description sounds like the Bill and Melinda Gates Foundation (BMGF). Currently the world's wealthiest philanthropy, BMGF has become one of the most prominent actors in international and global health—and a prominent target for critics. Interestingly, these same criticisms and concerns emerged nearly 100 years earlier when John D. Rockefeller endowed his eponymous foundation. Thanks to its International Health Division (IHD), the Rockefeller Foundation (RF) took a leading role in infectious disease control during the

interwar period. Its actions won some acclaim, but also provoked much criticism over its methods and motivations.

The parallels between the experiences of and reactions to the Rockefeller and Gates Foundations raise important questions about global health governance and global governance on two levels. Firstly, they interact with powerful questions and concerns about the role of private authority within international relations. International relations typically focuses on state and state-based actors, but groups like the Rockefeller and Gates Foundations demonstrate that private actors can play significant roles that alter how the international community operates. The similarities between these two philanthropic organisations' experiences and works lead us to reconsider the role of private actors in global health governance—and global governance more broadly. Secondly, they call into question some of the assumptions about the unprecedented nature of contemporary global health governance. Instead of seeing contemporary global health architecture as unprecedented and wholly unique, the Rockefeller Foundation's experience encourages us to adopt a more circumspect posture. This is not to deny the incredible changes that have occurred in recent years in global health governance, but it does encourage us to more closely identify *what* exactly has changed.

In this article, I begin by briefly examining the question of private authority in international relations. The second and third sections discuss the operations and structures of the Rockefeller and Gates Foundations. The fourth section details the common criticisms levied against these two organisations, highlighting how similar many of the concerns have been. The fifth section looks at the potential positive benefits for global health governance from the involvement of these two philanthropies. The article ends by examining the role of philanthropic foundations in political science, global governance and global health politics.

Global Governance and Philanthropic Foundations

Contemporary global governance aims to come to terms with the role of non-state actors and private authority, positing that their rise is something new and unique to the modern era and potentially challenging long-held assumptions about the role of the sovereign state in international relations. Sending and Neumann identify three key themes that have emerged in this literature. First, government processes are no longer based on hierarchy and sovereignty, but are rather more horizontal and inclusive. Second, non-state actors are becoming more powerful as international actors, with the consequence of making states far less powerful. Third, political authority is no longer invested so much in the sovereign state, which is now but one of a wide range of actors involved in a given policy area.[1] Hall and Biersteker summarise this stance: "While these new actors are not states, are not state-based, and do not rely exclusively on the actions or explicit support of states in the international arena, they often convey and/or appear to have been accorded some form of legitimate authority".[2]

1. Ole Jacob Sending and Iver B. Neumann, "Governance to Governmentality: Analyzing NGOs, States, and Power", *International Studies Quarterly*, Vol. 50 (2006), p. 651.

2. Rodney Bruce Hall and Thomas J. Biersteker, "The Emergence of Private Authority in the International System", in Rodney Bruce Hall and Thomas J. Biersteker (eds.), *The Emergence of Private Authority in Global Governance* (Cambridge: Cambridge University Press, 2002), p. 4.

The consequences of the rise of non-state actors in contemporary global governance inspire fierce debate. Strange sees such private authority as a new, independent and impersonal power centre that increasingly overwhelms the power and authority of sovereign states.[3] Pauly describes this process as weakening states, although he argues that states seek to mask the extent of their power's decline.[4] Nanz and Steffek identify a common objection to the rise of non-state actors in global governance; namely, that it promotes a democratic deficit. The legitimacy of non-state actors does not derive from a mandate from the masses, so their growing strength within global governance is symptomatic of a growing divide between the rule-makers and the ruled.[5] Ottaway decries the corporatist links between international organisations, business and civil society in contemporary global governance. Instead of being a progressive opportunity for fostering greater public involvement, such a move serves to keep existing power structures intact and blunt calls for greater reform.[6] Others see the change as more benign. Sending and Neumann challenge the state-in-decline narrative within global governance. The rise of non-state actors is not about a transfer of power away from the state, but rather a change in the logic and rationality of government and one in which states are actively complicit.[7] Schwab shares a similar perspective, ascribing the shift to the nature of problems in the modern world. Contemporary global problems require broad solutions and greater resources than those available solely to governments.[8] Webb argues that non-state actors can fill gaps in services and authority that states either cannot or will not address,[9] and Hirschland finds that private business and multinational corporations may be particularly well placed to address these gaps.[10] Within both the optimist and pessimist camps, though, there is little challenge to the idea that the rise of non-state actors and private authority is something unique and modern.

Curiously, the debates over contemporary global governance largely ignore one prominent realm: that of the philanthropic foundation. Philanthropic foundations differ from charities, non-governmental organisations and private business. Unlike charities, philanthropic foundations do not generally accept donations from the public. Instead, their resources generally come from private or corporate wealth.[11] Unlike non-governmental organisations, philanthropic foundations

3. Susan Strange, *The Retreat of the State: The Diffusion of Power in the World Economy* (Cambridge: Cambridge University Press, 1996), pp. 76–90.

4. Louis W. Pauly, "Global Finance, Political Authority, and the Problem of Legitimization", in Hall and Biersteker, *The Emergence of Private Authority*, op. cit.

5. Patrizia Nanz and Jens Steffek, "Global Governance, Participation, and the Public Sphere", *Government and Opposition*, Vol. 39 (2004), p. 314.

6. Marina Ottaway, "Corporatism Goes Global: International Organization Networks and Transnational Business", *Global Governance*, Vol. 7 (2004), pp. 266–267.

7. Sending and Neumann, *op. cit.*, pp. 652–654.

8. Klaus Schwab, "Global Corporate Citizenship: Working with Governments and Civil Society", *Foreign Affairs*, Vol. 87 (2008), pp. 107–118.

9. Douglas Webb, "Legitimate Actors: The Future Roles for NGOs against HIV/AIDS in Sub-Saharan Africa", in Nana K. Poku and Alan Whiteside (eds.), *The Political Economy of AIDS in Africa* (Aldershot: Ashgate, 2004), pp. 19–32.

10. Matthew J. Hirschland, *Corporate Social Responsibility and the Shaping of Global Public Policy* (New York: Palgrave Macmillan, 2006), p. 142.

11. Owain David Williams and Simon Rushton, "Private Actors in Global Health Governance", in Simon Rushton and Owain David Williams (eds.), *Partnerships and Foundations in Global Health Governance* (New York: Palgrave Macmillan, 2011), p. 3.

rarely rely on volunteers to implement the programmes they fund. Unlike private businesses, the selling of goods and services is not central to the mission of philanthropic foundations. While there exists a tendency to lump philanthropic foundations together with private business and non-governmental organisations, it is important to recognise the unique position philanthropies hold within the international community.[12]

Despite these obvious differences, however, philanthropic foundations have the potential to have a similar sort of effect on global governance. Some of them possess significant financial and human resources. Some have programmes and operations in many countries around the world. Some can influence policy and governance decisions, as their ideas, knowledge and expertise may help to define a spectrum of choices available on a given issue.[13] While researchers have highlighted the role of philanthropic foundations and non-state actors in influencing government policy historically in the domestic realm,[14] the global governance literature has paid relatively little attention to the role of philanthropic foundations. This oversight is all the more puzzling when one considers that "[p]hilanthropy's historical promise grows out of its ability to take risks, to pursue issues and problems, and to serve people in circumstances that either government or profit-making institutions cannot".[15]

Health has traditionally been a leading area of interest for philanthropic foundations, and this remains true within the realm of global health governance. Many of the same questions raised about private actors in global governance play out in discussions of philanthropic foundations in global health governance. They can offer significant financial resources, but that raises questions about political influence and a lack of legitimacy.[16] They present themselves as being able to apply new and innovative methods to addressing global health concerns, but their efforts often carry an implicit mistrust and contempt for government and the public sector.[17] They can be a tool for generating collective action on global health issues, but the processes for incorporating and overseeing philanthropic foundations largely remains *ad hoc* and underspecified.[18]

The role of philanthropic foundations in global governance, and specifically global health governance, remains relatively underdeveloped. While there is a recognition that they can play a role, the nature of that role and its effects deserve greater attention. Furthermore, the global governance literature writ large has taken a fairly ahistorical approach to examining how private actors in general, and philanthropic foundations in particular, have contributed to the emergence

12. Michael Moran, "Private Foundations and Global Health Partnerships: Philanthropists and 'Partnership Brokerage'", in Rushton and Williams, *op. cit.*, p. 125.

13. James Allen Smith, "The Evolving Role of Foundations", in Virginia A. Hodgkinson, Richard W. Lyman and Associates (eds.), *The Future of the Nonprofit Sector: Challenges, Changes, and Policy Considerations* (San Francisco: Jossey-Bass, 1989), p. 63.

14. See, for instance, Joanna Innes, *Inferior Politics: Social Problems and Social Policies in Eighteenth-Century Britain* (New York: Oxford University Press, 2011).

15. Robert L. Bach, "New Priorities for Philanthropy", *Ethics and International Affairs*, Vol. 16 (2002), p. 25.

16. Williams and Rushton, *op. cit.*, p. 4.

17. David McCoy and Linsey McGoey, "Global Health and the Gates Foundation—In Perspective", in Rushton and Williams, *op. cit.*, pp. 146–147.

18. Kelley Lee and Richard Smith, "What is 'Global Health Diplomacy'? A Conceptual Review", *Global Health Governance*, Vol. 5 (2011), p. 9.

and maintenance of governance structures. Examining the Rockefeller Foundation and the Bill and Melinda Gates Foundation provides an opportunity to hone in on both the role of philanthropic foundations in global health governance and the nature of their involvement over time. This article cannot provide a comprehensive historical overview of these two philanthropic foundations, but it can highlight some of the motivations that have inspired their involvement in global health issues and the effects they have had on the international health agenda.

The Rockefeller Foundation

Founded in 1913, the Rockefeller Foundation (RF) dedicated itself to "a search for a cause, an attempt to cure evils at their source" to improve physical conditions for humanity.[19] International health took a prominent role in these efforts, and the International Health Division (IHD) coordinated these activities. Between 1913 and 1951, IHD operated in more than 80 countries. Its health work was of such importance that Farley declared: "Before the founding of the WHO in 1948, it [IHD] was arguably the world's most important agency of public health work".[20]

RF's significance came partially from its wealth. In 1913, John D. Rockefeller, Jr., gave RF an initial contribution of $35 million. Over the next 14 years, Rockefeller gave the foundation $182.9 million,[21] or approximately $4.09 billion in 2011 dollars. Its largesse allowed IHD to spend, on average, $18 million per year between 1913 and 1951. At its most active, between 1925 and 1935, IHD averaged closer to $25 million per year on international health programmes.[22] IHD's financial contributions took on even greater importance given the international climate at the time. It emerged shortly before World War I, and its operations reached their peak during the interwar period. At this time, few governmental entities had either the willpower or the financial resources to support international programmes. IHD's monies therefore took on even greater significance.

RF emphasised international health for three reasons. Firstly, RF had demonstrated its health expertise domestically and believed that it could apply those lessons to the international stage.[23] The foundation-led hookworm campaigns in the southern United States cut disease prevalence rates from 54.6 per cent in 1919 to 28.1 per cent in 1922, and RF believed it could replicate that experience internationally.[24] Wickliffe Rose, the first head of IHD, wrote a letter to Frederick Russell, his successor, that laid out the justification for IHD's work: "There are certain health functions that are international in character; national governments cannot undertake them; they are important for the health of the people of all

19. Robert Shaplen, *Toward the Well-Being of Mankind: Fifty Years of the Rockefeller Foundation* (Garden City, NY: Doubleday and Company, 1964), p. 1.

20. John Farley, *To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation (1913–1951)* (Oxford: Oxford University Press, 2004), p. 2.

21. Shaplen, *op. cit.*, p. 8.

22. Farley, *To Cast Out Disease*, *op. cit.*, pp. 19–20.

23. Anne-Emmanuelle Birn and Armando Solorzano, "Public Health Policy Paradoxes: Science and Politics in the Rockefeller Foundation's Hookworm Campaign in Mexico in the 1920s", *Social Science and Medicine*, Vol. 49 (1999), p. 1198.

24. Farley, *To Cast Out Disease*, *op. cit.* p. 83.

lands".[25] Rose, Russell and their compatriots recognised that the post-World War I world required new types of health organisations, and they saw philanthropic foundations like RF as uniquely well suited to addressing those tasks.

Secondly, RF believed that promoting public health internationally would lead to greater political and economic stability worldwide. Better hygiene and public health systems would create happier human societies. Health improvements among the workers in a given state would facilitate economic growth, which would in turn increase productivity and decrease the likelihood of destabilising political and economic shocks to the system.[26] RF trustees also believed that addressing health concerns would decrease support for radical labour and socialist movements around the world.[27]

Thirdly, IHD drew on the ideals of the Progressive Era. It believed in the ability of science to rationally solve a whole range of ills that befell humanity and to position its suggested solutions as non-ideological.[28] Progressive Era reformers combined the energies of philanthropic organisations and the law-making powers of governments.[29] They sought to "harness the positive and eliminate the negative attributes of industrial capitalism" and emphasised efficiency, eliminating waste, alleviating misery and establishing a more just society.[30]

In the aftermath of World War I, when the League of Nations formed and discussed creating a health organisation, IHD saw that it would be in its best interests to support that new organisation and ensure its viability. Creating a health office was one of the League of Nations' early objectives. At the first meeting of the Assembly of the League of Nations in late 1920, the delegates adopted a report that resolved to create a new international health organisation.[31] After initially considering a merger with an existing organisation, the League opted to create its own. In 1922, the League of Nations Health Organization (LNHO) came into being.

LNHO's creation provoked some consternation among League members that the new group would require a large budget—something the League could ill afford. LNHO leaders sought to allay these fears by announcing that they were negotiating with IHD for financial support. IHD funding was absolutely vital for LNHO's operations. IHD provided its first grant to LNHO in 1922, pledging $492,000 over five years to create a "personnel interchange program". Over the next 15 years, IHD monies funded nearly half of LNHO's budgetary outlays.[32] IHD contributed $1.3 million to LNHO between 1922 and 1930, and gave

25. Cited in Paul Weindling, "Philanthropy and World Health: The Rockefeller Foundation and the League of Nations Health Organization", *Minerva*, Vol. 35 (1997), p. 269.

26. E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley: University of California Press, 1979), p. 116.

27. *Ibid.*, pp. 116–119.

28. Birn and Solorzano, *op. cit.*, p. 1198.

29. Arturo Vargas, Nan Aron and Gail Christopher, "The Role of Foundations in Influencing Public Policy", *National Civic Review*, Vol. 87 (1998), p. 117.

30. Edward H. Berman, *The Influence of the Carnegie, Ford, and Rockefeller Foundations on American Foreign Policy: The Ideology of Philanthropy* (Albany: State University of New York Press, 1983), pp. 16–17.

31. Norman Howard-Jones, *International Public Health between the Two World Wars—The Organizational Problem* (Geneva: World Health Organization, 1978), p. 22.

32. Craig N. Murphy, *International Organization and Industrial Change: Global Governance since 1850* (New York: Oxford University Press, 1994), p. 183.

another $723,000 between 1930 and 1934.[33] IHD's financial resources proved crucial for establishing LNHO and allowing the nascent international organisation to carry out its mission.

IHD funding also allowed LNHO to circumvent the League's budgetary austerity measures. In 1925, the League capped LNHO's budget at 1 million Swiss francs, but it excluded funds from IHD from this limit. Four years later, the League lifted LNHO's budget cap, but the Great Depression severely reduced the amount of funding available to the League as a whole. All League programmes, including LNHO, saw their budgets cut. With IHD support, however, LNHO's budget decreased far more slowly and less severely than other League programmes.[34] Dubin noted:

> These grants were a pittance in the Foundation's total public health budget, but they were a life-line for [LNHO director Ludwik] Rajchman. They permitted him to carry out important projects the League probably would not have financed, and, by conferring prestige on him and the LNHO, probably stimulated the LN to appropriate more funds than it might otherwise have provided.[35]

This allowed LNHO to maintain viable and visible programmes at a time when the League of Nations as a whole came under increasing fire and scrutiny.

IHD's importance for LNHO went beyond its financial generosity. IHD helped to shape LNHO's agenda and direct its attention towards particular strategies for addressing ill health. IHD's core belief was that "disease was the determining factor in ill health and health could be attained only by the control or elimination of communicable disease".[36] To achieve these ends, IHD prioritised vector control, drug development and vaccine research as part of a "utopian, millenarian vision of applied science uniting a divided world".[37] Farley described this stance as "a totally biomedical view of health from which they rarely diverged and which carried all before it".[38] This led to an emphasis on laboratory research, fieldwork on disease control and prevention, and experimental local health organisations—areas which LNHO lacked the resources or expertise to address on its own.[39]

Indeed, LNHO officials themselves seemed to recognise IHD's influence on the organisation's activities and operations. During a speech in London in 1924, Rajchman explained LNHO's purpose and activities. Most of LNHO's activities, he explained, focused on things like standardising medical definitions and measurements, providing medical courses, encouraging dialogue among medical officials from different countries and facilitating international agreements on health. However, he noted that LNHO's fortunes were buoyed by "the special interest

33. Martin David Dubin, "The League of Nations Health Organization," in Paul Weindling (ed.), *International Health Organizations and Movements, 1918–1939* (Cambridge: Cambridge University Press, 1995), p. 72.

34. *Ibid*., p. 63.

35. *Ibid*., p. 72.

36. Farley, *To Cast Out Disease*, *op. cit*., p. 5.

37. Lion Munard and Patrick Zylberman, "Seeds for French Health Care: Did the Rockefeller Foundation Plant the Seeds between the Two World Wars?", *Studies in History and Philosophy of Science C: Studies in History and Philosophy of Biological and Biomedical Sciences*, Vol. 31 (2000), p. 463.

38. Farley, *To Cast Out Disease*, *op. cit*., p. 5.

39. Weindling, "Philanthropy and World Health", *op. cit*., p. 270.

of the Rockefeller Foundation, which has supplemented the League's slender budget for health purposes *by donations for particular purposes*".[40] Rajchman essentially saw a division of labour between LNHO's general orientation towards more traditional public health practices and IHD's support for scientific research and drug development under LNHO's aegis. This is not to say that IHD directed specifically how its money would be spent; indeed, Wickliffe Rose specifically mandated a hands-off policy to allow LNHO to formulate its own agenda.[41] Given IHD's interests and philosophical orientation, though, it is unsurprising that LNHO officials would opt to direct RF's monies towards those areas in which the foundation was particularly concerned. A 1926 report, for example, described the specific purposes for which IHD funds would be used: scientific studies, epidemiological intelligence services and exchange programmes for medical personnel (but that LNHO would gradually phase out using IHD funds for this).[42] These programmes are in line with IHD's emphasis on a biomedical approach rather than addressing underlying social issues and concerns that give rise to ill health.

Through this division of labour, LNHO could direct IHD's appropriations towards laboratory science and drug development while the rest of the organisation concentrated on other concerns. For example, the Greek government requested assistance from LNHO to reform its public health service and combat malaria outbreaks in 1928. LNHO and IHD recommended the Greek government create the Athens Health Center to serve as the centre of a revitalised national health service. The set-up of the Athens Health Center reflected the respective areas of expertise of LNHO and RF. LNHO, for example, took responsibility for the Division of Hygiene and Preventative Medicine and appointed its director. IHD oversaw and appointed the directors of the Divisions of Sanitary Engineering and Malariology. Within these two divisions, RF oversaw field studies on preventing malaria's spread and coordinated research on and production of quinine as an antimalarial.[43] While IHD concentrated on its research, LNHO funds focused on training public health officers in modern public health practices and infusing proper hygiene training procedures in the newly established School of Hygiene attached to the Athens Health Center.[44] In this way, both LNHO and IHD could concentrate on their areas of expertise. It also allowed IHD to have a significant effect on the international health agenda. By emphasising the importance of a biomedical perspective on public health and elevating it above social considerations, IHD ensured that scientific research and drug development played a significant role in international public health until the termination of its programmes.

By 1951, IHD disappeared from the international scene. How did IHD go from central to supporting global health programmes to not even existing? Two reasons are particularly important for explaining this shift. Perhaps most prominently, a

40. "Public Health Work by the League of Nations", *The Lancet*, Vol. 203 (1924), p. 811; emphasis added.

41. Weindling, "Philanthropy and World Health", *op. cit.*, p. 270.

42. "International Health: Expanding Activities of the League of Nations", *British Medical Journal*, Vol. 2 (1926), p. 567.

43. Dimitra Giannuli, "'Repeated Disappointment': The Rockefeller Foundation and the Reform of the Greek Public Health System, 1929–1940", *Bulletin of the History of Medicine*, Vol. 72 (1998), pp. 47–60.

44. Frank G. Boudreau, "Health Work of the League of Nations", *Milbank Memorial Quarterly*, Vol. 13 (1935), p. 14.

host of new organisations emerged to fill the niche that IHD had occupied. The World Health Organization (WHO) replaced LNHO and was explicitly designated as the international community's lead organisation for addressing international health concerns.[45] With WHO's funds coming from member-state dues and its near-universal membership, IHD's previous role no longer seemed quite so vital. IHD officials themselves recognised that their work would be overshadowed by WHO and various regional health organisations.[46] If its earlier support for LNHO was motivated in part by supporting activities that LNHO could not undertake on its own, and the new WHO demonstrated that it *could* handle those functions itself, then IHD's programmes would simply duplicate services.

Secondly, IHD's biomedical perspective assumed greater prominence on the international health agenda. The optimistic faith in technology that buoyed RF in its early days was prominent in the post-World War II environment. IHD's methods and ideas infused the programmes of the new World Health Organization and its various regional organisations. For example, the Global Malaria Eradication Program (GMEP) began in 1955 under the aegis of WHO, staffed by many former IHD employees. GMEP premised its operations on the idea that new technological developments like dichlorodiphenyltrichloroethane (DDT) would permit the eradication of the mosquitoes that carry malaria. Eliminating malaria would in turn permit economic growth in poor states.[47] This sort of faith expanded IHD's original biomedical conception of public health to the realm of international development writ large. It posited that control of disease by technical means was a prerequisite for increasing human wealth and happiness. A failure to realise the biomedical public health paradigm imperilled not only human health, but its potential prosperity. Farley explains: "Attacks on disease plus development aid were assumed to be the means by which poorer countries could progress, become modernized, and thus westernized".[48] While GMEP ultimately proved unsuccessful,[49] it drew its inspiration from that same faith and emphasis on biomedical approaches that animated IHD's involvement with LNHO.

The Gates Foundation

It is nearly impossible to talk about the role of philanthropic organisations in contemporary global governance without discussing the Bill and Melinda Gates Foundation (BMGF). BMGF is the world's wealthiest philanthropic organisation, with an endowment of $33.5 billion as of 30 September 2011 and $2.47 billion in grants paid in 2011.[50] Since its inception, the Foundation has provided grants totalling $26.2 billion in its three focus areas: global health, global development,

45. Mark W. Zacher and Tania J. Keefe, *The Politics of Global Health Governance: United by Contagion* (New York: Palgrave Macmillan, 2008), p. 7.

46. Farley, *To Cast Out Disease*, *op. cit.*, p. 279.

47. *Ibid.*, pp. 284–286.

48. *Ibid.*, p. 284.

49. For a discussion of the failure of malaria eradication campaigns, see Laurie Garrett, *The Coming Plague: Newly Emerging Diseases in a World Out of Balance* (New York: Penguin, 1994), pp. 30–52.

50. Gates Foundation, "Foundation Fact Sheet", available: <http://www.gatesfoundation.org/about/Pages/foundation-fact-sheet.aspx> (accessed 16 February 2012).

and the United States. The global health programme has received the most funding, comprising $15.3 billion between 1994 and 2011.[51]

BMGF has, in a relatively short period of time, become a major player in global health and helped to set its agenda. While global health is not BMGF's only area of interest, it has received nearly 60 per cent of the foundation's grant monies. BMGF argues that it uses its philanthropy to address overlooked social goods and needs. As Bill Gates wrote, "Foundations bring something unique when they work on behalf of the poor, who have no market power, or when they work in areas like health and education, where the market doesn't naturally work toward the right goals and where the innovation requires long-term investments".[52]

BMGF portrays itself as a partner for governments, providing resources and funds that governments cannot. Gates notes that the global economic recession has placed greater strain on national budgets, making it unlikely that many traditional donor states can even maintain their current levels of foreign aid. Into this gap, he notes, foundations like his can enter.[53] Chen notes, however, that BMGF has restrictions on what types of global health activities it will fund. In particular, BMGF takes a biomedical approach and focuses its funds on research and development of treatment for infectious diseases. It offers little support for health care infrastructure, since it sees that as a primary responsibility of government.[54]

Over the past decade, BMGF has become one of the dominant funders of global health projects. Between 2000 and 2002, it donated $400 million for international AIDS research. By comparison, the United States government appropriated $242.7 million for international AIDS programmes in 2000.[55] In 2004, the Foundation gave $119.1 million for international AIDS-related projects. Two years later, its pledges totalled $735.7 million—a 518 per cent increase.[56] In 2006–2007, BMGF disbursed $308.9 million for international AIDS projects—more than half of all private funds for such work during that biennium.[57] One of the more prominent projects receiving funding from BMGF is the African Comprehensive HIV/AIDS Partnership (ACHAP). Founded in 2000, ACHAP is a country-led public–private partnership between BMGF, the Government of Botswana and Merck Pharmaceuticals with the goal of preventing HIV transmission and providing treatment for those already infected. In particular, it has focused

51. *Ibid.*

52. Bill Gates, *2009 Annual Letter from Bill Gates*, p. 16, available: <http://www.gatesfoundation.org/annual-letter/Documents/2009-bill-gates-annual-letter.pdf> (accessed 15 March 2009).

53. Bill Gates, *2010 Annual Letter from Bill Gates*, pp. 15–17, available: <http://www.gatesfoundation.org/annual-letter/2010/Documents/2010-bill-gates-annual-letter.pdf> (accessed 22 March 2010).

54. Ingfei Chen, "Thinking Big about Global Health", *Cell*, Vol. 124 (2006), p. 663.

55. Priya Alagiri, Chris Collins, Todd Summers, Steve Morin and Thomas Coates, *Global Spending on HIV/AIDS: Tracking Public and Private Investments in AIDS Prevention, Care, and Treatment* (San Francisco: Henry J. Kaiser Family Foundation, 2001), p. 5, available: <http://ari.ucsf.edu/science/reports/global_spending.pdf> (accessed 16 February 2012).

56. Funders Concerned About AIDS, *US Philanthropic Commitments for HIV/AIDS: 2005 and 2006* (New York: FCAA, 2007), p. 16, available: <http://www.fcaaids.org/Portals/0/Uploads/Documents/Public/FCAART0605.pdf> (accessed 20 March 2009).

57. Funders Concerned About AIDS, *US Philanthropic Support to Address HIV/AIDS in 2007* (New York: FCAA, 2008), p. 2, available: <http://www.fcaaids.org/Portals/0/Uploads/Documents/Public/FCAArT08.pdf> (accessed 20 March 2009).

energies on providing free access to antiretroviral drugs (ARVs) in a country with one of the world's highest adult HIV prevalence rates.[58] BMGF pledged $56.5 million to implement the programme.

Observers credit BMGF's donations to HIV/AIDS research with creating a major ripple effect that has increased international funding for AIDS research. Peter Piot, the then-head of UNAIDS, argued that the Foundation's donations "sham[ed] many 'donor' governments" into contributing more.[59] The fact that a private philanthropic organisation was spending as much, if not more, than many leading governments on international AIDS research, care and prevention encouraged governments to increase their donations to show they were serious about combating the disease. BMGF's donations may also have helped to demonstrate to government officials that there existed worthwhile international AIDS projects that could benefit from significant funding.

While its work on AIDS may have received the most attention, BMGF's contributions have spanned a wide range of diseases. The Foundation contributed $1.2 billion to malaria research and more than $900 million to tuberculosis research between 2000 and 2008.[60] In so doing, its actions encouraged other public and private donors to increase their tuberculosis-related donations too.[61]

BMGF's Grand Challenges in Global Health (GCGH) programme is emblematic of the organisation's approach to global health. Announced in 2003, GCGH initially made $200 million worth of grants available to researchers working on issues and diseases that had poor market incentives. Recipients had to work in research areas with a high degree of promise for saving and improving lives in developing countries.[62] These were the diseases that private industry paid too little attention to, since they saw little chance of recouping their investments or creating a large enough market.[63]

GCGH recipients receive a great deal of latitude, but they must make certain pledges to receive funding. First, they must identify specific milestones by which outside evaluators can assess their progress. Second, they must create a timeline for their work. Finally, they must pledge to make any pharmaceutical discoveries that emerge from their research affordable to people in developing countries.[64] This programme has led BMGF to become the largest donor for research on diseases in developing countries.[65] It has also encouraged other public and private funders to get involved in research in developing country diseases. It creates an assumption that there must be something good or important happening if the Gates Foundation is willing to exist.[66] For instance, the United States' National Institutes of Health (NIH) increased their spending on global

58. Ilavenil Ramiah and Michael R. Reich, "Public-Private Partnerships and Antiretroviral Drugs for HIV/AIDS: Lessons from Botswana", *Health Affairs*, Vol. 24 (2005), p. 545.

59. Jon Cohen, "Gates Foundation Rearranges Public Health Universe", *Science*, Vol. 295 (2002), p. 2000.

60. Donald G. McNeil, Jr., "Gates Foundation Influence Criticized", *New York Times*, 16 February 2008.

61. Chen, *op. cit.*, p. 661.

62. Bill Gates, "Humane Research", *Wall Street Journal*, 26 January 2003.

63. Michael McCarthy, "A Conversation with the Leaders of the Gates Foundation's Global Health Program: Gordon Perkin and William Foege", *The Lancet*, Vol. 356 (2000), p. 154.

64. Chen, *op. cit.*, p. 662.

65. McNeil, *op. cit.*

66. McCarthy, *op. cit.*, p. 154.

health issues by $1 billion after BMGF announced GCGH at a time when most other NIH research programmes saw their budgets remain flat.[67]

Through its prodigious spending, BMGF has had an important effect on the global health agenda in a number of key ways. Firstly, its willingness to devote significant resources to global health issues has called attention to serious health challenges. Putting a lot of money towards an issue necessarily calls attention to that issue. It grabs international attention and helps to shape the global debate. Secondly, by providing funds for research and treatment of neglected diseases, it has called greater attention to diseases other than HIV/AIDS, tuberculosis and malaria. While HIV/AIDS, tuberculosis and malaria remain significantly underfunded, their relative prominence on the global health agenda has drowned out attention to other diseases that are less prominent but cause greater morbidity and mortality.[68] BMGF possesses the largesse to direct attention towards some of these other issues in addition to its support for HIV/AIDS, tuberculosis and malaria research. Finally, its emphasis on developing new pharmaceutical treatments and using new technologies has elevated the biomedical paradigm within global health. This does not mean that there is no attention paid to the social factors that give rise to global health issues today, but BMGF's wealth and emphases allow research on new drugs and vaccines to gain greater prominence within debates.

Criticisms of the Rockefeller and Gates Foundations

There exists a remarkable degree of consistency among the criticisms levied against the Rockefeller Foundation's work in the early part of the 20th century and against BMGF in the late 20th and early 21st centuries. Most of the criticisms fall into four broad categories. First, critics charge that these foundations are overly dominant, crowding out other voices. The Rockefeller Foundation was easily the wealthiest philanthropic organisation operating in the world in the early 20th century, and its wealth gave it an inordinate level of power and prestige. Cunningim describes the Rockefeller Foundation as a "center of immense and perhaps inimical power … it wields large influence on public affairs. It exercises control over many institutions of society, and thus over many individuals. It shapes and moves and works its own will".[69] This power gave the Rockefeller Foundation the ability, according to its critics, to ensure that its desired outcomes would rule the day. Such programmes would, in turn, generate better economic conditions and stabilise political systems, furthering the Rockefellers' business interests.[70]

In essence, critics of RF's health work saw its health philanthropy as a business strategy. Brown lays out the sequence of events. IHD's health programmes abroad would allow the US to develop and control resources and markets abroad. Controlling the resources available in poor countries was crucial for promoting

67. Kirstin R.W. Matthews and Vivian Ho, "The Grand Impact of the Gates Foundation", *EMBO Reports*, Vol. 9 (2008), p. 409.

68. Jeremy Shiffman, "Has Donor Prioritization of HIV/AIDS Displaced Aid for other Health Issues?", *Health Policy and Planning*, Vol. 23 (2008), pp. 95–100.

69. Merrimon Cunningim, *Private Money and Public Service* (New York: McGraw-Hill, 1972), p. 72.

70. John Farley, "The International Health Division of the Rockefeller Foundation: The Russell Years, 1920–1934", in Paul Weindling (ed.), *International Health Organizations and Movements, 1918–1939* (Cambridge: Cambridge University Press, 2005), pp. 203–204.

American prosperity, particularly the prosperity of the upper classes. Tropical diseases, however, inhibited economic development and made it difficult to gain access to those very resources so vital for ensuring the prosperity of the upper classes. Hence, Brown argued, improving public health through IHD programmes would increase productivity and promote the embrace of Western/American values, which would in turn lead to more money for the Rockefellers.[71]

BMGF has been criticised for being a veto player when it works with other organisations. The massive financial resources available to BMGF allow it to dominate other organisations, pushing its priorities over others.[72] Pablo Eisenberg, a senior fellow at the Georgetown Public Policy Institute, describes the imbalance: "You may have foundations with assets larger than almost 70 percent of the world's nations making decisions about public policy and public priorities without any public discussion or political process".[73] The priorities of BMGF, allege critics, may not necessarily align with those of local governments. This line of objection argues that recipient governments are in subservient positions because of their reliance on funds from BMGF. That prevents them voicing objections or reorienting the Foundation's work towards more vital programmes. Instead, critics charge BMGF with promoting groupthink among its recipients, creating a cartel mentality and discouraging debate.[74]

The Gates Foundation's work on malaria has borne much of this criticism. In 2008, Arata Kochi, the head of WHO's malaria programme, wrote a memo to senior WHO officials complaining about the Foundation's influence. He argued that the Foundation was stifling debate on the best ways to treat and combat malaria, prioritising only those methods that relied on new technology or developing new drugs. Furthermore, because the Foundation provided grants to so many malaria researchers, it was nearly impossible to find independent, impartial reviewers for project proposals. Instead of being a partner, Kochi saw BMGF as trying to supersede WHO's policy-making function. One of Kochi's supporters described Gates Foundation-funded groups as "cowed into stomach-churning groupthink".[75]

Second, critics allege that these charitable actions are merely a ruse to hide the failures of the current international economic system. The philanthropic foundations attempt to whitewash the problems and inherent contradictions manifest within an exploitative economic system. Schervish and Ostrander note that philanthropy is typically a power relationship that privileges the donor and its needs over those of the recipient. Donors occupy a position that gives them more active choices about their transactions with recipients. Recipients, on the other hand, often lack agency because their futures are essentially at the mercy of the donors.[76] The imbalanced power relations allow donors like philanthropic

71. E. Richard Brown, "Public Health in Imperialism: Early Rockefeller Programs at Home and Abroad", *American Journal of Public Health*, Vol. 66 (1976), p. 897.

72. Andrew F. Cooper, "Beyond One Image Fits All: Bono and the Complexities of Celebrity Diplomacy", *Global Governance*, Vol. 14 (2008), pp. 269–270.

73. Cited in Meredith Wadman, "State of the Donation", *Nature*, Vol. 447 (2007), p. 248.

74. Roger Bate, "Stifling Dissent on Malaria", *The American*, 8 December 2008, available: <http://www.american.com/archive/2008/december-12-08/stifling-dissent-on-malaria> (accessed 22 March 2010).

75. McNeil, *op. cit.*

76. Paul G. Schervish and Susan Ostrander, "Giving and Getting: Philanthropy as a Social Relation", in Jon Van Til (ed.), *Critical Issues in American Philanthropy: Strengthening Theory and Practice* (San Francisco: Jossey-Bass, 1990), pp. 70–75.

foundations to use their wealth to maintain the status quo and punish those who may try to challenge the system.

When IHD began its work in 1913, its energies "were directed more generally at improving the health of each country's work force to facilitate sufficient economic development to provide the United States with needed raw materials and an adequate market for this country's manufactured goods", according to its detractors.[77] As such, any profession of humanitarian interest merely hid the Rockefellers' true interest in enriching themselves and their cronies. Some critics allowed that genuine humanitarian interest did play at least some role in encouraging the Rockefeller Foundation to get involved in health work, but they also noted that the programmes sought to transform regions of the world to be more economically and politically receptive to US interests.[78] The health programmes, critics alleged, "were explicitly intended to develop and strengthen institutions that would extend the reach and tighten the grasp of capitalism throughout the society".[79] RF programmes sought to "make 'them' (the poor of the Deep South, the inhabitants of Asia and Latin America, of Southern and Eastern Europe, and even the tuberculosis-ridden French and the malaria-infested Italians) more like 'us' (middle class, white Protestant Americans)".[80] Facilitating better health would also discourage the growth of radical movements that sought to challenge the very political and economic systems that allowed the Rockefeller Foundation to acquire all of its money in the first place. Supporting health would decrease the appeal of radical labour and socialist movements by hiding the miseries caused by capitalism.[81]

BMGF has faced similar charges. Instead of fundamentally challenging the existing order, BMGF's work provides a cover for the deleterious effects of global neoliberal capitalism. Hindmarsh writes: "To overcome widespread disaffection with the new order's gross inequalities and labor relations, and to strengthen the institutions of capitalism, elite managerial ideals combined with corporate philanthropy".[82] Critics charge that the Gates Foundation seeks to mask the anger about and contradictions of globalisation through its philanthropic activities. Its emergence and dominance is a sign of neoliberalism's hegemony, and its desire to create new drugs and technologies reflects an overt market orientation. Thus, according to critics, BMGF consciously opts not to promote the sorts of radical changes to the political and economic system that would ultimately be more beneficial to the vast majority of people.[83]

Reports in the *Los Angeles Times* assert that BMGF invests its endowment in publicly traded corporations whose actions cause the very health problems that the Foundation seeks to alleviate. However, instead of trying to use its financial and moral clout to encourage those companies to change their practices and reduce their harmful and polluting actions, the Foundation very publicly rejects the

77. Brown, *Rockefeller Medicine Men*, *op. cit.*, p. 116.

78. Ilana Löwy and Patrick Zylberman, "Medicine as a Social Instrument: Rockefeller Foundation, 1913–45", *Studies in the History and Philosophy of Biology and Biomedicine*, Vol. 31 (2000), p. 368.

79. Brown, *Rockefeller Medicine Men*, *op. cit.*, pp. 8–9.

80. Löwy and Zylberman, *op. cit.*, p. 367.

81. Brown, *Rockefeller Medicine Men*, *op. cit.*, pp. 116–119.

82. Richard Hindmarsh, "Genetic Modification and the Doubly Green Revolution", *Forum*, Vol. 40 (2003), p. 12.

83. Moran, *op. cit.*, pp. 131–133.

idea of shareholder activism and establishes firm firewalls between its investment and philanthropy arms.[84] Critics thus charge that there exists a severe contradiction in using money raised from nefarious sources to fund global health programmes. Investing in companies with poor environmental and health records and receiving donations from autocratic governments who deny adequate healthcare to their populations contradicts the very messages that these foundations claim to promote. BMGF is not the only philanthropic foundation whose investments may pose a conflict of interest, but its status as the world's wealthiest amplifies the negative consequences of these conflicts.

Third, critics charge these foundations employ inappropriate solutions and technologies. Their solutions ignore local needs and capabilities, and instead privilege predetermined favoured approaches. They have a technological, biomedical bias that pays no attention to local concerns and may be inappropriate in certain contexts.[85] For example, many of the Rockefeller Foundation-supported malaria control programmes focused on controlling and eliminating mosquitoes. This entailed developing drugs and chemicals to kill mosquitoes, draining swamplands to eliminate breeding sites, and spraying homes with DDT. Local doctors accused IHD of focusing on the technological side of malaria while neglecting any discussion or research into alleviating the suffering of those infected with the disease.[86] IHD programmes fetishised technology, but ignored the human element of the disease in favour of easily quantifiable results that required ever-higher degrees of technological sophistication.[87] It was relatively easy to say that the organisation had sprayed a certain amount of chemicals, drained a certain number of acres of swampland or disinfected a certain number of houses. Addressing the human side of things and focusing on alleviating suffering was "fuzzier" and would not produce results as dramatically or as quickly.

BMGF's wealth comes from high technology, and the health solutions they pursue follow that same vein. It encourages the development of high-tech solutions and favours the development of new drugs over providing better access to currently existing useful medicines.[88] By overemphasising the new and the high-tech, it focuses too much on those approaches that might lead to greater financial rewards down the road. Many criticisms of BMGF's efforts on malaria described above centre on its preference for developing new drugs, discovering vaccines and implementing technological solutions that may be inappropriate or unworkable in many settings. As a result, BMGF's emphasis on high-tech solutions for international health problems "create[s] shortsighted agendas that may miss the most pressing health problems".[89] The foundation seeks to draw on the

84. Charles Piller, Edmund Sanders and Robyn Dixon, "Dark Cloud over Good Works of Gates Foundation", *Los Angeles Times*, 7 January 2007, available: <http://articles.latimes.com/2007/jan/07/nation/na-gatesx07> (accessed 22 March 2010).

85. Moran, *op. cit.*, p. 141.

86. Darwin H. Stapleton, "Lessons of History? Anti-malaria Strategies of the International Health Board and the Rockefeller Foundation from the 1920s to the Era of DDT", *Public Health Reports*, Vol. 119 (2004), pp. 207–208.

87. *Ibid.*, p. 208.

88. McNeil, *op. cit.*

89. Amy Barth, "Can Bill Gates Buy a Better World?", *Discover Magazine*, December 2010, available: <http://discovermagazine.com/2010/dec/01-can-bill-gates-buy-a-better-world> (accessed 2 March 2011).

technological prowess that gave it its wealth in the first place, but fails to consider whether that approach is the most appropriate or useful for the majority of global health concerns it seeks to address. Obtaining new drugs and new technologies may be too expensive for those who need them.

Finally, critics disparage the lack of accountability measures within these foundations. They have significant public policy influence, yet the public has next to no opportunity to express its opinions about programmes. It replaces a mass democratic voice with a top-down autocratic one. Organisations like the World Health Organization and the Global Fund for AIDS, Tuberculosis, and Malaria offer opportunities for both donors and recipients to engage in a public dialogue about priorities and strategies. The Rockefeller and Gates Foundations, on the other hand, are not accountable to anyone other than themselves. While both organisations have trustees with fiduciary responsibility to the philanthropy, those overseers lack broad-based legitimacy since they do not obtain their positions through a mass deliberative process or public election.

The Rockefeller Foundation's entry into the international health realm raised concern about its motivations. It came to be seen in some quarters as part of an imperial American apparatus, obsessed with spreading particular values and interests outside the normal lines of democratic control. Indeed, these concerns about a lack of accountability nearly prevented the Rockefeller Foundation from even coming into existence. Between 1910 and 1912, John D. Rockefeller repeatedly sought a federal charter for his philanthropic organisation from the US Congress. Each time, Congress rejected the application due to objections over the nature of Rockefeller's wealth and his business practices. The proposed Rockefeller Foundation was derided as "tainted money" and symbolic of a "creeping capitalism" that took advantage of the poor. Since federal legislators saw Rockefeller's wealth as ill-gotten and lacked the ability at that time to regulate Rockefeller's business interests, they did not want to give Rockefeller yet another unregulated realm in which he could operate. After repeated failures, Rockefeller bypassed the federal government and received a charter from New York state in 1913.[90] Once in operation, critics continued to charge the organisation with not being accountable to those it was ostensibly designed to serve.[91]

Contemporary critics charge BMGF with being unaccountable and undemocratic. Instead of providing these communities with their own voice, BMGF assumes the voice for those they claim to represent. To the critics, this hardly qualifies as representation. Rothkopf writes: "It is great to have Bono or the Gates Foundation or the Clinton Global Initiative speak for [the poor]. It would be better to give them the means to speak for themselves".[92] Concerns about stifling debate and credit-claiming are, at their heart, concerns about whose voices are influencing the international health agenda and whether that influence is malignant.

These criticisms of the Rockefeller and Gates Foundations paint a picture of disconnected, unresponsive organisations that promote their own agendas over the needs of the people they purport to help. They express anxiety about private,

90. Cunningim, *op. cit.*, p. 20.

91. Steven Palmer, "Migrant Workers and Hookworm Science: Peripheral Origins of International Health, 1840–1920", *Bulletin of the History of Medicine*, Vol. 83 (2009), p. 681.

92. David Rothkopf, *Superclass: The Global Power Elite and the World They Are Making* (New York: Farrar, Straus, and Giroux, 2008), p. 307.

unaccountable entities overtaking the role of national governments and international organisations controlling the global health agenda and thus distorting that agenda to meet their own needs. These criticisms should certainly provide some pause to the international community, but, as the next section will demonstrate, philanthropic foundations may play a beneficial role in global health politics.

Benefits of the Rockefeller and Gates Foundations

Supporters of philanthropic foundations playing a role in global health governance argue that these organisations can make three important contributions to the global health agenda. First, philanthropic foundations increase the diversity of funding sources available for global health issues. This can help to fill gaps that governments are unable or unwilling to address. Weisbrod explains that non-profit organisations and the voluntary sector, including philanthropic foundations, emerge to satisfy an unfulfilled demand for a public good.[93] In this case, governments and international organisations are unable or unwilling to provide the level of funding necessary to address global health needs. Philanthropic foundations can thus satisfy a need through a paradigm of partnership and an informal division of labour between governmental and non-governmental sources.[94]

When the Rockefeller Foundation started investing in international health programmes, there existed little funding for cross-border health concerns. The nascent international health organisations had small budgets with little operational capacity, and many within the international community cared about cross-border health concerns only if it hindered trade. With IHD's emergence, the realm of possibilities for addressing international health concerns widened significantly. It provided the necessary resources to conduct fieldwork, develop medical training programmes and build laboratory facilities. Furthermore, it took a lead in researching and developing vaccines for infectious diseases such as yellow fever and malaria. In a similar vein, BMGF programmes have increased funding sources available for scientific research on global health issues. They have also partnered with non-governmental organisations like Rotary International and national governments to conduct vaccination programmes. In all of these instances, BMGF funds go above and beyond what national governments can spend themselves.

Second, private philanthropic actors can direct attention towards neglected aspects of the global health agenda. Bill Gates remarked in 2003: "Every year, $70 billion is spent on medical research and development, yet only 10 percent is devoted to diseases that cause 90 percent of the global health burden". He further highlighted the fact that the US Food and Drug Administration had approved 1500 new drugs in the previous 25 years, but that fewer than 20 of those drugs addressed diseases that primarily afflict developing countries.[95]

93. Burton Weisbrod, "Toward a Theory of the Voluntary Nonprofit Sector in a Three-Sector Economy", in Edmund S. Phelps (ed.), *Altruism, Morality, and Economic Theory* (New York: Russell Sage Foundation, 1975), pp. 171–195.

94. Lester M. Salmon, "The Changing Partnership between the Voluntary Sector and the Welfare State", in Hodgkinson *et al.*, *op. cit.*, pp. 42–44.

95. Gates, "Humane Research", *op. cit.*

These health concerns receive less attention because they seemingly have little direct effect on donor states. Furthermore, there exists little commercial incentive for pharmaceutical companies to invest in this research because they see little commercial potential for these drugs. If the people who would most benefit from these drugs cannot afford to purchase them, then pharmaceutical companies will not target their resources towards those diseases.[96]

Philanthropic foundations can help to fill this gap. They lack the commercial incentive of pharmaceutical companies, and their lack of a direct constituency may give them freer rein to invest resources in underexplored areas. BMGF provided more money than any other single organisation in 2008 for research on malaria.[97] Danzon argues that developing drugs for diseases that primarily afflict developing countries requires a combination of subsidisation and differential pricing.[98] She finds that private philanthropic organisations can play key roles in both of these areas through providing transparency and fostering public–private partnerships with governments. In these ways, BMGF seeks to encourage other actors to get more involved in international health issues. Matthews and Ho cite BMGF's high-profile health activities as raising international health's profile within the US government and encouraging the federal government to devote more resources to these issues.[99] For the Rockefeller Foundation, its health interventions and programmes focused solely on areas that did not receive attention from governments or that governments could not address on their own. Governments in many malarial areas lacked the resources to effectively combat the disease or were not in a position to undertake the massive operations necessary to, say, drain swamplands. Diseases like hookworm and yellow fever received relatively little attention from other quarters because they tended to affect marginalised groups. These neglected diseases were only rescued from oblivion and received the sustained attention necessary to effectively treat them *because of* the Rockefeller Foundation.

Third, private philanthropic actors can spur innovation and offer unique tools for encouraging new approaches for advancing the global health agenda. By having more actors involved, there is likely to be a greater diversity of approaches and strategies tried. Moran describes how philanthropic foundations can provide the risk capital essential for getting new ventures and new approaches off the ground.[100] This sort of philanthrocapitalism applies a sort of business acumen to achieve social change by mobilising the same sort of logic that animates the market.[101]

The Gates Foundation approaches health issues with what it describes as an entrepreneurial approach, employing business methods and adapting them to global health. It wants to encourage flexibility and results-oriented processes. It wants to be nimble in ways that governments often are not. BMGF uses the

96. Alex Matter and Thomas H. Keller, "Impact of Non-profit Organizations on Drug Discovery: Opportunities, Gaps, and Solutions", *Drug Discovery Today*, Vol. 13 (2008), pp. 347–348.

97. Mary Moran, Javier Guzman, Anne-Laure Ropars, Alina McDonald, Tanja Sturm, Nicole Jameson, Lindsey Wu, Sam Ryan and Brenda Omune, *Neglected Disease Research and Development: How Much Are We Really Spending?* (Sydney: George Institute for International Health, 2008), pp. 16–17.

98. Patricia M. Danzon, "At What Price?", *Nature*, Vol. 449 (2007), pp. 176–179.

99. Matthews and Ho, *op. cit.*, pp. 411–412.

100. Moran, *op. cit.*, p. 139.

101. McCoy and McGoey, *op. cit.*, p. 146.

Grand Challenges in Global Health programme described above to spur innovation. "With greater encouragement and funding," advisors to GCGH wrote, "contemporary science and technology could remove some of the obstacles to more rapid progress against diseases that disproportionately affect the developing world."[102] The programme provides a fiscal incentive to get involved with addressing gaps in the global health agenda. There is nothing that would inherently prevent a government from doing the same thing, but private philanthropic actors have so far shown themselves more able and willing to use these sorts of innovative techniques to get more people involved in global health issues.

For the Rockefeller Foundation, the innovation came from simply engaging in international health work in a variety of different countries. In many ways, IHD's activities helped to create the notion that international cooperation on health matters could exist outside of those diseases that negatively affected commercial interests. IHD took on those issues that crossed borders and demonstrated that cooperation could bring about solutions to these problems. The Rockefeller Foundation's activities encompassed those issues that afflicted multiple states and diseases that bedevilled disfavoured populations. Its support of the League of Nations Health Office helped to convince the delegates who crafted the new United Nations in the aftermath of World War II that a new international health organisation was of the utmost importance. It was the Rockefeller Foundation's support that convinced the international community to take up these issues.

Conclusions

Comparing the activities and influence of the Rockefeller Foundation and the Bill and Melinda Gates Foundation in global health points to three important lessons for political science, health politics and studies of global governance. Firstly, the comparison demonstrates that philanthropic foundations can be important actors in global governance. Both RF and BMGF used their wealth to fund important and highly visible global health interventions. More important than their money, however, these philanthropic foundations have helped to shape how the rest of the international community conceptualises the global health agenda and thinks about its obligations to address cross-border health concerns. They could not determine these agendas on their own, and there was not a wholesale rejection of other points of view, but both philanthropic foundations possessed the clout and stature to make them significant actors. Furthermore, they demonstrate that philanthropic foundations—operating without the overt backing or support of a sovereign state—could alter the nature of political debates.

Secondly, the comparison casts doubts on the assertions common in much of the literature on global governance that the emergence of private actors is unique to the modern era. Instead, the parallel experiences of RF and BMGF reinforce Sending and Neumann's argument that the rise of non-state actors in global governance is a reflection of changing logics and rationalities that undergird governmentality. The activities of RF and BMGF suggest that governance is not a zero-sum game between state and non-state actors, but rather a shifting conceptualisation of how political authority should be exercised.

102. H. Varmus, R. Klausner, E. Zerhouni, T. Acharaya, A.S. Daar and P.A. Singer, "Grand Challenges in Global Health", *Science*, Vol. 302 (2003), p. 398.

Thirdly, philanthropic foundations like RF and BMGF can offer benefits to the international community and its attempts to address cross-border phenomena like global health. The spread of infectious disease across international borders is not the only issue that requires global cooperation to adequately address, and global health remains a significant issue for the international community today, but RF and BMGF show how philanthropic foundations possess the ability to influence the international community's conceptualisation of cross-border problems. These two foundations championed particular approaches, called attention to the importance of global health as a significant issue and spurred state governments to commit more resources to addressing health concerns. They have had an effect, and it is incumbent upon students of political science and global governance to develop the tools and techniques to adequately incorporate philanthropic foundations into their studies.