

# The Bill and Melinda Gates Foundation: business versus bureaucracy in international development

Ian Anderson

## Abstract

New forms of aid, including “philanthrocapitalism” such as The Bill and Melinda Gates Foundation, are rapidly altering the international aid architecture for health. These organisations have financial power, actively shape agendas and influence policy. The rise of non-traditional donor organisations creates opportunities and has implications for Australia as it scales-up its aid program. AusAID could collaborate, complement, compete with, or copy these organisations. Arguably the biggest strategic implication is that they expand AusAID’s programming choices. This increased flexibility could be used to leverage and accelerate further reforms in the UN and elsewhere. But choice is a two way street. Developing countries may prefer large, grant financing from non-traditional aid organisations and choose to bypass traditional multilateral and bilateral development agencies.

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# **The Bill and Melinda Gates Foundation: business versus bureaucracy in international development**

## **1. Purpose and scope of this paper**

The 'aid architecture' for international health is rapidly changing. Several large non-traditional organisations have emerged in recent years: the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM); the Global Alliance for Vaccines and Immunisation (GAVI); the Bill and Melinda Gates Foundation and the Clinton Foundation. These new organisations are increasingly shaping the international health agenda as well as the level and direction of resource flows. This paper takes the global health program of one such non-traditional organisation that scaled up rapidly – the Bill and Melinda Gates Foundation – to identify possible lessons and implications for Australia as it continues to double its aid program.

## **2. The Bill and Melinda Gates Foundation in context**

International development assistance for health has grown noticeably over recent years, with an increasing share coming from or coursed through new, non-traditional institutions. In an important study published in *The Lancet* – and funded from a research grant of the Bill and Melinda Gates Foundation – Ravishankar and colleagues track the trends (Ravishankar et al. 2009). They find that global development assistance for health grew from \$US 5.6 billion in 1990 to \$US 21.8 billion by 2007. The proportion of funding coursed through UN agencies – UNICEF, UNFPA, WHO etc. – fell over that period from 32% to 14%. Funding through the World Bank and regional development banks fell from a peak of 21% in 2000 to 7.2% by 2007. Funding through bilateral agencies fell from 46.8% in 1990 to 27% in 2001, rising to 34% in 2007.

Much of the squeeze in relative contributions is explained by the rapid emergence of new, non-traditional financing organisations for international health. GFATM, GAVI, and BMGF grew from less than 1% of international development assistance for health in 1990 to 8.3%, 4.2%, and 3.9% respectively. Business philanthropies that support international development are not new. The Rockefeller Foundation has been operating since 1913. It has provided a cumulative total of more than \$US 14 billion in current dollar and claims to have provided more foreign aid than the United States Government

up until World War Two (Rockefeller Foundation 2009). It has been a strong supporter of the “Green Revolution”. Similarly, The Ford Foundation has been active since 1936. It approved \$US 490 million worth of programs in 2009, including \$US20 million to South Asia, \$US 16 million to both China and South Africa, and \$US 32.6 million for sexual and reproductive health.

What is new is the scale and reach of the new “philanthrocapitalism” typified by the Bill and Melinda Gates Foundation (BMGF). Total grant commitments since inception of BMGF in 1994 to March 2011 now total \$US 24.8 billion. The Asset Trust Endowment is \$US 37.1 billion. Grant payments totalled \$US 2.6 billion in 2010. Grants have been provided to over 100 countries, and each of the 50 states within the US. One commentator notes that:

“At the end of 2005, the Gates Foundation endowment stood at \$ US 35 billion, making it the largest in the world. Then in June 2006, Warren E. Buffett, the world's second-richest man after Bill Gates, pledged to add about \$US 31 billion in installments from his personal fortune. Not counting tens of billions of dollars more that Gates himself has promised, the total is higher than the gross domestic products of 70% of the world's nations.” (Piller et al. 2007)

The single largest area of investment is Global Health: \$US 14.4 billion (58%) of total commitments between 1994 and March 2011.<sup>1</sup> A review in *The Lancet* concluded that:

“In 2007, the amount spent by the Gates Foundation on global health was almost as much as WHO’s annual budget (approximately \$1.65 billion), and was substantially more than the total grant spending of the Rockefeller Foundation across all programmatic areas in the same year (\$0.17 billion). The Gates Foundation’s effect on global health is evident in malaria research. In the late 1990s, only \$84 million was spent on malaria research yearly; since 2000, the Gates Foundation has helped to roughly treble this amount.” (McCoy et al. 2009)

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<sup>1</sup> BMGF are also large and important funders of broader development goals including agricultural development, microfinance, and, in the United States, education programs. However, Global Health is the major activity.

However even the largest organisations need to be seen in context. An influential article in *The Lancet* notes that the four largest contributors to international health – the World Bank, BMGF, US Government and GFATM – together account for around 0.1% of all health expenditures in non OECD countries (Sridhar & Batniji 2008). Indeed *all* donors combined still account for only around 0.3% of total expenditures on global development health. In India, *total* external resources for health were just 1.4% of total expenditure on health (WHO, 2010). Nevertheless, donors can still wield disproportionate influence on policy and programs: witness the long standing debate in international health circles about whether donor funding for HIV and AIDS distorts, or supports, national health programs. Country context matters.

### **3. Key Global Health Operations of BMGF**

BMGF concisely describe their work to support Global Health as follows:

“Our work in infectious diseases focuses on developing ways to fight and prevent enteric and diarrheal diseases, HIV/AIDS, malaria, pneumonia, tuberculosis, and neglected and other infectious diseases. We also work on integrated health solutions for family planning, nutrition, maternal, neonatal and child health, tobacco control and vaccine-preventable diseases. Three cross-cutting programs help us successfully address our areas of focus. These include:

- Discovery – Closing gaps in knowledge and science and creating critical platform technologies in areas where current tools are lacking.
- Delivery – implementing and scaling up proven approaches by identifying and proactively addressing the obstacles that typically lie in the path of adoption and uptake
- Policy & Advocacy– Promoting more and better resources, effective policies, and greater visibility of global health so that we may effectively address the foundation’s priority health targets” (Gates Foundation 2011)

### **4. How BMGF scaled up**

BMGF were able to scale up their program, and their profile, in such a relatively short time for three reasons.

First, having decided that global health would be a priority for them, they then had the means, motive, and opportunity to ‘think big’ right from the start. Second, the Gates profile and financial strength meant they could bring in, off the shelf, a critical mass of highly paid<sup>2</sup> technical expertise to develop their own strategies, and make an international presence. This included bringing in several people with already international reputations for technical expertise. It was the combination of money, the Gates name, *and* a pool of internationally credible technical expertise that opened doors internationally and let BMGF move fast. Third, and most importantly, BMGF deliberately chose to be “funders and shapers...we rely on others to act and implement”.<sup>3</sup> Thus, BMGF provided \$US 1.5 billion to the Global Alliance for Vaccines and Immunisation. Providing large tranches to existing, compatible, agencies enabled rapid scale up of activities.

However BMGF are certainly not just ‘hands off’ funders that simply outsource global health work to other organisations. Instead, BMGF engage actively in international debates that, in turn, affect global aid flows.<sup>4</sup> BMGF also engage directly, and indirectly, in the management of major institutions supporting global health, and actively seek to shape their agendas. This is something of a mixed blessing. Participation by BMGF brings a welcome sense of urgency, respect for evidence, commercial nous, and a capacity for quick financial follow up to international meetings. But private power and high profile of a foundation like BMGF has risks too. As one thoughtful analysis in *The Lancet* finds:

“All the key contributors to global health have an association with the Gates Foundation through some sort of funding arrangement. Coupled with the large amount of money involved, these relations give the foundation a great degree of

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<sup>2</sup> Compensation of \$US 2.627 million was paid to the five highest paid employees of BMGF in 2009. (Reference: Readers Guide to the form 990 PF. Available at [www.gatesfoundation.org](http://www.gatesfoundation.org).)

<sup>3</sup> BMGF Guiding principle number four.

<sup>4</sup> In his latest annual newsletter, Bill Gates worries that large fiscal deficits in OECD countries will squeeze aid programs. He says: “Deficits are not the only reason that aid budgets might change. Governments will also be increasing the money they spend to help reduce global warming. The final communiqué of the Copenhagen Summit, held last December, talks about mobilizing \$10 billion per year in the next three years and \$100 billion per year by 2020 for developing countries, which is over three quarters of all foreign aid now given by the richest countries. I am concerned that some of this money will come from reducing other categories of foreign aid, especially health. If just 1 per cent of the \$100 billion goal came from vaccine funding, then 700,000 more children could die from preventable diseases. In the long run, not spending on health is a bad deal for the environment because improvements in health, including voluntary family planning, lead people to have smaller families, which in turn reduces the strain on the environment”.

influence over both the architecture and policy agenda of global health. Through its funding of non-governmental organisations and policy think tanks, the foundation also confers power and influence on a selected number of organisations and in doing so, establishes some leverage over the voice of civil society. These observations are pertinent because the Gates Foundation is not a passive donor. The foundation actively engages in policy making and agenda setting activities; it has representatives that sit on the governing structures of many global health partnerships; it is part of a self-appointed group of global health leaders known as the H8 (together with WHO, the World Bank, GAVI Alliance, the Global Fund, UNICEF, the United Nations Population Fund, and UNAIDS); and has been involved in setting the health agenda for the G8.” (McCoy et al. 2009)

The Gates Foundation is also involved in setting the research agenda of several public health priorities, a role that was controversially criticised by the former head of WHO’s malaria programme, who complained that the dominance of the Gates Foundation in malaria research risked stifling the diversity of views among scientists.

## 5. Strengths and Weaknesses of BMGF

BMGF has five main strengths, listed below in what I see as their order of significance.

1. They invest cleverly in rigorous operational research that shapes broader, strategic, evidenced based policy and resource flows by governments and their development partners. Development partners speak warmly and often about the need for evidenced based policy in global health. But few actually invest in it. BMGF have funded numerous, large, operationally relevant field studies in developing countries.<sup>5</sup> The underlying rigour, including funding of randomised control trials, and consideration of the counter – factual, provides a strong evidence base for subsequent policy making. Rigorous but relevant results then

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<sup>5</sup> For example BMGF were sole, major, or contributing, funders to the following applied research, many of which involved randomised control trials: ‘Oral Misoprostol in preventing postpartum haemorrhage in resource-poor communities: a randomised controlled trial’ (Derman et al. 2006); ‘Evidence based, cost effective interventions: how many newborn babies can we save?’ (Darmstadt et al. 2005); ‘Implementing community-based perinatal care: results from a pilot study in rural Pakistan’ (Bhutta et al. 2008).

have the potential to influence not just the resourcing and approaches of all development partners but – more importantly – the developing country’s *overall* health budget. This is arguably BMGF’s greatest and most strategic contribution to international development. Generating - and disseminating - usable evidence for policy in influential journals like *The Lancet* is taken seriously by BMGF. BMGF are also investing in the Malaria Control and Evaluation Partnership in Africa (MACEPA) and are part of the Alliance for Case Studies in Global Health. There are now 139 separate evaluation reports on the BMGF website.<sup>6</sup>

2. They invest, at scale, in evidenced-based but underfunded interventions, including vaccines. This is what they are most well known for. For example, they provided \$US 1.5 billion to the Global Alliance for Vaccines and Immunisation. They also invest in response to neglected diseases.<sup>7</sup>
3. They “crowd in” additional, or expand existing, private finance for international development. Warren Buffett has provided \$US 8.01 billion to BMGF: arguably money that may not have gone to international development otherwise. BMGF has itself expanded other private ventures: for example, joining a \$US 500 million program with the *Bloomberg Initiative* to reduce the tobacco epidemic in developing countries.
4. They take bold, but calculated, investment risks. Their “Grand Challenges” program has supported over 400 high risk / high impact research grants to encourage innovation.<sup>8</sup> At the policy level, BMGF has invested \$US125 million to fight the tobacco epidemic: a high impact initiative in health, but with high risks given the complex policy environment of tobacco production in China.
5. They bring a sense of urgency, and efficiency, to the table.

There are, of course, criticisms of the BMGF. Importantly, many such criticisms are not unique to BMGF, and can apply to most if not all organisations involved in global health. The more important claims are summarised below:<sup>9</sup>

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<sup>6</sup><http://www.gatesfoundation.org/Pages/Search.aspx?meta=MDContentType:Research%26Evaluation>.

<sup>7</sup> Further details available at <http://www.gatesfoundation.org/topics/Pages/neglecteddiseases.aspx>.

<sup>8</sup> For example, testing a smart phone that can verify drug compliance in a patient and then reward the person by allocating free extra phone credits.

<sup>9</sup> Including criticism that the BMGF endowment invests in companies that harm the environment in developing countries. (see Piller et al. 2007).

The funding potentially distorts priorities by focusing on a few high profile diseases, thereby draining resources from other needs of concern to the poor. One study found that the 'big four'<sup>10</sup> 10 funders of global health, including BMGF, allocated funding equivalent to \$US 1029 for every death arising from HIV AIDS (Sridhar and Batniji 2008). However, the big four provided much less for other causes that disproportionately affect the poor: \$US 20.3 for every death arising from malnutrition, and just \$US 3.2 per death from non- communicable diseases. (See, however, above comment about BMGF funding for neglected diseases).

Interventions focus too much on technological fixes, whereas management, governance, and cultural issues are key determinants for health in developing countries. A common criticism is that a preference for science based technical solutions overlooks the need for broader health system strengthening.

Grants favour US and OECD based institutions. One careful study of BMGF grant making in *The Lancet* found that

“of the 659 grants awarded to non-governmental or non-profit organisations, 560 went to organisations in high-income countries, primarily in the USA. Only 37 grants were made to non-governmental or non-profit organisations based in low-income and middle-income countries.” (McCoy et al. 2009)

The overall grant making process lacks transparency. An independent evaluation<sup>11</sup> commissioned of grantees by BMGF found that BMGF had lower ratings than comparable organisations in terms of clarity of goals, transparency, and consistency of decision making. Staff turnover was a source of complaint too.

## **6. Some implications for AusAID as it scales up.**

Appendix Two summarises some of the interesting similarities and differences between AusAID and BMGF.

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<sup>10</sup> World Bank, US Government, GFATM, and BMGF.

<sup>11</sup> Center for Effective Philanthropy: Details of the evaluation available at [www.gatesfoundation.org](http://www.gatesfoundation.org).

One implication from that table is that AusAID could collaborate, complement, compete with or copy the BMGF approach, depending upon the circumstances.

Collaboration can – and has – occurred between BMGF and AusAID in program areas of common concern, such as maternal and child health. Collaboration has also occurred in knowledge generation. For example, AusAID, BMGF, and the University of Queensland collaborated in estimating the costs of scaling up proven interventions for maternal and child health in Asia. Arguably, the *combination* of these three institutions working together magnified the profile and reach of the work much more so than if each had acted separately.

AusAID and BMGF can also complement each other's strengths. AusAID has excellent, ongoing, access to key Government policy makers throughout Asia and the Pacific; is experienced in service delivery; has professional and experienced staff posted across the Asia and Pacific; and has a scholarships program that builds capacity. BMGF has excellent access to scientific research in health; has convening power amongst many stakeholders including the private sector; and is deeply and widely engaged in Africa.

However, in some circumstances, AusAID and BMGF may be competitors. Both are grant, untied, financiers chasing *viable* development opportunities. Both wish to recruit good, experienced, international and local talent. Both operate in the same sectors in the same countries: potentially with quite different policy advice to Government. BMGF are increasingly likely to win policy debates at the country level, at the expense of AusAID views, unless AusAID continues to build up its own in – house technical expertise, and invest more in operational research. Both BMGF and AusAID are also likely to compete for influence and ideas on the boards of international organisations.

AusAID could also copy some of the BMGF approaches, particularly the emphasis given by BMGF to rigorous operational research. Access to finance is rarely the binding constraint to development in fast growing Asia or the aid supported Pacific, but access to useful and usable knowledge is. Developing countries often know what to do, but are less sure about *how* to do it in their own country circumstances. Consultancy based advice is no substitute for field based operational research and assessment of the counter – factual.

BMGF have invested heavily, and strategically, in field experiments that yield rigorous results, exploring the counter – factual, that can then form an evidence base for shaping policy. They fund top class research institutions to undertake ethical, randomised, or quasi experimental, interventions and invest heavily in collecting and interpreting the data. They then fund dissemination of peer reviewed results in high impact journals such as *The Lancet*. AusAID could and should copy this commitment to operational research, especially as it scales up itself. There are good, sound, practical approaches available to draw on.<sup>12</sup>

Perhaps the most strategic implication for AusAID is the *competition* that BMGF and similar organisations introduce into the international aid architecture. Twenty or thirty years ago, Australia’s choices for allocating large sums of ODA were limited to the World Bank, the Asian Development Bank, and certain UN agencies. Importantly, those agencies knew that there were reasonably limited choices available for Australia too. Threats by Australia to reallocate or reduce funding unless those organisations stepped up their reform agendas were seen as just that: threats. These days, Australia and other development partners are under even sharper scrutiny to demonstrate “results” including from the multilaterals and UN.

But Australia and other development partners now have real options, especially in international health where non – traditional institutions are increasingly present. In principle, part of Australia’s rapid scale up of funding could just as easily go to GFATM, GAVI, Clinton Foundation, or BMGF as it could to the multilaterals and UN. Just the *availability* of those new options therefore gives Australia enhanced, credible, negotiating coin in its replenishment negotiations with the multilaterals and the UN. If they don’t pursue their reform agendas as purposefully as they claim they will, some of the additional “new” money from Australia’s scale up will go to the new, non – traditional agencies. Strengthening the hand of reformers within the large multilaterals and UN may turn out to be one of the more strategic impacts of an expanding Australian aid program, if coupled with the exercise of expanded choice.

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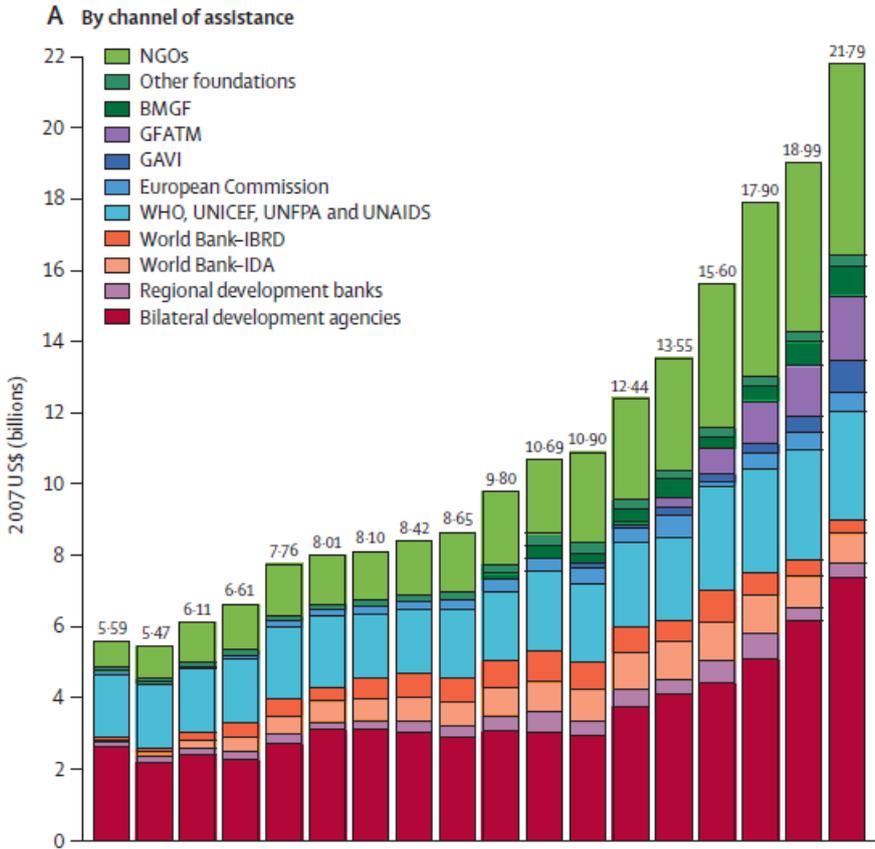
<sup>12</sup> For example: Duflo 2004, Duflo & Kremer 2003, Clemens & Demombynes 2010.

Ironically, the very competition that Australia could use to push reforms could be used against it. The existence of large, untied, grant financing for rapid expansion of an immunisation program, sourced ultimately from BMGF, is an attractive option for a developing country government. It may well be seen as preferable in some circumstances to the alternative of Australian sponsored “policy dialogue” about governance and corruption. That would especially be the case if Australia was unable to consistently ground its policy dialogue in health on a strong evidenced base of operational research and deep technical expertise as BMGF do.

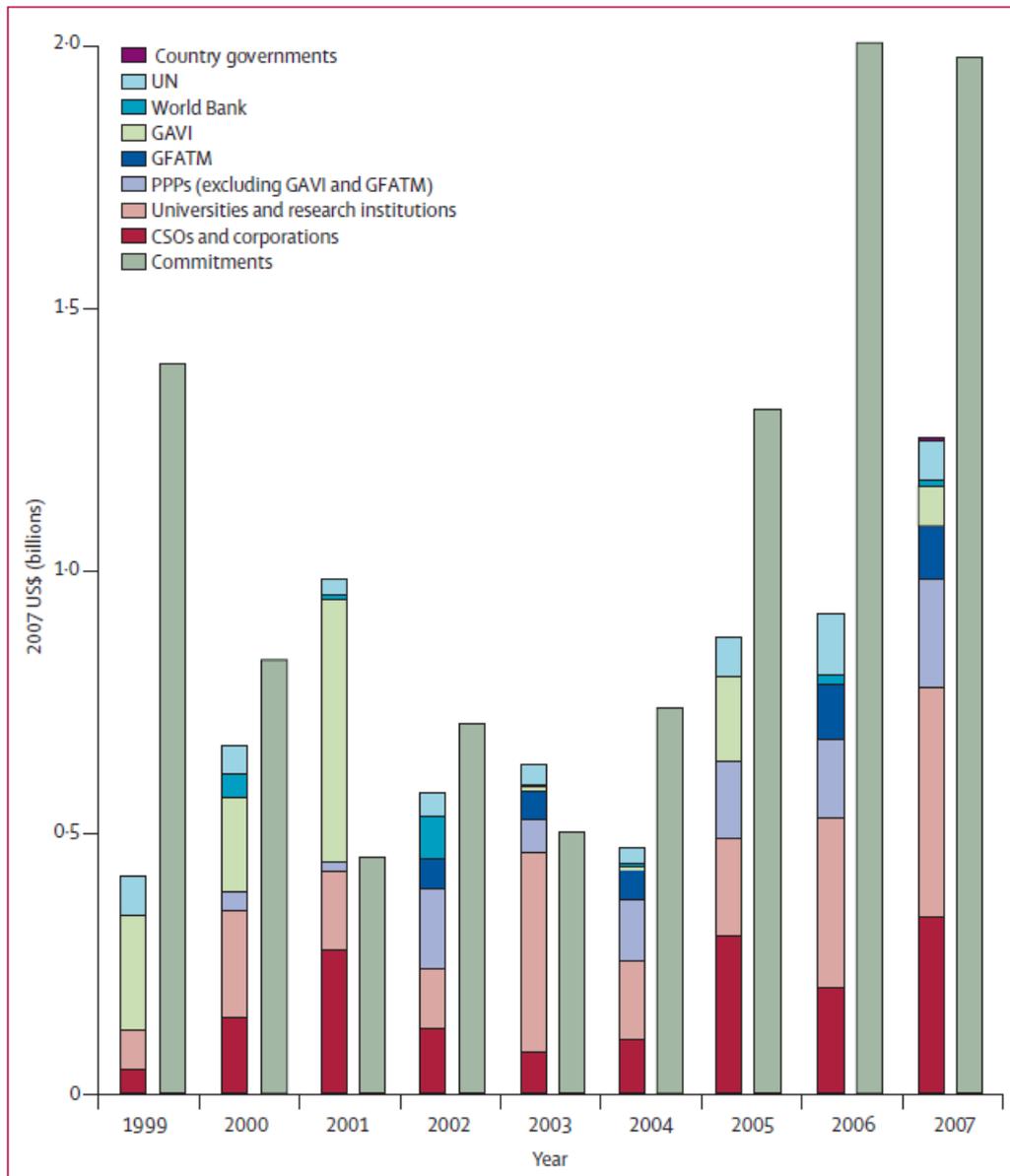
## **7. Conclusion**

The international environment – especially for health – is rapidly changing. Standing still is to be left behind, less and less able to influence global health events that will affect developing countries, as well as Australia. Australia’s decision to scale up its development assistance program is a sound investment in the future, especially in an increasingly inter-connected world. Making good choices – including how to best work with relatively new, but influential, institutions such as the Bill and Melinda Gates Foundation will be an important part of that task.

# 8. Appendix 1: Engagement of the Bill and Melinda Gates Foundation in International Health



Source: Ravishankar N et al "Financing of Global Health: Tracking Development Assistance for Health from 1990 – 2007" *The Lancet* 2009: 373.



**Figure 4: Bill & Melinda Gates Foundation commitments and disbursements from 1999 to 2007**  
 The recipients of disbursed grants, which we coded, are also shown. The category universities and research institutions includes universities, non-governmental organisations, foundations, and government institutions in all countries with a research focus. The category country governments includes all non-research oriented government agencies. GAVI=Global Alliance for Vaccines and Immunization. GFATM=Global Fund to Fight AIDS, Tuberculosis and Malaria. PPPs=public-private partnerships. CSO=civil society organisations, including non-governmental organisations and foundations.

Source: Ravishankar N et al "Financing of Global Health: Tracking Development Assistance for Health from 1990 – 2007" *The Lancet* 2009: 373.

## 9. Appendix 2

Theme	AusAID	BMGF
<b>Goal setting</b>	Reflects Australian Government national interest priorities, and partner government requests	"This is a family foundation, driven by the interests and passions of the Gates family". <sup>13</sup> Specific goal setting influenced by science
<b>Accountability and scrutiny</b>	Minister, Parliament, and public (eg via FOI Act).	Board, Annual Report, Ethical code, whistle-blower policy etc.
	Subject to various Acts and regulations including Finance, Procurement, Employment, Freedom of Information Act, etc.	"We take risks, make big bets, and move with urgency. We are in it for the long haul." <sup>14</sup>
<b>Focus</b>	Several sectors, including governance, education and health	Global health a priority.
	Focus on Asia and the Pacific	Active in over 100 countries and every state in the USA
<b>Financing</b>	Subject to annual appropriations. 100% grant, untied, in yearly appropriations	Endowment size affected by stock market. 100% grant, untied, but long multi - year commitments possible
<b>Operations</b>	Direct access to highest levels of Government in developing countries.	Strong credibility and convening power amongst private sector
	In country delivery, often using AusAID staff and/or consultants, often 3 – 5 year time frame. Use, at least historically, of managing contractor firms, consultants, and advisers to government	"We are funders and shapers. We rely on others to act and implement". <sup>15</sup> Typically grant funding to another body (eg GAVI) or research institute, often long time frame
	Actively engages in the policy and programming of IFIs, UN and MDB	Actively engages in the policy and programming of IFIs, UN and MDB
	"Knowledge" and evidence base increasingly important: "knowledge hubs" and research grants gaining profile.	Latest evidence drives decision making. If important evidence not available, invest heavily in creating it
	Risk of fragmentation of effort. See AusAID ARDE 2009.	Risk of fragmentation of effort: 1094 global health grants were awarded between January, 1998, and December, 2007
		Strong emphasis on research institutions and Universities
<b>Size and staffing</b>	\$A 4.3 billion in 2010/11. Good, but limited number, of in-house people with up to date technical expertise. Relatively limited career stream based around technical expertise.	\$US 3 billion grant approvals in 2009. 874 staff, mainly technical specialists. Strong in – house technical expertise, some of which is world class.
	At 30 June 2010, AusAID had 1487 staff: 1004 were Australian Public Service employees, and 483 were "Overseas Based Staff" (often local nationals).	BMGF has approximately 927 employees in March 2011.
	AusAID Departmental Expenses were \$134 million in 2009/10. Employee benefits were \$86.5 million in 2010.	Compensation of \$US 2.627 million was paid to the five highest paid BMGF employees in 2009.

<sup>13</sup> *Guiding Principles of the Bill and Melinda Gates Foundation*. This is the first Guiding Principle. The fifteen *Guiding Principles* are available at <http://www.gatesfoundation.org/about/Pages/guiding-principles.aspx>.

<sup>14</sup> Guiding Principle Number 7.

<sup>15</sup> Guiding Principle Number 4.

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