

# The Gates Foundation, Ebola, and Global Health Imperialism

By JACOB LEVICH\*

**ABSTRACT.** Powerful institutions of Western capital, notably the Bill & Melinda Gates Foundation, viewed the African Ebola outbreak of 2014–2015 as an opportunity to advance an ambitious global agenda. Building on recent public health literature proposing “global health governance” (GHG) as the preferred model for international healthcare, Bill Gates publicly called for the creation of a worldwide, militarized, supranational authority capable of responding decisively to outbreaks of infectious disease—an authority governed by Western powers and targeting the underdeveloped world. This article examines the media-generated panic surrounding Ebola alongside the response and underlying motives of foundations, governments, and other institutions. It describes the evolution and goals of GHG, in particular its opposition to traditional notions of Westphalian sovereignty. It proposes a different concept—“global health imperialism”—as a more useful framework for understanding the current conditions and likely future of international healthcare.

## Introduction

On March 18, 2015, the world’s wealthiest man issued a public call for an ambitious new project: the creation of a global, militarized, supranational authority capable of responding decisively to outbreaks of infectious disease (Gates 2015a). Appearing in the pages of the prestigious *New England Journal of Medicine (NEJM)*, Bill Gates’s article “The Next Epidemic — Lessons from Ebola” was a “global call to action” designed for maximum impact. A *New York Times* op-ed by Gates (2015b), timed to appear simultaneously with the *NEJM* piece, launched a flurry of

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media coverage that uncritically reproduced the multi-billionaire's arguments.

As chieftain of the most powerful private foundation in history, Microsoft founder Bill Gates was already accustomed to setting the agenda for global healthcare. The Bill & Melinda Gates Foundation (BMGF) had come to dominate the field, wielding an endowment worth \$43.5 billion and distributing nearly \$4 billion annually to fund initiatives aimed at fighting malaria, polio, tuberculosis, HIV, and other diseases. (Guardian 2015). In the words of one NGO official: "You can't cough, scratch your head or sneeze in health without coming to the Gates Foundation" (Global Health Watch 2008).

Gates's *NEJM* article seemed to call for an unprecedented and far more muscular style of health-care management. Building on the worldwide panic inspired by the 2014 Ebola outbreak, Gates warned of catastrophic future epidemics that could be contained only through the intervention of a powerful "global warning and response system" explicitly modeled on the North Atlantic Treaty Organization (NATO). U.N. officials had deemed the international response to Ebola too slow but ultimately effective and, in some cases, "spectacularly successful" (WHO 2014e). But Gates called it a "global failure," especially by comparison with "our preparations for another sort of global threat—war" (Gates 2015a).

Gates conceded that an international epidemic response system already exists under the auspices of the World Health Organization (WHO), but described it as "severely understaffed and underfunded." Since BMGF is already WHO's leading funder, it might be asked why Gates, leader of a network of billionaire philanthropists worth at least \$125 billion, did not simply move to increase funding of programs now in place (Harmer 2012; Harris 2009). On this question the *NEJM* article is silent, but answers are implicit in the text. Gates (2015a) envisions an organization empowered to:

- Work closely with Western military forces, specifically NATO, in operations targeting the developing world. (Planning "should include military alliances such as NATO"; "in a severe epidemic, the military forces of many or all middle- and high-income countries might have to work together.")

- Bypass national safety regulations in order to fast-track testing and use of novel vaccines and other medications. (New Ebola drugs “were not tested in patients with Ebola until after the epidemic had peaked—in part because there was no clear process for approving a novel trial format or for providing indemnity against legal liability.”)
- Suspend constitutional guarantees in sovereign nations affected by epidemics. (“Because democratic countries try to avoid abridging individuals’ rights to travel and free assembly, they might be too slow to restrict activities that help spread disease.”)
- Create worldwide surveillance networks, presumably free of privacy protections, that would make information about people in developing countries instantly available to the imperial core. (“Access to satellite photography and cell-phone data” would permit tracking “the movement of populations and individuals in the affected region.”)

Gates is plainly skeptical of the ability of traditional international institutions (particularly the United Nations) to create an authority so extravagantly empowered. Rather, he anticipates implementing his proposal via a consortium of public and private entities, including the World Bank and the G7 countries, NATO, and “some combination of foundations and technology companies.” The U.N. role in this undertaking is left ambiguous. Gates calls for discussion “about which parts of the process [WHO] should lead and which ones others (including the World Bank and the G7 countries) should lead in close coordination.” While the article contains perfunctory nods to U.N. authority, as well as brief lip service to the idea of strengthening public health services in poor countries, there can be little doubt that Gates is advocating a new form of international institution, transcending the United Nations, targeting the developing world, and effectively controlled by the wealthy nations of the West.

The thinking behind Gates’s piece was widely hailed as original, even oracular. But in the tradition of Microsoft, which rose to global dominance in the software field by adapting and exploiting the ideas of other firms, Gates was merely appropriating a concept that now pervades the field of public health: that of “global health governance”

(GHG). First articulated in the context of the post-Soviet “unipolar world,” GHG aims to consolidate the management of transnational health-care issues under Western stewardship. Public health has been redefined as a security concern; the developing world is portrayed as a teeming petri dish of SARS, AIDS, and tropical infections, spreading “disease and death” across the globe and requiring Western powers to establish centralized health systems designed to “overcome the constraints of state sovereignty” (Cooper and Kirton 2009: Ch. 1; Stevenson and Cooper 2009).

Thus no one familiar with the literature would have found Gates’s proposals surprising. What was new was the context—a worldwide panic arising from overheated press reports about a frightening infectious disease—and the source. For the first time, the most powerful figure in the field of international health had aligned himself unambiguously with the GHG agenda. The theory of global health governance might now become a real-world reality, thrust forward by the unprecedented muscle and reach of Bill Gates’s private charity. Moreover, Gates’s overt militarization of GHG thinking laid bare an underlying truth of Big Philanthropy: that the “soft power” of charitable foundations has always worked hand-in-hand with the hard realities of Western imperialism.

### **Foundations and Imperialism**

Private foundations are often perceived as purely humanitarian endeavors, affording the wealthy a means of “giving back” to the community in a spirit of generosity and gratitude. On occasion, however, philanthropists have revealed their aims more bluntly as making the world safe for their kind. In a letter published on the BMGF’s website, Bill Gates invokes “the rich world’s enlightened self-interest” and warns that “[i]f societies can’t provide for people’s basic health, if they can’t feed and educate people, then their populations and problems will grow and the world will be a less stable place” (Gates 2011).

The pattern of such “philanthropic” activities was set in the United States about a century ago, when industrial barons such as Rockefeller and Carnegie set up the foundations that bear their names, to be followed in 1936 by Ford. As Joan Roelofs (2003) has argued, during

the past century large-scale private philanthropy has played a critical worldwide role in ensuring the hegemony of neoliberal institutions while reinforcing the ideology of the Western ruling class. Interlocking networks of foundations, foundation-sponsored NGOs, and U.S. government institutions like the National Endowment for Democracy (NED)—notorious as a “pass-through” for CIA funds—work hand-in-hand in support of imperialism, subverting people-friendly states and social movements by co-opting institutions deemed helpful to U.S. global strategy. In extreme, but not infrequent, cases, foundations have actively collaborated in regime change operations managed by U.S. intelligence. To cite just one example:

In Indonesia the Ford Foundation-sponsored knowledge networks worked to undermine the neutralist Sukarno government that challenged U.S. hegemony. At the same time, Ford trained economists (both at University of Indonesia and in U.S. universities) for a future regime supportive of capitalist imperialism. (Roelofs 2012)

More recently, foundations helmed by billionaires Pierre Omidyar and George Soros were shown to have collaborated with the U.S. Agency for International Development (USAID) in funding opposition groups behind the 2014 *coup d'état* that unseated Ukrainian president Viktor Yanukovich (Ames 2014). Ordinarily, to be sure, private foundations exert their influence less directly and more broadly. An important element of U.S. “soft power,” they are used as levers by the ruling class to move public policy in a direction favorable to corporate profits and to the capitalist system in general.

International health charity is rooted in the first schools of tropical medicine, established in Britain and the United States in the late 19<sup>th</sup> century, with the explicit aim of increasing the productivity of colonized laborers while, not incidentally, safeguarding the health of their white overseers. As a journalist wrote in 1907:

Disease still decimates native populations and sends men home from the tropics prematurely old and broken down. Until the white man has the key to the problem, this blot must remain. To bring large tracts of the globe under the white man's rule has a grandiloquent ring; but unless we have the means of improving the conditions of the inhabitants, it is scarcely more than an empty boast. (quoted in Brown 1976: 897)

The same reasoning underlay the formation of the Rockefeller Foundation, which was incorporated in 1913 with the initial goal of eradicating hookworm, malaria, and yellow fever. (From its earliest days, Rockefeller's philanthropy hid a domestic agenda as well. The foundation was forced to retreat from sponsorship of research into labor relations after the 1916 Walsh Commission Report found it was "corrupt[ing] sources of public information" in an effort to whitewash predatory business practices and industrial violence [Brisson 2005:35]). In the colonized world, public health measures encouraged by Rockefeller's International Health Commission yielded increases in profit extraction, as each worker could now be paid less per unit of work, "but with increased strength was able to work harder and longer and received more money in his pay envelope" (Brown 1976: 900). In addition to enhanced labor efficiency—which was not necessarily a critical challenge to capital in regions where vast pools of underemployed labor were available for exploitation—Rockefeller's research programs promised greater scope for future U.S. military adventures in the Global South, where occupying armies had often been hamstrung by tropical diseases (Killingray 1989: 150–151).

As Rockefeller expanded its international health programs in concert with U.S. agencies and other organizations, additional advantages to the imperial core were realized. Modern medicine advertised the benefits of capitalism to "backward" people, undermining their resistance to domination by imperialist powers while creating a native professional class increasingly receptive to neocolonialism and dependent on foreign largesse. Rockefeller's president observed in 1916: "[F]or purposes of placating primitive and suspicious peoples, medicines have some advantages over machine guns" (Brown 1976: 900).

In the aftermath of World War II, public health philanthropy became closely aligned with U.S. foreign policy, as neocolonialism embraced the rhetoric, if not always the substance, of "development." Foundations collaborated with USAID in support of interventions aimed at increasing production of raw materials while creating new markets for Western manufactured goods. A section of the U.S. ruling class, represented most prominently by Secretary of State George Marshall, argued that "increases in the productivity of tropical labor would require investments in social and economic infrastructure including greater

investments in public health.” In a 1948 address to the Fourth International Congress of Tropical Diseases and Malaria, Marshall, a leading architect of U.S. policy during the early years of the Cold War, outlined a grandiose vision of healthcare under “enlightened” capitalism:

Little imagination is required to visualize the great increase in the production of food and raw materials, the stimulus to world trade, and above all the improvement in living conditions, with consequent cultural and social advantages, that would result from the conquest of tropical diseases. (quoted in Packard 1997: 97).

Marshall’s speech reads like a template for the rhetoric produced today by the Bill & Melinda Gates Foundation (BMGF) and similar foundations, and it served a similar purpose—high-flown sentiments providing cover for post-colonial *realpolitik*. To Paul Hoffman, president of the Ford Foundation during the 1950s, “the Communist victory in the Chinese Civil War taught the ‘lesson’ that Communism thrived on social and economic disorder” (Hess 2003: 319). The mission of post-war philanthropy was therefore to encourage development schemes that might pacify third-world peoples. The seminal Gaither Report, commissioned in 1949 by Ford, explicitly charged the foundations with advancing “human welfare” in order to resist the “tide of Communism . . . in Asia and Europe” (Gaither 1949: 26). By 1956, a report to the U.S. president by the International Development Administration Board openly framed public health assistance as a tactic in aid of Western military aggression in Indochina:

[A]reas rendered inaccessible at night by Viet Minh activity, during the day welcomed DDT-residual spray teams combating malaria. . . . In the Philippines, similar programs make possible colonization of many previously uninhabited areas, and contribute greatly to the conversion of Huk terrorists to peaceful landowners. (quoted in Packard 1997: 99)

Big Philanthropy’s agricultural interventions in post-independence India, where Ford invested heavily in rural development initiatives like the Community Development Programme (CDP), were hailed by Nehru as “a model for meeting the revolutionary threats from left-wing and communist peasant movements demanding basic social reforms in agriculture” (RUPE 2003). But like public health assistance, foundation-

sponsored agricultural development could never proceed far beyond cosmetic measures. As Paul Baran and others have argued, postwar imperialism thrived by constructing a relationship of dependency between the periphery and the core. Foreign capital benefited from the perpetuation of semi-feudal political and social structures guaranteed by a “coalition of wealthy compradors, powerful monopolists, and large landowners dedicated to the defense of the existing feudal-mercantile order” (Foster 2007). Meaningful reform, entailing the uprooting of feudalism and the empowerment of underdeveloped states and economies, would tend to threaten the very system of post-colonial dependency that the managers of capitalist institutions wished to preserve.

Thus the foundations needed to strike a delicate balance, operating so as to placate third-world peoples without unduly encouraging real reform or functional independence. Sometimes, the foundations condescended to relinquish control of infrastructure and trained personnel to national health ministries (Downs 1982: 8), but in no case were the health systems of poor countries permitted to become genuinely self-sustaining. Actual investment in third-world healthcare was meager by comparison with the extravagant promises of Cold War rhetoric. Nevertheless, visible collaboration with the governments of the periphery was deemed necessary in the context of the postwar struggle for “hearts and minds.” With the end of socialism in Russia and China, however, both the theory and practice of international health assistance underwent a drastic change.

### **Global Health Governance (GHG)**

The concept of “global health governance” (GHG) was first articulated in the West in the early 1990s, reflecting Washington’s confidence that the fall of the Soviet Union was about to usher in a unipolar world dominated by U.S. interests. President Bush’s concept of a “new world order” found its way into scholarship as “global governance,” describing a loosely defined transnational regime effectively led by the United States and consisting of both public institutions (the United Nations, the World Bank, NATO, the ICC, and so on) and some combination of



private actors, including transnational corporations (TNCs), private foundations, and nongovernmental organizations (NGOs).

This was in no sense a proposal for formal global government: the wealthy West had no wish to take on direct responsibility for the problems of the underdeveloped world, still less to accommodate the demands of several billion impoverished voters. It was, rather, a vision of diffuse, omnipresent power to be exercised collaboratively by the institutions of global capitalism and guaranteed, in the last resort, by the U.S. military. Such a regime would function most effectively without the traditional impediments of democratic accountability and Westphalian sovereignty.<sup>1</sup> By undermining the nation-state, imperialism might begin to resolve what István Mészáros has identified as its “grave failure to constitute the state of the capitalist system as such, as complementary to its transnational aspirations and articulation, so as to overcome the explosive antagonisms between national states that have characterized the system in the last two centuries” (Gürcan 2015).

“Global governance” was originally deployed descriptively—merely explicating a *de facto* state of affairs—but it soon took on a prescriptive dimension, particularly in the wake of the 1999 attack on Yugoslavia by a U.S.-led international coalition. Foreign policy analysts looked forward to “taming the arrogance of princes and princesses, and curbing some of their worst excesses within and outside of their territories” and openly argued that doing so would entail the abandonment of traditional ideas of national sovereignty (Held 2002). Globalization, wrote one legal scholar, required

reconceiving legitimate political authority in a manner which disconnects it from its traditional anchor in fixed territories and, instead, articulates it as an attribute of basic cosmopolitan democratic arrangements . . . which can, in principle, be entrenched and drawn upon in diverse associations. Significantly, this process of disconnection has already begun, as political authority and forms of governance are diffused “below,” “above,” and “alongside” the nation-state. (Held 2002)

Thinking so subversive of the idea of national sovereignty was to prove highly useful during a period of renewed imperialist expansion. “Global governance” provided theoretical underpinnings for a series of U.S. military actions branded “humanitarian interventions” and justified

with reference to a purported “responsibility to protect.” It also spawned a new literature, helpfully applying the concept to nearly every issue of interest to Western capitalism: “global legal governance,” “global financial governance,” and “global cultural governance.” In this context the production of GHG theory was inevitable. Beginning in 2002 and coincident with the U.S. “global war on terrorism,” GHG rapidly rose to the top of the worldwide public health agenda (Lee and Kamradt-Scott 2014: 28).

GHG in its simplest form has been defined as:

the use of formal and informal institutions, rules and processes by states, intergovernmental organizations, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively. (Fidler 2010: 3)

This seemingly straightforward definition embodies a crucial difference from earlier models of international healthcare: “nonstate actors”—meaning primarily foundations, NGOs, and public-private partnerships (PPPs)—are recognized as having significant scope and authority to function in an area once reserved to national governments. In part, GHG theory was designed to account retrospectively for the phenomenal growth of “civil society,” which consists of nonprofit organizations that assist in the construction of popular consent to ruling-class power while outflanking the authority of sovereign states (see generally Roelofs 2003).

Previously, world health was typically seen as a collaborative effort among sovereign nations under the guidance of the World Health Organization. Its stated goal was “health for all” in the spirit of the Declaration of Alma Ata Declaration (1978). Based implicitly on the “barefoot doctor” program that revolutionized public health in the People’s Republic of China, Alma Ata proposed a philosophy of primary care in which the people were held to have “a right and duty to participate individually and collectively in the planning and implementation of their health care” (Declaration of Alma-Ata 1978). In theory at least, wealthy states and philanthropists were expected to assist the developing world only on condition of respecting local concerns and national sovereignty.

Alma Ata was effectively discarded during the subsequent triumph of neoliberalism, as structural adjustment programs required ruinous disinvestment in public health throughout the developing world (Colgan 2002). In its place arose “a collective of partially overlapping and non-hierarchical regimes” (Youde 2012)—that is, a profusion of foundation- and state-sponsored NGOs, based primarily in the West and funded more or less directly by multi-billionaires. Providing support for national health-care operations was no longer on the agenda; to the contrary, health ministries were systematically bypassed or compromised via PPPs and similar schemes. As national health systems were hollowed out, health spending by donor countries and private foundations rose dramatically (Global Health Watch 2008: 210–211). The U.S.-based Council on Foreign Relations now envisions a withering away of state-sponsored health-care delivery, to be replaced by a supranational regime of “new legal frameworks, public-private partnerships, national programs, innovative financing mechanisms, and greater engagement by nongovernmental organizations, philanthropic foundations, and multinational corporations” (Fidler 2010).

Western governments and foundations see an opportunity to effect a “shift to a post-Westphalian framework” (Ricci 2009: 1). Indeed, according to leading scholars in the field, the *central argument* of global health governance is that “the old formulas of Westphalian governance have failed and a new generation of innovation from many actors is emerging to take its place” (Kirton and Cooper 2009: 309).

For obvious reasons, the attenuation of national sovereignty is only rarely discussed as a conscious aim of global health governance. Instead, GHG is proposed as a necessary defense against the Apocalypse. The world, advocates say, now stands at a critical, unprecedented juncture—one at which the acceleration of cross-border travel, urbanization, and trade has made “emerging infections” inevitable and potentially catastrophic. (This is asserted as self-evident, despite the fact that two of the three most deadly pandemics of the past century—the Spanish Flu of 1918 and the Asian flu of 1957–1958—took place decades before “global interconnectedness” became a fashionable concept.) The menace is invariably framed in terms reflecting colonialist assumptions and summoning racial fears: communicable diseases are discussed as phenomena *emerging from* poor countries and *threatening to* the

Western world. The standard textbook on GHG sets forth its key case studies in revealing language:

SARS arose from non-human sources and spread in uncontrolled fashion with great speed *from South to North*. Avian influenza ... likewise rose from non-human sources and has spread in uncontrolled fashion, although more slowly and still largely where it *started among countries of the developing South*. HIV/AIDS *emerged from non-human sources in the South but was spread by humans to and in the North* ... . (Kirton and Cooper 2009: 10)

Infections inconvenient to this line of argument—the 2007–2008 global mumps resurgence originating in Halifax, Nova Scotia, or the ongoing cholera epidemic brought to Haiti by MINUSTAH peacekeepers (Engler 2011)—go unmentioned. GHG theory is “global” in a very specific sense: it is concerned with addressing perceived threats to the wealthy core posed by the impoverished periphery. It is an ideology that meshes neatly with the present phase of imperialism.

Insofar as GHG articulated a demand that the West should set about defending itself against foreign threats, it was only natural that it should be folded into the larger discourse of “security” that arose in the wake of the 9/11 attacks. Worldwide alarm about bioterrorism provided an opportunity to “link together two previously separate fields: health and national/international security” (Rushton and Youde 2015: 18). This linkage was envisioned as reciprocal: not only would health-care workers “open up a medical front in the War on Terror” (Elbe 2010: 82), but military forces would now be mobilized as a response to health disasters. Global health security was a major pretext for Operation Unified Response, the U.S. military reaction to the 2010 earthquake in Haiti. Though purportedly motivated by humanitarian concern, the operation amounted to a full-scale invasion of a nation long dominated by U.S. imperialism: 17,000 U.S. troops entered Haiti along with 17 ships, 48 helicopters, and 12 fixed-wing aircraft (U.S. Fleet Forces Public Affairs 2010; CNN 2010). The following year, President Obama proclaimed the “Global Health Security Agenda,” outlining a U.S.-led “multi-sectoral response” to “every kind of biological danger—whether it’s a pandemic like H1N1, or a terrorist threat, or a treatable disease” (U.S. Dept. of HHS 2014). Partners in the initiative included USAID and the U.S.

Department of Defense. Imperialist interventions in the health field could now be justified in the same terms as recent “humanitarian” military interventions: “[N]ational interests now mandate that countries engage internationally as a *responsibility to protect* against imported health threats or to help stabilize conflicts abroad so that they do not disrupt global security or commerce” (Novotny et al. 2008: 41, emphasis added).

Some analysts denounced the militarization of public health as “worryingly authoritarian, bad for public health, and strategically counterproductive” (de Waal 2014), but to Bill Gates it was a welcome development:

One of the things I am saying that is pretty radical—and people may disagree—I’m saying the military should be cross-trained not just for military action but for natural disasters and epidemics. . . . If you pair them with this so-called medical corps, you get something pretty dramatic without spending. (Fried 2015)

Gates’s endorsement was especially significant because his foundation had become the leading exemplar of philanthropy in the era of global health governance. Vastly endowed, essentially unaccountable, unencumbered by respect for democracy or national sovereignty, floating freely between the public and private spheres, BMGF is ideally positioned to intervene swiftly and decisively on behalf of the interests it represents. As Bill Gates remarked, “I’m not gonna get voted out of office” (“Transcript: Bill Moyers Interviews Bill Gates” 2003).

### **The Bill & Melinda Gates Foundation (BMGF)**

Established in 1999 and initially endowed with a portion of Bill Gates’s Microsoft riches, the Bill & Melinda Gates Foundation (BMGF) is now by far the world’s largest private foundation, dwarfing once-dominant players such as the Ford Foundation, the Rockefeller Foundation, and the Carnegie Corporation (Foundation Center 2015).

In a field populated by the world’s richest and most ruthless capitalists, BMGF has acquired a reputation for exceptional high-handedness. It is “driven by the interests and passions of the Gates family,” evasive about its financials, and accountable to no one except its founder, who

shapes and approves foundation strategies, advocates for the foundation's issues, and sets the organization's overall direction" (BMGF 2015c).

Gates's approach to charity is presumably rooted in his attitude toward democracy:

The closer you get to [government] and see how the sausage is made, the more you go, oh my God! These guys don't even actually know the budget. . . . The idea that all these people are going to vote and have an opinion about subjects that are increasingly complex—where what seems, you might think . . . the easy answer [is] not the real answer. It's a very interesting problem. Do democracies faced with these current problems do these things well? (Waters 2013)

The Gates charitable empire is vast and growing. Within the United States, BMGF focuses primarily on "education reform," providing support for efforts to privatize public schools and subordinate teachers' unions. Its much larger international divisions target the developing world and are geared toward infectious diseases, agricultural policy, reproductive health, and population control. In 2009 alone, BMGF spent more than \$1.8 billion on global health projects (Salazar 2011).

BMGF boasts of applying the norms of business planning and corporate competition to the field of philanthropy. According to one observer, "[t]he way [Bill Gates] talked about wiping out malaria was how he used to talk about wiping out Netscape" (Youde 2010). Like Fortune 500 corporations, BMGF seeks to leverage its investments via strategic partnerships and evaluates the success of its endeavors in numerically quantifiable terms:

The foundation does not invest in delivering health or education services. Instead, we identify ways to *leverage systems and innovate* so these services achieve better outcomes for people. All strategies leverage our partnerships to achieve impact. All strategies underscore the *role of technology*. (BMGF 2013a, emphasis added)

Accordingly the Gates Foundation exercises power not only via its own spending, but more broadly through an elaborate network of "partner organizations" including nonprofits, government agencies, and private corporations. As the third largest donor to the U.N. World Health

Organization (WHO), it is a commanding presence in the formation of global health policy (Global Health Watch 2008: 250).

BMGF's outsize influence has not always been welcome in Geneva: in a 2008 memo leaked to the press, Arata Kochi, chief of the malaria program at WHO, charged that "the growing dominance of malaria research by the Bill and Melinda Gates Foundation risks stifling a diversity of views among scientists and wiping out the health agency's policy-making function" (McNeill 2008).

The foundation orchestrates vast, elaborate public-private partnerships. These charitable salmagundis tend to blur distinctions between governments, which are at least theoretically accountable to citizens, and profit-seeking businesses, which are accountable only to their shareholders. For example, a 2012 initiative that was aimed at combating neglected tropical diseases listed among its affiliates USAID, the World Bank, the governments of Brazil, Bangladesh, and the UAE, and a consortium of 13 drug firms, comprising the most notorious powers in Big Pharma, including Merck, GlaxoSmithKline, and Pfizer (BMGF 2012b).

BMGF is the prime mover behind prominent "multi-stakeholder initiatives" such as the "Global Fund to Fight AIDS, Tuberculosis and Malaria," and the GAVI Alliance (a Gates-funded PPP linking the World Health Organization with the vaccine industry). Such arrangements allow BMGF to leverage its stake in allied enterprises, much as private businesses enhance power and profits through strategic investment schemes. The U.S. government is a key strategic partner. BMGF works closely with USAID and CDC; through its founder, the Gates Foundation enjoys unlimited access to the White House (Jackson 2010; Dedman 2009). BMGF also avails itself of U.S. tax laws, which, by sheltering private charities, place the government in the position of effectively co-financing its activities (Drobny 2006).

The Gates Foundation intervenes directly in the agendas and activities of national governments, ranging from its financing of the development of municipal infrastructure in Uganda (BMGF 2012a), to its recently announced collaboration with the Indian Ministry of Science to "Reinvent the Toilet" (BMGF 2013b). At the same time BMGF supports NGOs that lobby governments to increase spending on the initiatives it sponsors (Global Health Watch 2008: 251). BMGF even feels free to "sit

down with the Pakistan government” to demand security measures in support of its operations (Tweedie 2013).

Influence with the governments of poor countries is critical to one of BMGF’s central missions: creating demand for the products of health-related transnational corporations (TNCs), especially Big Pharma. Despite annual revenues approaching \$1 trillion, the global pharmaceutical industry finds itself in a perpetual state of crisis, for which it lays most of the blame on costly regulatory requirements. Bringing a new drug to market requires staggering outlays in R&D, testing, and advertising; substantial assistance from government buyers is typically required to make even the most successful drugs profitable. BMGF functions as a crucial go-between, using its muscle to induce national health ministries to invest ever larger percentages of their meager social spending on medicines, especially vaccines and contraceptives (Levich 2014). Needless to say, the burden of these drug purchases falls on the taxpayers of the developing world—those least able to pay, while the profits flow from the periphery to the core.

At the same time, BMGF exerts its power to “streamline” safety testing. Foundation publicity describes its support for R&D strategies tailored to the realities of the developing world, where “[t]o speed the translation of scientific discovery into implementable solutions, we seek better ways to evaluate and refine potential interventions—such as vaccine candidates—before they enter costly and time-consuming clinical trials” (BMGF 2015b). In plain language, BMGF promises to assist Big Pharma in its efforts to circumvent regulatory regimes by sponsoring cut-rate drug trials in the developing countries. Shortly after the 2014–2015 African Ebola epidemic stabilized, BMGF announced a lobbying effort to cut drug registration times by 50 percent in Sub-Saharan Africa within three years (Torjesen 2015). This would be done, the foundation claimed, “without sacrificing quality or safety” and justified the initiative as an emergency measure that would save many lives. In the past, however, BMGF’s efforts to outflank safety regulations have sometimes resulted in considerable human suffering and death, as when an illegal Gates-sponsored clinical trial of HPV vaccine in India killed seven adolescent girls and injured hundreds (Levich 2014).

Presumably, BMGF executives submitted these deaths to a form of cost-benefit analysis, in keeping with their commitment to practices



derived from the business world. Indeed, the Gates's operation resembles nothing so much as a massive, vertically-integrated multinational corporation, controlling every step in a supply chain that reaches from its Seattle-based boardroom, through various stages of procurement, production, and distribution, to millions of nameless, impoverished "end-users" in the villages of Africa and South Asia. Emulating his own strategies for cornering the software market, Gates has created a virtual monopoly in the field of public health. The Gates Foundation's global influence is now so great that former CEO Jeff Raikes was obliged to declare: "We are not replacing the UN. But some people would say we're a new form of multilateral organization" (Pickard 2010). The Ebola outbreak of 2014–2015 was to supply ample confirmation of Raikes's boast.

### **Ebola**

In March 2014, WHO reported a serious outbreak of Ebola, a viral hemorrhagic fever, in Guinea, Liberia, and Sierra Leone, all West African nations previously free of the disease (CDC 2014). As the epidemic spread to other African countries, including Mali and Nigeria, a worldwide panic ensued, stoked by overheated press coverage and an attendant social media frenzy. Predictions of an uncontrollable global epidemic were common, sometimes reaching apocalyptic proportions (Daily Beast 2014; Bond 2014), and Americans who ordinarily gave little thought to African diseases were increasingly alarmed. By October 2014, two-thirds of Americans said they were worried about a widespread Ebola epidemic in the United States; 91 percent now supported Ebola-related immigration restrictions (Dennis and Craighill 2014).

A year later, the outbreak seemed to have been contained, with deaths and new diagnoses declining in all affected countries. The toll was indeed grim: as of March 25, 2015, more than 10,000 deaths had been recorded (WHO 2015a). Seen in perspective, however, Ebola looked like a relatively minor threat to the people's health. During the same year, an estimated 1.5 million died from HIV-related illness, another 1.5 million from diarrheal diseases, and 1.3 million from road accidents (WHO 2014f).

In fact, Ebola is neither as contagious nor as deadly as its fearsome reputation suggests. Infection occurs from direct contact—through broken skin or mucous membranes—with the bodily fluids of infected people; it does not appear to spread through vectors (like bubonic plague) or coughs and sneezes (like influenza or SARS) (WHO 2014d). Early findings that the virus kills 90 percent of its victims proved exaggerated; WHO now reports an average 50 percent death rate, while one expert projects a survival rate as high as 90 percent with adequate treatment (WHO 2014a; Farmer 2014). Prior to the 2014 outbreak, only 1,548 people were known to have died from the disease (CDC 2015).

Ebola's uniquely monstrous reputation in the West dates from the appearance of Richard Preston's 1992 *New Yorker* article, "Crisis in the Hot Zone," and subsequent 3.5-million-copy bestseller *The Hot Zone: A Terrifying True Story* (Preston 1992, 1994). In the overheated style of a paperback thriller, Preston tells the story of a 1989 incident in which Reston virus, one of the five known viruses within the genus *Ebolavirus*, was discovered in a primate quarantine facility affiliated with USAMRIID. (USAMRIID is an Army institute involved in biowarfare research; U.S. germ warfare programs ostensibly ended in 1969, after which such research was rebranded "biodefense" or "biosecurity" [Riedel 2004].) Preston's book creates suspense by suggesting, falsely, that the virus is liable to become airborne at any moment, and dramatically distorts the symptoms of the disease—for example, patients are described as "bleeding out" from every orifice and "weeping tears of blood" while their internal organs "liquefy." One epidemiologist has called *The Hot Zone's* lurid exaggerations "one of the banes of my existence" and "infuriating to so many of us in epidemiology and infectious disease" (Perry 2014).

Preston's book spawned a 1995 Hollywood movie, *Outbreak*, which consolidated the Ebola myth. Both book and film frame the virus in unmistakably racial terms. Ebola appears as an ogre lurking in the dark forests of Africa, always threatening to break free of primitive regions to infect and destroy the "civilized" world. As scholar Lisa Lynch has observed, *The Hot Zone* and its progeny exemplify "the persistence in contemporary pandemic tales of colonialist racial discourse about the biologically polluted native. . . . [T]he horror of [the] narrative is mainly the xenophobe's horror of the civilized world being infiltrated and penetrated by savages" (Lynch 1998: 235).

Reflecting the enduring potency of such myths, a colonialist worldview underlies most Western accounts of the 2014 outbreak. Typical news stories describe Ebola as “the killer hiding in the jungle,” a “savage African disease ready to break out anywhere at any moment,” emerging from the West African bush where “it’s ... like *The Heart of Darkness*” (Sieff 2015; French 1995; Novack 2014). Laurie Garrett’s 2014 bestseller *Ebola: Story of an Outbreak* opens with a racist fantasy seemingly plucked from 19<sup>th</sup>-century colonialist adventure fiction:

Fully dilated pupils struggled to decipher shapes in the pitch darkness, spotting the pinpoint lights of millions of dancing fireflies. Gentle footsteps betrayed what the eye on a moonless night could not see; the constant movement of people, their dark skin hiding them in the unlit night. ... There were ancient ceremonies handed down by the ancestors that could purge evil spirits—they usually lifted the *landa-landa*. But not this time. The magic was too powerful. (Garrett 2014: Kindle locations 105–107, 120–121)

The colonialist discourse surrounding Ebola was useful to the propagandists of U.S. imperialism, who eagerly compared the “insurgent” virus to Washington’s designated enemies. “Contain These Contagions: Ebola, ISIS and Putin” demanded the *Financial Post*, while *Forbes* grouped Ebola with ISIS and Putin as dangerous symptoms of a “revolt against the 21<sup>st</sup> Century” (Francis 2014; Kaylin 2014). A transparently bogus report that Islamic state fighters had weaponized the virus received widespread media attention (Dorminey 2014). Writing for the Council on Foreign Relations, U.S. Air Force Colonel Clint Hinote compared the spreading virus to ideological contamination and urged public health workers to employ counterinsurgency tactics (Hinote 2014).

Public health professionals and philanthropists typically eschewed such politically charged language, but were not above exploiting the Ebola panic to advance their own agendas. Margaret Chan, the director general of WHO, called the 2014 outbreak “the largest, most severe and most complex that we have ever seen” and “a global threat that requires urgent action” (Viebeck 2014). Joan Liu, president of the international NGO Doctors Without Borders, courted melodrama as she addressed a U.N. gathering in September:

Six months into the worst Ebola epidemic in history, the world is losing the battle to contain it. . . . In Sierra Leone, infectious bodies are rotting in the streets. Rather than building new Ebola care centers in Liberia, we are forced to build crematoria. . . . This is a transnational crisis, with social, economic and security implications for the African continent. It is your historic responsibility to act. (United Nations 2014)

Thus, even as the outbreak began to subside, a perfect storm of sensationalized publicity swept through the Western media. No one doubted that the threat was unprecedented and potentially catastrophic; all agreed that somebody, somewhere, needed to do something soon.

National health systems were deemed hopelessly inefficient and inadequate to the task at hand. The history of exploitation and dependency that crippled local response to the outbreak went unmentioned. To the contrary, Western private firms were typically praised for purported competence in the face of catastrophe. For example, Firestone Tire and Rubber Co., owner and operator of the world's largest rubber plantation near Monrovia, received favorable press for the ruthlessness of its response. Soon after Ebola was diagnosed in Liberia, the company rushed to protect its assets, using money and political muscle to appropriate resources, like hazmat suits and trained medical personnel, that were all but unavailable elsewhere in the country. In Harbel, a company town named for Firestone's founder, 80,000 workers were already employed under conditions constituting "the modern equivalent of slavery," subject to an authoritarian corporate regime that functioned with minimal regard for national sovereignty or human rights (Verite 2012: 16). In this context it was relatively simple for Firestone to lock down the plantation, isolate patients, and quarantine their families. In effect, an Ebola-free private island was created in the midst of impoverished Liberia. National Public Radio enthusiastically declared: "Firestone Did What Governments Have Not: Stopped Ebola in Its Tracks" (Beaubien 2014). Rarely mentioned were the fates of Firestone's healthy workers, who earned the equivalent of \$5 a day, or the Ebola victims' families, who were summarily evicted from their Harbel homes with a one-time payment of \$1,900 in lieu of pension. Each also received a bag of rice (Chamberlain 2014).

State and private institutions saw a unique opportunity to advance various longstanding agendas, and were quick to respond. For health NGOs, Ebola hysteria offered an opportunity for “disaster fundraising” of the type perfected by the American Red Cross, which drew criticism in the aftermath of Hurricane Sandy for diverting donated funds into public relations and executive salaries (Elliott and Eisinger 2014). Doctors Without Borders was able to raise \$47 million—nearly doubling its annual operating budget—via Ebola-related appeals (Kunkle 2014). The Disasters Emergency Committee organized the “Fashion Against Ebola” fundraiser around supermodel Naomi Campbell, who auctioned off wardrobe castoffs in a glitzy event that opened London Fashion Week (Klasa 2015). The super-wealthy, having recently experienced critical scrutiny as “the One Percent,” opened their wallets and issued self-laudatory press releases: Facebook multi-billionaire Mark Zuckerberg parted with \$25 million, while Microsoft co-founder Paul Allen launched #TackleEbola, organizing members of his NBA team, the Portland Trailblazers, to act as celebrity touts (Kunkle 2014).

The money raised by Zuckerberg and Allen went primarily to the CDC Foundation, a little-known quasi-private corporation created by the U.S. Congress to supplement funding to the Centers for Disease Control. The foundation’s ties to the state had special appeal to entrepreneurs accustomed to leveraging their investments. According to James M. Ferris, director of the Center on Philanthropy and Public Policy at the University of Southern California, government-associated foundations are attractive to wealthy philanthropists “because they can amplify their donations”:

They are looking to have a greater social impact, and even the larger philanthropic organizations can only go so far. That’s why they partner with government—to influence public policy. (Cha 2014)

Meanwhile AFRICOM, the U.S. military command charged with responsibility for all African nations with the exception of Egypt, was in the midst of a rapid expansion aimed at securing U.S. interests across the continent. Established in 2007 with the purported goal of facilitating disaster relief and “war prevention,” AFRICOM was widely understood among U.S. planners as a counter to growing Chinese influence in a

region rich with strategic resources (Hofstedt 2009; Glazebrook 2012). By 2013 AFRICOM was active in 49 nations and was conducting joint military exercises and covert special operations across the continent (Turse 2013). Yet the scope of U.S. ambitions was hampered by the need to secure approval from sovereign states, and AFRICOM had managed to station a mere 2,000 soldiers in Africa as of 2012 (Glazebrook 2012).

The Ebola crisis offered useful cover for a substantial escalation in U.S. military presence. Calling Ebola a “top national security priority for the United States,” in September 2014 the White House authorized the deployment of 3,000 troops to Guinea, Liberia, Sierra Leone, Nigeria, and Senegal under AFRICOM command—more than doubling U.S. military presence in Africa—and simultaneously established a new military base in Monrovia (White House Press Office 2014). U.S. armed forces arrived in West Africa to the accompaniment of media fanfare and proceeded to erect a number of Ebola Treatment Units (ETUs)—essentially, large tents containing rows of cheap plastic mattresses. For the most part, these facilities were to stand empty. As of April 2015, only 28 Ebola patients had been treated at the 11 ETUs built by the U.S. military; nine centers never received a single Ebola patient (Onishi 2015). According to the *Washington Post*, “the disease had already drastically subsided before the first American [treatment] centers were completed,” belying the “alarming epidemiological predictions” that supposedly prompted an aggressive U.S. response (Sieff 2015b). As of early 2015, it remained unclear how \$2.6 billion allocated to the Ebola operation had been spent (Vlahos 2015); presumably, not all of the sum was invested in healthcare.

Some troops were later withdrawn as the outbreak waned, but important precedents had been established. African nations previously somewhat resistant to AFRICOM’s encroachments had buckled under intense pressure and invited large-scale U.S. deployments. The Pentagon could now envision intervening at will in the event of further African health emergencies. Meanwhile, a framework was established for future militarized collaborations between health NGOs and the Pentagon that appeared to outflank issues of national sovereignty. Wasting no time, in March 2015 AFRICOM announced the first-ever conference on Medical Support Operations, introducing representatives from NATO and the Spanish Armed Forces to such NGOs as the British Red Cross and Save the Children (“Premier Medical Support Operations” 2015).

Perhaps the most significant development in the military field was the rebranding of the “humanitarian intervention”—a catchphrase significantly tarnished by recent slaughter in Libya—under the rubric of an elastic new concept called “human security.” U.S. President Obama invoked the phrase, which emerged from GHG literature, as a justification for the deployment of AFRICOM and in an appeal to the U.N. Security Council for a broader effort “to stop a disease that could kill hundreds of thousands, inflict horrific suffering, destabilize economies, and move rapidly across borders” (Pellerin 2014). In response, the United Nations passed Resolution 2177 on Ebola relief, officially marking “the emergence of a discourse concerning non-traditional threats to international peace and security” (Burci and Quirin 2014).

The *Washington Post* explained:

[W]hereas we typically think of security threats as a threat to a country’s national interests, human security broadens the notion of security to focus on the individual and thus considers things such as poverty, health pandemics and climate-related disasters—as security threats. . . . [H]umanitarian intervention occurs in response to conflict situations, and often external actors intervene only when their national interests are at stake. . . . Defining the Ebola crisis as a human security issue is a game changer. There is no conflict in the West African countries most heavily affected by Ebola (at least not yet), thus the security threat highlighted by the UNSC is a threat to people and their humanity—the right to life with dignity. (Deloffre 2014)

The U.N. espousal of “human security” provided cover for prominent NGOs, such as Doctors Without Borders, to abandon longstanding ethical commitments to neutrality and impartiality in joining the call for an overtly militarized response to a humanitarian crisis (Dionne et al. 2014). More ominously, the new doctrine seemed limitlessly expansive: If poverty, disease, or climate change were now considered grounds for military action *tout court*, where in Africa could interventions *not* be justified? In effect, the West had written itself a blank check for future military operations in the developing world. Thus was the Ebola epidemic exploited to introduce a justification and a quasi-legal framework for the realization of militarized “global health governance”—intervention any time, anywhere in the developing world, under cover of humanitarian concern.

In the end, the U.S. military contributed little or nothing to controlling the epidemic (Onishi 2015). The most effective international aid came from Cuba, which made use of a robust universal health-care program to place nearly 500 health professionals on the ground in Sierra Leone, Liberia, and Guinea (Taylor 2014). In three African nations—Nigeria, Senegal, and Mali—response was swift and successful. Not coincidentally, these countries were able to draw on the resources of relatively well-funded national health systems (WHO 2015b). Even Bill Gates was compelled to acknowledge that the Ebola outbreak signaled an “urgent need to strengthen health systems in the world’s poorest countries” (Gates 2014). Yet a close analysis of BMGF’s well-publicized response to Ebola suggests that it was geared, not to assisting local health-care systems, but to advancing the foundation’s broader agenda.

### **The Gates Foundation and Ebola**

The Gates Foundation at first seemed reluctant to intervene. Making emergency grants for disaster relief ran counter to the organization’s business model, which emphasizes strategic, long-term solutions with quantifiable results. As the world’s leading health charity, however, the Bill & Melinda Gates Foundation (BMGF) could not stay on the sidelines without damage to its reputation. Consequently, on September 10, 2014, BMGF announced plans to commit \$50 million “to support emergency response to Ebola” (BMGF 2014a). Gates’s urgent call to strengthen national health systems appeared on his blog soon after. BMGF publicity suggested, without precisely saying so, that the entire sum would be committed to near-term disaster relief and investments in local health infrastructure.

In the event, however, BMGF’s response to Ebola was carefully calibrated to advance the organization’s long-term strategic goals. Although a small portion of the money pledged was immediately released to existing emergency responders—\$5 million to WHO; \$5 million to UNICEF; \$2 million to the Centers for Disease Control (CDC)—the remainder was vaguely allocated to “work with public and private sector partners to accelerate the development of therapies, vaccines, and diagnostics that could be effective in treating patients and preventing further transmission of the disease” (BMGF 2014a). In practice this



meant a variety of investments in projects of the kind BMGF typically funds—for example, biomedical R&D, Big Data initiatives, vaccine development—as well as the creation of new U.S.-based PPPs designed to override the authority of local health systems. Although BMGF has not released a full accounting of its “emergency response” expenditures, subsequent reports of Ebola-related grant-making give a fair indication of how the money was actually spent:

- An award of \$5.7 million was given to a vast private-public consortium charged with scaling up the production of convalescent blood products. Partners in the enterprise included pharmaceutical firms, private foundations, and universities, as well as the U.S. Army “biodefense” outfit, USAMRIID (BMGF 2014c). These funds were directed not toward emergency care but toward longer-term research that might in future prove profitable to the biomedical industry. In one respect, however, the initiative required speedy action: BMGF proposed to accelerate large-scale collection of blood and plasma from Ebola sufferers. Although the project held no therapeutic benefits for the sick, WHO was persuaded to issue emergency approval in light of the crisis (WHO 2014c).

For BMGF, Ebola created an opportunity to advance a central plank of the GHG agenda: the replacement of national health systems with supranational public-private combines. Analysts took notice: “Pre-existing formal and informal relationships between many of the parties set the groundwork for the rapid formation of consortia that enabled this extraordinarily fast and broad response. . . . From the beginning, it became clear that these alliances were much wider across functions and borders than responses to any previous global epidemics” (Barnes-Weise and Rutschman 2015).

- Tucked into BMGF’s September 10 press release was a single reference to development of a controversial antiviral drug called brincidofovir. Originally touted as a treatment for smallpox, brincidofovir had a troubled history. Patent-holder Chimerix had been unable to secure approval for trials necessary to bring the drug to market, and, in early 2014, it attempted to apply pressure on the FDA via a sensational social media campaign

that many deemed unethical (Kroll 2014a). The overnight rebranding of brincidofovir as an Ebola drug took the industry by surprise: according to one analyst, “no one in the field even had this drug on their radar” (Kroll 2014b).

With BMGF backing the drug, ethical considerations evaporated. WHO swiftly approved large-scale trials in West Africa, suspending longstanding concerns that poor people were being used by pharmaceutical firms as guinea pigs for experimental treatments. “In the particular context of the current Ebola outbreak in West Africa,” WHO ruled, “it is ethically acceptable to offer unproven interventions” (WHO 2014b). The FDA, meanwhile, granted an emergency waiver permitting therapeutic use of the untried drug in Ebola patients. Shortly thereafter, Chimerix raised \$121.7 million in a public stock offering (Kroll 2014b). For BMGF and its Big Pharma partners, a relatively small investment in an experimental treatment gave a short-term boost to the industry and set a precedent that could be used to facilitate future drug approvals.

- WHO’s emergency suspension of testing safety protocols opened the door for further large-scale drug testing in West Africa; rushing to take advantage, BMGF granted nearly \$6 million to Clinical Research Management to conduct unspecified clinical trials intended “to inform potential future treatments” (BMGF 2015a). Clinical Research Management, founded by a USAMRIID alumna, is a leading contract research organization (CRO), a type of firm that provides testing support services, typically in developing countries, to pharmaceuticals seeking to bring new drugs to market.
- Three grants totaling more than \$1 million were bestowed on Rockefeller University and the private firm Mapp Biopharmaceuticals to accelerate production and testing of ZMapp. This experimental drug was developed by Mapp in conjunction with USAMRIID and DARPA, a U.S. Department of Defense agency responsible for development of emerging military technologies (BMGF 2014e, 2014d, 2014f).
- Nearly \$3 million was granted to GlaxoSmithKline (GSK), the world’s sixth-largest pharmaceutical firm, “to accelerate Ebola

vaccine production and development” (BMGF 2014d). The BMGF funds were likely used to underwrite fast-tracked trials of GSK’s vaccine for the Zaire strain of Ebolavirus, developed in conjunction with the U.S. National Institutes of Health and, under ordinary circumstances, still years away from the market (Kelland 2015). Recently, GSK had attained worldwide notoriety as the result of its guilty plea to criminal fraud charges and safety violations in a \$3 billion settlement with the U.S. Department of Justice, the largest payment ever by a drug company (U.S. DOJ 2012). In industry publications, the firm’s seemingly selfless involvement in Ebola vaccine research was touted as “a PR win” (Savage 2014).

- The Tony Blair Africa Governance Initiative received \$700,000. This is a foundation devoted to advancing neoliberal reforms and bolstering the involvement of Western NGOs in African states (BMGF 2014g). Although its publicity insists that “Africa’s future lies in the hands of Africa’s leaders,” the charity can be assumed to work in the interests of the imperial core: major donors include the World Bank and USAID (Smith 2015).
- Fio Corporation received \$736,048 for a system allowing data capture and sharing through intelligent mobile devices. The commercial initiative promised to facilitate electronic communications between frontline health-care workers and remote health-care managers and organizations (BMGF 2014b). The apparent purpose of the investment was to assist in on-the-ground tracking of epidemics, but it might also be seen as a first step toward the global health surveillance network envisioned by Gates.

Another major move by BMGF was not directly related to the epidemic but seemed timed to take advantage of Ebola-related turmoil. In March 2015, the foundation announced that it had taken a \$52 million stake in CureVac, a private pharmaceutical firm involved in the development of vaccines using genetically engineered mRNA (Herper 2015). For the first time, BMGF would hold a direct financial interest in the success of a commercial pharmaceutical business. Since the foundation takes a leading role in shaping the vaccine purchases of governments worldwide, the investment constituted a clear-cut conflict of interest.

Yet the world of Big Philanthropy, formerly boastful of its independence from crass commercial pressures, remained silent, and no criticism appeared in the popular or business press. Public interest was by now so thoroughly intertwined with private gain that the CureVac story seemed unremarkable.

Overall, BMGF's Ebola funding decisions are best seen as an acceleration of GHG trends in accordance with longstanding BMGF policy. Response to the epidemic was deftly folded into the Gates agenda; hysteria was ably exploited to stimulate progress toward a goal shared by BMGF and the theorists of GHG: the outflanking of international health institutions in the interest of Western capital. Gates's subsequent "call to action" in the pages of *NEJM* did not represent a shift in the direction of global health management as such; rather, it reflected his desire to consolidate and intensify the status quo under the rubric of a powerful new institution, one that would be immediately responsive to the prerogatives of the global ruling class.

U.N. officials did not fail to grasp the import of Gates's intervention. WHO issued a statement conceding flaws in the organization's response to the outbreak and launching a counter-proposal. It called for the creation of a new Global Health Emergency Workforce under U.N. auspices, coupled with a new contingency fund and various organizational reforms (WHO 2015c). WHO's statement, an implicit challenge to Gates, laid emphasis on the need to strengthen capacity at the national level, disdained "market-based systems," and stressed the importance of "community and culture" in the control of disease. The stage was set for a struggle over the reins of global health management. The outcome remains to be seen.

### **Global Health Imperialism**

In a discussion of imperialism and globalization, Samir Amin (2001) observes:

There is a global political strategy for world management. The objective of this strategy is to bring about the greatest possible fragmentation of the forces potentially hostile to the system by fostering the breakup of the state forms of organization of society.

I have argued that the operations of this strategy are now as clearly evident in the field of public health as they have been in the strictly political arena. “Global health governance,” the phrase typically used to describe health management in the era of Bill Gates, is perhaps too narrow to comprehend the character and ambitions of the project I have attempted to outline. It may be more useful to employ the term “global health imperialism,” describing a system with the following features:

- Global health crises are held to *originate from* poor countries and constitute a *threat to* wealthy countries. Response to such crises is regarded as a security concern.
- Westphalian national sovereignty is considered an impediment to effective management of transnational health issues.
- Overarching health-care planning, policies, and programs for the people of poor countries are determined by the experts and financiers of wealthy countries. Foundation funding is used as leverage to ensure that national health systems cannot function independently.
- Existing national and local health-care management is subordinated to, and must be cooperative with, the goals of Big Philanthropy and Western capitalism.
- Militarization of health-care delivery and disaster management is deemed appropriate and necessary. Military forces involved are drawn from the United States, NATO, and allied countries.
- Health philanthropy is modeled on the philosophy and practices of private corporations. Health-care funding is conceived as an investment activity; quantifiable return on investment is the guiding principle for grant-making.
- Big Philanthropy underwrites vertical initiatives potentially profitable to Western-based transnational corporations—for example, vaccines and other pharmaceuticals—instead of supporting primary care and strengthening national health systems. Drugs and other health-care commodities produced by Western TNCs are financed by the taxes of the poor.
- Existing systems of international health-care governance are being superseded by new forms of supranational governance comprising the formal institutions of global capitalism—the

World Bank, the G7—as well as health-related TNCs, the major U.S. based-foundations, and associated networks of NGOs. The scope for democratic participation by the people in their own healthcare is radically narrowed.

As a worldwide system, what I have called “global health imperialism” is clearly on the ascendant, but it is not yet universal or irreversible. Powerful non-Western states, like India and China, have begun to challenge U.S. hegemony in the field (Huang 2013). Public health professionals are becoming increasingly vocal in their criticisms of Big Philanthropy. Most importantly, popular resistance is emerging in poor countries as part of a broader struggle for an egalitarian and sustainable society. As Adam Habib, Vice Chancellor of the University of Witwatersrand, recently remarked: “The dilemma of the poor is not about resources. It is about power. If the poor have power, they will leverage the resources needed” (Mahomed and Mayo 2013). Bill Gates has informed the people of his plans for their future, but the people have yet to be heard from.

#### **Note**

1. Editor’s note: The Treaty of Westphalia, in 1660, signed at the end of the Thirty Years’ War in Europe, established the modern system of nation-states and the concept of national sovereignty. Clearly, the European powers had long ignored the principle of national sovereignty as it might apply in colonized territories, and, as the author here explains, they continued to ignore it after colonized nations became nominally independent.

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