

Influence through Affluence? Conceptualizing Private Foundations as Agents of Change

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Abstract:

A decade after it was established the Bill and Melinda Gates Foundation has evolved into a well-known figure in international development cooperation, especially in global health. Similar to the Rockefeller Foundation which was actively involved in shaping health as an international policy field in the first half of the 20th century, the Bill and Melinda Gates Foundation is looked upon as an “influential” actor in global health today. The examples of the Rockefeller and Bill and Melinda Gates Foundation invite to look into how the two philanthropic foundations could become political actors and “agents of change”. Therefore the paper concentrates on the question of what makes an actor “influential”. The answer to that question usually starts with power. Power as empirical phenomenon always rests on a range of resources, both material and immaterial. But “power over” is not equivalent to “power to”. Consequently, the paper focuses on how to conceptualize the translation of power into influence, i.e. into an (observable) outcome or impact. The historical comparison of two instances of institutional innovation in international/global health governance, which are attributed to the influence of the Rockefeller and Gates Foundation, allows us to determine various factors which may contribute to creating influential policy actors.

1. Introduction¹

Private Foundations are one of the oldest social institutions whose history dates back to ancient Rome and Greece (Coing 1981). But our “modern” concept of philanthropy originates in the advent of a new type of foundation in the wake of the industrial revolution. In the original charity model of foundations the basic template or mode of operation was to fight against poverty and provide some health care and social services. In the early 20th century, however, foundations turned to a more scientific philanthropy in their quest to tackle the underlying causes of problems rather than curing the symptoms (Anheier/Toepler 1999: 7). This move from “charity” to “philanthropy” was attributed to a new type of businessmen who had accumulated some considerable wealth in a rather short time and ran their businesses based on the principles of rationality, organization and efficiency (Karl/Katz 1981: 243). John D. Rockefeller and Andrew Carnegie epitomize perfectly this new type of philanthropist whose foundations spent large parts of their annual budgets on scientific research. Interestingly, for about the last decade, the traditional landscape of foundations is said to have been supplemented by the “new philanthropy” of entrepreneurs (Center on Philanthropy and Public Policy 2000) who gained their wealth at the height of the “new economy” as heads of information technology companies (like Bill Gates of Microsoft or the Google founders Larry Page and Sergey Brin), or entertainment corporations (e.g. Richard Branson of Virgin). These new types of philanthropists are running their foundations based on a corporate style of management and economic thinking, and are using their resources as a lever for social change. For the more recent developments in philanthropy some authors use terms like “strategic philanthropy”, “venture philanthropy” or “social investment” (Anheier/Leat 2006: 5, Bertelsmann Foundation 2001, Eilinghoff 2005).

The phenomenon of private foundations as “agents of change”, however, is not new. Private foundations have been involved in international (development) cooperation throughout the 20th century. Some prominent examples include the role of the Rockefeller Foundation in combating diseases like hookworm or yellow fever or its role in starting off the “Green Revolution” in Mexico in the 1940s. Like the Ford Foundation, the Rockefeller Foundation also ran population programmes in developing countries from the 1950s onwards (OECD 2003: 89-96). Therefore, when the discipline of International Relations started to use the concept of “transnational actors” as new type of non-state actors in international relations in the early 1970s, also foundations were looked upon as “significant transnational actors not

¹ I am grateful to Paula Becker and Bastian Knebel for research assistance on activities of the Gates and Rockefeller Foundation. My thanks also go to Elena Heßelmann for discussions on the outline of the paper and comments on an earlier version of modeling foundations’ influence.

only because of the direct outcome of their grants but also because of their direct and indirect influence on other actors in world politics” (Bell 1971: 466).

The example of the Rockefeller Foundation with its role in shaping international health politics in the first half of the 20th century is clearly an empirical proof of the influence of foundations. Looking back at the history of the Rockefeller Foundation’s “International Health Division”, Anne-Emmanuelle Birn concludes:

“In sum, the RF [Rockefeller Foundation] was involved in all aspects of public health: ideas, theory, research, professional training, practice, implementation, organization and institution building. As the only health agency truly operating internationally until the founding of the WHO in 1948, it helped to shape global public health to a greater extent than any other organization of its day” (Birn 2006: 31f).

Some observers regard the Bill and Melinda Gates Foundation (hereafter: Gates Foundation) as the new “global health colossus” (McMahon 2006), and compare its role in global health during the last decade to that of the Rockefeller Foundation in international health almost a century ago. In contrast to other foundations of its time, the Rockefeller Foundation as some novel type of foundation exhibited a similar style like the new “strategic philanthropists” of today, in that it tried to use its wealth in a systematic way, relying heavily on the advancement of modern sciences as important tool for the economic and social development of societies (Howe 1980). When you read about the Gates Foundation in the media its influence is largely attributed to its wealth, similar to its historical precursor, the Rockefeller Foundation. Although common sense and practical experience tells us that “money makes the world go around”, nevertheless the interesting question that arises for a social scientist is how philanthropic foundations can become political actors and “agents of change”. The more so, since commentators argue that “the Gates Foundation is not a passive donor” (McCoy/Kembhavi/Patel/Luintel 2009: 1650). Not being a “passive donor” implies that you have to spend your money “actively” in some specific way to gain influence. Therefore, the paper concentrates on the question of what makes an actor “influential” and how you can conceptualize “influence” as an analytical category.

I start off with a short discussion on the concept of “influence” and give an overview on the state of the art of research on “influence”. Traditionally, research in political science on “influence” focussed on explaining political decisions, the voting behaviour of decision-makers in parliaments or the outcome of negotiation processes. The influence attributed to Foundations like the Rockefeller and Gates Foundation is said to relate to shaping international or global health governance respectively. In other words, their influence does

not only refer to processes but to structures and institutions as well. Therefore, in a second step I briefly present some empirical details on the Rockefeller Foundation's role in creating the League of Nations Health Organisation and both the Rockefeller and Gates Foundation's role in establishing public-private partnerships in global health. Based on these examples I will discuss various factors which seem to be relevant for making an actor "influential" and which can be used to model the influence of foundations as "agents of change".

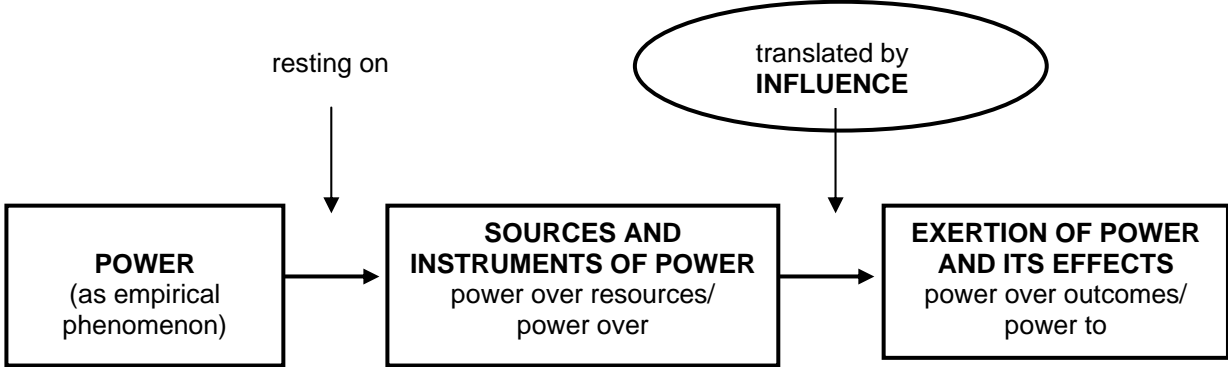
2. Affluence = Influence? How To Grasp Influence When You (Think To) See It

Generally speaking, the answer to the question what determines the influence of an actor is "its power". Therefore, "influence" as a theoretical concept is closely related to "power". Like power influence is defined as "ability to get others to act, think, or feel as one intends" (Banfield 1965: 3). Or to use the definition of Robert Cox and Harold Jacobson in their seminal work on "The Anatomy of Influence": "Influence means the modification of one actor's behaviour by that of another" (Cox/Jacobson 1974: 3). As far as power is concerned, the supplementary qualification is added that power is exerted when one gets others to act as one intends *even against their will* (cf. Max Weber).

In their study on decision-making in international organizations Cox and Jacobson point to two very crucial aspects of "influence": Firstly, it is a relational concept that is not "given", which means that influence emerges in the process of interaction. And secondly, influence is not boundless, but limited to a specific scope in the sense of a sphere of activity or issue-area (cf. Cox/Jacobson 1974: 4). You can assume some kind of influence at work, whenever one factor in a causal chain contributes to some kind of outcome, i. e. the outcome would not have been possible without the factor in question (cf. March 1955: 436f). Therefore, influence is also closely related to our notion of causality. Power as such, in the sense of an empirical phenomenon which is attributed to someone, does not inevitably lead to some kind of effect. Power rests on specific resources (material and immaterial) and is channeled via a range of instruments before it can lead to (observable) effects. This is why we distinguish between "power over (resources)" and "power to (do something)" or "power over outcomes". For the sake of clarifying the relation of power and influence we will assume that to actually exert power, the resources and instruments on which power rests will be translated into effects by influence (see figure 1). Thus, to contrast power from influence, power can be defined as "general ability to influence", whereas influence is the "realization of a single effect" (Arts/Verschuren 1999: 413). This leads us to the question, how translating power into

influence actually works. Or in other words: What kind of factors contribute to an actor's being "influential" and how can you measure "influence"?

Figure 1: Relationship between "power" and "influence"



From the onset, research on influence was plagued by methodological problems of how to measure influence (see e.g. March 1955). Although influence like power is looked upon as some kind of vague and contested concept, still social scientists want to assess the political influence of actors. This is not only due to democratic concerns of "who (really) governs" (Dahl 1961), but also to the idea of establishing if non-state or private actors are able to voice their ideas and interests in politics. Especially in international politics, NGOs were welcomed as means of "democratizing" policy processes which were said to unfold behind closed doors, before the UN opened up for NGO admittance in its world conferences starting with the UN Conference on Environment and Development in Rio de Janeiro in 1992. Meanwhile there are a number of studies that focus on the influence of NGOs in international negotiation processes (Willetts 1996, Metzges 2006) ranging from environmental issues (e.g. Arts 1998, Corell 1999) to security issues like banning landmines (e.g. Anderson 2000, Short 1999). At the national level or supranational level like in the European Union, however, researchers have a strong interest in understanding the role of interest groups in shaping policy processes (e.g. Desbordes/Vauday 2007, Egdell/Thomson 1999, Fordham/McKeown 2003, Jacobs/Page 2005, Michalowitz 2007).

Essentially, there are two types of research on "political influence": In the first type, influence is conceptualized as *independent variable*, thereby trying to explain single decision-making processes and/or the voting behaviour of decision-makers on the one hand or negotiation processes and their outcomes on the other. This type of research does not really question, what "influence" means or how it might work. In fact, actors have exerted influence whenever

their preferences and positions are reflected in the outcome. In terms of methodology, this would entail that researchers have to establish preferences and positions before decisions have been taken, and assess to which degree the outcome meets those preferences and positions. But by using this method you always run into problems of attribution, since there might have been a number of other factors leading to the outcome (Dür 2008: 566f).

In a second type of research “influence” has the analytical status of *dependent variable*, which means that you open up the black box of influence and try to explain why the outcome is due to the activity of a specific actor or groups of actors. Then researchers ask by which means and modes actors are able to exert influence. Social interaction is typically characterized by two modes of communication: bargaining (exchange of promises and threats) and arguing (persuasion), both of which can determine the type and amount of influence an actor is able to exert. Still, you have to establish what kind of activities help actors to get other actors to act, feel or think as they intend. Methodologically, you can proceed either by using process-tracing or by assessing the (self-) attributed influence of actors or groups of actors by means of surveys. Since the attribution problem still exists and causal connections remain unclear, it is advisable to use a mix of different data and methods at the same time (triangulation).

Figure 2: Overview of research on influence

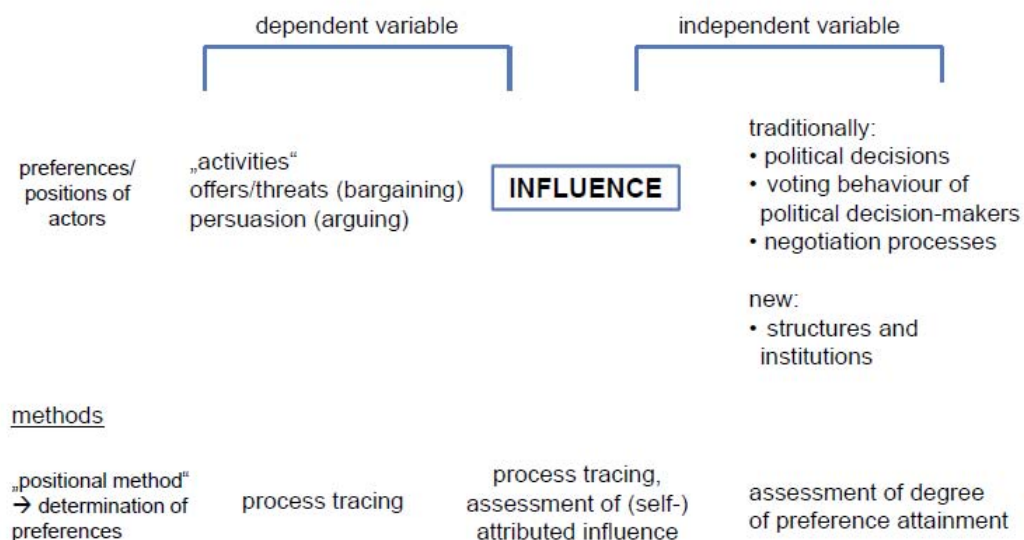


Figure 2 sums up this overview of different analytical and methodological approaches of research on influence. We do know that certain activities and modes of communication determine if an actor is able to translate the power resources he has at his disposal into

influence with an observable outcome. But in the case of philanthropic foundations our empirical knowledge of how this process actually works is very limited. Therefore, I will present two examples of institutional innovation in international/global health, both of which are attributed to the influence of philanthropic foundations, to gain some insights into factors that determine influence. Both cases are also instructive in terms of context factors which shape actors' preferences for specific problem-solving strategies.

3. From Inter-National to Global Health: The Rockefeller and Gates Foundation as Institutional Innovators

3.1 Going Inter-National to Spread the Idea of National Systems of Public Health: The Rockefeller Foundation and the League of Nations Health Organization

Even before the Rockefeller Foundation was founded in 1913 John D. Rockefeller Sr. spent parts of his fortune he had made with his oil company on philanthropic “investments” in the medical field. Rockefeller’s interest in “modern” medicine was stimulated by his philanthropic adviser Frederick Gates, who formulated what became known as the “Rockefeller Creed”: “Disease is the supreme ill of human life, and it is the main source of almost all other human ills – poverty, crime, ignorance, vice, inefficiency, hereditary taints, and many other evils” (quoted in: Farley 2004: 5). Consequently, the aim was to control or eliminate communicable diseases to improve public health. After the Rockefeller Foundation was established, the medical work of the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease (founded in 1909) was taken up by the Foundation’s newly-formed International Health Commission. The International Health Commission which was to be renamed into International Health Board from 1916 onwards became the famous International Health Division (IHD) in 1927, which was in operation until 1951. In his history of the IHD John Farley describes the IHD as “the world’s most important agency of public health work” (Farley 2004: 2) before the WHO was created in 1948.

The Rockefeller Foundation operated in a health context which was characterized by the growth of international cooperation, albeit with a low degree of institutionalization.² Due to an increase in commerce and mobility of people, epidemic diseases began to spread in the 19th century. Therefore a series of international sanitary conferences took place between 1851 and 1903 culminating in the adoption of International Sanitary Regulations in 1903 (Zacher/Keefe 2008: 27-34). Only in 1902 the first permanent (regional) international health

² Interestingly, the majority of international organizations created in the 19th century were non-governmental organizations (see Loughlin/Berridge 2002: 9).

organization was created, the International Sanitary Bureau (later renamed the Pan American Sanitary Bureau), which was followed by the establishment of the Office International d'Hygiène Publique (OIHP) in Paris in 1907. The main task of the OIHP was to gather and disseminate information on disease outbreaks. Critics, however, thought the spread of diseases could be better prevented if their sources were treated than by trying to put infected persons in quarantine when they were crossing borders. Still, the focus of international health cooperation was mainly on the exchange of information. In the early years of the 20th century, apart from colonial powers, health assistance for non-industrialized countries was only provided to a limited extent by organizations like the International Sanitary Bureau or non-governmental bodies like the Rockefeller Foundation or the League of Red Cross Societies (Zacher/Keefe 2008: 35, 37).

As a consequence of World War I the number of governmental international organizations grew, one of the most famous – alongside the International Labour Organization (ILO) - being the League of Nations which was one of the most contested at the same time. This growth in governmental international organizations was also due to the rise of the welfare state in reaction to a growing socialist movement and the Communist Revolution in Russia. This phase coincides with the advent of the new type of philanthropists who put an emphasis on science based on empirical research and technological approaches to solving social problems (Bulmer 1995).

It is against this background that the Rockefeller Foundation took the decision to support the establishment of the League of Nations Health Organization (LNHO). According to Paul Weindling the foundation's officers had realized that

“...to attain any improvement in national health systems, it [the Rockefeller Foundation] should encourage the international transfer of expertise: for medical science and epidemiology to advance, it was necessary to develop international standards, collaborative tests and coordinated international medical assistance. [...] The foundation saw the latter [LNHO] as a means of advancing its strategy of raising overall health levels throughout the world by enhancing scientific and medical knowledge and the institutional resources of expert elites” (Weindling 1997: 269).

The interesting fact is that the private actor Rockefeller Foundation supported the idea of creating an inter-governmental body thus strengthening the war-torn (European) states. We have to keep in mind that a governmental model of an international health authority was not the only option for establishing an international body for disease control. There were also attempts to employ the League of the Red Cross Societies (LRCS), which was founded in

1919, to overtake that function (Loughlin/Berridge 2002: 14). But this idea never really materialized, since the Red Cross societies were not able to agree on a joint position (Weindling 1995: 271). Not opting for a non-governmental solution, however, meant that the relationship between medical experts and state representatives in the newly founded inter-governmental body was unclear. Therefore, the mandate and degree of autonomy of the LNHO was open to dispute (Weindling 1995: 273). The more so, since health experts thought the LNHO would merge with the OIHP, which never happened since the United States did not join the League of Nations (Zacher/Keefe 2008: 7). Moreover, throughout the 1920s support for the LNHO was not without controversy at the Rockefeller Foundation. Frederick Russell, who was director of the International Health Board from 1923-1935, argued that the LNHO should be treated as any other (governmental) public health department and should not receive more than 25 % of its funding from the Rockefeller Foundation. The rationale behind it was to ensure that the LNHO would not gain too much autonomy (Weindling 1995: 275).

The Rockefeller Foundation cultivated a permanent relationship with the LNHO until the mid-1930s, because foundation officers looked upon it as a useful instrument to spread the idea of public health, modernize medical research and health care and create a professional group of (bio)medical experts. The regular financial budget support, which the Rockefeller Foundation provided, helped to secure the existence of the LNHO. Apparently the Rockefeller Foundation was well aware that trespassing the delicate (and not clearly delineated) borderline between what states claimed to fall unto their authority and the contested authority of the newly created international body, would endanger the strategic goal it was pursuing. Therefore, it did not direct the political guidelines or programmes of the LNHO in any way and tried not to duplicate the work of the LNHO (Weindling 1997: 270), but trusted that the medical director of the LNHO, Ludwik Rajchman, who shared the Rockefeller Foundation's vision of promoting public health, would shape the LNHO according to their ideas. Some observers have compared the cooperation of the Rockefeller Foundation and the LNHO to that of a "public-private partnership", in that "[t]hey penetrated deeply into national societies drawing domestic administrative, research and educational agencies into a transboundary biomedical/public health infrastructure" (Dubin 1995: 73). But formally, the two bodies operated separately.

The example of the Rockefeller Foundation sponsoring the LNHO clearly shows that the foundation placed its funds strategically into a new institutional mechanism, which was used to complement its own work, "allowing for two-way paths of influence between the international and the national and local scenes that were exemplified by Rockefeller

Foundation's campaigns and the League of Nations Health Organization endeavours" (Rodríguez-Ocaña/Zylberman 2005: 21). But the Rockefeller Foundation did not only contribute a considerable share of the LNHO's regular budget. It also provided funds to train public health personnel and awarded fellowships for the international interchange of these new experts. In conjunction with its support for clinics and laboratory services and the establishment of schools of public health it thus was "creating an international network of public health experts, contributing to biomedical/public health episteme" (Loughlin/Berridge 2002: 13, see also Weindling 1995: 275-278). A number of studies show, how the Rockefeller Foundation contributed to put new, but already existing ideas of reforming medical teaching into practice in North America, Europe and the Far East (Fedunski 2005, Kohler 1991, Lawrence 2005, Schneider 2002). Interestingly, donations of the Rockefeller Foundation attracted matching funds both from public and other private sources allowing to pay for the "continuing scientization of medicine" (Fedunski 2005: 5), which is a clear indication of successful agenda-setting by the Rockefeller Foundation owing to its ability to create networks of health professionals.

Critics of this ideational influence of the Rockefeller Foundation, which did not only extend to the natural sciences but also to the social sciences and policy-making (Parmar 2002), assume that the Rockefeller Foundation acted as agent of American imperialism (Arnove 1980, Brown 1976). But with respect to the LNHO we can witness that the Rockefeller Foundation "pursued a much more interventionist and ameliorative programme than the American government was willing to contemplate at the time" (Loughlin/Berridge 2002: 12). Certainly, the Rockefeller Foundation promoted a world view and a set of norms that was firmly rooted in Western capitalism. But as far as the export of a specific technocratic and science-based model of public health is concerned, more recent studies (Litsios 2005, Palmer 2010) question the long-time consensus that the Rockefeller Foundation only used a top-down approach (e.g. Birn 2006, Farley 2004). Interestingly, those newer studies draw a different picture, in which the Rockefeller Foundation was also willing to adapt its programmes to local circumstances and even learn from different models. We should keep in mind, that the capacity and willingness to put learning experiences into practice can also be used as a resource on which influence can be based.

3.2 The Re-Privatization of Health Politics: The Rockefeller and Gates Foundation as “Midwives” of and Agents in Global Health Partnerships

With the advent of the HIV/AIDS pandemic, the resurgence of tuberculosis (TB) and malaria and the realization of the detrimental effects of health threats in developing countries the 1990s witnessed some important changes in what was formerly called international health politics.³ Within the framework of a globalizing world, to many observers the former *international* efforts to tackle health threats turned *global* (Dodgson/Lee/Drager 2002, Hein/Bartsch/Kohlmorgen 2007, Kickbusch 2000, Lee 2003). This transformation was also marked by a trend to include more and more private actors in global health policy (Buse/Walt 2000). Even before the idea of a “global partnership for development” became part of the Millennium Development Goals (MDGs), public-private partnerships (PPPs) were welcomed as a new and innovative instrument of development cooperation (Tennyson/Wilde 2000).⁴ PPPs are especially thriving in the health sector. A survey estimated something between 75 to 100 Global Health Partnerships (GHPs), varying according to the definition (Caines 2005: 6). A wide definition would also include relatively informal forms of cooperation between public (governments, international organizations) and private actors (NGOs, foundations, business). As far as transnational PPPs are concerned, most authors only count institutionalized collaborative relationships between public and private actors as PPP that last for some time and aim at setting norms and standards for their members, try to implement programmes or deliver services to a wider public (Linder/Vaillancourt Rosenau 2000, Börzel/Risse 2005). Based on collective decision-making of public and private actors as the defining criteria an alternative assessment identified only 23 initiatives in the global health sector as PPPs (Buse/Harmer 2007: 260).

No matter how PPP are defined specifically, as new types of horizontal governance instruments they are rather contested. Proponents favour the inclusion of private actors because they are regarded as enhancing the problem-solving capacities of governance systems and as offering new avenues of participation (Tesner 2001, Nelson 2002, Ruggie 2002). Critics, however, suspect them to determine the agenda of international institutions aiming at an “institutional capture”, which will contribute to a commercialization of public goods and thereby undermine the public welfare (Richter 2003, Utting 2000, Zammit 2003). In terms of effectiveness, GHPs show a record of considerable achievements (cf. Dodd et al. 2007, Buse/Harmer 2007, Bartsch 2011): They were able to bring health issues on national and international agendas, which had been neglected before. Moreover, their advocacy

³ For a historical overview on the development of global health politics see Zacher 2007.

⁴ On the emergence and effectiveness of PPPs see Schäferhoff/Campe/Kaan 2009.

helped to mobilize not only new resources for major diseases but also the political will of governments to focus on priority diseases. By including private actors and civil-society organizations in the fight against health threats they created a new momentum for research and development of new medicines and types of interventions. At the same time, GHPs also contributed to improving access to free or reasonably priced medicines and vaccines. These activities helped to establish new international norms and standards. But what has to be noticed on a more critical note, is that the majority of GHPs concentrate on communicable diseases, particularly on HIV/AIDS, malaria and tuberculosis, i.e. they are very issue-specific and often oriented towards a quick impact (Buse/Harmer 2007).

This is not the place to go into detail about the range of more specific reasons that led to the emergence of GHPs,⁵ I would rather like to concentrate on why philanthropic foundations, in this case the Rockefeller Foundation and the Gates Foundation, looked upon it as a useful institutional mechanism and how they were instrumental in bringing it about, i.e. used their influence to create and sustain it.

Financing scientific research for the control of (neglected) diseases is in accordance with the Rockefeller Foundation's traditional portfolio. But doing this within the framework of public-private partnerships opens up new problem-solving strategies: Firstly, it allows more competition, in that different approaches are developed and tested in parallel rather than sequentially. Secondly, it makes use of the expertise, experience and resources of pharmaceutical and biotechnology companies. And thirdly, joining public and private partners alike, may lead to accelerate access to new drugs and technologies, even for patients in developing countries (cf. Widdus/White 2004: 7, see also Rockefeller Foundation 1994: 12f). GHPs are characterized by flexibility and make use of corporate styles of research and development of products and services. They do not question the capitalist mode of production and consumption as such, but are considered to redress system or market failures. PPPs in general and GHPs specifically are adequate tools of "making capitalism more creative", as Bill Gates wrote in an article for the Time Magazine:

"Capitalism harnesses self-interest in a helpful and sustainable way but only on behalf of those who can pay. Government aid and philanthropy channel our caring for those who can't pay. And the world will make lasting progress on the big inequities that remain — problems like AIDS, poverty and education — only if governments and nonprofits do their part by giving more aid and more effective aid. But the improvements will happen faster and last longer if we can channel market forces, including innovation that's tailored to the needs of the poorest, to

⁵ On this point see Widdus/White 2004: 3-6.

complement what governments and nonprofits do. We need a system that draws in innovators and businesses in a far better way than we do today” (Gates 2008).

In line with this reasoning the Gates Foundation had announced a “Grand Challenges in Global Health” initiative in 2003 to invite researchers all over the world to submit ideas for research areas “with the greatest promise for saving and improving lives in the developing world” (Gates 2003).⁶ This is an example of how the Gates Foundation uses material incentives to spark competition about ideas and problem-solving strategies. To the mind of the leaders of the Gates Foundation governance mechanisms like the Global Health Partnerships and other initiatives like the “Grand Challenges in Global Health” are the adequate market-based approaches to correct existing deficits of the capitalist system.

How did the two foundations proceed in establishing GHPs? Michael Moran nicely describes this process with the term “partnership brokerage”, comprising “a mix of material resources (for example, seed finance) and in-kind resources (such as management advice) to structure relations between various (sometimes adversarial) actors” (Moran 2011: 134). In this process, the two foundations focus on different aspects and phases: Various examples showed that whereas the Rockefeller Foundation was more active as “incubator” of GHPs and withdrew from a leading role once the GHP was established, the Gates Foundation was still more actively involved in governing particular GHPs, most notably the Global Alliance on Vaccines and Immunization (GAVI Alliance).

Especially the Rockefeller Foundation is seen as quite instrumental in bringing about Global Health Partnerships, in particular for product development, through its historical position as important player in international/global health and its experience in creating networks (see Moran 2009: 125). With its Bellagio Center, nicely situated at Lake Como in Northern Italy, the Foundation provided a platform for intellectual exchange and networking.⁷ A meeting convened there in 1994 was the starting point of one of the earliest GHPs on AIDS vaccines, what later became known as the International AIDS Vaccine Initiative (IAVI). Participants agreed that “the new initiative must have a well defined mandate, and must work closely with and be responsive to the needs of industry, national research agencies, national governments, and international agencies” (Rockefeller Foundation 1994: 14). Some essential characteristics identified were

⁶ See also <http://www.grandchallenges.org>.

⁷ See <http://www.rockefellerfoundation.org/bellagio-center>.

- The ability to mobilize the collective efforts of a number of different sectors of the world economy - national governments, private companies, non-governmental organizations, and international organizations.
- The ability to act decisively, rapidly and to be flexible.
- The ability to undertake innovative development projects entailing calculated scientific and financial risks” (Rockefeller Foundation 1994: 14).

To establish IAVI and other GHPs the Rockefeller Foundation organized a wide consultation and consensus development process. In contrast to that the Gates Foundation often acted as the only start-up funder of initiatives (Widdus/White 2004: 9, see also below).

The example of IAVI illustrates another point which is important for securing influence: Seth Berkeley, who became later leader of IAVI after its inception, was working at the Rockefeller Foundation using his position there to bring about the first meeting of relevant parties in 1994 (Widdus/White 2004: 6f). It is not unusual to find staff members of GHPs who have worked for foundations before or are still being paid by them. Thus, a network of experts is established that has close ties to the foundations. By shaping the network structure in such a way, foundations also have the means to influence who will be included or excluded from it (see Moran 2011: 140).

Joining various actors for a common purpose may be no easy task. But it is just a first step in establishing GHPs. Funding is the most important factor to start up a GHP and keep it running. Public and media attention focuses especially on the Gates Foundation for this task, which is an important aspect in its project portfolio. 32.5 % of the global health grants given by the Gates Foundation during 1998 to 2007 were awarded to GHPs (McCoy/Kembhavi/Patel/Luintel 2009: 1649). From the perspective of GHPs this means that a considerable number of them are dependent on the Gates Foundation as only source of funding or that the Gates Foundation is the single largest contributor to its budget.⁸

By taking funding decisions foundations make a deliberate choice and set priorities which have effects on the broader development landscape.⁹ The Gates Foundation as the biggest private donor in global health has been particularly heavily criticized for its “technological approach” to health, due to “a narrowly conceived understanding of health as the product of technical interventions divorced from economic, social and political contexts” (Birn 2005: 2). Interestingly, the top 50 international grants awarded by U.S. foundations (mostly by the

⁸ In a study of Kent Buse and Andrew Harmer out of a sample of 23 GHPs nine were reported to rely entirely on the Gates Foundation for funding and for nine the Gates Foundation was the single largest donor (Buse/Harmer 2007: 266f).

⁹ This paragraph and the following one are based on Ulbert/Hamm 2011: 191f

Gates Foundation) in 2007 do indeed focus on research and development of new vaccines and drugs, mainly against infectious diseases (Foundation Center 2009).

It has also been widely noted that foundation funding has focused narrowly on the fight against infectious diseases, notably HIV/AIDS, malaria and tuberculosis.¹⁰ On the one hand, the development community has welcomed the new financial resources, especially since they are used for developing new drugs and technologies or funding research. But by placing these health issues so high on their agendas private donors also influence government policies and spending what we have already seen with the historical example of the Rockefeller Foundation in the first half of the 20th century. There are clear indications that either government spending follows the private health funds or is substituted by it (Farak et al. 2009). Whilst these infectious disease challenges are some of the most pressing global health issues today, forecasts for the year 2030 predict a changing pattern of causes of death with chronic diseases like heart diseases, diabetes or chronic obstructive pulmonary diseases on the rise even in low-income countries (WHO 2008: 30). To date, however, these clear indications of a changing trend in the burden of disease have not attracted much of the funds of philanthropic foundations in comparison to funds targeted at curing communicable diseases. Some commentators point out this is because chronic diseases “do not lend themselves to prevention or cure nor to spectacular results through vaccines or treatments, at least not in the short term” (Prentice 2008: 69S). Indeed, critics argue that foundation spending is focused too much on projects and programmes which promise a “quick impact” and a direct or indirect economic value.

This focus on impact is also due to the corporate style of management and economic thinking exhibited by the new type of “corporate philanthropy” like the Gates Foundation. Subsequently, the emphasis on process management and results is growing (Chataway/Mugwagwa/Muraguri 2009). Especially the Gates Foundation has been at the forefront of evaluating and increasing the effectiveness of GHPs. From the beginning its aim was to develop “successful” GHPs. Therefore it commissioned several studies undertaken by McKinsey (Bill & Melinda Gates Foundation 2002, Bill & Melinda Gates Foundation/McKinsey & Company 2005) to find out which factors contribute to the effectiveness of the new governance instrument and what effects it yields at country level. Together with other foundations the Gates Foundation strongly supports various initiatives that focus on enlarging data collection, alleviating access to data, expanding information sharing and promoting evaluation (Savedoff/Levine/Birdsall 2006: 4).

¹⁰ For an overview on global health funding see McCoy/Chand/Sridhar 2009, Ravishankar et al. 2009.

In contrast to the Rockefeller Foundation, the Gates Foundation is also actively involved in managing GHPs. The GAVI Alliance is the most prominent example of the foundation's commitment to improving the effectiveness of GHPs by shaping its programme, governance structure and management processes. Thus, the Gates Foundation holds seats on various governing boards of GHPs. Evaluating the effectiveness of governance mechanisms is also an example of how the Gates Foundation tries to transfer its learning experience into action. In accordance with its "repertoire of action" adopted from the corporate world, the Gates Foundation puts an emphasis on consultancies for evaluations. Over time it also broadened its ties with practitioners of governmental and non-governmental organizations and academia. The approach of the Gates Foundation is very much "evidence-based". Therefore, amongst others, it provided start-up funding for the Evidence-to-Policy Initiative (E2Pi), launched in April 2010, which is an international partnership between the Global Health group at the University of California San Francisco (headed by Richard Feachem, the former founding executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria) and SEEK Development, a global health and development consulting group based in Berlin, Germany.¹¹ The Gates Foundation also uses this results-oriented approach for advocacy. In late 2009, it launched the "Living Proof Project" a multimedia campaign to "highlight successes of U.S.-funded global health initiatives" and to show the U.S. taxpayer that "[i]nvestments in global health are achieving real, demonstrable results".¹²

What can we infer from the historical example of the Rockefeller Foundation's relationship with the LNHO and the more recent role of the Rockefeller and Gates Foundation in establishing a new governance mechanism in global health? Let us now turn to sum up what makes an actor "influential" and how a possible model of grasping foundations' influence analytically may look like.

4. A Preliminary Model of Influence

Obviously, money does matter, but it is not only the amount of money spent that decides if a foundation does exert influence, i.e. if it is able to make others act, think or feel as it intends. The crucial factors seem to be *how the money is spent and what it is used for*. Moreover, the examples cited show, that every funding decision is embedded in a set of strategic goals

¹¹ E2Pi "is dedicated to narrowing the gap between evidence synthesis and practical policy-making, to support informed decision-making and accelerate progress in global health (<http://www.seekdevelopment.org/en/e2pi>).

See also <http://globalhealthsciences.ucsf.edu/GHG/e2pi.aspx>.

¹² <http://www.gatesfoundation.org/livingproofproject/Pages/what-is-living-proof-project.aspx>.

which are based on ideas and norms by which actors are guided. Both the Rockefeller Foundation in the early 20th century and the Gates Foundation today are guided by specific views on how to solve problems best, which are rooted in a normative understanding of how economic and social systems should work.

In addition, context matters. The two foundations did not operate in a vacuum, but within a specific governance and problem structure, in which the issue area was embedded at a time. Whereas the move of the Rockefeller Foundation to support a League of Nations Health Organization led to the creation of a system of inter-national health governance (with the idea of establishing national systems of public health in mind), the decision to support public-private partnerships was taken against the backdrop of a system of *international* health governance which had been in existence for about 50 years and which was looked upon as inadequate in the face of *global* health challenges. In other words: Preference formation depends on the context and is, again, *both* related to strategic goals *and* ideas about what are adequate problem-solving strategies.

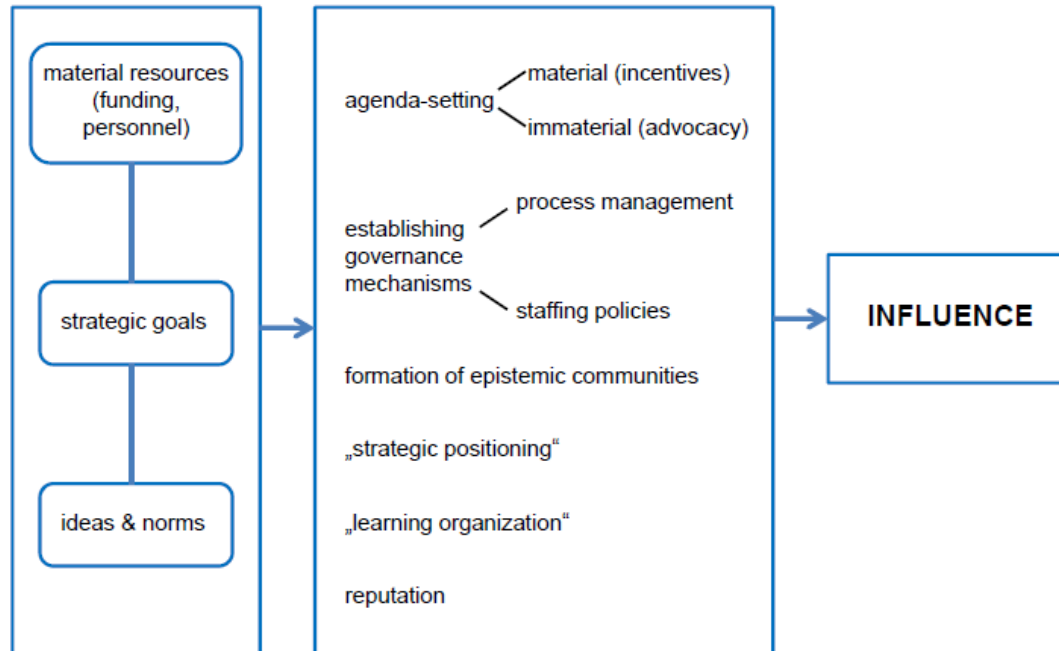
The aim of the paper was to open up the black box of influence and ask by which means and modes actors are able to exert influence. In relation to our cases the more specific question was how the two foundations proceeded to assist in establishing the new institutions and how they made sure they could shape this new institutional structure after it had been established. Again a range of factors that determine if an actor gets influential came to the fore. The means and instruments used by the Rockefeller and Gates Foundation can give us an idea, what it means to be an “active donor” (see also figure 3):

- Both foundations proved to be active *agenda-setters* based on *material incentives*, e.g. through the funding decisions they took. But they also promoted their agendas by *advocacy* which was based on *arguments and persuasion* (e.g. the “Living Proof Campaign”).
- Creating a *governance mechanism* that is apt to pursue your strategic goals seems to be crucial for yielding influence. But with *designing and establishing* such a mechanism you are just the half way there. The example of the Gates Foundations is quite instructive, in what way *process management* of governance mechanisms offers an avenue of exerting influence more effectively. Another option for shaping a governance mechanism to your visions may be based on a specific *staffing policy*, i.e. placing your (former) staff on boards or on the operative level.
- The last point is closely connected with forming an “*epistemic community*” that shares your ideas, definitions of a problem and preferences for specific problem-solving

strategies. From the cases above we can infer that this can be achieved through *training* professionals and building-up *networks* of “like-minded”.

- Using networks effectively, on the other hand, depends on the ability to *position oneself strategically* within a specific network. Over a period of a decade, the Gates Foundation managed to have associations with all key actors in Global Health. From this some observers draw the conclusion that “these relations give the foundation a great degree of influence over both the architecture and policy agenda of global health” (McCoy/Kembhavi/Patel/Luintel 2009: 1650). But as the example of the Rockefeller Foundation’s relationship with the LNHO shows, strategic positioning also entails not to interfere too closely with a partner’s business in order to leave its authority unharmed.
- Both the Rockefeller and the Gates Foundation can be regarded as “*learning organizations*” that try to evaluate their work, readjust programmes and strategies accordingly and adapt to changes in their environment. This is due to their results-based orientation, which leads them to question the effectiveness of their work.

Figure 3: Determinants of Influence



- Last but not least, an immaterial resource on which both foundations base their influence is their *reputation*. The example of today's Rockefeller Foundation nicely illustrates how an actor's influence might be determined by his reputation. Being far from the "health colossus" that is portrayed by the Gates Foundation, the reputation which the Rockefeller Foundation has established over a century as an expert in global health makes it an authority in the field and leads experts to follow its call to the Bellagio Center and join new global initiatives. The fact that other donors followed the example of both foundations and governments diverted their funds to areas that were acknowledged by the two foundations as important issues also speaks to the good reputation which both foundations enjoy (irrespective of the criticism they attract at the same time).

This range of factors discussed above can give us an idea, how power resources might be translated into observable effects. But we just took a glimpse of what may happen in the black box of influence. Nevertheless, I hope that what we could see will open up new avenues of research into foundations' influence.

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