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Misguided charity: the bane of global health

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INTRODUCTION

The COVID-19 pandemic exposed the failures of global health leadership and institutions.[1 2] Although global vaccine inequity[3] is an important legacy of leadership ineptitude, it is merely a sign of deeper problems. Correcting the failures requires understanding and overhauling the behaviours that make global health institutions dysfunctional, be they financiers or technical agencies. While assuming good intentions on the part of individuals, an important consideration is that groups, and thus institutions dominated by such groups, are less moral than individuals who might seek to do the right things within such groups.[4 5]

Contemporary pledges of good practice in development cooperation often invoke fidelity to respectful partnership and ownership by the beneficiaries.[6] Such promises are related to a trilogy of propositions dating back to the time of Plato: the fitness of any construct should be judged by reference to its intended use; the user of a thing has the widest experience of it and must tell the maker how it has performed regarding its intended use; and while makers of equipment have beliefs about their creations' merits and defects, they are obliged to get those beliefs by listening to the users who know the realities of the equipment.[7] It follows that the legitimacy of donor-financed global health programmes must derive from the reality and judgement of beneficiaries. However, potential beneficiaries of donor-funded health technologies in low-income and middle-income countries (LMICs) are often excluded from important decisions that affect them. They are treated like expendable props in a global theatre of misguided charity, a problem with four interrelated features: (1) insular presumption of superior wisdom, (2) abdication of the duty of care, (3) pontificating outside the circle of competence and (4) irrational escalation of commitment. These features are illustrated below.

SUMMARY BOX

- ⇒ Exposed by the COVID-19 pandemic, the failures of global health leadership and institutions continue to generate discussions and a search for solutions.
- ⇒ Correcting the failures requires understanding and overhauling the behaviours that make global health institutions dysfunctional, be they financiers or technical agencies.
- ⇒ The potential beneficiaries of donor-funded health technologies in low-income and middle-income countries are often excluded from important decisions that affect them. They are treated like expendable props in a global theatre of misguided charity, a problem with four interrelated features: (1) insular presumption of superior wisdom, (2) abdication of the duty of care, (3) pontificating outside the circle of competence and (4) irrational escalation of commitment.
- ⇒ Global health charity is dysfunctional, and overhauling it requires the protagonists to reflect on, atone for, and commit to revamping status quo. The measures proposed in this paper provide markers for candid reflections and positive changes.

INSULAR PRESUMPTION OF SUPERIOR WISDOM

The Geneva-based COVAX was the vaccine pillar of the Access to COVID-19 Tools Accelerator (ACT-A). By the end of September 2021, COVAX had delivered over 319 million vaccines, which was about 16% of its original end-of-year goal of two billion doses.[8] When African leaders wanted to buy COVID-19 vaccines at the peak of the pandemic, vaccine hoarding by HICs relegated African countries to the uncertainties of donations.[9] COVAX ultimately failed to achieve the goal of ensuring that people in LMICs had timely and equitable access to vaccines against COVID-19.[10 11] Gavi, the vaccine alliance that purchased COVID-19 vaccines in the ACT-A construct, has not publicly and fully addressed questions about a financial imbroglio arising from its deals with pharmaceutical companies for shots it no longer needs.[12]

Accountable leadership would embrace the facts of COVAX's failure, learn from them

and commit to doing demonstrably better. But the Gavi leadership did the opposite and brazenly claimed that it had developed 'a blueprint of how to deliver vaccines at scale in an emergency to low-income countries'.[13] That detachment from reality compounded a blunder by WHO's Special Envoy for the ACT-A, who claimed not to understand why some stakeholders might feel excluded from a review of ACT-A:

> I don't know what that means… We can't reinvent the world. These are the actors that are there.[14]

Two questions arise from the foregoing. The first is whether leaders of ACT-A would have been equally unconcerned about exclusion from decision-making in a hypothetical scheme in which an insular group from LMICs funded and decided what Western Europeans and North Americans could have, when they could have it, and on whose terms they could have it. The second is whether the Board of Directors of Gavi, which is funded by an array of governments, foundations, corporations and institutions,[15] endorses the declaration of COVAX as a blueprint for success in emergencies.

Solving these problems at Gavi requires its Board to explicitly recognise the dysfunctions associated with Gavi's ever-expanding scope of engagement beyond the temporary financing of a core set of routine vaccines for maternal and child health services. Gavi should concentrate on those vaccines and resolutely require countries to transition out of their dependent status without undue prolongation. When that is done, Gavi should wind down, with countries self-financing routine vaccines for their own populations.

ABDICATION OF THE DUTY OF CARE

A TRIPS waiver on technologies to prevent, diagnose and treat COVID-19 was part of a package of measures that could have enabled more robust responses to the pandemic. Yet, fierce opposition to a waiver crippled efforts by India, South Africa and other countries to secure its passage at the World Trade Organization. Amidst the raging pandemic, the President of the World Bank reportedly opposed the TRIPS waiver: 'We don't support that, for the reason that it would run the risk of reducing the innovation and the R&D in that sector'.[16] The World Bank President cited no credible study to justify that assertion. In fact, much of the research by large COVID-19 vaccine manufacturers derived from research funded by taxpayers.[17] There is no evidence that a TRIPS waiver on COVID-19 technologies would discourage taxpayer-funded innovations on which vaccine manufacturers rely.

Similarly, abdication of the duty of care shows in the Bill & Melinda Gates Foundation's reported attitude to expediting equitable access to diagnostics, vaccines and therapeutics, including non-exclusive, royalty-free licences to support free of charge, at-cost or cost plus limited margin supply, as in the published position of Oxford University.[18 19] That attitude is at odds with the Foundation's claim of being 'guided by the belief that every life has equal value'.[20] It is in stark contrast to Jonas Salk's wisdom, as stated in his response to a question about ownership of the polio vaccine patent: 'Well, the people, I would say. There is no patent. Could you patent the sun?'[21]

To resolve these problems, the World Bank and the Bill & Melinda Gates Foundation should unequivocally back and finance what is needed: an open-science model to ensure vaccine equity and end a pattern of dependency.[22]

PONTIFICATING OUTSIDE THE CIRCLE OF COMPETENCE

The WHO is central to global health leadership, but its behaviour repeatedly ignores prioritisation and comparative advantage. WHO complains with reason about being underfunded, but it seeks to be everything to everybody, every time. A recent example of this behaviour is its push to establish 'The WHO Global Pandemic Supply Chain and Logistics Network' as proposed in the Zero draft of the proposal for a 'WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response, 'WHO CA+".[23] WHO has no comparative advantage in supply chains and logistics. Its quest demonstrates the policy equivalent of acute-on-chronic hyperactivity disorder, which does not augur well for rigour and follow-through. That is a disservice to the world, especially to those who live in LMICs.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has contributed positively to global efforts to curb those three diseases. However, its fundraising pitches celebrate hyperbole that borders on falsehood. For example, there is no empirical evidence to justify the following assertion by the Global Fund: 'Given the extensive synergies between investments in health systems to fight the existing pandemics and those to prepare for new threats, the Global Fund is uniquely positioned to help countries further strengthen their pandemic preparedness capacities.'[24]

To its credit, the Global Fund is the largest multilateral grant financier for activities generally called health systems strengthening. However, there is no basis to presume that the Global Fund is better than other multilateral financiers in strengthening health systems in LMICs. Its own Technical Review Panel noted that those health system investments have modest potential for lasting benefits beyond the period of investments, and they do not help to build resilience and sustainability. This underwhelming outlook arises from a combination of factors: incoherence between its core mandate on three diseases and its ambition on health systems; the Global Fund's own processes; the lack of appropriate indicators in Global Fund grants; and the absence of meaningful monitoring and course correction in case of underperformance.[25]

The Global Fund has no unique capabilities in pandemic preparedness and response. The relentless and

unsubstantiated advocacy to expand its scope of work is a distraction from the core mission of ending HIV/AIDS, tuberculosis and malaria as major public health problems. That distraction has opportunity costs for its core mission and is a disservice to LMICs.

One solution is for the Boards of WHO and the Global Fund to retrofit the institutions' leadership and managerial incentives with the discipline to do better within their circles of competence. A leaner and more effective WHO would be more useful to the world than a bigger but flailing entity. The Global Fund could explore how to increase support for consortium of local research institutions and local civil society groups to play more active roles in identifying and catalysing locally relevant solutions. A focused Global Fund that winds down after helping to end the three diseases as major public health problems would be worthy of celebration.

IRRATIONAL ESCALATION OF COMMITMENT

The United States Agency for International Development (USAID), the largest bilateral health financier funded by taxpayers, persists in channelling money into a business model that seems designed to develop US-based contractors instead of enabling development in LMICs. Its ranking is abysmal in the Quality of Development Assistance, which measures and compares financiers on indicators most relevant to development effectiveness and quality.[26] According to its Office of Inspector General, USAID's award oversight is insufficient to hold those contractors accountable for achieving results: 'Regardless of award outcomes, USAID paid implementers essentially the full award amount for underperforming awards'.[27]

Successive USAID leaders have railed against but remained beholden to the development industrial complex that has captured USAID's budgets.[28 29] Despite its track record of waste and misalignment with development, USAID is using that same approach for its biggest supply chain contract ever, valued at about US$17 billion.[30] Moreover, refusal to learn and denial of evidence compound the escalation of commitment bias at USAID. For example, in 2012, USAID and its President's Malaria Initiative bullied the Board of the Global Fund into ending instead of expanding a highly successful pilot initiative, the Affordable Medicines Facility for malaria.[31] That coercion signalled that preserving the hegemonic and wasteful approach of USAID was worth sacrificing the lives of people in LMICs, who were thus denied access to affordable malaria medicines.

Solving the USAID problem requires the United States Congress to address the chronic dysfunction and waste outlined above. That means going beyond the cosmetics of 'localisation' to fundamentally redesign USAID's development assistance for health in the 21st century. The reforms would include how USAID would fit into the policies of developing countries, rather than the other way round; an independent arbiter of scientific evidence to inform USAID's decisions and insulate them from special interests; the elimination of US-based contractors as default channels for USAID's work in developing countries; and a timebound exit date, when USAID's engagement in global health programmes would end.

CONCLUSION

Crucial institutional decisions and preferences are detached from the realities of countries that such institutions purportedly serve. This is a problem that needs solutions because people in LMICs pay dearly for charity that is determined or mediated by those institutions. Global health charity is dysfunctional, and overhauling it requires the protagonists to reflect on, atone for, and commit to changing status quo for a better future. The measures proposed in this paper provide markers for candid reflections and positive changes.

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