

## Global health and the Bill & Melinda Gates Foundation

Your May 9 Editorial<sup>1</sup> is a valuable contribution to the dialogue about how best to address global health inequity.

At the Bill & Melinda Gates Foundation, we welcome diverse viewpoints about our global health strategy and grant making, and we seek candid feedback from experts, policy makers, and advocates. The advisers who participate in the review of our programmes, strategies, and grant applications number in the hundreds.

We are also committed to programme transparency and keeping our partners informed about our work. We have recently redesigned our website in an effort to provide clear and up-to-date information about our funding priorities and grants, and are preparing to post a description of our core strategies by the end of the year.

You argue that the foundation's grant making should align more closely with the disease burden in developing countries. Disease burden, as measured by disability-adjusted life years (DALYs), is the most important consideration in our funding decisions. Indeed, the great majority of our grants address infectious and parasitic diseases, which represent the largest share of DALYs lost in low-income countries.<sup>2</sup>

But this must be coupled with a sense of where our limited dollars can make the biggest difference. We are just a small part of the overall picture of development assistance in global health. We believe our contribution is to help find technology-based solutions that will have a big impact on the people we are trying to serve.

The major health challenges in developing countries can only be solved through close and effective partnerships among many stakeholders. We will continue to engage in active dialogue to identify how, working together, we can have the greatest possible long-term impact.

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- 1 The Lancet. What has the Gates Foundation done for global health? *Lancet* 2009; **373**: 1577.
- 2 World Health Organization. The global burden of disease: 2004 update. Geneva: WHO, 2008.

David McCoy and colleagues' analysis of the grant-making programme of the Bill & Melinda Gates Foundation<sup>1</sup> raises many questions that can be addressed properly only by extended study and debate. However, as recipients of major Gates Foundation awards for malaria programmes, there are some conclusions in the article, and in the accompanying Comment by Robert Black and colleagues,<sup>2</sup> with which we disagree.

First, McCoy and colleagues' acknowledged under-representation of developing-country recipients and the failure to take into account subrecipients of awards is a serious flaw in their approach and undermines their conclusions. In fact, six of the Gates-funded malaria programmes with which we are associated, and for which European or American institutions are classified as the major recipients of the awards, are partnerships between southern and northern institutions focused entirely on the needs and priorities of disease-endemic developing countries. The greatest part of the funding in all cases goes to the developing countries.

Second, McCoy and colleagues conclude that the awards are made through an informal system of personal networks and relationships, with no independent or technical peer review. This has certainly not been our experience. The relationships developed with the knowledgeable, experienced, and committed project officers (a system also operated by other major funders) have been very beneficial but in no way lessens the rigour of the review process or of the reporting procedures required.

The opportunity that Gates Foundation funding has provided

through these malaria programmes represents precisely what it is being criticised for not doing. Our consortia focus on approaches to health improvement in developing countries in partnership with the countries where the problems are found. It is unfortunate that McCoy and colleagues give a very different impression.

We have all received research funding from the Bill & Melinda Gates Foundation. We belong to one or more of the following consortia: ACT Consortium, Gates Malaria Partnership, INDEPTH Effectiveness and Safety Studies Platform, Intermittent Preventive Treatment in Infants Consortium, Malaria Capacity Development Consortium, Malaria Clinical Trials Alliance, Malaria in Pregnancy Consortium, and Malaria Transmission Consortium.

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- 1 McCoy D, Kembhavi G, Patel J, Luintel A. The Bill and Melinda Gates Foundation's grant-making programme for global health. *Lancet* 2009; **373**: 1645–53.
- 2 Black RE, Bhan MK, Chopra M, Rudan I, Victora CG. Accelerating the health impact of the Gates Foundation. *Lancet* 2009; **373**: 1584–85.

David McCoy and colleagues<sup>1</sup> note that half of all Gates Foundation funding goes towards vaccination. US\$1.5 billion provided by the Gates Foundation and some donor countries go to fund the GAVI Alliance's "advance marketing commitments" to purchase vaccines and provide them at subsidised costs in developing countries.<sup>2</sup>

The advance marketing commitments for pneumococcal vaccine illustrate the problem with this policy quite lucidly. Madhi and colleagues<sup>3</sup> have calculated that 1000 children have to be vaccinated

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to prevent approximately four cases of pneumonia. Given that the vaccine costs \$250 per child, \$250 000 will be spent to prevent these four cases of pneumonia. Treatment of four children with pneumonia with oral cotrimoxazole, in accordance with the WHO protocol,<sup>4</sup> will cost \$1 in India.

The hope that GAVI's funding of vaccines would push down their prices has been belied. One review found that prices actually went up after GAVI funding,<sup>5</sup> meaning that the higher costs are borne by poor nations when GAVI funding is withdrawn. Entering into advance commitments to market this vaccine in developing countries allows GAVI to divert Gates Foundation money to vaccine manufacturers, without providing commensurate benefits to the children it is supposed to help.

We agree with McCoy and colleagues that, given the substantial public subsidies that the foundation receives in the form of tax exemptions, its programmes must be subjected to public scrutiny.

We declare that we have no conflicts of interest.

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## Preserving objectivity in medical education

As a student at Brighton and Sussex Medical School (BSMS), I was interested to read about the benefits of the partnership between my institution and Pfizer (May 2, p 1504).<sup>1</sup> I share the opinion that future doctors should leave medical school with a greater understanding of the wider determinants of access to medicines, including the process of drug development. However, omission of any mention of independent, objective teaching from the partnership's goal, "to provide valuable training and insight into how drugs are developed",<sup>1</sup> is concerning.

The hazards of interaction between physicians and the pharmaceutical industry are well documented, and include provision of inaccurate information and an influence on prescribing.<sup>2,3</sup> Nevertheless, as medical students we are insufficiently informed about the potential effects of these interactions on our practice, and are thus inadequately prepared to protect ourselves and our future patients.<sup>4</sup> Reservations must exist as to the objectivity of teaching about industry roles that is provided by the industry itself. From experience, I have no doubt that BSMS takes therapeutics and pharmacology teaching very seriously, but surely this aspect would be better covered by academics with a broad view of the subject rather than those with a vested interest? Can we really expect Pfizer, which lies near the bottom of the Access To Medicines Index,<sup>5</sup> to teach objectively about drugs for the developing world?

I declare that I have no conflicts of interest.

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We would like to express our concern about a future model of undergraduate medical education in the area of clinical pharmacology that envisages a strengthened "academia-industry partnership".<sup>1</sup> Although we accept that a basic knowledge of how drugs are developed, assessed, and brought to the market is important for all prescribers of the future, this learning should be deliverable independently, and in sufficient depth, at any medical school. A small number of students might wish to develop specialised knowledge of this process through dedicated industry contact, but this should be regarded as exceptional.

Arguably the emergence of such industry-based educational initiatives is symptomatic of the recent malaise in the teaching of clinical pharmacology and prescribing at undergraduate level in the UK.<sup>2</sup> This shortcoming has been highlighted by medical students themselves<sup>3</sup> and also in an independent study commissioned by the General Medical Council.<sup>4</sup> In this regard, it is timely that a national initiative to deliver independent eLearning opportunities to support tomorrow's prescribers, supported by the UK Department of Health, is now underway.<sup>5</sup>

We declare that we have no conflicts of interest.

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