

arrived migrants.^{9,10} We strongly support innovations in migrant screening and health-care delivery. However, policy makers need to be aware that thousands of migrants in the UK and Europe—including refugees, asylum seekers, and undocumented migrants from high-incidence countries—will completely bypass national screening programmes. Underlying all these new developments in the field of migrant health care, therefore, is the crucial need for innovative strategies to improve migrants' access to host health systems, which will ensure timely screening for not only tuberculosis, but also other common infections that disproportionately affect migrants, as well as delivery of vaccinations and affordable health care and treatment. We, for example, are exploring one-stop testing for latent tuberculosis, hepatitis B and C virus infections, and HIV through emergency departments, where a high number of migrants are thought to present.

Another essential consideration is that once screened, poor follow-up and low treatment completion rates are well documented in migrant patients—particularly for latent tuberculosis—which might render screening programmes ineffective and will necessitate unique approaches.^{2,11} Although the evidence base is incomplete, the European Centre for Disease Prevention and Control is currently developing much-awaited guidance on migrant screening.¹² Aldridge and colleagues' study therefore is a welcome contribution to evolving policy discussions around improving health outcomes in migrants across Europe.

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The black box warning on philanthrocapitalism

On Sept 21, 2016, Mark Zuckerberg and his wife Priscilla Chan announced plans to invest US\$3 billion in a mission to “cure, prevent or manage all diseases” by 2100, part of an earlier promise to donate 99% of their stock in Facebook, a company Zuckerberg founded. It is the latest example in a growing number of pledges by billionaires to give away their wealth for social causes rather than pass it down to descendants. On the face of it, the pledge by Zuckerberg and Chan is generous, worthy, and inspired. It encapsulates a new force in global health funding, philanthrocapitalism; a term coined to describe philanthropists harnessing the

market to make their giving more efficient and achieve better results. But is it good for health?

Aside from the unlikelihood of \$3 billion being enough to manage all disease, there are at least three reasons why the global health community should pay more critical attention to the potentially adverse effects of philanthrocapitalism.

The first is that philanthrocapitalist entities often lack sufficient accountability and disclosure of activities, especially when it comes to new financial vehicles established by a young generation of donors. Zuckerberg and Chan set up a limited liability company



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(LLC), which is not a charitable trust or private foundation, so they are not bound by disclosure requirements about what they do with their pledge. Donors who use LLCs can invest their donation in for-profit ventures from which they can garner financial return. There is nothing to prevent donors from advancing personal causes by spending the money on lobbyists, political advertisements, or political contributions.¹ And the structure of an LLC limits the ability of anyone to gauge or monitor the impact of the company's activity. A traditional philanthropic foundation such as the Bill & Melinda Gates Foundation is legally obligated to provide public access to every grant disbursed. This structure has enabled researchers to critically assess the strengths and weaknesses of the foundation's funding portfolios, such as a 2009 *Lancet* study which showed that only a small proportion of global health grants went to researchers based in the global south.² When it comes to the Chan-Zuckerberg Initiative, the public may never know—and we have no legal right to know—whether any of the promised money will actually go to charity at all.³ Much of the warm glow surrounding the new philanthrocapitalism stems from the belief that business principles can make philanthropy more efficient and impactful, but unless the public can scrutinise where the grants are disbursed, it is difficult to evaluate the cost-effectiveness of private investments compared with public-sector spending.

Even traditional philanthropic foundations do not have the kind of accountability that has been urged

for global health governance.⁴ In the case of the Bill & Melinda Gates Foundation, its contributions to WHO account for up to 10% of the agency's budget⁵ and in some years exceeds those of all member states.⁶ But the accountability is to the foundation's management committee and is "driven by the interests and passions of the Gates family".⁷ The Gates family can direct their giving to whichever causes they wish, reflected in the foundation's historical focus in global health on infectious rather than non-communicable diseases. Research has shown that voluntary contributions to WHO are less aligned to the global burden of disease than assessed contributions from member states,⁵ which should worry global health advocates.

Second, philanthrocapitalism impinges on the public purse. By transferring personal wealth to a foundation or LLC, individuals avoid capital gains or inheritance taxes that would otherwise go to their government's general tax revenue for social spending.^{1,8} In other words, philanthrocapitalists are receiving subsidies for activities they can already afford to do. Likewise, public support of corporate initiatives can boost the revenues of profitable companies, eating into governmental money available for public goods. For example, in 2003 the UK's Department for International Development offered a non-repayable grant to Vodafone to establish m-Pesa, a mobile banking system that now contributes 43% to Kenya's gross domestic product.⁹

In other examples, private funds are directed to public services. When billionaire George Soros announced in September, 2016, that he was investing \$500 million to help refugees,¹⁰ it created a situation in which the responsibilities traditionally of government are offloaded. Situations like this can be challenging for global health in two ways. One is that it can erode support for government spending at a time of shrinking funds for global health and development aid but enormous and persistent need and inequality. The other is that it can create cover for states or public bodies from fulfilling their commitments; governments are steadily rescinding their aid promises.¹¹ The challenge for the global health community is to highlight and interrogate growing philanthropy in health in the context of the need for political solutions that ensure the distribution of wealth in societies and meaningfully address inequalities.

Third, uncritical acceptance of philanthrocapitalism elevates moral authority in global health and development to perceived technological wizards. That is, to individuals successful in the technology or financial sectors, but not necessarily otherwise skilled or experienced in the social and health development of countries and their populations. By virtue of business success, philanthrocapitalists like the Gates and Richard Branson, and Andrew Carnegie and John D Rockefeller before them, command moral ground and acquire influence on the basis of entrepreneurial efficiency, innovation, and delivering financial gains. By virtue of the sheer size of their donations, non-elected figures influence decision making at global institutions like WHO.¹² However, where the real messy business of global health development takes place on the ground—in the cultural and economic realities of people's lives, in ways that cannot be wholly quantified—is where more than business acumen is needed.

Moreover, the global health community must contend with the fact that philanthrocapitalism can shield donors from legitimate criticism about the industries on which they have built their wealth. Historically, major US philanthropists like Carnegie, Henry Ford, and Rockefeller were able to point to their philanthropy to offset criticisms of meagre pay for their workers and anti-consumer business practices.¹³ Today, newer philanthrocapitalists such as Charles and David Koch, who have directed millions to undermine regulation of the industries from which they profit,^{13,14} should not go unchallenged in their attempt to disrupt efforts to mitigate climate change.

So who benefits from philanthrocapitalism? Global health should and will. But powerful institutions demand serious scrutiny. As philanthrocapitalists increasingly enter into and shape the global health agenda, we mustn't simply welcome new monies. We must strengthen independent accountability.^{15,16} To help do so, we call for an independent scientific advisory group to monitor philanthropic investments made in global health and the returns on those

investments, with a mandate to publish annual reports for public scrutiny.

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