D3 | MANAGEMENT CONSULTING FIRMS IN GLOBAL HEALTH

When Anthony Banbury was appointed at the helm of the newly established UN Mission for Ebola Emergency Response (UNMEER) in September 2014, he made a series of expected decisions and one surprising move: he called the Boston Consulting Group (BCG) (The Boston Consulting Group, 2015a). "The risks to the world were significant. We needed to move fast. This challenge was so complex that I knew I needed to call BCG," Banbury recalls. BCG consultants took part in planning meetings in New York, and flew to Accra with him to assist with the set-up, strategy and deployment of the mission. They would accompany his every move for the following period.[1] How BCG was chosen, what the basis of its legitimacy was, the details of what the consultants recommended or who they were accountable to in this process – none of this information is available in public domain.

The involvement of management consulting firms in the Ebola response is the tip of the iceberg. While many global health actors have been carefully examined, the role of management consulting firms, which can be linked to all significant global health institutions over the past decade and to critical junctures in countries in crises, has remained by and large hidden from public eye. Drawing from desk research and interviews with global health practitioners, former and current consultants, and health advocates,[2] this chapter describes the growing role of management consulting firms in global health and the impact of their involvement. It also explores the questions of governance, accountability and transparency that arise.

How management consulting firms became ubiquitous in global health

The entry of consultants into the field of global health and their engagement in crises predates the West African Ebola crisis. HIV/AIDS advocate and activist Gregg Gonsalves remembers when the penny dropped for him in the early 2000s. A young Harvard graduate who had been working for McKinsey & Company for no more than a couple of years showed up at a Global Fund (Global Fund to Fight Aids, Tuberculosis and Malaria – GFATM) meeting on anti-retroviral drugs, and "gave a presentation on what needed to happen for scale up. No one knew who he was, but everyone was transfixed"[3] The timing is corroborated by other observers, who note that management consultants began to enter the health arena over a decade and a half ago, at a time when the market for management consulting showed signs of saturation

in the USA and in the rest of the Global North. With the scope for further domestic growth becoming limited, consulting firms needed to look elsewhere. As Duff McDonald (2013) recounts, "[B]y the early 2000s, McKinsey had not seen meaningful growth in the US and [was seeing] dramatically slower growth in Europe, and started turning to Africa, India [and] then China." This was the time when AIDS brought to global health the attention that it had lacked; a time when, to use the phrase coined by Allan Brandt (2013, pp. 2149–52), "AIDS invented Global Health."

In the wake of the HIV/AIDS crisis came the Millennium Development Goals (MDGs), the upsurge in development funding for health and the rise of global philanthropists led by the Bill & Melinda Gates Foundation (BMGF). There were suddenly significantly more resources and opportunities than ever before in global health.[4] "Huge amounts of money flew into the field – a field where there was not enough capacity," says Gonsalves.[5] There were demands to rethink the traditional models and public institutions (seen by many to self-serving and inefficient), to bring in new actors and to transcend traditional public–private divides. Public–private partnerships (PPPs), which would come to characterize the health field in the subsequent decade, were born with the blessing of the then Director General of the World Health Organization (WHO), Gro Brundtland, who famously stated in 1998: "When public and private sectors combine intellectual and other resources, more can be achieved." Global health institutions began proliferating outside of the UN system and traditional international organizations. The shift was not only in terms of the number of actors in the health field but in qualitative terms as well, with a redistribution of roles. Setting priorities and formulating policies on particular health matters ceased to be the sole prerogative of institutions such as the WHO that had until then held the mandate (McCoy et al., 2009, pp. 1645–53).

The evolving landscape also meant global health became a wedge to enter new markets. In a 2011 video, BCG's senior partner and managing director, Wendy Woods, reflected on the dramatic growth in the amount of funding going into global health and the tremendous "opportunities for improving the situation that the individuals in the developing world are facing regarding their health" (The Boston Consulting Group, 2011). The phenomenon did not escape McKinsey either, who saw in the creation of "high-aspiration foundations and new global entities…large, complex entities that are servable by the Firm".[6] Providing advice to "governments around the world the same way [as to] corporate clients" was an idea whose time had come (McDonald, 2013).

Entry by invitation Consultants were often brought to the discussion table by like-minded individuals, at times former consultants themselves, frustrated by perceived public-sector sluggishness, lack of impact and corrupt practices. They shared the belief that what the public sector needed was an injection

of private-sector efficiency, cost effectiveness, project management skills and monitoring frameworks. With the exponential growth of new institutions, there was a capacity gap that the consultants filled. "Here were the management consultants saying this is what we do; we can show you how to run programmes, spend money," observes long-term health policy advocate Rohit Malpani.[7]

Consulting firms often participated in the creation of new public–private partnerships (PPPs), as was the case with BCG, whose initial foray into global health included building new organizations and developing their strategies (The Boston Consulting Group, 2011). Many of the senior leaders in the early days of public–private partnerships were themselves from consulting circles, as the example of the Global Fund illustrates. Rajat Gupta, McKinsey's managing director between 1994 and 2003, was a founding board member and subsequently became the chairman of the Board of the Global Fund. In February 2002, one month after the Global Fund Board met officially for the first time in Geneva, the services of McKinsey were "solicited to bolster the staff of the Secretariat, with management consultants working alongside the Secretariat staff for much of the year" (GFATM, 2003). The way in which the firm was selected raised eyebrows, as memorialized in the minutes of the third board meeting: "[Q]uestions regarding the use of competitive bidding processes to contract McKinsey and the currently confirmed LFAs [local fund agents] were raised by some delegations. It was emphasized that transparent procedures should be used in future which [would] result in cost-effective selection of LFAs and other contractors." (GFATM, 2002)

When UNITAID was set up in 2006, the BMGF funded McKinsey's engagement from the onset, and McKinsey developed key policy documents on "added value, procurement policy, market dynamics, monitoring & evaluation system, corporate key performance indicators and expertise requirements" (UNITAID, 2006).

Filling a capacity gap, reassuring boards Management consulting firms rapidly made themselves indispensable. Tactically offering their services (pro bono, at a reduced rate or paid for by a donor) at the onset of relationships, they were welcomed by new institutions in need of capacity but struggling to hire staff. The example of UNITAID is telling: the organization wrestled with the complex and lengthy procedures of its host, the WHO, to hire much-needed personnel. The executive board discussed the issue repeatedly in its meetings, acknowledging that "WHO rules made it very difficult for the Secretariat to recruit" and encouraged its team to hire consultants as a stopgap measure (UNITAID, 2007).

Management consulting firms also played an important function in building the confidence of board members and donors that contributions would be well spent, and operations efficiently conceived and overseen. According to a Geneva-based interviewee, a point was reached when you could only put

Image D3.1 There are huge conflicts of interest inherent in the way management consultancy firms operate (IndranilMukhopadhyay)

in bids to persuade donors and boards if, at some stage, you had brought in management consultants to show that you had "understood the math, sums and costs".[8] The initial pro bono or secondment arrangements at the beginning of a relationship also meant that the engaging of consultants had no effect on headcounts or operating ratios, keeping board satisfaction high with what appeared to be lean structures.

Consultants not only established themselves as key features of these new institutions, but also gradually moved from providing organizational advice to offering strategic guidance. By the ninth session of the UNITAID Executive Board in November 2008, McKinsey was the one presenting the UNITAID strategy to its board (UNITAID, 2008). Once in a relationship, consultants would meet people, go to board meetings, get to know all stakeholders and their agendas, and gather privileged insights. The next time around, when a tender went out, they would have far more experience from within and be better positioned than anyone else might be. What was remarked with respect to the corporate sector generally seemed to be true in the global health field too: "Once they get the wedge end of a relationship into a company in the form of one engagement, they usually manage to hammer in the rest" (McDonald, 2013).

Becoming ubiquitous Today, management consulting firms have become ubiquitous in global health institutions and in countries in crises, with McKinsey and BCG being most prominent. They are known to operate on a mixed revenue model, which includes *pro bono,* secondments, discounted rates (traditionally 50 per cent of the rate charged to private clients) and

full rates, with full fees for a senior consultant in a prestigious firm reaching US$ 10,000 a day.[9] Discounted or *pro bono* support often turns into further lucrative engagements, either with the institution initially supported or within the field. The Ebola crisis offers an interesting illustration of how firms capitalize on initial investments: BCG, which estimates that it invested a total of US$ 2.2 million in *pro bono* professional fees and expenses to support UN Mission to support Ebola Emergency Response (UNMEER), went on to produce background reports for the World Economic Forum (WEF) on 'Managing the risk and impact of future epidemics: options for public–private cooperation' and to shape debates on epidemic responses at high-profile convenings of world leaders and policymakers. They also undertook research on behalf of the Swiss-based Foundation for Innovative New Diagnostics (FIND), to better understand the gaps and opportunities in diagnostics in the wake of Ebola (including the role of diagnostics in the outbreak; diagnosis preparedness for unknown pathogens during outbreak situations; and semi-open platforms for product development and delivery).[10] In May 2015, McKinsey, whose staff initially supported the WHO Ebola response, went on to win a 9-month contract from the Department for International Development (DfiD), worth GBP 2.9 million, to support Sierra Leone in its post-Ebola early recovery efforts (Gov.UK 2015), followed by an additional 15-month contract for GBP 8.8 million in May 2016 for Phase II (Gov.UK, 2016). McKinsey positioned itself as a key adviser within the President's office in Sierra Leone in this time of reconstruction. McKinsey was also contracted in mid-205 by the Foundation for the National Institutes for Health (FNIH), with the support of the BMGF, to assist in a review of the response to the Ebola crisis, with the view to improving future preparedness (Wellcome Trust, 2015).

Revenues of consulting firms come from both public and private sources, including bilateral donors, public–private partnerships and philanthropic institutions. In the past decade, both BCG and McKinsey have benefited from lucrative contracts from the BMGF, underlining the alignment in vision and approaches between management consulting firms and philantro-capitalist ventures. Firms retained by the BMGF support both its own programmes and that of its grant recipients (Holtzman, 2009). BMGF spends millions of dollars on BCG and McKinsey contracts (Table D3.1).

It appears from the (scarce) publicly available information, that both McKinsey and BCG have worked with the GFATM and WHO over the years, in addition to each having worked closely with multiple other significant global health institutions. BCG has, for instance, been associated with Roll Back Malaria (Winsten and Woods, 2011); World Food Programme (The Boston Consulting Group, 2015c; UNICEF, 2015); and GAVI, the global vaccine alliance (The Boston Consulting Group, 2013). The fingerprints of McKinsey can be found on UNITAID (UNITAID, 2006); the World Bank's International

TABLE D3.1: Bill & Melinda Gates Foundation contracts with McKinsey & Co. and BCG (in US$)

	McKinsey	BCG
2014	23,357,590	24,937,541
2013	22,936,500	13,850,816
2012	30,571,834	12,901,927
2011	19,472,506	18,051,829
2010	19,672,631	12,063,397
2009	14,357,648	8,109,531
2008	17,064,659	15,345,909
2007	6,696,149	7,352,820
2006	7,300,236	N/A
	161,429,753	112,613,770

Source: BMGF Internal Revenue Services I-90 forms

Finance Corporation (The World Bank, 2008); and the Stop TB partnership (McKinsey & Company, 2008), to name only a few. This is by no means an exhaustive list, but gives a sense of the depth and breadth of engagement of management consulting firms – from Ukraine to West Africa, and Haiti to Nigeria – making good on Winston Churchill's astute words: "Never let a good crisis go to waste." It should come as little surprise that by 2010, the public-sector practice of McKinsey was one of the fastest growing in the firm, with work spanning the USA, Europe, Asia and Africa (McDonald, 2013).

Applying a management consulting frame to the health field

Faced with the omnipresence of management consulting firms in global heath it is necessary to reflect on the impact of applying a management consulting frame to health. Many interviewees note that consulting firms have helped to professionalize the field. Their contribution to figuring out meaningful organizational processes, as well as their ability to translate ideas into marketable business terms for boards and for donors sensitive to such discourses, have been repeatedly highlighted as powerful assets. These positive observations notwithstanding, the questionable implications of using management consultants warrant examination.

Tendency to undermine systemic, root-cause interventions Management consultants tend to be generalists, who pride themselves in being able to solve problems in any area, regardless of the complexity of the issue at hand. A 2006 McKinsey report stated: "[I]n many ways, McKinsey seems ideally suited for tackling certain cross cutting issues. We solve problems for a living.'[11] They analyze problems through an organizational management lens, and use this as the basis upon which their proposed response to a problem is built. This prompted David Oliver (2014), a British hospital consultant, to observe: "They

are going to resort to what they know, which is consultancy approaches based on an industrial model."

This has far-reaching consequences. When an international organization or a bilateral donor chooses or presses its partners to choose for-profit management consultants over not-for-profit groups or academic institutions to advise a country or carry out work on its behalf, the choice that is made is not neutral. By choosing to frame issues primarily as things to be solved through problem-fixing and 'efficiency' gains, combined with a focus on immediate results, management consulting firms and those they advise, tend to collapse health and human development into a technical exercise.

Consequently, choosing a consulting firm to inform organizations and shape strategies often means weeding out upstream, alternative pathways and solutions, which may be more fundamental or long term, and not focusing on the systemic dimension of a problem or its root causes. It also often means, observes Malpani, that "[F]rom the start, you assume that there is a market-based solution".[12] Thus for example, the challenge of medicine pricing is addressed through PPPs or advanced market commitments, rather than by addressing issues related to the patent system, monopoly pricing or other issues. Lack of access to care is to be solved through assessment of infrastructure and logistical barriers, leaving aside questions of discrimination, rights and power, which might stand in the way of care.

The pathway to solving some of the most intractable health challenges is never merely technical, but requires engaging the power dynamics underpinning exclusion and marginalization. Health policymaking also requires that political choices and trade-offs be made, based on societal values, which in turn demands democratic participation. Such considerations are absent from consultants' playbooks. "I never heard a discussion of inequality or diversity, ever, led by consultants and yet clearly those are the challenges we face today," notes Roxana Bonnell, and once interventions aimed at the root causes are crowded out, it often means "entrenching the status quo when it comes to systems and power, rather than challenging power".[13]

Impact of leading with 'value for money' metrics Building on their for-profit private-sector expertise, management consultants bring with them tools, vocabulary and metrics emblematic of their ways of operating. Thus we see the widespread use in the global health arena of such terms as 'value for money', 'results-based financing' or 'high-impact interventions'. Having introduced these ideas, they move to implement them, working with not-for-profit entities or public–private partnerships to help them streamline their operations, get more out of their scarce resources or hone in on interventions whose impact would be more immediate and measurable. Such approaches have often been lauded by donors.

They have, however, received less than universal praise from health advocates, particularly when 'value for money' or impact analysis have caused the

demise of efforts considered by many as essential, but whose metrics do not fit the framework and criteria set out by consulting firms. 'Value for money' approaches are often presented as intrinsically positive or as propositions no one can argue against. But as experiences in the humanitarian field have taught us over the years, it will almost always be more expensive to reach out and respond to those with the greatest needs: 'value for money' pushes in the direction of the easier wins and biggest bang for the bucks – not the greatest needs. The recent transition at the GFATM offers an interesting illustration of this phenomenon (Box D3.1).

Box D3.1: The transition at the Global Fund

Following the departure of Michel Kazatchkine from the GFATM (Rivers, 2012), Gabriel Jaramillo, a former chairman and chief executive officer of Sovereign Bank, was named as general manager by a board concerned with the alleged fund mismanagement and unmet fundraising goals. Jaramillo made no secret of the fact that he wanted to bring his "private-sector experience to addressing the problems of global health" and wholeheartedly embarked on "preparing a plan to save a crucial financial institution in trouble" by "re-engineering its internal systems, bringing greater efficiency to its operations, refocusing its management and creating a new investment strategy" (The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2013).

With the support of Levitt Partners, BCG, McKinsey and Results for Development (R4D), Jaramillo initiated a set of ambitious reforms, in the areas of, tracking and investing of the funds of the GFATM, managing its grants, interacting with recipients and partners, and providing assurance on its investments. To address what were seen as issues with the funding model that the Global Fund had been using, the GFATM Board gave the green light to "explore new options that might lead to more strategic investment of resources, focusing on highest-impact countries and allowing for greater predictability". BCG and R4D were engaged in this process, completing various phases of work, including benchmarking, building models and simulating results for different options, and splitting the resources envelope among the three diseases. Some staff seconded by BCG to the GFATM worked on how 'qualitative' criteria, such as past performance, impact, risk, absorptive capacity and co-financing amounts would impact a country's funding allocation, and subsequently helped as 'change managers' to assist with the transition to the new model. Some went on to be hired by the Global Fund as staff.[14]

Julia Greenberg, who conducted the evaluation of the GFATM's partnership forum in 2011, remembers the central role of BCG in the

development of the new funding model: "BCG is responsible for the new funding model—Round 10 has been cancelled. BCG was seen as a legitimate back-up to a dwindling leadership. It was believed that they would be able to produce more documentation and increase the accountability to the donors, who were questioning the way the Fund was being run".[15]

The final model, approved by the board in November 2012 and rolled out in 2014, assigned totals to countries, no longer calling on them to estimate their own needs, and used country disease burden and gross national income (GNI) per capita in eligibility formula, *de facto* kick-starting a shift of resources to interventions in low- or lower middle-income countries.

Though this certainly satisfied the donors eager to get "the most bang for their buck" (*Devex*, 6 September 2012), it also meant a focus on low-hanging fruits and in practice reducing support for key prevention activities, cutting support for high-risk groups such as injection drug users in upper middle-income countries, or reducing funds available for organizing civil society – all activities whose usefulness in controlling the HIV/AIDS epidemic have been documented over the years, but which failed to fit the new business-inspired approach. In several upper middle-income countries such as Romania, the gap in funding led to a drastic increase in HIV cases, specifically in key populations. The proportion of new cases of HIV related to injection drug use in Romania soared from 3 per cent in 2010 to 29 per cent in 2013. Much of this increase is linked to the lack of funds to provide basic prevention such as condoms and syringes (Health GAP, n.d.).

Undermining civil society and communities The impact of consulting language is also being felt in spaces where civil society is meant to engage. The very language used in documents, meetings and deliberations has evolved. Everyone is expected to master advanced market commitment or fiscal space discourses, and be able to engage on those technical issues, as opposed to contributing their rights-based or practical viewpoints. "By forcing them to engage in that frame, they become so driven by wanting to understand the details that they fail to see the bigger picture", observes Greenberg who adds: "It creates a language paradigm that you have to engage in. Why? Because there is a sense that that is where the power is, and you need to talk in the language of power. That language is given top credibility, and you have to challenge it on their terms".[16]

With the introduction of obscure jargon, management consultants have turned discussions on health into elitist debates, diminishing the space for

people with different, practical experiences, and downgrading consideration for how change actually happens. As Gonsalves observes, "[T]his changes the nature of activism and advocacy. They are now filtered through the efficiency model."[17] Often vocal civil society groups from the South and representatives of partner governments tend to be pushed to the margins.

This also plays out upstream, in the groundwork consultants are often mandated to carry out, such as scoping and drawing up lists of people to interview. "Civil society is last. They will come up with a few names, such as MSF [Médecins Sans Frontières]. Very few organizations that work primarily at the country level or have limited resources will ever be included," remarks Malpani.[18] If an NGO is chosen for an interview, it tends to be a well-established group in the North. Very rarely would a local Ministry of Health (MoH) staff be included. As they define who the key stakeholders are, management consulting firms further the imbalance of representation, with represented voices tending to speak from a similar viewpoint.

Governance issues that ought to be explored

The evidence base While a systematic exploration of management consulting recommendations in the health field is made difficult by the lack of comprehensive, publicly accessible information, it is quite clear that consulting firms consistently champion the public–private model of cooperation as the quasi-universal solution to health challenges: from the response to epidemics (The Boston Consulting Group, 2015b) to the construction and operation of secondary and tertiary hospitals (Sharma, 2012) or access to medicines. While such recommendations may be straightforward and meaningful in business and financial terms, they are not necessarily backed by evidence when it comes to public health outcomes.

Consider the specific example of PPP model for hospitals. The evidence remains, at best, mixed. Research conducted by Martin McKee et al., (2006) on models in which a public authority contracts with a private company to design, build and operate an entire hospital seems to indicate that such new facilities, though more likely to be built within agreed-upon timeframes "have, in general, been more expensive than they would have been if procured using traditional methods". The experience on health PPPs indicates that "[E]scalating costs are a common feature of the model itself—some inherent and some due to serious oversights in the contracts underpinning them" (Marriott, 2015). PPP models for hospitals are nonetheless being promoted in places ranging from Sub-Saharan Africa to India. In 2012, McKinsey & Company recommended the public–private partnership route for improving healthcare delivery in India by 2022 (Sharma, 2012). In its 2008 report 'The business of health in Africa: partnering with the private sector to improve people's lives', produced for the World Bank with BMGF funding, McKinsey also laid the ground for PPPs to become a central strategy of the bank's International

Finance Corporation (IFC) (The World Bank, 2008). The 425-bed Queen Mamohato Memorial hospital, which replaced Lesotho's national referral hospital, was set up. Today, 51 per cent of the national health budget is being spent on payments to South Africa-based Netcare (one of the biggest private healthcare providers in the UK), which has built the hospital and runs it. The MoH is locked in an 18-year contract signed in 2009; this is siphoning off large amounts of the national health budget, while Netcare receives a 25 per cent return rate on its investment (Oxfam, 2014).

Consultants' briefs and presentations, when they are publicly accessible, rarely reference peer-reviewed articles or build on research on public health. While there may be evidence of the failure of public health systems to deliver, systematic research is lacking to support the opposing claim that the private sector can do better. Proprietary data, financial and otherwise, is rarely made available for public/academic scrutiny, rendering such claims difficult to sustain.

Confidentiality trumps transparency Management consulting firms are not bound to disclose the names of their clients or the products they generate for them. This practice is set to continue; in June 2016 McKinsey successfully weathered a court case that would have forced the firm to reveal the names of scores of its clients (Kary and Schoenberg, 2016). In fact, the firm prides itself on guarding the confidentiality of its clients and not publicizing their work (McKinsey & Company, n.d.), and "build[s] into its contract language that prevents clients from mentioning that the firm [has] been hired"(McDonald, 2013). Thus even when funding is public, the identity of their clients, the nature of the deals they enter into or the advice they provide remain largely hidden from public scrutiny. The issue becomes further murky when private foundations, which benefit from tax exemptions if they advance charitable purposes, second consultants to public or public–private institutions; or when consultants work *pro bono* for international organizations that seem to escape public scrutiny. There is currently no easy access to information on contracts awarded and amounts received by consulting firms for health-related work with PPPs or public health institutions, or details about the nature of the work. Those are neither made public by consulting firms themselves nor by institutions relying on their services. Consider the following:

- The *value of individual contracts*, such as the one granted to McKinsey & Company by the WHO-hosted Special Programme for Research and Training in Tropical Diseases for work on pooled funding for voluntary contributions towards research and development (R&D), is not made public. (In this case, informants privately revealed that the bill amounted to CHF 2 million and was borne by the Swiss Development Cooperation.)
- The absence of transparency extends to the *nature of the advice given* and the influence firms may have as a result. James Love, founder and direc-

tor of Knowledge Ecology International (KEI) recalls how, at some point, consultants began offering advice that he felt were policy recommendations. In the context of WHO's vaccine work, they recommended "shutting down government production of vaccines in favour of private production. If there is an emergency, the country that manufactures will get it first. How is this not a policy recommendation".[19] As Knowledge Ecology Initiative (KEI) noted in 2015 in a statement delivered at the session of 'WHO framework of engagement with non-state actors': "We believe the WHO has been discouraged from advancing very important reforms…sometimes this happens through the in-kind services the Gates Foundation provides to the WHO, such as through the consulting services of firms [like] the Boston Consulting Group (BCG) or McKinsey & Co., two firms hired by Gates that have recommended staff changes at the WHO." (Cassedy, 2015)

- Products generated by management consulting firms are generally kept private as well, unless it is otherwise negotiated in advance. Many interviewees described how, because of contractual agreements, detailed consultants' reports that they contributed to as informants, at times extensively, were never made available to them. "You often hand over very sensitive information, and yet you do not get access to the results. Nobody ever sees the data. You are only ever, at best, given the final overall picture," remarks Malpani.[20] The very stringent terms they impose often mean that not only is the textured analysis they produce not shared, but often the consultants are entrusted to filter the raw data and information and shape recommendations on the basis of assumptions they cannot disclose.

This opaque way of operating both limits the contribution consultants can make to public knowledge and debates, and enhances the consultants' own position in the field through the amassing of intelligence and proprietary information. Predictably, this often leads to consultants being hired time and time again on issues they have already worked on. This allows them to capitalize on the unique information and networks they have been paid to tap into, while their engagement in the public sphere and connections with decision-makers contribute to their enhanced reputation as informed and efficient counterparts in new fields. As they say in the business world: "Want to know what the competition is up to? Hire McKinsey" (McDonald, 2013).

Effectiveness and accountability The lack of robust transparency in the working of global health institutions, combined with the typical practice of management consulting firms to neither take blame nor credit for how their advice is used, creates major stumbling blocks for accountability. As the WHO's own 2015 procurement strategy document highlights, the current approach raises questions of business ownership, accountability and reporting, with particular risks identified in the areas of monitoring and governance, transparency,

Box D3.2: UNITAIDS funding scheme: 'massive' failure

Following its creation in 2006, UNITAID was universally acclaimed for establishing a new sustainable funding stream (through a small tax on airlines tickets in some countries), generating close to US$ 300 million in revenues in its very first year of operations. By 2007, though, bringing new countries with significant airline markets on board was proving much harder than anticipated. UNITAID's chairman, Philippe Douste-Blazy, and some of his close allies in the tourism business came up with an alternative idea: why not work with the industry directly and offer travellers the possibility to make voluntary micro-contributions every time they purchased travel services?

In December 2007, he presented the concept to the UNITAID Board, urging it to "make voluntary contributions the focus of the year 2008". Board members registered interest, and suggested that a feasibility study be conducted to validate the approach and add credibility to the endeavour. McKinsey & Company estimated that it could undertake the three-month study for US$ 1 million. The price tag made some supporters gasp, but Douste-Blazy was himself convinced that "it would be easier to get the UK, the BMGF and the WHO to sign off if such a document existed."

The BMGF had been contributing to UNITAID from its inception through the funding of McKinsey's involvement (UNITAID, 2006), and agreed to financially support the modelling of the initiative and the development of its business plan. The McKinsey study on the voluntary solidarity contribution was presented to the UNITAID Board in April 2008 and suggested that the new mechanism could raise between US$ 500 million and US$ 1 billion annually from private sources within five years, almost doubling UNITAID's budget from the airline-ticket tax and other contributions. The Board endorsed the plan and allocated a provisional budget of US$ 9 million for the first year, and US$ 12 million for the second year.

A director was appointed to set up the Millennium Foundation, which would host the project, and the team rapidly grew to be over 20-people strong. By July 2010, as the *Financial Times* reported, the foundation had fallen drastically behind schedule by year 1, "raising about [US$] 14,000 directly from the public while spending [US$] 11 [million] given to it by governments on salaries, advertising and legal expenses" (Jack, 2010). Several members of the board expressed "concerns that UNITAID has invested such a large amount of funds with very little return so far" (UNITAID, 2010), and it was decided that the initiative, plagued by recurring problems and failing to get on track, should be independently assessed. To do so, UNITAID went on to hire another firm, Dalberg.

Its study, whose costs were not made public, was damning and pointed at flaws in the assumptions and initial revenue modelling produced by McKinsey. In December 2012, UNITAID's chair reported that the Millennium Foundation had failed to reach its objectives and that, consequently, its board had passed a resolution to approve its dissolution (UNITAID, 2012). And so it – and millions of US dollars – was gone.

It is striking that McKinsey and its consultants were never held to account for the loss of public resources, in which their work played a large role. This naturally points to one of McKinsey's methods, whereby it takes neither responsibility nor credit for how an institution uses its advice. The UNITAID Board itself remained mostly silent about the incident, mindful of its own failure to appropriately scrutinize the proposal and oversee the efforts. While it might have had an opportunity to demand accounts, it chose not to, unwilling to create further backlash against funding for health and expose UNITAID to the types of criticism for wastefulness once levelled against traditional health institutions from which they were supposed to differ.

quality assurance and cost-effectiveness (WHO, 2015). The impact of the recommendations made by management consultants is rarely, if ever, evaluated. This lack of systematic research or evaluation is particularly ironic given how often consulting firms are invited into the health sphere based on claims of increased impact or value for money. And paradoxically, governments and bilateral donors, otherwise committed to transparency and accountability, de facto overlook these considerations when they employ consultants. At the country level, the situation is rarely much better as the "nomads of McKinsey or BCG have no formal commitments to the countries they work in, no connection with communities. It drains their engagement of any political accountability."[21]

The story of Massive Good, which was launched by UNITAID in 2009 and faded from the public eye by 2012, offers a telling example of the gap between the rhetoric of efficiency gained through management consulting advice and the reality, and the lack of accountability surrounding consulting firms' engagement (Box D3.2).

Revolving doors and conflicts of interest

Another set of questions regarding consulting firms pertain to networks, revolving doors and conflicts of interest. It is no secret that one of McKinsey's assets is its far-reaching alumni network. The firm's website proudly states that McKinsey counts over 30,000 alumni, who work in "virtually every business sector in 120 countries. Through formal events and informal networking,

former McKinsey consultants make and sustain professional relationships." Alumni can open doors, provide a source of insider information, and act as future contracts; they also "tend to hire from old stomping grounds" (McDonald, 2013).

This phenomenon has been extensively documented in the UK, with evidence presented to the UK Public Administration Committee, prompting voices such as David Oliver's to state that "[T]here is far too much traffic between government bodies and consultancies and private health providers and lobbying companies which does verge on a form of institutional corruption" (Oliver, 2014). This phenomenon also comes into play with global health institutions, when former consultants take on positions with the institutions they have been advising, as was witnessed when Global Fund consultants who worked on the new funding model subsequently joined the fund as staff. This is also seen when staffers from global health institutions go on to work with consulting groups, at times staffing portfolios of clients that include their former employers.[22]

Conflict of interest considerations need scrutiny when consultants advise global institutions in areas where they also have, or are believed to have, private clients. Although 'Chinese walls' are allegedly put in place in a firm as soon as a perception of conflict might arise, the absence of publicly available information feeds doubts about potentially unstated conflicts. In February 2011, at the consultation with civil society during the "WHO open-ended working group of member states on pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits" KEI asked a number of questions pertaining to the role of McKinsey in the preliminary findings for the technical studies conducted under the World Assembly Resolution WHA63.1 on pandemic influenza preparedness (Knowledge Ecology International, 2011a). The study itself notes, in its 'process' section, that "Given the significant breadth of the areas under study, and the limited human and financial resources of the Organization to carry out the full studies, the Secretariat sought external support. The Bill & Melinda Gates Foundation agreed to provide support through a contract with McKinsey & Company, which was selected on the basis of its broad expertise in public health, financing, health economics, and influenza vaccines; its ability to start working on the project quickly; and its global team". (WHO, 2010)

KEI formally enquired as to what the process of selection for McKinsey had been, and whether the WHO had used a competitive bidding process. It also asked whether the WHO had required the firm to disclose any conflicts of interest. WHO, in its response to KEI, (Knowledge Ecology International, 2011b) explained that member states had been informed at the onset about the BMGF offer of in-kind assistance to the WHO in the form of the services of McKinsey, and that since the practice of the WHO was to treat consulting firms as companies, no formal declaration of interest had been required.

How much McKinsey received for its work was not disclosed, nor was the arrangement between McKinsey and the BMGF.

KEI was motivated by its interest in having disclosure of possible conflicts, in particular where McKinsey might have had clients in the vaccine business. This would seem a legitimate concern in a context where publicly available information indicates that McKinsey has done work for at least three of the five top vaccines manufacturers in the world: Novartis, Merck and Sanofi (Bouchard, 2001; *Consultor.fr*, 24 April 2012; Cristofari, 2011); it has also been involved in the development of the business plan of GAVI (GAVI Alliance, n.d.); and it has had other vaccine-related engagements, including the preparation of a report for the Organization of Pharmaceutical Producers of India titled 'Transforming India's vaccine market' (McKinsey & Company, 2012).

Whether consulting firms' inroads into public institutions or PPPs get translated into enhanced engagements with private-sector clients remains in the realm of speculation. But the fact that consulting firms make recommendations that create a climate favourable to businesses, while bringing to the field of health a set of private sector–inspired methods and tools, and connecting with the entire health spectrum (from pharmaceutical companies to the WHO; from the largest private hospitals chains in India to the Global Fund, the BMGF, the NHS and the Food and Drug Administration) contributes to feeding the worry that the issue could range from simple connivance to outright conflict of interest.

Conclusion

The mix of private and public, state and non-state, for profit and not-for-profit actors has become a definitional trait of today's global health field. The legitimacy and efficiency of public institutions to tackle crises continue to be tested, including at the height of crises such as Ebola. Progress in entire swathes of the health field is now spearheaded by private-sector actors, who have become *de facto* prescribers of public health policy priorities.

In the past decade and a half, management consulting firms have also risen to prominence. Yet although they contribute to shaping the functioning and direction of public institutions, international organizations and PPPs, their influence has remained largely unexamined.

They bring to the health field the same principles that govern how they work in the business realm: a premium on confidentiality and the policy of not taking blame or credit for the advice they provide. This might be perfectly fine in case of wholly private endeavours, where corporations choose to employ management consultants to improve their bottom lines, with their shareholders' support and scrutiny. But when the work of consultants is subsidized, at least in part, by public funds, or when it influences the direction of public institutions, the public ought to have a greater sense of what is being proposed and the possible impact.

Management consulting firms seem by and large exempt from publicly articulating the basis upon which they ground their legitimacy in the health field or from providing evidence in terms of health outcomes that underpins their views. In the absence of both publicly available information and solid research, management consultants' forays into global health may be understood as well-choreographed profit-seeking endeavours. Through the engagements may often appear free of cost initially to the recipients, consultants gradually attach themselves to key stakeholders and gain access to information and funding streams. More often than not, the engagements get translated into lucrative dependencies. These engagements bring the additional benefit of burnishing a firm's reputation with conventional clients, as well as with leaders and policymakers. Health is, for consultants, a low-risk enterprise: an opportunity to learn and become familiar with a large field, using someone else's money, with no accountability and very few strings attached. Not unlike the pharmaceutical companies they serve, consultants appear to have mastered the art of socializing risks and privatizing benefits.

There is no evidence that the ascent of consulting firms in the health sector has led to approaches and solutions to radically improve health outcomes for the poor and most marginalized. The framing of health as a technical exercise and the related focus on value for money, efficiency gains and rapid results has led to the exclusion of those most in need; the sidelining of systemic long-term solutions and the downgrading of community voices. We must urgently ask whether we have examined closely enough the impact of choosing management consulting firms to support and guide institutions in their search to improve health outcomes. Public interest is seldom served by secrecy; and in the absence of robust participatory processes, transparency and accountability mechanisms, we risk letting go of functions essential to preserve health as a public good – without even realizing we are doing so.

Notes

1 WHO response team and UNMEER coordination member (2015), interview, September.

2 Interviews were conducted between August and December 2015. While interviewees were eager to provide first-hand accounts of their experience with management consulting firms, most were reluctant to be quoted by name, either due to confidentiality agreements or because of concerns about their professional development.

3 Gregg Gonsalves (2015), interview, September.

4 It was estimated that in the USA alone, individuals had donated US$ 5.5 to 7.4 trillion to charitable causes between 1998 and 2017. See Schervish (2005), pp. 15–37.

5 Gonsalves (2015), interview.

6 McKinsey & Company's reflection paper about the firm's possible increased engagement in global health.

7 Rohit Malpani (2015), interview, October.

8 Health access advocate (2015), interview, September.

9 Former consultant (2015), interview, December.

10 A number of leaders in the field received emails asking for their participation in this study.

11 McKinsey & Company's reflection paper

about the firm's possible increased engagement in global health.

12 Malpani (2015), interview.

13 Roxana Bonnell (2015), interview, October.

14 Global Fund employee (2015), interview, September.

15 Julia Greenberg (2015), interview, September.

16 Ibid.

17 Gonsalves (2015), interview.

18 Malpani (2015), interview.

19 James Love (2015), interview, September.

20 Malpani (2015), interview.

21 Gonsalves (2015), interview.

22 Malpani (2015), interview.

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