

Making experts accountable in global health

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International donors are transnational actors that pursue various strategies to influence policy decisions in Global South countries. In addition to conditionality, which typically involves imposing policy requirements on recipient countries as part of aid packages, such actors also use persuasion by diffusing specific policy ideas at the transnational level and within the countries they seek to influence.¹ Beyond donors, the transnational field of policy influence is populated by a host of actors, ranging from scholars and academic networks to private consultants, technical assistants and think tanks who seek to shape the policy agenda and impose their problem definitions and policy solutions at the global, regional and country levels.²

Policy choices made in countries dependent on international aid are at the heart of global health geopolitics. For instance, research has shown that African countries' ownership of universal health coverage (UHC) policies is limited compared with donors' influence.³ Even though we are in an era that values evidence-based policy, the realpolitik of global health diplomacy and the science of using science show that the ideas of donors and their consultants significantly influence decisions alongside evidence. There is even an expression in Niger to describe this influence of donors: "*à cheval donné, on ne regarde pas les dents*" (don't look at a gift horse's mouth).⁴

In global health, governments have long been influenced by consultants and private-sector ideas.⁵ Decision-makers and politicians are intertwined in porous networks of mutual acquaintances and interdependent organisations. A typical example is the role of the community of practice (CoP), which facilitated the expansion of performance-based financing (PBF) in Africa. Dominated by a core group of consultants from high-income countries (HICs), the CoP shaped the consensus on the desirability and key attributes of PBF design.⁶ This consensus was questioned only by a few experts—mostly

SUMMARY BOX

- ⇒ Unaccountable experts influence the choice of health policies.
- ⇒ The dissemination of expert-driven neoliberal ideas on health financing has adverse consequences.
- ⇒ The social and individual responsibility of experts should be better considered.
- ⇒ An international and multidisciplinary directory of experts should be established (background, career paths, reports and results).
- ⇒ Urgent need to organise a process of accountability for global health experts.

from HICs—but it did not trigger a genuine debate within the CoP.⁷ This raises the question of whether consultants are not, in fact, the real 'policy makers'. They most often come from the private sector but can also be academics who engage in private activities, which is known to have adverse consequences for the quality of science in Africa.

However, while the social responsibility of states and private companies is often invoked during health crises (often with little impact, as in the case of private mining companies in Africa⁸), the accountability of those advising on policy is rarely questioned. One might think that the quality of expert advice could affect their future contracts. But this ignores the fact that they know each other and may even have ideological or professional ties, if not conflicts of interest,⁹ in the advice they give and in their desire to spare the feelings of those concerned when conveying certain ideas. While experts may sometimes refer to codes of practice (for evaluators) or codes of ethics (for researchers), they are rarely held personally liable when their advice has adverse consequences for the populations concerned.

Drawing on examples of the commodification of health in Africa, at the heart of the global effects of neoliberal ideas,¹⁰ this commentary aims to highlight the social and individual responsibilities of global health consultants. Indeed, in line with the 2023

Lusaka Agenda, the governance of global health policies requires major changes.

IMPACTS OF NEOLIBERAL ADVICE AND IDEAS ON HEALTH POLICIES IN AFRICA

While international organisations are often criticised, particularly for their influence on policy,¹¹ they are composed of individuals with their own histories and ideas about how health policies should be implemented. These people sometimes move from one institution to another, without the policy mistakes resulting from their past advice having any real impact on their careers. In the '80s and '90s, several experts advised many African countries to generalise user fees for healthcare. However, research has consistently shown that this solution is unfair and ineffective. These people continued their careers at the WHO, UNICEF, the World Bank or the African Development Bank.¹² With user fees, however, we are at the heart of neoliberal ideology, which focuses on individual responsibility. In the 2000s, it was often these same experts who continued to advise development banks to lend money to these same countries to implement PBF. These two new public management policy instruments have been failures in terms of healthcare system performance, population access to care, equity and efficient public spending.

Sometimes (rarely in public), these experts apologised long after the fact, explaining that they had made mistakes in their advice.^{13 14} But the damage had been done not to these experts and their careers, which have been boosted by these projects and the scientific publications they have produced, but to the populations. There is no demagoguery in our analysis, but the individual responsibility of these experts (whatever their origin) does not seem to be recognised. We know of only one case of a person who promoted these policy instruments and lost their academic position because they prioritised their paid consultancy work over their academic

publications, which were sometimes considered biased. However, she was quickly recruited by someone whose career had focused on spreading these neoliberal ideas and who supported the expert's ideas within the WHO.

Beyond user fees, we could apply the same analysis about these experts from consulting firms (Europe, Northern America) and members of mutual organisations (Belgium, France) who, since the '90s, have been influencing African states to set up small-scale mutual health organisations.¹⁵ However, research has always shown that they are not the solution.¹⁵ Because of the spread of this idea, Senegal has lost at least a decade in its UHC policy.¹⁶

Table 1 provides a very summary of these health financing ideas and their impact on policy outcomes. Due to space constraints, we cannot explore evidence in greater detail—it could be the topic of a more comprehensive article. However, those interested will find a wealth of literature on the subject to support our comments, including literature on other sectors (social affairs, education, etc) and on policy instruments other than the one we use in our demonstration.

The circulation of (neoliberal) ideas is facilitated by experts travelling across all continents, who influence development policies in Africa.⁶ The World Bank has even produced a guide to support the organisation of study tours. Many countries and international organisations continue to send experts on long-term missions to 'advise' health ministries and institutions, replicating colonial processes. France has created a public institution dedicated to sending these experts, which has become a service of its Development Bank. These experts tend to favour the approaches of organisations that pay them very high salaries rather than supporting the needs of the countries that host them and even to put forward ideas that could upset the balance of power and radically change policies. Taking risks in advisory work often comes at too high a cost for experts. But these experts

Table 1 Summary of some health financing ideas that influence policy outcomes

Policy instruments	Ideas	Policy outcomes	Key references
User fees	Patients do not value free healthcare and are already paying substantially through informal channels	Improve essential drugs availability, exclusion of the poorest; failure to income generation; community nepotism	22 23
PBF	The quality of care is poor because staff are not motivated, and financial premiums are a key motivating factor	Dependence on donors; focus on revenue-generating activities; perverse effects; exclusion of the poor; creation of parallel systems and institutions; lack of sustainability	24 25
CBHI	Collecting voluntary membership contributions through small-scale risk-sharing promotes local ownership, early access to care and good relationships with health staff	Fragmentation; exclusion of the poorest; elite capture	15 26
CBHI, community-based health insurance; PBF, performance-based financing.			

are also sometimes scientists who promote their ideas not only on the basis of evidence and in accordance with their academic code of conduct, but also in line with their beliefs, which are sometimes methodologically or even ideologically flawed.^{7,17} Take, for instance, the promotion of a single (positivist) method of impact assessment (the counterfactual), which has also been widely disseminated within the European Commission through the circulation of economic ideas. All in all, even if requested to include positionality statements, the latter often remain superficial, allowing experts to acknowledge their privileges without challenging the power structures they benefit from, turning reflexivity into a way to claim moral innocence rather than to assume real accountability.¹⁸

INDIVIDUAL RESPONSIBILITY OF PATIENTS OR EXPERTS?

Relationships between experts and decision-makers are complex but rarely discussed is the social and individual responsibility that the former's advice entails for the latter. This is particularly the case for experts with neoliberal ideas whose harmful consequences for public health are recognised,¹⁰ a paradox given the emphasis on individual responsibility in the approaches they recommend.

Scientists who provide expertise or advice as part of their job must comply with their institution's expertise charter. Consultants working for international organisations are sometimes required to sign a conflict-of-interest declaration. However, these declarations focus on financial issues (eg, owning shares in a company) rather than ideologies that could influence their advice. How can we imagine experts declaring their ideologies? However, organisations that consult experts can review their previous work and recruit them with a full understanding of their ideas. Experts who have spent their entire careers defending a particular idea are unlikely to change their minds when advising a new organisation.

However, we must not underestimate the agency of beneficiary governments and domestic policy leaders that receive financial aid/loan and expert advice. Ghana's move towards a national health insurance scheme was home-grown and initially resisted by its major donors and policy advisors, who only supported the programme after the government pushed forward without their buy-in. Yet, in many cases, national experts also act as intermediaries for international organisations, and their advice may lack the necessary critical distance or evidence. Recruiting national experts (ex-government officials) who then advise their former colleagues is also a long-standing strategy used by donors, WHO and non-governmental organisations (NGOs) to exert influence.

In this context, do organisations and the people who run them tend to recruit people who share their collective beliefs about the use of certain public policy instruments? Does this process contribute to explaining the permanence of certain long-standing choices—known as the autonomy of instruments¹⁹—as shown in the use of

neoliberal health financing instruments since the era of French colonisation in West Africa?²⁰

Furthermore, these health financing experts have often been the same for decades, called on by different organisations but working in the same countries and always defending the same ideas, which are rarely innovative but allow them to remain in place, retain power and secure contracts. What are the risks that the role and relationship of the private sector with the WHO has grown over time, particularly under the impetus of Brundtland in the late '90s²¹ so that their ideas influence the content of the policies they advocate?

MOVING FORWARD

We are therefore faced with two main problems. First, highly paid experts rarely pay the price for the advice and ideas they put forward when these have catastrophic effects on populations. Second, decision-makers tend to recruit experts based on ideological criteria, particularly the alignment of their ideas with the organisation's dominant vision. Thus, the impunity of experts and their selection on ideological grounds are obstacles to formulating groundbreaking, context-specific and evidence-based policies (we often even see the reproduction of previously proposed solutions) and to implementing public policies capable of truly improving people's lives on the ground.

How can we tackle these two problems? One possibility would be to create a publicly accessible international directory of public policy experts, enabling the tracing of their ideas and advice, the degree of satisfaction of recipient countries and organisations with their 'soft skills', as well as the results of the policies they have helped implement. This could be a way to increase transparency and accountability. In some countries, politicians and senior civil servants are required to submit a conflict-of-interest declaration, even though supervisory bodies do not always have the resources to fulfil their roles. This new international database would also be useful to researchers seeking to better understand the role of experts, as well as to citizens, civil society organisations and journalists seeking to monitor the role of expertise and the ideological considerations that guide it.

Fortunately, although our analysis focuses on the negative effects of expert advice, some experts share evidence-based solutions with decision-makers, rather than their own beliefs. This advice can also have positive impacts on populations, as demonstrated by the effective fight against smoking and child malnutrition. The contribution of these experts should therefore also be publicly acknowledged, beyond their academic recognition. This article is clearly not intended to lump all experts together. Some, of all nationalities and backgrounds, do their work exceptionally well, with rigour, independence and professionalism. In future research, it would be interesting to examine how they operate, what their habits are and what their skills are. Moreover, even if we consider

neoliberal ideas and experts as an example, our criticism of ideological blindness and the need to hold experts accountable apply to many other cases, including those involving ideas of social progress. Ignoring this would be a mistake.

The future of geopolitics calls for the decolonisation of global health and the greater use of evidence to inform public policy.¹⁷ However, given the lack of investment by most governments of Global South countries, it is likely that international aid will continue to exert a strong influence in the coming decades, even as it currently declines. As a result, experts will continue to play an important role in policymaking. Beyond reiterating the importance of using context-specific evidence, we must consider how to better engage with the ideas and ideologies these experts convey. Geopolitics is a matter of influence, and for it to be useful to populations, the social and personal responsibility of experts must not be forgotten.

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