

### **An essay on how senior health-quality work should actually be staffed.**

There is a quiet dishonesty in much of global-health consulting. A proposal goes out under a senior name. The room is impressed. Then the work is done by whoever was junior and available, and the senior name reappears only at the readout. The client paid for seniority and received leverage.

The collective model is a deliberate answer to that.

### **The leverage pyramid is the wrong shape for this work**

Large firms are built as pyramids: a few senior partners win the work, and a broad base of junior staff deliver it. That shape is efficient for commoditised work. It is actively wrong for health-system reform, where the hard part is judgement — knowing which framework choice will survive a ministerial transition, which data-collection assumption will break on contact with the ward, which partnership will drift and which will hold.

Judgement does not delegate well. It is precisely the thing the senior person was hired for, and precisely the thing the pyramid hides from the client.

### **What "pooled experience" actually means**

A collective inverts the pyramid. Instead of one senior name and a base of juniors, it fields a **bench of peers** — each senior in a different domain, each showing up on the engagements where their domain is the binding constraint. The accreditation architect, the clinical-governance lead, the workforce-development specialist, the improvement scientist: not one person pretending to be all four, and not four juniors supervised from a distance, but four practitioners who have each carried the work.

The honest version of a track record is therefore *pooled*. The decades of combined practice are real, but they are the sum of several careers, applied where each fits — not a single heroic biography stretched to cover everything.

### **Why this serves the client better**

- **The room matches the work.** The seniority in the proposal is the seniority in delivery. There is no bait-and-switch because there is no base to switch to.
- **The engagement scales to the problem, not to a margin target.** A collective does not need to staff up a pyramid to be profitable, so it can right-size.
- **Blind spots get caught.** Peers challenge each other. A lone consultant, however brilliant, has exactly one perspective and every incentive to defend it.

### **The catch, stated plainly**

Collectives are harder to run. There is no army to throw at a deadline, and coordinating senior peers is more like chamber music than conducting an orchestra. That is a real constraint, and it is the right one: it keeps the model honest about what it can take on.

The test of any model is simple — *who actually does the work, and is it the people you were promised?* For senior health-system work, the collective is the configuration most likely to give an honest answer.

*How this was built.* This essay reflects two decades of international health-quality practice across donor-funded programmes, regulators, and hospital systems — and a deliberate choice to organise the next chapter of that work as a collective rather than a pyramid.