NORMS IN TENSION:
DEMOCRACY AND EFFICIENCY IN BANGLADESHI HEALTH AND POPULATION SECTOR REFORM

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Abstract

Spurred on by donors, a number of developing countries are in the midst of fundamental health and population sector reform. Focused on the performance-oriented norms of efficiency and effectiveness, reformers have paid insufficient attention to the process-oriented norms of sovereignty and democracy. As a result, citizens of sovereign states have been largely excluded from the deliberative process. This paper draws on political science and public administration theory to evaluate the Bangladeshi reform experience. It does so with reference to the norms of efficiency, effectiveness, sovereignty and democracy as a means of making explicit the values that need to be considered in order to make health and population sector reform a fair process.

Keywords

Asia, Bangladesh, health policy, population policy, democracy, sovereignty.
INTRODUCTION

A handful of less industrialized countries are in the midst of enacting some of the most far-reaching health and population sector reforms in the post-colonial era. National leaders are streamlining, decentralizing and privatizing components of health systems for efficiency gains that they hope will lead to improved health outcomes, particularly for the poor. Also, they are abandoning population control objectives in favor of reproductive health agendas that focus on the needs of clients.

These reforms have multiple causes, but two are key. For health sector reform the primary factor is the World Bank's emergence in the 1990s as a leading international organization concerned with health, and the Bank's promotion of an agenda focused on state commitment to essential services, an enhanced private sector role in service delivery, resource prioritization based on standardized indicators, and comprehensive sector-wide rather than fragmented project-based approaches to health planning (Buse and Gwin, 1998; World Bank, 1993). For population sector reform the primary factor is the formation of a transnational alliance of international organizations, NGOs and governments pushing for a reproductive health agenda to replace the population control paradigm that has dominated family planning policy since World War Two. The alliance gained prominence at the 1994 United Nations-sponsored Third International Conference on Population and Development (ICPD) in Cairo.

These reforms raise a number of normative issues that have received little explicit attention by their promoters. Enacted in the name of the performance-oriented objectives of efficiency, effectiveness and client satisfaction, the reforms have generated little meaningful attention to the process-oriented objectives of democracy, sovereignty and participation. The literature on health
reform in developing countries has focused almost exclusively on issues of performance to the neglect of process. For theory on process one must venture outside this body of work to the literature on democratic political theory, public administration and international relations. Presumably, it matters not just whether the reforms are achieving what they were intended to accomplish, but also how they were enacted in the first place. Who made the decisions? Whose voices were heard? Was there a consultative, participatory policy formulation process? Did parliaments and legislatures have a chance to debate the content of reform packages? Did democratically-elected governments have the last word on national decisions, or were they overwhelmed by the voices and power of donors, international organizations, transnational advocacy networks and the governments of rich countries? At the level of principle, reformers have embraced the values of democracy and sovereignty that these questions explicitly raise. For instance, World Bank officials have stated publicly that sector-wide approaches should be prepared by local stakeholders (Denning, 1994), and these approaches are premised on enhancing domestic capacity to plan and implement health policy. The problem comes at the level of practice, where reformers often set aside concerns for sovereignty and democracy in the name of gains in efficiency and effectiveness that they presume will result from speedy enactment and smooth implementation.

This paper evaluates one health and population sector reform experience through the year 2001 - that of Bangladesh - with reference to this set of norms. Few countries are in the midst of such far-reaching health and population-related change as is Bangladesh, which makes the country a revealing case for consideration (see appendix). The system that will emerge from the present set of transformations is unlikely to resemble that which has been in place for the entirety of the country's three decades of existence as an independent nation. Bangladesh's health and population sector has experienced extreme fragmentation, with more than one hundred projects
operating largely independently of one another, resulting in considerable duplication and waste of resources. It has also been characterized by separate health and population bureaucracies competing for resources, and cooperating on mutually shared aims only on the rarest of occasions. It is being transformed - or reformers hope it is being transformed - into a system marked by comprehensive sector-wide planning, strategic vision, and a unified bureaucracy that integrates health and population activities. The participants in this reform process are numerous and include actors within the government itself, bilateral and multilateral donors, United Nations agencies, and, to a lesser extent, domestic non-governmental organizations. While the case of Bangladesh is examined in its own right as intrinsically important, the deeper aim of the paper is to demonstrate that process, not just performance, is a critical normative issue for health sector reform in developing countries.

We begin with an analysis of norms in health and population sector reform, and then address the case of Bangladesh in detail. In the discussion and conclusion we evaluate the Bangladeshi experience in light of these norms and argue for balanced consideration of process and performance in health and population sector reform.

**THEORY: NORMS IN HEALTH AND POPULATION SECTOR REFORM**

Reformers have promoted health and population sector transformation in less industrialized countries largely with the performance-oriented values of efficiency and effectiveness in mind. These values are not the only ones worth pursuing, but they are essential.

**Performance norms: efficiency and effectiveness**
The World Bank, and more recently the World Health Organization, have been strong advocates of the pursuit of efficiency in health system performance. The norm of efficiency refers to the extent to which resource output-input ratios are maximized. It concerns the employment of these resources in the most cost-effective way. As the World Health Organization puts it, efficiency is directly connected to performance in that, "an efficient health system achieves much, relative to the resources at its disposal" (WHO, 2000, p. 42).

The World Bank and World Health Organization have developed and actively promoted the use of an indicator to measure efficiency in health resource allocation. The disability-adjusted-life-year, or DALY, facilitates a process whereby a cost is assigned to preventing the loss of one healthy life-year, and decisions made on a cost-effectiveness basis concerning how resources will be distributed to fight various diseases so as to minimize total loss of DALYs. The DALY is increasingly being employed on a national and global basis for public health resource allocation decisions (Murray and Lopez, 1997).

Improved efficiency is one of the explicit objectives of health sector reform (Berman, 1995; Carr-Hill, 1994). For instance one element of reform, the sector-wide approach, is intended to generate enhanced coordination among donors and host governments with better efficiency as a goal. This approach stems from concerns that health systems have been functioning unproductively due to poor coordination of donor resources and duplication of service delivery systems (Buse, & Walt, 1997; World Bank, 1993).

In addition to efficiency, the effectiveness of health systems has also been a central goal of reform. Effectiveness is to be distinguished from efficiency in that it more directly concerns final health outcomes. There has been considerable debate among reformers concerning just which
performance-oriented outcomes should be pursued. The most comprehensive recent treatment of the subject is that contained in the World Health Organization's *World Health Report 2000*. The report takes performance effectiveness to be multi-dimensional and introduces three intrinsic objectives: good health in the population; fairness of financial contributions, a distributional concern; and responsiveness to the expectations of the population, a concern that includes non-health goals such as respect for the dignity and autonomy of individuals. These are to be contrasted with instrumental goals such as accessibility to health services, which are only a means toward an end.

**Process norms: sovereignty and democracy**

It is usually with the norms of efficiency and effectiveness in mind that reformers and health policy analysts begin and end. There are other values, however, that political theory suggests also need consideration. Imagine a health system that has functioned with considerable inefficiency and ineffectiveness, and a group of donors concerned with waste in the sector and the national health ministry's unwillingness to reform. In the name of ensuring that in the forthcoming health plan all the rural poor have access to essential services, a donor consortium meets with the prime minister and informs her that no further health sector loans will be forthcoming unless a sector-wide approach is adopted. The prime minister bows to the pressure and gives power to the donors to shape a national health plan and monitor progress. Over the course of the plan, by all objective measures, health outcomes improve for the poor.

In this hypothetical case, health performance has been enhanced. However, the health agenda is set largely by the donor community and health decision-making power resides primarily, if not exclusively, in the hands of donors. The host government serves at best as a junior partner in a health reform coalition, and at worst as an institution with no meaningful voice in the health
affairs of the nation it is supposed to govern. One might argue that this state of affairs does not matter so long as the healthcare needs of the poor are being met. But this line of argument is a slippery slope, one that might justify the complete disempowerment of the host government in the name of health outcome effectiveness.

At issue is the norm of sovereignty - the right of the host nation to have the last word in decision-making on matters within its territorial jurisdiction (Friedrich, 1946; Montgomery, 2002). Sovereignty has been a fundamental concern of scholars in the political science sub-fields of political theory and international relations, but has received little explicit treatment in the health reform literature. Since the treaty of Westphalia in 1648, sovereignty has been a fundamental norm governing relations between states in the international system. Rich and poor states alike have operated on the principle that sovereignty ought not to be violated except in cases of humanitarian abuse and government incapacitation. In practice the principle has been overlooked repeatedly, and globalization trends are weakening its power even further. It is not an absolute principle, as there are many cases of state-directed human rights abuses that justify ignoring sovereignty in the name of preventing further violations. Nevertheless, sovereignty remains a fundamental principle underpinning relations among nation-states, contributing to the stability of the international system and ensuring the right of peoples to be free from domination by external powers.

There is yet another norm concerning process of relevance to health sector reform: democracy. To an even greater extent than sovereignty, this norm has been ignored in health reform in poor countries. Political philosophers have long argued that just governance is a matter not only of performance but also of fair process (Locke, 1954; Rousseau, 1997). Modern theorists and analysts of democratization emphasize a similar point in arguing for procedural over performance
or outcome definitions of democracy (Huntington, 1991; Linz, & Stepan, 1996; Schumpeter, 1947). Huntington, for instance, explicitly rejects definitions of democracy based on sources of authority or purpose in favor of an understanding that democracy involves, "the selection of leaders through competitive elections by the people they govern" (p. 6). Inherent in all these discussions is the recognition that true democracy inevitably involves outcome uncertainty. Democratic systems give all adult citizens the right to participate in the political process. Such rights become meaningful only if choices are respected, and these choices may well lead to public policies that have neither efficient nor effective outcomes.

This tension between democracy and efficiency in bureaucracies has been one of the longest-standing concerns in the field of public administration. Early scholars (Gulick, 1937; Wilson, 1887) emphasized efficiency as the ultimate administrative value and advocated rational, hierarchical organization. More recent scholars (Ostrom, 1989) have dismissed this paradigm, calling for fragmentation of authority and overlapping jurisdictions in order to ensure accountability and democratic responsiveness. Rosenbloom (1983) has noted an irreconcilable tension in public administration between managerial approaches focused on executive authority that value efficiency and effectiveness, and political approaches concerned with legislative functioning that value representation, responsiveness and accountability. Most recently, industrialized states have pursued government reinvention to achieve market-oriented efficiency and customer satisfaction. This agenda has sparked concern among theorists that the reforms present threats to equity, democratic procedures and public accountability (Dahl, 1999; Lynn, 1998).

If the ideas of democracy and representation are to be taken seriously, it matters not just whether resource-poor nations have the power to shape their health agendas. It matters also who within
these nations has such power. Which parties are consulted, and who is bypassed in the process? Are legitimate democratic and participatory mechanisms used? Or are agendas set by small groups of officials at the pinnacles of health bureaucracies, international organizations, donor consortiums, pharmaceutical ventures and transnational advocacy networks?

Often the values of public deliberation and legislative oversight are downplayed when the setting is a resource-poor country. The reason for this state of affairs may lie in the presumption that the people of these nations are unaware of their health needs and are best guided by the input of senior medical experts, both domestic and international. There is little doubt that such experts bring considerable knowledge to the table, including biomedical expertise, understanding of best practices from other resource-poor settings, and extensive managerial competence. However, citizens and social groups offer other forms of expertise, including the capacity to identify the most critical health issues, solutions for problems in service delivery and quality of care, knowledge of local resources that can be employed to enhance community healthcare, and identification of local cultural, political, economic and social barriers that must be surmounted to achieve health.

Public deliberation is critical also because health and population officials make mistakes, and checks are required to ensure that their mistakes do not become doctrine. Related to this point is the need to ensure accountability for policy decisions. Citizens in democratic systems can hold national bodies accountable for their actions. If policies fail, citizens can exercise their political rights to bring about policy revisions or changes in government. National leaders therefore are forced to exercise caution when they act. By contrast, few mechanisms exist to ensure that external actors such as donors and international organizations are held accountable for their actions. The citizens of developing countries rarely have leverage over these actors, with the
result that donors can use developing countries as experimental sites for their policy ideas, and run away largely unscathed if these ideas fail, avoiding the consequences of their decisions.

In sum, democratic processes matter in health and population sector reform because they facilitate the input of local forms of expertise into policy-making, because public discussion is a check against mistakes, because such processes bring about accountability, and because inclusive deliberation is a value of intrinsic worth.

We now turn to the case of Bangladeshi health and population sector reform, focusing on the historical detail that enables us to assess how the norms of efficiency, effectiveness, sovereignty and democracy played out in practice.

**METHODOLOGY**

Research for the case study was part of a larger investigation of the transnational forces shaping health policy-making in the nation-states of South and Southeast Asia, involving extensive fieldwork in India, Bangladesh and Indonesia. The case study was exploratory in nature. We began with a theoretical interest in how sector-wide reforms in health were altering the balance of power between donors and the governments of recipient nation-states. We presumed that increasing coordination among donors may be giving them more and more power vis-à-vis domestic governments and leading to increasing instances of sovereignty violations. We chose Bangladesh as a case to investigate this issue, since it was widely known as a country in which the sector-wide approach in health was moving forward, and since there was an existing body of scholarship on donor-state relations in the health sector (Buse, 1999; Buse, & Gwin, 1998; Khuda, Barkat, Helali, Miller, & Haaga, 1994; Rob & Nager, 1995). We could rely on that scholarship to provide information on the pre-sector wide approach period and the period of change, and conduct our own research to gather information on later stages in the reform period.
We began also with a set of normative assumptions concerning the value of both efficiency and democracy in health reform, sympathetic to the concerns of reformers to promote better health outcomes for the poor, but wondering whether democratic processes were being bypassed in the process.

We used a process-tracing methodology in constructing the case history, seeking to employ multiple sources of information in order to establish common patterns of causality. Our aim was to determine the major events in Bangladeshi health reform and examine the normative presumptions driving the actors involved. The case study was constructed based on multiple interviews with major actors, as well as consultation of government documents and local research reports. Lengthy unstructured interviews were conducted in Dhaka with Bangladesh-based officials in the World Bank, the United States Agency for International Development, UNICEF, the United Nations Population Fund, the Canadian International Development Agency, the British Department for International Development, the Population Council, the International Centre for Diarrheal Disease Research in Bangladesh (ICDDR-B), the Bangladeshi Ministry of Health and Family Welfare, the Management Change Unit (MCU), the Programme Coordination Cell (PCC) and Gonoshasthaya Kendra (the People's Health Centre). Documents consulted included the major national health and population plans developed in the 1990s, World Bank reports, NGO reports, and internal documents of the MCU and PCC, the two units referred to below that were intimately involved in the reform. In addition, a senior donor official of Bangladeshi nationality who was involved in the reform process reviewed the manuscript for factual accuracy. We employed these various sources of information to crosscheck the accuracy of the details of the reform history.
THE CASE OF BANGLADESH

The origins of sectoral reform: 1993-1998

The problems that spurred the reform of the Bangladeshi health and population sector had their roots in the way the system had developed since the 1970s. Only two years after Bangladeshi independence in 1971, the World Bank became involved in the country with an appraisal for a first population project (Buse, & Gwin, 1998). Three more population sector loans followed, each bringing on additional donor partners and doubling the value of external aid (Buse, & Gwin, 1998). By the early 1990s the sector was crowded with donor agencies, with at least 13 multilateral and 18 bilateral agencies committing funds and an estimated 400 active NGOs (Buse, 1999). While providing much needed resources to a country facing rapid population growth and extensive health problems, this large aid presence also resulted in an extremely fragmented sector, little coordination among hundreds of projects, a health planning process dominated by donors, and a domestic health ministry without the capacity to effectively manage the sector.

The fragmentation problem was alleviated in part by the creation of a donor consortium. This World Bank-led grouping emerged out of the first population project, and by the period of the fourth population project from 1992 to 1998 brought together nine agencies (Buse, 1999). An adverse effect of the consortium, however, was that it heightened donor dominance of the sector, as this coordination displaced the development of independent sectoral planning capacity in the ministry itself.

The funds pooled by the nine agencies represented only 35% of the country's aid in the sector as many donor agencies, most prominently USAID, declined to join. By the late 1990s there were two rings of donors. The inner ring was the most extensively integrated: it pooled funding and
dispersed it in a unified way to the government. This included the World Bank, Sweden, Canada, the Netherlands, the EU, and Great Britain (the British and Canadians also kept some funding outside the pooling arrangement). The outer ring was considered part of the consortium - participants engaged in joint donor planning meetings so as to present a unified front to the government - but did not pool funds. The most prominent member of this group was USAID.

It was not until the mid-1990s, two and a half decades after independence, that reform initiatives to address these problems were undertaken in earnest, and by the end of the decade Bangladesh was in the midst of fundamental transformation of its health and population sector. This reform movement did not take place in a vacuum. It occurred in the context of global health and population developments shaping many resource-poor countries, as well as political developments in Bangladesh itself. Globally, the World Bank's push to bring efficiency to developing world health systems moved into full swing in the middle of the decade. At the same time scholars and development practitioners were engaged in extensive debate concerning the creation of more effective health aid coordination mechanisms, the promotion of sector-wide approaches to health development in poor countries, and the appropriateness of the World Bank's new role and agenda (see for instance Buse, & Gwin, 1998; Buse, & Walt, 1997; Cassels, 1996; and Ugalde & Jackson, 1995). Also, in 1993 reproductive health organizations were mobilizing globally in anticipation of challenging the population control movement at the 1994 Cairo population conference. Meanwhile, in Bangladesh in 1996, parliamentary elections brought down a ruling party for the first time in the country's history. Thus, an environment for reform existed both globally and nationally, setting the context for domestic developments.

In 1996 the World Bank's fourth population sector loan was due to end. In anticipation of this development a meeting was held in Paris in September 1995 concerning the future of the
Bangladeshi health and population sector. Approximately fifty donor representatives and government officials participated. They discussed a variety of reform issues, most already a part of the global health and population discourse (Barkat et. al, 1999; MoHFW, 1998). Upon returning from Paris, officials in the Ministry for Health and Family Welfare (hereafter referred to as the Ministry) prepared a new strategy document for its family planning program through the year 2005 (MoHFW, 1998, p. 26).

In 1995, around the time of the Paris meeting, the World Bank had written to consortium partners about setting up a sector-wide approach (Buse, 1999). The Bank subsequently made clear to the government that it would not process a new loan unless the government agreed to sector-wide reform (Buse, & Gwin, 1998). Under the pressure of the loss of donor funding that historically had constituted more than a third of public population and health expenditure, in January 1997 the government produced a document, entitled the Health and Population Sector Strategy (HPSS - see MoHFW, 1997a), whose content strongly reflected the new reform agenda. Both donor and government officials participated in its creation.

The issue then arose of how to push these highly contentious reforms through the political system, particularly the troublesome unification of the health and population directorates-general. Unification meant that numerous civil servants would lose power and have to serve as subordinates to their counterparts in the rival directorate-general. Reformers decided to circumvent the bureaucracy and parliament and appeal directly to the new prime minister. The Secretary of the Ministry at the time was the conduit. He was pro-reform and close to Sheikh Hasina, and broached the idea of unification with her directly. Shortly thereafter she agreed to the creation of a special committee whose mandate was to investigate unification and health reform options. It received financial support both from the Ministry and from DfID, the British
development agency (MoHFW, 1997b). In September 1997 it produced a restricted government report that delineated a full-scale unification proposal (MoHFW, 1997b) whose approval the Prime Minister secured.

Government acceptance of the reform agenda delineated in the Health and Population Sector Strategy (HPSS) and the special committee report set the stage for the next major phase of reform: the creation and adoption of an official reform program. Between 1996 and 1998 a number of overseas consultants, invited by donors and the government, traveled to Bangladesh to conduct workshops and offer reform ideas. Also, working groups were formed that included some NGO and civil society representatives. Recommendations from these meetings, as well as the principles and ideas of the HPSS and special committee reports, were used to put together the Health and Population Sector Program (HPSP) that laid out every major change to be taken during the years 1998 to 2003 in the Bangladeshi health and population sector (MoHFW, 1998).

Specifically, it delineated a plan of action for: unification of the health and family planning directorates-general; decentralization of power from the top of the Ministry to its lowest levels; the phasing out of a project-based system in health planning and the creation of a sector-wide approach; a re-orientation of the health and family planning systems toward client service; the ongoing pooling of funding among donors; the mainstreaming of gender into health planning; and the adoption of an essential package of health services for the poor. The HPSP anticipated expenditures of US$ 3.37 billion over the course of the five years, approximately one-third of which was to come from a consortium of donors, and the rest from the government. The HPSP mentioned a consultation process taking place between May and December of 1997 in order to generate the input of "clients, providers, professional associations, media and other stakeholders" (MoHFW, 1998, p. 396-397).
Approval for the HPSP came not through parliament but rather through a vote of ECNEC – a national economic council chaired by the prime minister. It officially took effect on July 1, 1998, a day after an extension of the World Bank's fourth population loan program terminated. In essence it took the place of a fifth loan, but was not called that, since it was so much more far-reaching in scope.

**The implementation of sectoral reform: 1998-2001**

By 1998 the political decisions to reform had been made and a plan of action delineated. However, the equally difficult challenge of operationalizing the commitment remained. Heavy bureaucratic resistance was expected, particularly from senior civil servants within the Ministry who stood to lose power and rent opportunities from a reformed system.

In order to manage this implementation challenge, two new units were created, the Programme Coordination Cell (PCC) and the Management Change Unit (MCU), that on paper were components of the Ministry. Staff members were approved by, and on leave from, the government, were in day-to-day contact with Ministry officials and were accountable to the government for their performance. Yet the units also bore the marks of donor influence. For instance, they were not located inside the Ministry's main complexes but rather in an office building next door to the World Bank, several floors apart from one another. The Canadian International Development Agency funded a large portion of the PCC budget, and UNICEF had personnel oversight over this body. The MCU also received considerable donor funding. The former Secretary, whose ideas were in line with those of the World Bank and had taken the reform program to the Prime Minister, and who was now retired from the Ministry, was appointed head of the MCU.
The two units evolved into bodies fully beholden neither to donors nor to the Ministry, wielding considerable power over the reform process. Several factors facilitated the development of this power and autonomy, including: the former Secretary’s use of high-level political connections; influence over the allocation of financial resources provided by donors; strong ties with both ministerial and donor officials, making the two units natural intermediaries; and existing political commitment for the reform program, a function of national approval of the special committee report and the HPSP, the guiding documents of reform. The main authors of these documents actually resided within the units.

Through the work of the MCU and PCC, with the backing of the donor consortium and reform-minded officials within the Ministry itself, the reform program advanced considerably over the period 1998-2001, the first three years of the HPSP. A series of annual performance reviews indicated that bottlenecks existed, but that most of the reforms were moving forward. Reports from this series of meetings expressed donor and government satisfaction concerning: progress on the unification of the health and population bureaucracies; the devolution of authority to line directors within the ministry, giving them more planning and decision-making power; and most importantly, the establishment of a sector-wide planning process to replace the previous, fragmented approach (APR report, 1999; APR report, 2000; APR report, 2001; APR report - review, 1999). While challenges remained, Bangladesh appeared to be in the midst of the most far-reaching reform of its health and population sector in its history.
DISCUSSION

These are the basic facts concerning the Bangladeshi health and population sector reform experience through the year 2001. Evaluated with reference to the norms of efficiency, effectiveness, sovereignty and democracy, how does this experience fare?

Assessing the performance norms of efficiency and effectiveness

Many bottlenecks hampering efficiency are in the process of being remedied. Most procurement, training and accounting tasks and systems, as well as other planning functions, will be unified under approximately 25 line directors within the Ministry, individuals who will have more autonomy and power than ever before to develop strategic plans in functional areas for the sector as a whole. Sector-wide planning mechanisms are being established, and as time passes, should be further institutionalized. Donors and government health and population officials meet in regularly scheduled annual performance reviews, where they assess past experience and agree upon future priorities. At the thana level (the geographic area below the district level) and below, unification of the health and family planning directorates-general is moving forward, and plans are in place for integrating these systems at higher levels. As of 2001, decentralization of authority to the lowest levels of the bureaucracy had yet to be enacted; however this reform was at least on the books. Efficiency gains from these reforms are probable.

It is likely also that the reforms will lead to improved effectiveness of the Bangladeshi national health system. Efficiency changes should translate into better health outcomes for the poor, more equitable access to health facilities across the country, and enhanced client service. The institutionalization of sector-wide planning should enable policy-makers to determine the country's priority health needs more effectively and to channel resources appropriately to meet
these needs. Unification of the health and family planning directorates-general should, in line with the reproductive health agenda that emerged from the Cairo population conference, lead to a system of government services that emphasizes the needs of clients rather than those of bureaucrats. If it is ever meaningfully implemented, decentralization will give those officials who know local health needs the best - the health and family planning workers at the thana level and below - the power to make decisions that serve their communities. Most importantly, the focus on essential services, a major element of reform, prioritizes communicable disease control over more costly curative interventions and is therefore clearly pro-poor in its orientation. If carried out conscientiously, the reform should significantly enhance the health status of the country's most impoverished citizens.

Assessing the process norms of sovereignty and democracy

Assessing sovereignty and democracy leads to less certain conclusions. It would be tempting to dismiss the case of Bangladesh as one in which the sovereignty of the country was clearly violated by a World Bank-led consortium of donors. That would be an oversimplification. The ideas for reform, particularly the sector-wide approach, the essential services focus and the reproductive health agenda, emerged globally. While they had some domestic roots, they were pushed primarily by donors, particularly the World Bank, DFID and USAID. Also, the World Bank put enormous pressure on the government of Bangladesh by threatening to forego lending if the health and population sector was not reformed. This being said, certain government officials also became heavily involved in the reform process and ultimately came to own the changes. The former secretary of the Ministry believed genuinely in the necessity of reform. His subordinates in the MCU, and other former civil servants in the PCC, were strong advocates of reform, and played a central role in both design and implementation. Those who gained power within the
Ministry - particularly the line directors - became reform advocates. The Prime Minister herself was convinced of the value of reform after being approached by the Secretary.

At the same time, there were many in the government skeptical of reform, including a former Minister for Health and Family Welfare and many of the civil servants just below the minister, who stood to lose power as a result of change. As of 2001 many Ministry civil servants perceived the donors to be collaborating with the MCU and PCC in usurping their rightful power to guide the health and population sector. Some even in the donor community were skeptical of many of the changes made, both on grounds of ineffectiveness and of disempowerment of the Bangladeshi government.

With reference to the issue of sovereignty, then, this was not a simplistic black and white picture of donors versus the state, the former usurping the power of the latter. While donors were largely pro-reform, there was some disagreement among them concerning the content and pace of change. Furthermore, several senior donor officials were themselves Bangladeshi nationals. And within the state there were both pro and anti-reform elements. The situation is best characterized as one in which an alliance of donors initiated the reform process and used their control over financial resources and their political connections to pressure the government to enact change. Once they pushed for change, however, a number of senior health and population civil servants agreed that reform made sense and used their own political ties to pressure their resistant colleagues within the government. In the end it was the retired civil servants in the MCU and PCC who became the most active champions of reform. In sum, the donors influenced but did not usurp the government’s right to the last word (the definition of sovereignty employed in this paper).
Democracy is the norm that fares most poorly. A group of officials from the donor community and the government initiated, pushed through the political system, and generated the operational commitment for the reform program. They were pro-poor, concerned with gender equity, determined to eliminate waste, concerned that their resources would be put to good use, and intent on enhancing the capacity of the Bangladeshi health sector. Purity of intentions, however, is not the measure of democracy. Democracy is a procedural issue and is to be assessed by the level of participation in the decision-making process by the public and its elected bodies, and by whether these bodies were able to exercise final authoritative decisions on national policies. On these counts democracy was lacking, if not absent. There was public consultation in the creation of the health and population sector program (HPSP). However, the main ideas came from officials in the government and donor communities, as well as international experts brought in by both groups who by virtue of their positions, control over financial, technical and human resources, and knowledge-based authority, were able to shape the primary content of the reform program. The direct participation of segments of society most affected by the reforms, particularly rural Bangladeshi citizens and the urban poor, was marginal at best, a common exclusion in the Bangladeshi policy process.

With reference to legislative participation and the exercise of authoritative decision-making power, the situation also was uncertain. It was the political networking of the World Bank, other donor officials, and pro-reform bureaucrats that brought the reform agenda on to the national political stage. They came to believe that the timely negotiation of the difficult political terrain they faced and the smooth implementation of the reform program would be greatly facilitated by appealing directly to the prime minister, Sheikh Hasina. They effectively secured her support and she pushed the program through the system, appointing a special high-level commission to facilitate the task, and gaining approval through a vote of the National Economic Council.
Technically, this procedure was legal. However, the process almost completely bypassed the Bangladeshi parliament. Bangladesh's democracy is fragile, and many criticisms can be leveled against parliament, including corruption, lack of transparency, and insufficient commitment to democratic practices. One charge that cannot be made, however, is that its members gained their positions by appointment. The parliament is the only major national-level political body whose members are elected by the Bangladeshi citizenry. A program that fundamentally transformed the entire health and population sector was enacted without ever having been discussed by Bangladesh’s only democratically-elected national political assembly.

Norms in dynamic tension

The norms of efficiency, effectiveness, sovereignty and democracy do not sit easily with one another. On the contrary, they exist side-by-side in dynamic tension, a state of affairs that has received little explicit attention from scholars of developing world health policy. The tension is particularly problematic in the health and family planning sector, since unlike many others policy sectors, the issues involved are decisively humanitarian. All individuals have a right to adequate healthcare and family planning services. Yet in practice only a small percentage of the world's poor are properly served. Given this situation, is it not the norms of effectiveness and efficiency that matter most - ensuring that people do have such access - and not the more idealistic norms of democracy and sovereignty?

This question is not easily resolved, but it is dangerous to discard the values of democracy and sovereignty out-of-hand. There are many reasons these norms deserve far greater attention than health and population reformers have given them in practice. First, democracy as often enhances effectiveness and efficiency as it hampers these outcome-oriented norms. Popular participation and legislative review add valuable ideas to the reform agenda, and offer checks against bad
ideas. A handful of officials operating from far off capitals are unlikely to be able to anticipate all the needs of people in peripheral areas, and are highly likely to push through ideas that affect such people adversely.

Second, even when democracy hampers efficiency - and there are many instances of conflict between the two norms - public deliberation and legislative oversight are still worthwhile. Citizens of industrialized democracies consider it a right to be able to participate in the political process of their countries. They take this to be a value of intrinsic importance regardless of outcome, and view unreasonable restrictions on this right to be severe violations of justice. Why should this be any different for citizens of less industrialized nations?

Third, if we consider health and family planning policy-making in poor countries to be an exception to the need for democratic deliberation since this policy sector has such a high humanitarian content, we are in danger of descending down a slippery slope that removes all democratic checks in the name of swift and efficient enactment and implementation. Where will we set the boundary? If health is immune, then what about the environment, education, pension policy, taxation? The humanitarian argument can easily be abused to justify a host of authoritarian practices.

Fourth, democratic processes are critical for accountability. In the absence of public checks on government and donor behavior, officials may perceive themselves to be immune from the consequences of their actions, act imprudently and make policy mistakes that cause significant harm to the citizens they are supposed to serve.
Finally, with regard to sovereignty, no one, least of all the donor and government officials who pushed the reform program in Bangladesh, hope for a universe of health systems in less industrialized countries dominated by and dependent upon donors from rich nations. Rather, they seek health and population ministries and sectoral actors capable of devising and implementing effective policy with minimal foreign assistance, able independently to act as agents of change for the promotion of health among their own populations. This requires respect for sovereignty from the inception of reform.

**CONCLUSION**

Health sector reform raises tensions between process and performance-oriented norms. These are inherent: they will not disappear with more refined policy packages. In the face of normative tensions reformers have favored the pursuit of efficiency and effectiveness over democracy and sovereignty.

We argue that there is a need for greater balance. Democracy and sovereignty are norms of intrinsic worth. Political philosophers have long recognized that their ethical foundations should not be grounded exclusively in performance-based criteria. An important step toward achieving greater balance would be the refinement of the increasingly influential and constantly evolving World Health Organization framework for the evaluation of health systems. The model in its present form includes a concern for responsiveness, but remains predominantly a performance-oriented set of norms. We suggest an additional principle: health sector transformation should be carried out with respect for the sovereignty of the nation-state and for democratic institutions, and with adherence to democratic procedures.
ACKNOWLEDGEMENTS

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APPENDIX

Most countries undergoing large-scale health sector reform with donor involvement share several characteristics in common: widespread poverty; low levels of spending per capita on health; poor health conditions; and a large donor presence in the health sector. In this sense Bangladesh stands as a representative case among this group, as the table below indicates.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>1388</td>
<td>13</td>
<td>60</td>
<td>Extensive: Donors provided approximately one-third of health and population sector expenditures between the years 1998 and 2001.</td>
</tr>
<tr>
<td>Cambodia</td>
<td>1345</td>
<td>20</td>
<td>54</td>
<td>Dominant: From 1992-1995 aid expenditures for health were more than double government expenditures.</td>
</tr>
<tr>
<td>Mozambique</td>
<td>705</td>
<td>5</td>
<td>45</td>
<td>Dominant: The international community has provided around 50% of recurrent expenditures and more than 90% of capital expenditures.</td>
</tr>
<tr>
<td>Zambia</td>
<td>784</td>
<td>25</td>
<td>43</td>
<td>Extensive: In 1997 and 1998 donor funds made up an estimated 40% of total public expenditures in the health sector.</td>
</tr>
</tbody>
</table>

Data on GDP per capita, health expenditure per capita and life expectancy at birth from World Bank at http://devdata.worldbank.org/hnpstats/. For information on donor presence see APR team, 2001 and a 1999 issue of Health Policy and Planning (vol. 14, issue 3) devoted entirely to issues of health reform in developing countries.
REFERENCES


APR report (Bangladesh health and population sector program, aide memoire, annual program review, first phase) [unpublished report]. (1999).

APR report (Bangladesh health and population sector program, draft aide memoire, annual program review second phase) [unpublished report]. (2000).


sector: A review. *Social Science and Medicine, 45*(3), 449-463.


