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Bringing the Public into Policymaking: National Participatory Institutions in Latin America

By Lindsay Rose Mayka

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

Political Science

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Ruth Berins Collier, Co-chair
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Fall 2013

ABSTRACT

Bringing the Public into Policymaking: National Participatory Institutions in Latin America

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Doctor of Philosophy in Political Science

University of California, Berkeley

Professor Ruth Berins Collier, Chair

Participatory experiments have been adopted throughout Latin America in an attempt to reinvent democracy to be more responsive to *all* citizens – not just an elite few. Participatory policymaking institutions are formal, institutional spaces that engage civil society groups in policy debates and decision-making processes. Participatory policymaking is particularly strong in Latin America, where 12 countries require subnational governments to incorporate civil society organizations into the policymaking process in policy sectors ranging from health to the environment to agriculture policy. Yet there is great variation in what happens after participatory institutions are created: some participatory institutions develop a major role in policymaking, while others only exist on paper. This project seeks to explain under what conditions national participatory experiments become institutionalized.

In the late 1980s and early 1990s, Brazil and Colombia established the region's most expansive national participatory frameworks, requiring dozens of participatory institutions across a range of policy sectors. Facing major legitimacy crises, both countries created participatory institutions as part of democratizing reforms that sought to amplify the voices of excluded groups and enhance accountability. Despite their shared origins, participatory institutions followed very different trajectories in the two countries. Why has participatory policymaking become institutionalized in Brazil, yet decayed over time in Colombia?

While national participatory institutions were created with the goal of deepening democracy, this democratizing impulse is insufficient to secure institutionalization, which requires ongoing material, human, and political investments from the government. Governments will only sustain these investments when pressured to do so by a reform coalition of diverse stakeholders. I show that such a broad coalition only arises when councils are created alongside the introduction of substantive policy changes, and when elite stakeholder groups mobilize other stakeholders in support of the councils. The broad reform coalition will unite to advocate for council implementation as a means to ensure overall reform implementation, as happened in Brazil. In contrast, participatory institutions are doomed when adopted as part of reforms that seek to deepen democracy but do not shift the substance of policy. This was the case in Colombia, where the councils only attracted those stakeholders directly interested in participatory policymaking. The narrowness of this reform coalition hampered its ability to apply pressure on the government, ultimately resulting in failed institutionalization.

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LIST OF ACRONYMS

ADM-19	*Acción Democrática/Movimiento 19 de Abril* – Democratic Action/April 19th Movement
ANASSELBA	*Associação Nacional dos Servidores da Legião Brasileira de Assistência* – National Association of LBA Workers
ANUC	*Asociación Nacional de Usuarios Campesino* – National Association of Peasant Users
ARENA	*Aliança Renovadora Nacional* – National Renovation Alliance
BPC	*Beneficio de Prestação Continuada* – Non-Contributory Pension
CDD	Community-driven development
copacos	*comités de participación ciudadana en salud* – community participation in health committees
CONSEA	*Conselho Nacional de Seguridade Alimentar* – National Anti-Hunger Council
CNAS	*Conselho Nacional de Assistência Social* – National Social Assistance Council
CNDM	*Conselho Nacional dos Direitos da Mulher* – National Council for the Rights of Women
CNP	*Consejo Nacional de Planeación* – National Planning Council
CNS	*Conselho Nacional de Saúde* – National Health Council
CNSS	*Conselho Nacional de Serviço Social* – National Social Welfare Council
CNSSS	*Conselho Nacional de Seguridad Social en Salud* – National Health Council
CTSSS	*Consejos Territoriales de Seguridad Social en Salud* – Municipal Health Councils
DNP	*Departamento Nacional de Planeación* – National Planning Department
FARC	*Fuerzas Armadas Revolucionarias de Colombia* – Revolutionary Armed Forces of Colombia
INAMPS	*Instituto Nacional de Assistência Médica e Previdência Social* – National Institute for Medical Care and Social Security
INPS	*Instituto Nacional de Previdência Social* – National Social Security Institute
IPEA	*Instituto de Pesquisa Econômica Aplicada* – Applied Economic Research Institute
LBA	*Legião Brasileira de Assistência* – Brazilian Social Assistance League
LOAS	*Lei Orgânica de Assistência Social* – Social Assistance Charter
M-19	*Movimento 19 de Abril* – April 19th Movement
MDB	*Movimento Democrático Brasileiro* – Brazilian Democratic Movement
MDS	*Ministerio de Desenvolvimento Social e Combate à Fome* – Ministry of Social Development and the Struggle against Hunger

MPAS	*Ministerio de Previdênica e Assistência Social* – Ministry of Pensions and Social Assistance
NGO	Non-governmental organization
PDS	*Partido Democrático Social* – Social Democratic Party
PMDB	*Partido do Movimento Democrático Brasileiro* – Party of the Brazilian Democratic Movement
PSDB	*Partido Social Democrático Brasileiro* – Brazilian Social Democratic Party
PT	*Partido dos Trabalhadores* – Workers' Party
SGSSS	*Sistema General de Seguridad Social en Salud* - General System of Social Security in Health
SUAS	*Sistema Único de Assistência Social* – Unified Social Assistance System
SUS	*Sistema Único de Saúde* – Unified Health System
UnB	*Universidade de Brasília* – University of Brasília
USAID	United States Agency for International Development

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the intellectual, professional, and personal support provided by friends and colleagues.

Ruth Berins Collier and David Collier have had a profound impact on how I approach political science research and my development as a scholar. Ruth has supported this project with enthusiasm from the very beginning, long before I was able to articulate my ideas clearly. She has been involved integrally at every step of the way, from my first year seminar in Latin American politics, to the development of the prospectus, to field research, and finally in the writing stages. Ruth has high standards and a remarkable capacity to pinpoint the logical flaws in an argument, which ultimately made this dissertation a far better work than it might have been. I am grateful for David's s tireless advocacy for high quality qualitative research in the field of political science. Along with Ruth, David has constructed a remarkable community of Latin Americanists at Berkeley, including both current and former students.

Other Berkeley faculty also provided useful aid throughout the course of this project. Chris Ansell served as the chair of my prospectus committee and has contributed valuable suggestions about the project's framing and overall causal logic. Kim Voss gave helpful aid at early stages. While Ann Keller joined at later in the project, she was crucial in guiding me through the policy reform literature. Margaret Weir first steered me towards this literature, a suggestion that ultimately would inspire the argument developed in this dissertation.

The group of Latin Americanists at Berkeley made an indelible impact on how I understand both politics in the region and how to do political science research. This community helped me at the earliest stages of my graduate career to the end, providing insight on funding applications, research design, the logistics of fieldwork in Latin America, writing, and the job search. The five other Latin Americanists that entered the Berkeley Ph.D. with me – Miguel de Figueiredo, Veronica Herrera, Danny Hidalgo, Simeon Nichter, and Neal Richardson – provided years of friendship, support, and delicious meals. I appreciated the input given by Adam Cohon, who read and commented on several chapters. Along the way I also benefited from input from Ben Allen, Mauricio Benítez, Taylor Boas, Chris Chambers-Ju, Tasha Fairfield, Candelaria Garay, Eugenia Giraudy, Ben Lessing, Sam Handlin, Maiah Jaskoski, Diana Kapiszewski, Brian Palmer-Rubin, Mekoce Walker, Jessica Rich, and Wendy Sinek.

I have also benefited from the support of other Berkeley comparativists. Sarah Garding, Brendan McSherry, and Betsy Carter provided feedback and empathy as part of dissertation writing groups at an early (and messy) stage of the writing process. Jody Laporte and Sara Newland gave sharp and insightful suggestions on chapters.

Two Berkeley friends, and former roommates, merit extra mention. Neal Richardson helped me navigate São Paulo, Rio, and Brasília, providing research advice along the way as well as invaluable humor, kindness, and understanding along the way. I forever will be grateful for his friendship and support during that year. Jessica Rich served as both an intellectual partner and a cherished friend. Even when my thinking about this project was convoluted, she could pinpoint the most important elements of the project. Her feedback on written work was among the best I have received, while her main contributions came from in-depth discussions about my project. Jessica is also a model friend. She is hilarious and buoyant when levity is needed, and thoughtful and dependable at more serious times.

Outside of Berkeley, I have benefitted from the input and guidance of people in the United States, Brazil, and Colombia. Above all, I want to thank all of those Brazilians and

Colombians who took the time to explain their perspectives and experiences, as well as supply data and documents. Many interview respondents are cited in the text, and others shaped my understanding of participatory institutions, policy reform, and politics in general in Brazil and Colombia. This dissertation would not be possible without the help of these individuals. In Brazil, I benefited from the counsel of Adrian Gurza Lavalle and Vera Schattan at CEBRAP. Rebecca Abers dissuaded me from early and mistaken ideas about the political dynamics underlying Brazil's councils, and pointed me in more fruitful directions. Paulo Durán gave excellent research assistance and insight into the Brazilian health councils. In Colombia, Carlos Alberto Garzón Flores and Daniel Coronell helped me better understand the complexities of Colombian politics, and put me in touch with many useful contacts. I also benefited from the input and friendship of Jaime Ramirez and Bertha Niño Martinez. In the United States, Phil Oxhorn, Brian Wampler, and Kent Eaton commented on chapter drafts. Alisha Holland has served as a friend and colleague par excellence as she provided me comments on a dissertation chapter, feedback on job talks, and camaraderie. Chris Gibson has provided particularly insightful and useful suggestions given his expertise in participatory politics and health in Brazil.

I completed this dissertation while serving as a Democracy Fellow at the Harvard Kennedy School's Ash Center for Democratic Governance and Innovation. In addition to their financial support, the Ash Center has served as a wonderful intellectual setting. Archon Fung has created a supportive and stimulating environment at the Ash Center, and has offered useful suggestions on the framing of this project. Quinton Mayne and Paolo Spada were delightful colleagues that helped me sort through the complexity and messiness of my cases and distill them into an argument. I also benefited from the contributions of Shauna Shames, Emma Saunders-Hastings, Hollie Russon-Gilman, Laura Roth, Viviane Petinelli, Sean Gray, and Kivanc Ulusoy.

This project would not have been possible without financial support from donors. The Social Science Research Council and the Fulbright program funded nearly two years of field research. The UC Berkeley graduate division and the Berkeley Center for Latin American Studies helped finance preliminary field research in 2006 and 2007. The Department of Education's Foreign Language and Area Studies fellowship enabled me to travel to Brazil to learn Portuguese in 2006. The UC Berkeley political science department and Harvard Kennedy School's Ash Center provided the financial assistance during the writing stages.

A number of friends gave support at some of the more challenging times of the project, while also ensuring that my life did not only revolve around political science. Ruth Graham has been a dear friend for nearly two decades, and I am a better person because of our friendship. Fieldwork in Brazil would have been less rich without the companionship of Tricia Perry, Laura Scheiber, Kathleen Millar, Jenna Goodward, Alessandro Angelini, Jenee Slocum, and Yuri Kasahara. Special thanks are due to Natália Salgado Bueno, Nadir França, and Kristin Wylie for opening up their homes to me. In Colombia, Amy Ritterbusch, Renata Stepanov, and Candice Camargo were instant friends who added innumerably to my time in that beautiful country. To my delight, Renata joined me in Berkeley once our time in Colombia ended. In both countries and both languages she has been a great friend: empathetic, spontaneous, smart, and full of life.

I would not be where I am today without the support of my family. While she could not attend college until she was an adult, my mother insisted that I have every academic opportunity available to me. Moreover, my mother instilled in me from an early age that I should pay attention to injustices in the world and that we all have a responsibility to try to make the world a better place. It is because of these values that I became interested in Latin America in the first

place, and why I find the struggles for democracy and social justice so compelling. My sisters, Mary and Jennifer, have also had a major impact on my life, and I love them very much.

Finally, there are not enough words to express my gratitude towards my husband, Dan Burke. Not an academic, Dan has gone above and beyond in reading and commenting on my work and bearing through my political science ramblings. However, Dan's main contribution has been the sanity he has brought to my life. He has been a cheerleader when I doubted myself, a task master when I needed to write, and a distractor when I needed to put work aside. He has made my life better in immeasurable ways.

I dedicate this dissertation to those Latin Americans who fight to make the region a more just and equitable place. While in Brazil and Colombia, I met countless individuals that have dedicated their lives to make sure that democracy was not just something that existed on the books, but actually provided a voice to the voiceless. Some have risked their lives to do so. These Brazilians and Colombians have inspired and humbled me with their thoughtfulness, creativity, and dedication. They have given me hope and optimism for Latin America's future.

CHAPTER 1. THE POLITICAL LOGIC OF PARTICIPATORY POLICYMAKING

1. INTRODUCTION

When do experiments with participatory democracy take root to become legitimate institutions vested with real authority? Following the third wave of democratization in the 1980s, Participatory experiments have been adopted throughout Latin America in an attempt to reinvent democracy to be more responsive to *all* citizens – not just an elite few (Alvarez et al. 1998; Dagnino 2003: 4-5). Participatory policymaking institutions are formal, institutional spaces that engage civil society groups in policy debates and decision-making processes. According to their proponents, participatory institutions deepen democracy by expanding citizen engagement, improving interest representation, and enhancing transparency.

Participatory institutions have spread throughout the developed and developing world alike. Hundreds of cities, including New York City, Buenos Aires, Chicago, and Rome, have replicated the participatory budgeting process first introduced in the Brazilian city of Porto Alegre in 1989. Participatory policymaking is particularly strong in Latin America, where 12 countries require subnational governments to incorporate civil society organizations into the policymaking process in policy sectors ranging from health to the environment to agriculture policy.

While nationally-mandated participatory institutions have become ubiquitous throughout the world, we know surprisingly little about when and how they become institutionalized. Modifying the constitution or passing a new law is just the first step in the process of constructing participatory institutions. Yet laws alone are not enough. Institutionalization requires considerable material, human, and political investments from the government. In many cases, governments neglect to make these investments and participatory institutions exist only on paper. But in others, government *do* make the substantial investments needed for participatory institutions to gain a sustained, legitimate, and authoritative role in the policymaking process. Why would rational politicians make the costly investments needed for institutionalization given that participatory institutions – by design – limit politicians' discretion?

This study examines the political logic behind the institutionalization of participatory policymaking through a comparison of the Brazilian and Colombian cases. In the 1990s, both countries adopted elaborate legal frameworks for participatory policymaking, establishing dozens of mandatory participatory institutions in policy areas ranging from health to women's rights to urban planning. Yet despite their similar starting points, the fates of participatory institutions have diverged sharply in the two countries. Participatory policymaking in Brazil has become highly institutionalized. There, nearly all subnational governments comply with the participatory mandate. Brazilian councils have budgetary and law-making authority, and their prerogatives are protected through a variety of enforcement mechanisms. Moreover,, participatory policymaking has gained widespread acceptance as an essential component of democratic governance. In contrast, participatory policymaking has failed to become institutionalized in Colombia. Many "mandatory" councils exist only on paper. Others technically exist, but are consulted only after proposals have already been formulated – if they are consulted at all. Whereas Brazil's participatory framework has expanded into new policy areas, in Colombia there are *fewer* participatory institutions than there were in the 1990s.

Why has participatory policymaking become institutionalized in Brazil but not in Colombia? While most studies have focused on what types of politicians and civil society groups invest in participatory institutions, this project focuses on why some participatory institutions are more viable than others. I draw from the literature on policy reform and institutional change, which examines how the design of a project can unleash political forces that can ensure institutionalization of that reform. This literature explores how the design of a reform can facilitate the creation and entrenchment of a reform coalition, which in turn can ensure sustained implementation over time. In other words: policy creates politics, and vice versa.

While national participatory institutions were created with the goal of deepening democracy, this democratizing impulse is insufficient to secure institutionalization, which requires ongoing material, human, and political investments from the government. Governments will only sustain these investments when pressured to do so by a reform coalition of diverse stakeholders. I show that such a broad coalition only arises when councils are created alongside the introduction of substantive policy changes, and when elite stakeholder groups mobilize other stakeholders in support of the councils. The broad reform coalition will unite to advocate for council implementation as a means to ensure overall reform implementation, as happened in Brazil. In contrast, participatory institutions are doomed when adopted as part of reforms that seek to deepen democracy but do not shift the substance of policy. This was the case in Colombia, where the councils only attracted those stakeholders directly interested in participatory policymaking. The narrowness of this reform coalition hampered its ability to apply pressure on the government, ultimately resulting in failed institutionalization.

This introductory chapter develops the study's conceptual and theoretical framework. In the second section, I define national participatory institutions. The third section discusses the challenge of incorporating the poor into Latin American democracies, and the rise of participatory institutions to redress this problem. I then identify the project's outcome of interest: the institutionalization of participatory institutions. The fifth section shows how existing explanations cannot account for the divergence between the Brazilian and Colombian cases. I follow by developing the study's argument. In particular, I sketch the process of institutionalization, examine how reform coalitions advance institutionalization, and outline the role that reform leaders and substantive policy change play in mobilizing the kind of reform coalition needed for institutionalization. The seventh section elaborates the methodological approach, case selection, and data collection, while the final section outlines the remaining chapters of the dissertation.

2. DEFINING NATIONAL PARTICIPATORY POLICYMAKING INSTITUTIONS

Like Avritzer (2009) and Nylen (2011), I highlight the particularly *institutional* character of participatory institutions by focusing on how they distribute political power and resources. I define participatory institutions as formal, institutional spaces that engage societal groups in formulating, debating, and deciding on public policy. Participatory institutions operate within the executive branch and thus contribute to decisions about how to implement and regulate existing legislation. While involving participation from civil society, these institutions are considered to be part of the state itself.

When using the term "participatory institution" I refer to the overarching institutional framework for participatory policymaking as applied to a particular policy sector. In contrast, I use "participatory council" (or just "council") to refer to specific instances within the

participatory institution. For example, Brazil's overall system of participatory policymaking in health is a participatory institution, which in turn is composed of thousands of individual health councils, such as the National Health Council or the Municipal Health Council of São Paulo.

The institutional design and purpose of participatory institutions can vary widely. Participatory institutions may be found in any policy sector; Brazil has participatory institutions in sectors ranging from social policy to industrial policy to the justice system. Participatory institutions also can vary in terms of who participates. Councilors might only come from historically excluded groups (e.g., a health council composed only of poor patients), or may include a wide array of stakeholders (e.g. a health council composed of patients, healthcare workers, hospital associations, and pharmaceutical representatives). Councilors can include both civil society and governmental actors. For instance, Brazil's National Environmental Council includes government representatives, including those from the Ministry of the Environment and municipal governments, as well as societal stakeholders that range from environmental groups to scientific organizations to business associations. Colombia's National Planning Council, however, is composed solely of civil society organizations. Moreover, participatory institutions can fulfill a wide array of policymaking attributes. Some participatory institutions, such as Brazil's health councils, may oversee policy design and implementation for an entire sector. Others focus more narrowly on a specific program; Colombia's Medical Ethics Committees are limited to monitoring and evaluating service delivery in particular hospitals or clinics. Despite this great diversity in the policy scope, composition, and functions of participatory institutions, all share the common feature of incorporating new groups into the policymaking process.

While most literature on participatory policymaking examines local experiments with participation (e.g. Baiocchi 2005; Goldfrank 2011; Wampler 2007), this study focuses on participatory policymaking institutions that are created and regulated at the *national* level and operate throughout the country. Some councils contribute to national level policy decisions, while others act subnationally in accordance with the national legal framework. In contrast, local participatory institutions are created voluntarily by local politicians, and only operate in the narrow local jurisdiction.

National participatory institutions merit greater attention due to their broad policymaking purview. For example, Porto Alegre's participatory budgeting council, the most famous local participatory institution worldwide, managed an estimated budget of US$167 *million* in 2011 (Prefeitura de Porto Alegre 2011); in contrast, Brazil's National Health Fund, which is overseen by health councils at all levels of government, had a budget of nearly US$30 *billion* in 2010 (Ministério da Saúde 2010). Thus, national participatory institutions are a substantively important yet understudied phenomenon.

3. THE FAILURES OF INTEREST REPRESENTATION IN LATIN AMERICA AND PARTICIPATORY POLICYMAKING

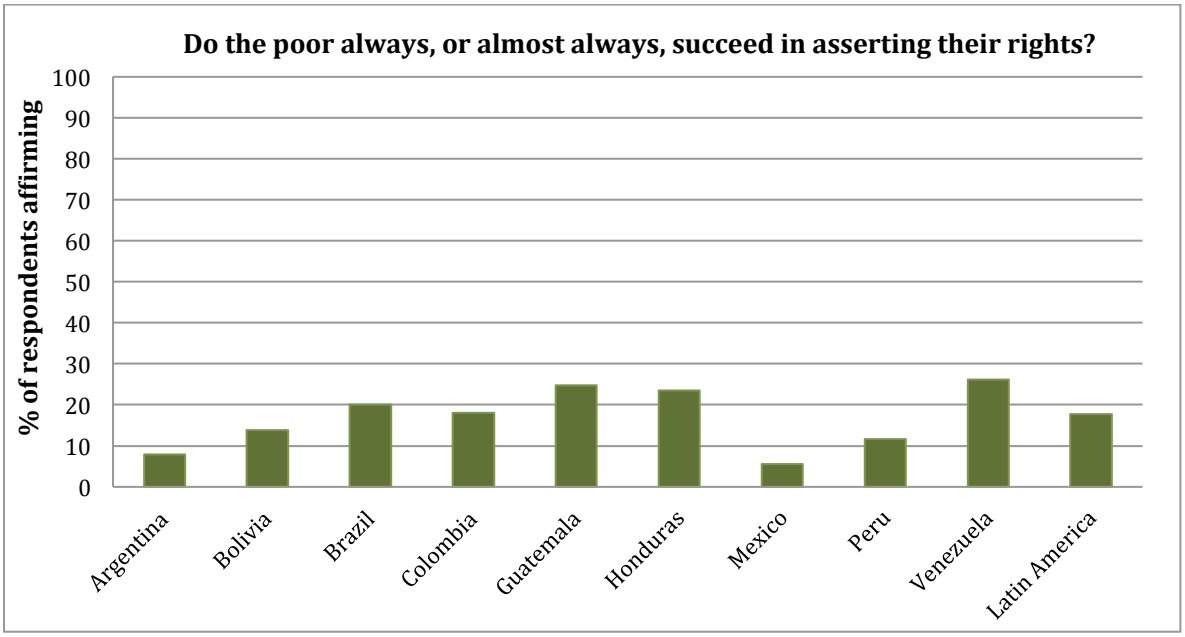
Advocates of participatory policymaking have argued that these institutions can combat the dual problems of socio-economic inequality and weak interest representation in Latin America. Participatory policymaking represents both a crucial new development for the academic study of interest representation and policymaking in Latin America, as well as a key normative development for those looking to enhance equality and strengthen democracy in the region.

For Latin American democracies, acute social stratification on the bases of class and race has made the incorporation of the poor into democratic politics particularly challenging. The democratic regimes of the mid-20th century proved exclusionary and unstable. During this period, the lower classes were incorporated into politics via state corporatism, which restricted their autonomy and narrowed their opportunities for mobilization. Labor unions served as the primary representative of the popular sectors, thereby excluding those outside of the formal labor market (R. B. Collier and Handlin 2009b). Including the poor at all – even in this restricted way – proved to be extremely contentious and caused a number of Latin American democracies to fall to military coups by the 1970s (R. B. Collier and Collier 1991; Linz 1978; G. A. O'Donnell 1973; Stepan 1973).

The new democratic regimes established in the 1980s and 1990s were designed to be more inclusive than the democracies of the past. Latin American countries dismantled corporatist institutions and adopted a "neopluralist" model of interest representation (Oxhorn 1998). Social movements, associations, and NGOs proliferated throughout the region and provided new avenues for political engagement that respected the autonomy of civil society organizations (Chalmers et al. 1997; R. B. Collier and Handlin 2009a; Eckstein 2001; Salamon 1999).

Despite this expansion of civil society activity, in some ways the popular sectors face more barriers to interest representation than in the past. They have freedom to mobilize, but in practice they are plagued by collective action problems and are excluded from major policy decisions. In public opinion surveys, the vast majority of Latin Americans believe that the poor have fewer rights and unequal access to the political system, as shown by Figure 1.1. Democracy has not yielded equal voice and rights.

Figure 1.1: Public Opinion about Political Access in Select Latin American Countries



Source: Latinobarometro 2002 data, cited in UNDP (2004:45). The Latin America score averages the scores for all 18 Latin American democracies.

The result has been a democratic political system that is unrepresentative but relatively stable. Democratic quality may be poor but the threat of long-term military rule has passed. Nevertheless, many Latin American democracies have experienced authoritarian incursions, such as the concentration of power in the executive or weak rule of law (Levitsky and Cameron 2003; McCoy and Myers 2004; G. O'Donnell 1996; G. A. O'Donnell et al. 2004; Velásquez 2006). Latin Americans have grown increasingly disillusioned and apathetic about democratic politics, even if they do not support authoritarian alternatives (Hagopian 1998; UNDP 2004).

Participatory policymaking has been promoted as a means of enhancing democratic quality and solving collective action problems in contemporary Latin American democracies. Representative institutions, such as legislatures, are inherently limited in representing the interests of all groups, over-representing the powerful and wealthy (Ackerman 2004). These limitations can be redressed through participatory institutions, which amplify the voices and access of those typically excluded from politics (Nylen 2003; Wampler 2008). Archon Fung and Erik Olin Wright explain:

> "Democracy" as a way of organizing the state has come to be narrowly identified with territorially based competitive elections of political leadership for legislative and executive offices. Yet, increasingly, this mechanism of political representation seems ineffective in accomplishing the central ideals of democratic politics: facilitating active political involvement of the citizenry, forging political consensus through dialogue, devising and implementing public policies that ground a productive economy and healthy society, and, in more radical egalitarian versions of the democratic ideal, assuring that all citizens benefit from the nation's wealth. (Fung and Wright 2003: 3)

Proponents argue that participatory institutions can alleviate inequality by granting marginalized groups greater access to state resources and by making governments more responsive to underrepresented groups (Ackerman 2004; Fung 2004; Marquetti 2003).

According to their advocates, a second salutary effect of participatory policymaking is that it makes governments more open and accountable (Nylen 2003: 14-20, 66-80). Participatory governance contrasts with "government" modes of decisionmaking which insulate bureaucracies and policymaking from societal control (Pierre 2000: 3-4; Rhodes 1998). Given the weakness of Latin American states, this insulation has facilitated the misuse of public funds and corruption. The greater transparency that comes with these institutions has the potential to limit the space for these ills (P. Evans 1996).

In a similar vein, participatory policymaking has been promoted to enhance the efficiency and effectiveness of public administration (Ansell and Gash 2007). Often, societal stakeholders have better knowledge of how policies operate on the ground than bureaucrats. Including this stakeholder knowledge will enhance efficiency. For example, some councilors from the National Rights of the Disabled Council in Brazil are themselves disabled and thus can provide useful information about the most important challenges to accessibility they face and which interventions should be prioritized. Moreover, participatory approaches draw on networked relationships between state and non-state actors to jointly address public problems, and thus can

amplify the resources dedicated to developing viable policy solutions (Imperial 2005; Peters and Pierre 1998: 223-25; Yaffee and Wondolleck 2003).

With an eye to these potential benefits, donors such as the World Bank and USAID have promoted participatory initiatives as a staple of "good governance" (Blair 2000; Cornwall 2006). As seen in Table 1.1, spending on participatory programs (called "community-driven development") from the World Bank's International Development Association grew from US$325 million in 1996 to US$2 billion in 2007, an increase of over 600%. When including funding to support an enabling environment for community-driven development (e.g. initiatives to improve transparency), support jumps to a staggering US$11.9 billion – 13% of all lending.

Table 1.1: World Bank Lending for Community-Driven Development (CDD), 1996-2007

Year	Direct Lending for CDD (billions – US$)	Total Support for CDD (billions – US$)*
1996	.325	3.0
2000	.6	4.4
2004	2	9
2007	1.6	11.9

Source: Mansuri and Rao (2004) and (2009). Data is for World Bank International Development Association lending and excludes the (more extensive) lending from the International Bank for Reconstruction and Development. Total support for CDD includes direct lending to establish and sustain participatory programs, as well as funding to promote an enabling environment for participation (support for the right to organize, the right to information, etc.) (Binswanger-Mkhize and Anklesaria Aiyer 2009; World Bank 1996).

As democratization and decentralization have deepened since the 1980s, participatory institutions have spread throughout both the developed and developing world. Participatory budgeting has spread to over 350 Brazilian cities with populations larger than 50,000 residents (Spada 2010: 3) and has been adopted in cities around the world, including Buenos Aires, Chicago, and Rome. In Latin America, all 18 democratic countries have experimented with participatory policymaking – and 12 of these countries have established national laws mandating the implementation of participatory policymaking. Moreover, participatory policymaking is not just a Latin American phenomenon; national mandates have also been instituted n countries including India, Indonesia, the Philippines, and South Africa. Moreover, participatory processes are a prerequisite for countries to receive debt relief under the World Bank's Highly Indebted Poor Countries II initiative.

Among those countries that have adopted participatory policymaking at the national level, Brazil and Colombia – the two countries examined in this dissertation – stand out as having perhaps the most ambitious and extensive national participatory frameworks. In the 1990s, both countries established legal frameworks for participatory policymaking that created dozens of participatory institutions in policy sectors ranging from social policy to the environment to planning. Given the extensive legal frameworks and popular support behind participatory policymaking, the participatory institutions in Brazil and Colombia seemed especially well-positioned to take root.

In the late 1980s/early 1990s, the two countries called constituent assemblies with the explicit purpose of reinventing their democratic systems in a way that would provide more opportunities for citizen participation and engagement in the policymaking process. Brazil's

1988 National Constituent Assembly (*Assembléia Nacional Constituinte*) established participatory democracy as a fundamental principle of the Brazilian state and mandated the creation of participatory institutions in a range of policy sectors. Brazil's 1988 constitution is called the "citizen constitution" (*constituição cidadã*) due its emphasis on participatory democracy and the ample opportunities for citizens to participate in drafting the constitution itself. The new charter marks a clear departure from the 1886 constitution, which called for a centralized and elite-centric state. The emphasis on citizen participation in Brazilian democracy can be seen throughout the constitution. The first article states that "all power emanates from the people and is exercised through elected representatives or directly…" The constitution goes on to mandate the participation of the community in policymaking for a variety of sectors, including urban planning (Article 29, section XII); agricultural policy (Article 187); health (Article 198); and social assistance (Article 204).

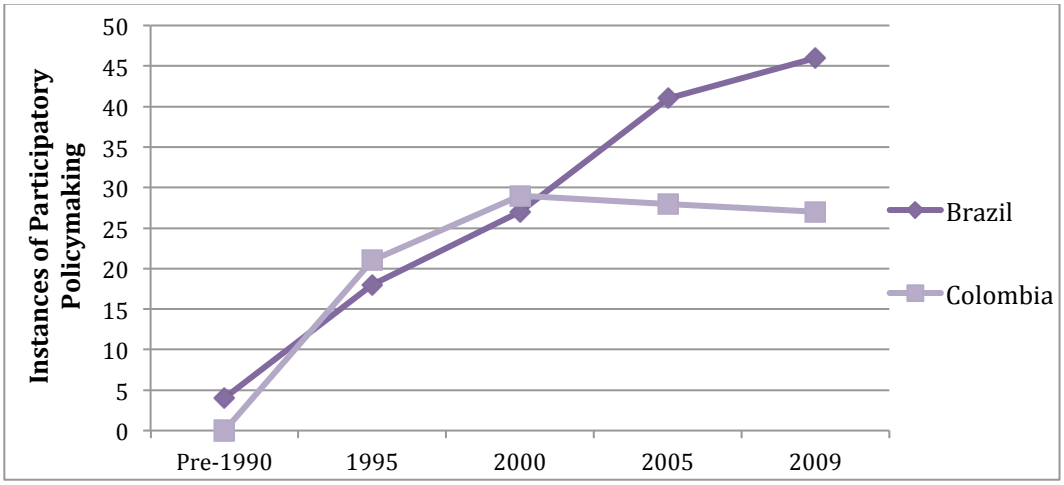
Colombia's 1991 constitution is even more explicit than Brazil's in establishing the importance of citizen participation. Articles 1 and 2 mandate that the Colombian state should be organized in a decentralized and participatory structure, and should promote and support community participation throughout all levels of government. Article 103 goes on to establish:

> …the state will contribute to the organization, promotion, and capacity building of professional, civic, labor, youth, charity, or public interest associations, without detriment to their autonomy, such that these associations constitute forms of democratic representation in the different spaces of participation, concertation, influence, and oversight of public administration that are to be established.

Similarly, Article 270 states: "The law will organize the forms and systems of citizen participation that enable the oversight of public administration implemented at the various administrative levels." Additional articles of the constitution call for the incorporation of societal participation in specific sectors, including health (Article 49), education (Article 68), the environment (Article 78) public utilities (Articles 106, 369), and planning (Articles 339-344).

Following the constituent assemblies, politicians spent the next several years creating an array of participatory institutions across diverse policy areas. When Brazil's constitution was approved in 1988, six participatory councils operated at the national level; as of 2010, this number had skyrocketed to 53 distinct types of participatory policymaking institutions across a range of policy areas and at various levels of government. As Figure 1.2 shows, Colombian lawmakers created over two dozen participatory institutions in the 1990s – fewer than in Brazil, but still an impressive number.

Figure 1.2: Instances of Nationally Mandated Participatory Institutions – Brazil and Colombia, 1990-2010



Source: Brazil: author's database of nationally-mandated participatory institutions; Colombia: Velásquez and González 2003.

As later chapters in this dissertation will show, these participatory frameworks enjoyed great popular support and political backing. In other Latin American countries, including Guatemala and Peru, participatory institutions were developed with strong backing from international donors such as USAID and the World Bank. In cases in which adoption is due to donor pressure, one could imagine that participatory policymaking might fail to become institutionalized due to a lack of domestic political support. Yet international donors only came to support participatory processes in the late 1990s and early 2000s, well after Brazil and Colombia's legal frameworks were established. Indeed, participatory policymaking was an idea with domestic, not international, roots for both countries.

Moreover, both countries appeared to have the institutional supports needed for participatory policymaking to take off. Goldfrank (2011) explains that decentralization is needed for participatory institutions to succeed, and yet the decentralizing reforms in Brazil and Colombia have been among the most extensive in the region. In 1995 subnational government expenditures totaled 45.6% of total spending in Brazil and 39.0% in Colombia, compared to the regional average of 14.6% (Daughters and Harper 2007; Inter-American Development Bank 1997: 224).

Thus, the participatory institutions in Brazil and Colombia both seemed well-positioned to succeed in providing civil society groups with access to policymaking. Yet in the years following their creation, the fate of participatory institutions diverged in the two countries. The next section will elaborate the study's outcome, institutionalization of participatory policymaking, and will show the higher levels of institutionalization in Brazil. We will see that passing legislation mandating participatory policymaking is a key first step in constructing these institutions – but it is only the first of many.

4. THE INSTITUTIONALIZATION OF PARTICIPATORY INSTITUTIONS

When does participatory policymaking go from being an idealistic reform on paper to being a legitimate and living institution? Both Brazil and Colombia established extensive participatory policymaking frameworks in the early 1990s, yet these participatory frameworks followed very distinct paths over the next two decades. Brazil's participatory institutions have developed consistent norms and practices for the councils throughout the country, whereas there is little uniformity for their counterparts in Colombia. Moreover, Brazilian participatory institutions are seen as legitimate by major stakeholders and have are included in policymaking, while participatory policymaking in Colombia is seen as an idealistic but ultimately impractical project.

The institutionalization of participatory policymaking is the outcome of interest for this study. In defining institutionalization, Offe (2006: 10) states that "Institutions are systems of *rules* that apply to the future behavior of actors. […] These rules are, consciously or habitually, observed and complied with by actors who are aware not only of the rules but also of the fact that these rules are being enforced and that deviant courses of action sanctioned." This project examines the extent to which the rules, practices, and authority of participatory institutions become an unquestioned part of the policymaking process.

Building on this framework, I utilize an approach to institutionalization that combines aspects of both rational choice institutionalism and sociological institutionalism. In particular, I assess institutionalization according to two dimensions: routinization (from rational choice institutionalism) and infusion with value (from sociological institutionalism).

This study examines institutionalization using two levels of analysis. I examine variation across countries to compare aggregate patterns in participatory policymaking *across* different countries. Analysis at the sectoral level enables us to more closely examine the micro-dynamics involved in the national pattern, and to discern different levels of institutionalization *within* each country. To capture sectoral variation in each country, I examine participatory institutions in health and social assistance in Brazil, and health and planning in Colombia.

It is important to note that this study does not focus explicitly on the influence of the councils. This is for two reasons. First, institutionalization and influence are separate and distinct concepts. While institutionalization may ultimately result in high levels of council influence on the policymaking process, influence itself is not a dimension of infusion with value. The second reason is a logistical one: measuring influence is a chronically thorny task for scholars studying interest representation and policymaking (F. R. Baumgartner and Leech 1998; McAdam et al. 1988). While some scholars of participatory policymaking have undertaken this difficult task, these studies narrow their focus to the level of the individual council as it operates in one locale (see, for example, Schattan et al. 2010; Perissinotto and Fuchs 2007). In contrast, this project uses a macro lens to examine participatory institutions as national institutions, exploring how the legal frameworks are implemented and operate throughout the country.

Below, I provide conceptual definitions of routinization and infusion with value as applied to participatory institutions. I also provide evidence that Brazil's participatory institutions have become more institutionalized than those in Colombia, despite some variation across policy sectors within each country.

4.1 Routinization

The first dimension of institutionalization, routinization, stems from rational institutionalism. Routinization focuses on the extent to which the rules of the game established by the institution are consistently applied and enforced. Routinization is defined as the extent to which the institution follows "regularized patterns of interaction that are known, practiced, and regularly accepted" (G. O'Donnell 1994). For a routinized participatory institution, the structure and practices of a council in one municipality should look comparable to those of councils on the other side of the country. I assess routinization using four criteria: the elaboration of a national regulatory framework behind participatory policymaking, the establishment of enforcement mechanisms to bolster this regulatory framework, state funding to support council operation, and government compliance with specific dictates in the regulatory framework. Below, I elaborate these criteria and show that Brazil's participatory institutions have become more routinized than their Colombian counterparts.

First, routinization requires the elaboration of national regulatory framework that provides governments with directives about the composition, structure, practices, and responsibilities of participatory councils. A clearly elaborated national regulatory framework is a necessary pre-condition for routinization because it provides a standard by which we can assess compliance throughout the country. In contrast, a vague national regulatory framework fails to specify what councils should look like or what they should do. Without clear guidelines on how to do participatory policymaking, implementation by subnational governments will vary widely. Both Brazil and Colombia established the institutional foundation behind participatory policymaking, yet only in Brazil did policymakers take the next step in elaborating a clear regulatory framework that provides the institutional guidelines needed to put participatory institutions into practice.

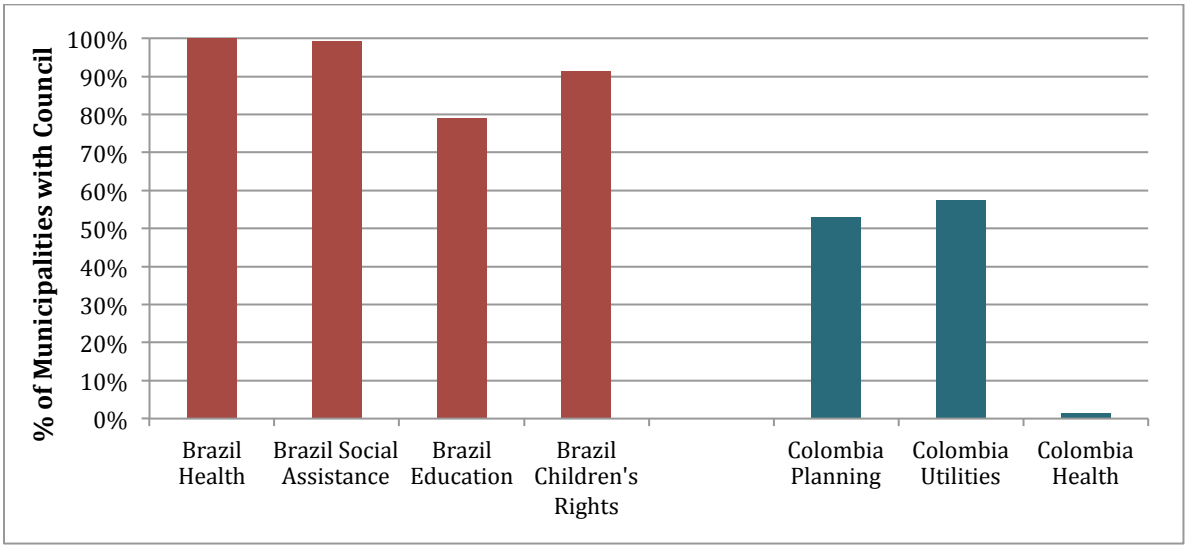
The second aspect of routinization is the presence of enforcement mechanisms for the regulatory framework. Enforcement mechanisms may include those that draw on the authority of horizontal accountability institutions such as the judiciary or public prosecutor, or budgetary incentives that make council operation a precondition for inter-governmental transfers. Enforcement mechanisms are central to routinization as a means of ensuring that the norms and procedures behind the participatory institution will be followed, even when doing so is not in a local politician's political interest. Brazil has established enforcement mechanisms that include withholding funding from governments that fail to comply with the participatory mandate, as well as other mechanisms involving the public prosecutor and the judiciary. In contrast, the Colombian legal framework has not specified potential sanctions that could be used against non-compliant governments. In fact, it is not even clear which agency is responsible for monitoring and enforcing compliance with the participatory mandate.

The third criterion behind routinization is the provision of stable government funding. To routinize, participatory policymaking councils need government funding to support the logistics of council operation, and to provide training, technical assistance, and oversight of subnational councils. This funding can come in the form of direct financing from the central government, earmarks from the central government, or a requirement that subnational governments must provide some guaranteed financing. The key factor is that funding for participatory policymaking is guaranteed in some way and is not simply subject to the discretion of subnational governments. As we will see, funding for participatory institutions is high in Brazil: the government directly invests millions of dollars into various councils, and subnational governments can take advantage of earmarks to fund their local councils. Once again, the story

is quite different in Colombia, where government funding for participatory policymaking is negligible.

The final aspect of routinization – government compliance with the terms of the regulatory framework – directly measures the implementation of participatory institutions. Do all governments (national, state, and municipal) implement mandatory councils? Do these councils exercise the responsibilities and authority formally ascribed to them? In other words, do all councils look as they are supposed to look and do what they are supposed to do in policymaking? Perhaps unsurprisingly, compliance is considerably higher in Brazil than in Colombia. The vast majority of Brazilian municipalities comply with mandates for participatory institutions in health, social assistance, education, and the rights of children, as shown in Figure 1.3. In Colombia, compliance is low. Even in the most successful policy sectors for participation – planning and utilities – the "mandatory" participatory policymaking councils operate in only around half of Colombian municipalities. The record is even worse in health, for which councils are present in only 15 of the 1080 municipalities.

Figure 1.3: Municipal Implementation of Selected Participatory Institutions



Source: Brazil: 2009 IBGE Perfil dos Municipios dataset. Colombia: Departamento Nacional de Planeación – Sistema de Información para la Captura de Ejecución Presupuestal (SICEP) 805 – 2008; Superintendencia de Servicios Públicos, Base de Datos de los Comités de Desarrollo y Control Social y Vocales de Control 2009; Ministerio de Protección Social – Encuesta Nacional de Participación en Salud 2010.

In sum, Brazil's participatory institutions prove to be considerably more routinized than their counterparts in Colombia using each of the four measures of routinization. The contrast between the two cases is summarized in Table 1.2.

Table 1.2: The Routinization of Participatory Institutions in Brazil and Colombia

CRITERIA	BRAZIL: Highly Routinized	COLOMBIA: Weakly Routinized
National Regulatory Framework	Clearly Elaborated	Vaguely Elaborated
Enforcement Mechanisms	Yes	No
Government Funding	High	Low
Compliance with Regulatory Framework	High	Low

4.2 Infusion with Value

Drawing from the sociological institutionalism literature, the second dimension of institutionalization is infusion with value. In his classic work, Selznick (1957) coined the term "infusion with value", which occurs when the institution is valued intrinsically and not just for the functions it performs. Building on Selznick's work, March and Olsen (1989) contend that institutionalization means that the institution has become part of the "logic of appropriateness" – in other words, taken for granted in how things are "supposed to be done." I assess the infusion with value of a participatory institution through two components: its legitimacy among stakeholders, and its inclusion in the policymaking process. As with routinization, Brazil's participatory institutions have a greater infusion with value than their Colombian counterparts.

I compare the national patterns of infusion with value by looking at two levels of analysis. I assess the legitimacy of participatory institutions and their inclusion in the policymaking process at a national level by looking at broad trends across a range of policy sectors. At this macro level, I am interested in the extent to which participatory policymaking, as a mode of public administration, has become infused with value. At a more micro level, I compare the infusion with value of the sectoral cases. This two-level analysis shows that despite some sectoral variation in each country, Brazil's participatory institutions are more institutionalized in terms of infusion with value than their Colombian counterparts.

The first aspect of infusion with value, legitimacy, captures whether stakeholders see participatory institutions as valuable spaces for groups in society to defend their rights. Relevant stakeholders may include politicians, bureaucrats, and societal groups such as service providers, workers, and policy beneficiaries. With a highly legitimate participatory institution, stakeholders will assert that these councils 1) deserve a central role in policymaking processes, alongside the executive and legislature, and 2) represent the public interest and not just special interests. High legitimacy means that stakeholders assume that the councils are a fixed part of the policy landscape and do not call for their elimination, even when disagreeing with council decisions.

On net, participatory policymaking has greater legitimacy as a mode of public administration in Brazil than it does in Colombia. In Brazil, no major actors question the idea that participatory institutions advocate the public interest and are an essential component of democratic rule. The legitimacy of the councils is underscored by the fact that councils are considered to be a central component of democratic public administration.

While uniformly higher than those in Colombia, the legitimacy of Brazil's participatory institutions does vary across different policy sectors. In particular, Brazil's social assistance

councils are less legitimate than the health councils. This stems from criticisms that social assistance councilors are more interested in pursuing policies that benefit their particular segment (for example, philanthropic organizations or social workers) rather than the public interest. Despite these critiques, however, no respondents questioned whether the councils should exist, and all believed that on net the social assistance councils were good for Brazilian democracy.

The legitimacy of participatory institutions is considerably weaker in Colombia, where even their proponents see participatory institutions as fatally flawed. Some even question whether the councils have damaged the quality of democracy. Policymakers see councils as neither legitimate representatives of the public will, nor as bodies that are capable of making valuable contributions to policymaking. The most influential civil society groups also have negative views of participatory institutions, which they see as co-opted by the government and ultimately a waste of their time. As in Brazil, participatory institutions in some sectors have higher legitimacy than those in others. In particular, the planning councils still command respect from some stakeholders, while the health councils reflect the national trend of low legitimacy.

The second component of infusion with value is the degree to which policymakers include councils in policymaking decisions. Participatory institutions' primary function, called the "technical core" by Thompson (1967), is engaging civil society groups in the policymaking process. Legitimacy alone is insufficient if the councils are barred from the policymaking process in practice. Do governments only comply with the most basic requirements for participatory institutions but exclude the councils when making major decisions? Or do these councils actually become central players in the policy process, developing proposals and deliberating with the government? Do policymakers voluntarily reach out to the councils to gain input or legitimacy in areas beyond those that are formally mandated?

The Brazilian councils have also gained a major role in the policymaking process: participatory institutions in a number of sectors have formal law-making and budgetary authority, and councils are included in informal policy negotiations. Council suggestions may not always be implemented, but they must be addressed.

In contrast, Colombia's participatory institutions are seldom endowed with any decision-making capacity in the policymaking process. There *is* some variation in infusion with value across policy sectors; the planning councils fare better than most Colombian participatory institutions. Nevertheless, even the planning councilors complain that their reports often go straight into the trash without being read.

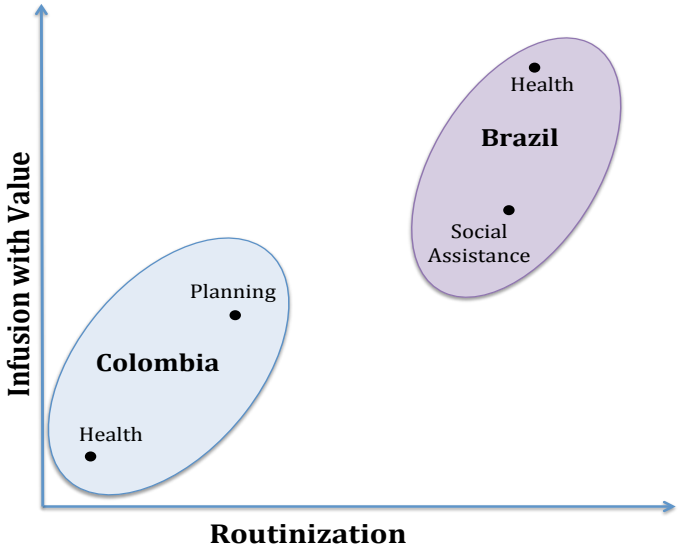
In sum, Brazil's participatory institutions have higher infusion with value than those in Colombia. These results are summarized in Table 1.3.

Table 1.3: Infusion with Value of Participatory Institutions in Brazil and Colombia

CRITERIA	BRAZIL: High Infusion with Value	COLOMBIA: Low Infusion with Value
Legitimacy	High	Low
Inclusion in Policymaking	High	Low

In sum, Brazil's participatory councils have become institutionalized in terms of routinization and infused with value, while Colombia's councils have struggled to do so. Figure 1.4 shows that institutionalization is greater in Brazil than in Colombia, while also capturing variation across policy sectors in each country. What accounts for these divergent patterns of participatory policymaking in Brazil and Colombia? And within each country, why have some participatory institutions become more institutionalized than others? In the next section, I outline the existing theories that might account for this variation and show the limitations of these explanations for the Brazilian and Colombian cases.

Figure 1.4: Routinization and Infusion with Value: National and Sectoral Cases



5. EXTANT EXPLANATIONS ON PARTICIPATORY INSTITUTIONS AND INSTITUTIONAL CHANGE

The literature on participatory policymaking provides key insights into how institutionalization happens, yet cannot explain why participatory institutions have institutionalized in Brazil while faltering in Colombia. Scholars have attributed successful institutionalization in participatory policymaking to three categories of explanations: institutional design, government will, and civil society strength. Below, I review each set of hypotheses and explain how they fall short in explaining the outcomes observed in Brazil and Colombia.

5.1 Institutional Design

Institutional design has a clear and direct impact on institutionalization, and scholars see an appropriate institutional design as a necessary but insufficient criterion for participatory policymaking (Ansell and Gash 2007; Avritzer 2009; Goldfrank 2006). Without the existence of enforcement mechanisms, politicians can implement or block councils according to their

electoral interests. If participatory institutions have no clearly established, formal authority in budgetary or other policymaking processes, governments can sideline councils from policy debates and decision-making. And if the government has the power to appoint or remove councilors, councils will have little capacity to develop autonomy.

In line with expectations, Brazil's participatory institutions have a more robust institutional design than those in Colombia. Brazilian councils have a clear formal role in overseeing the budget and the councils must approve the proposed budget in order for subnational governments to receive inter-governmental transfers. In contrast, Colombian councils lack clear responsibilities and enforcement mechanisms. Additionally, civil society groups select councilors to represent them in Brazil while the government appoints councilors for Colombian participatory institutions.

While the strength of institutional design correlates with the levels of institutionalization for the two cases, institutional design is not the *cause* of institutionalization but rather is endogenous to the process of institutionalization itself. Brazil's participatory institutions have an institutional design that facilitates greater autonomy and authority for the councils – yet why was this institutional design established in the first place? In contrast, this study examines the process of institutional construction and highlights how reform coalitions can shape institutional design over time.

5.2 Political Will

A second common theme in the participatory policymaking literature is that government will is a necessary condition for participatory policymaking to work. Participatory institutions rely on the state for resources, policy information, and access to informal debates and negotiations. Without proactive government investment, participatory institutions will never gain the authority needed to hold the government accountable (Goldfrank 2011; Nylen 2011; Wampler 2007).

Scholars have shown that governments invest in participatory institutions when they believe that doing so will advance their electoral interests (Cunill 1991; Herzer and Pirez 1991; Wampler 2007). Politicians that invest in participatory institutions typically come from the left, most famously the Workers' Party (PT) in Brazil (Avritzer 2006; Chavez and Goldfrank 2004; Nylen 2003). While many contemporary leftist parties have an ideological commitment to citizen participation, participatory innovations are typically established in response to politicians' short-term electoral interests and not due to ideology alone (Wampler 2007). Prior studies of participatory policymaking at the local level have shown that these institutions enable mayors to provide policymaking access to allied groups in civil society that can mobilize votes (Ackerman 2004; Avritzer and Wampler 2004; Goldfrank and Schneider 2006; Peruzzotti and Selee 2009).

However, the electoral linkages explanation fails to account for the difference between Brazil and Colombia. As empirical evidence from Brazil will show, it is not only leftist governments that have invested in participatory institutions. In fact, Brazil's participatory institutions expanded and strengthened most under the centrist administration of Fernando Henrique Cardoso (1994-2002), which was known for its technocratic rather than concertation-based governing style, and in fact had tense relations with several of the councils. Investment in the councils was clearly not a strategy to reward electoral allies since few councilors had voted for Cardoso; rather, most actively supported the opposition Workers' Party. Government support

for participatory institutions *was* instrumental in the institutionalization process in Brazil, but previous studies cannot explain the rationale behind this support.

5.3 Civil Society Strength

A third set of explanations cites civil society factors as the key force behind the institutionalization of participatory policymaking. Scholars have argued that without autonomous civil society organizations capable of sustained collective action, participatory institutions will either fall apart or will be co-opted by politicians (Avritzer 2006; Baiocchi 2005; Baiocchi et al. 2008; Cunill 1991; Wampler 2007). Whereas early scholars theorized that participatory institutions might democratize civil society in areas with clientelism, more recent studies have found participatory institutions only take root if vibrant associations already exist when participatory institutions are first created (Baiocchi 2003).

For the Brazilian and Colombian cases, however, the predicted impact of civil society factors is murky. Overall levels of political participation and civil society activity are comparable in Brazil and Colombia and thus do not account for the difference between these two cases (LAPOP 2009). Moreover, both countries are infamous for their hierarchical social relations and the persistence of clientelism (Hagopian 1996; Hartlyn 1988; Leal Buitrago and Dávila 1990; Mainwaring 1999; Nunes 1997). Both countries have associations engaged in clientelist dynamics, as well as more democratic organizations. Thus, it is difficult to argue that Brazil's participatory institutions have institutionalized to a greater degree because Brazilian civil society is more vibrant and democratic than that of Colombia.

Moreover, the empirical cases of Brazil's social assistance councils and Colombia's planning councils discredit the idea that civil society strength and/or prior levels of mobilization determine the path of participatory institutions. As Chapter 4 will show, social assistance is a policy sector for which civil society mobilization is extremely difficult, and historically there has been negligible civil society activity. Nevertheless, Brazil's social assistance councils have become fairly institutionalized. Conversely, Chapter 6 examines Colombia's planning councils. Grassroots groups and NGOs mobilized in support of the creation of the planning councils, and sustained this mobilization throughout the 1990s and 2000s. Prior mobilization and civil society strength was certainly higher in planning in Colombia when compared with social assistance in Brazil. Yet Brazil's social assistance councils are more institutionalized than the planning councils.

In sum, the existing literature provides important insights into the role of institutional design, government investment, and civil society characteristics on participatory policymaking. However, it falls short in explaining the causes behind the different levels of institutionalization in the Brazilian and Colombian cases. In the next section, I account for this divergence by highlighting the importance of policy reform coalitions in creating and constructing participatory institutions.

6. ARGUMENT: PARTICIPATORY POLICYMAKING THROUGH SWEEPING POLICY SECTOR REFORMS

This dissertation addresses two interrelated questions: *how* do participatory councils become institutionalized, and *why* have some institutionalized but not others? The institutionalization process is a long-term one that requires considerable investments by both government and societal actors. These investments will be sustained only when backed by broad reform coalition that includes a wide array of stakeholders that can mobilize diverse resources. I argue that these broad reform coalitions can form under two conditions. The first condition is that councils are created as part of sweeping policy sector reform that makes substantive changes to the objectives and content of public policy. The second condition is that the stakeholders leading the reform effort have a vested interest in having strong councils, and can mobilize diverse stakeholder groups to mobilize in support of both the councils and the substantive policy changes. Below, I first address the question of *how* institutionalization happens. I then explain *why* institutionalization happens. In particular, I explain why a broad reform coalition is needed to ensure institutionalization, and outline the role that reform type and leadership can play in developing the needed reform coalition.

6.1 Three Stages of Institutionalization

How does a proposal for participatory policymaking go from being an idea about democratizing the state, to functioning as a political institution? The institutionalization process happens through three stages: the creation stage, the implementation stage, and the institutionalization stage. I outline each below, focusing on the tasks that need to be accomplished at each stage. Later, we will discuss the political game between governments and reform coalitions that operates during the three stages.

Stage 1: Creation

The first stage in constructing a participatory policymaking institution is the creation stage. During the creation stage, the proposed participatory institution becomes part of the legal framework through national laws, and sometimes through constitutional changes. This initial legal framework outlines the composition of the new councils, their organizational structure, and their rights and responsibilities in the policymaking process. The councils' institutional design will be elaborated in greater detail in the implementation stage, but the core skeleton of the participatory institution should be in place by the end of the creation stage.

The main task at hand during the creation stage is to establish a strong institutional design for the new participatory councils. A strong institutional design will give the councils formal policymaking authority and substantial rights and responsibilities in the policymaking process. At this first creation stage, the Brazilian and Colombian participatory institutions diverged: Brazil's councils gained a strong institutional design, while Colombia's did not.

A number of Brazilian participatory institutions, including the health and social assistance councils, gained a strong institutional design during the creation stage. The councils were made mandatory for all municipal, state, and national governments. They were also granted formal policymaking and budgetary authority, and considerable policymaking prerogatives were outlined. Included in these prerogatives were oversight of health budgets,

contributing to the design and implementation of health plans, and the right to convoke national policymaking conferences that mobilize stakeholders in the sector.

A considerably weaker institutional design was established for Colombia's participatory institutions, including the planning and health councils examined in this study. While mandatory, most participatory institutions had few formally delineated prerogatives. Most importantly, Colombia's councils were only given consultative powers: the government was to include the councils in debates and discussions, but ultimately the councils would be impotent. Some councils, such as those in planning, were given comparatively more responsibilities – but the planning councils still lacked formal policymaking authority, and their responsibilities paled in comparison with those of the Brazilian councils.

A strong institutional design can advance future institutionalization in two ways. First, giving the councils formal authority can enhance their initial legitimacy: including the councils in policymaking is not just a nice idea, but legally mandated. Second, councilors might later use their formal policymaking authority to strengthen their institutional position and expand the councils' prerogatives in the policymaking process. A weak institutional design like those seen in Colombia might not necessarily doom a participatory institution, but it does make implementation, and ultimately institutionalization, more challenging.

Stage 2: Implementation

In the implementation stage, the legal framework established during creation is put into practice and councils begin to operate on the ground. There are a number of institutional steps that must be taken during this period to construct the councils. Councils are convened throughout the country, and councilors are selected to serve on these new councils. Both local governments and the new councilors will require some capacity building to fulfill their new institutional roles. A regulatory framework is needed to translate the general principles and responsibilities outlined in the law into more concrete guidelines about how the councils will operate and their prerogatives vis-à-vis other institutional actors. Moreover, during the implementation stage the informal rules and practices behind participatory institutions are developed. What will be the structure of council meetings? How frequently will the councils meet? And how frequently will the councils meet with government representatives – and who exactly will those representatives be? Much is up in the air during the implementation stage, and the institutional features established in this stage will set the councils either down the path towards institutionalization, or the path towards failed (or incomplete) institutionalization.

Undertaking these steps requires considerable government investments. These investments were more forthcoming in Brazil than in Colombia. Material and human investments include funds for basic council operations, headquarters, and staff. Moreover, resources are needed to provide training on the logistics of the policymaking process, the legal system, and how participatory institutions will operate. Political investments are also required. The administration must limit its own discretion by including the councils in policymaking decisions if the council is to gain legitimacy as a policymaking actor. This is particularly costly when the council criticizes the government and/or opposes its policies. Without these investments, it will be difficult for participatory institutions to establish regularized norms, practices, and roles in the policy process.

Stage 3: Institutionalization

By the institutionalization stage, the bulk of the institution-building work has already happened. This is the point at which we can ask whether or not the participatory initiative has become institutionalized. During implementation, that question is still premature. By the institutionalization stage, however, considerable material, human, and political resources have been invested in the councils already.

If the councils are on their way towards institutionalization, positive feedback effects should kick in as participating groups see their material and/or political objectives met and as the councils begin to serve a focal point for state-society interaction in policymaking. The councils will have become the site where civil society groups go to shape policy, and where the government goes to gain societal buy-in on its policy proposals.

Two types of positive feedback effects can kick in during the institutionalization stage. First, supporters of participatory policymaking will have a greater capacity to invest in the councils and pressure the government to do so as well. Council participation will have increased the material, organizational, and symbolic resources of councilors. Serving together as councilors can also help forge a shared identity, thereby facilitating collective action. Second, both stakeholder groups and government actors will have a greater incentive to invest in the councils as they increasingly become a focal point for state-society interaction. Even groups that originally had little vested interest in the councils will gain one as they recognize them as sites where they can influence policy. For example, conservative political parties might try to mobilize their supporters to participate on the councils, lest rival parties gain an advantage.

Conversely, negative feedback effects can also kick in during the institutionalization stage. The welfare state literature points to negative feedback effects that repress political mobilization in some sectors (Soss 1999, 2000). If by the institutionalization stage the participatory institution has provided civil society groups with negligible access to policymaking, even its advocates may stop investing in it. During the implementation stage, these original backers might have invested heavily in the councils, even if doing so did not immediately pay off. Yet if after several years the councils still have not developed a reputation as a site for policymaking access, original supporters may start to defect. Governments then will have less of an incentive to invest in the councils. Without the respected civil society groups, the councils will struggle to produce high-quality policy proposals. The councils will fail to provide legitimacy for the government, since they no longer represent civil society as a whole. Weakening of government support will lead to further defections, and so on in a negative feedback cycle. Over time, the councils may still survive and continue to operate; indeed, Colombia's planning councils still exist, albeit in a weakened state. However, these councils continue only with the support of the "true believers" who continue to participate due to personal convictions, even when the councils have not yielded any clear benefits in practice.

For Brazil's participatory institutions, positive feedback effects began to kick in, leading to institutionalization. There is some variation in the degree of institutionalization; feedback effects have been stronger in the health sector than in the social assistance sector. Still, on net, Brazil's participatory institutions have become institutionalized, both in terms of routinization and infusion with value. In Colombia, however, negative feedback effects ultimately resulted in deinstitutionalization (in the case of Colombia's health councils) or incomplete institutionalization (in the case of Colombia's planning councils).

6.2 The Need for Broad Reform Coalitions

Having explained *how* the process of institutionalization happens, we now explore *why* institutionalization happens in some cases but not others. Scholars have noted that the key to sustaining implementation of a public interest reform is the mobilization of a coalition of stakeholders with a vested interest in the reform (F. Baumgartner and Jones 1993; Patashnik 2008; Schattschneider 1960). Groups that benefit from the status quo will resist change and are in a privileged position to block reform attempts. Even if politicians initially supported the reform, their backing may fade once the most visible moments of reform have passed. A strong reform coalition can ensure reform implementation by countering entrenched interests and applying consistent pressure on politicians and bureaucrats. Below, I explain how a broad reform coalition composed of diverse stakeholders contributes to the institutionalization process.

There are three categories of explanations that account for how reform design can mobilize the stakeholders needed to ensure reform implementation: if vested interests from the old system are permanently and structurally weakened, if the reform is accompanied by supportive shifts in the political/institutional environment, and if the reform can develop positive feedback effects by mobilizing new supporters. Combined, these explanations suggest that reforms will take root only in the presence of a disruption of the existing interest representation order.

First, a reform that permanently and structurally weakens its opponents will have a greater chance of taking root through a process that Patashnik (2008) calls "creative destruction." Often, those who benefitted from the old status quo stand to lose if reforms are implemented: "major reform in a policy field already well populated by public or private arrangements is bound to encourage resistance from powerful stakeholders already organized around prevailing approaches" (Heclo 1996). For example, neoliberal reforms implemented in Latin America weakened the labor unions that had (unsuccessfully) opposed the economic reforms; trade and labor liberalization led to a decline in union membership. Neoliberal reforms had structurally weakened the unions and therefore secured the continued implementation of that economic model. A participatory reform that can displace or even eliminate the interest groups that were active before will have a greater chance of taking root.

Second, "a reform has better odds of sticking, and of serving as a platform for reinforcing policy changes over time, if its passage occurs simultaneously with supportive shifts in its structural environment." (Patashnik 2008: 26) Such changes can include strengthening the governing capacity of those charged with implementation (Skowronek 1982), eliminating "cozy policy subsystems" and "iron triangles" which can subvert a reform from within (McCubbins et al. 1987; Moe 1990), lowering or raising transaction costs to make the reform sticky (Dixit 1996; Epstein and O'Halloran 1999), or shifting control over the policy area to a new political venue (F. Baumgartner and Jones 1993). For each of these changes, the key is to block those that seek to undermine the participatory reform while strengthening the position of stakeholders in support of participatory policymaking.

Third, reforms are more likely to succeed when they give rise to positive feedback effects that expand and strengthen the reforms' beneficiaries and supporters. Scholars such as Andrea Louise Campbell (2003, 2012), Suzanne Mettler (2005), and Paul Pierson (1994, 2006) have noted that certain distributional reforms, such as those related to the welfare state, can provide beneficiaries with a shared identity, enhanced resources, and a deepened interest in the policy

area. In other words, policy reforms can actually change actors' preferences, as well as their political actions.

Beyond these disruptions in patterns of interest representation, mobilization by a pro-participation reform coalition is needed to construct the participatory institution. Broad reform coalitions, or those that include many different types of stakeholders, can sometimes be more effective than more narrow coalitions. Brazil's health councils serve as an example of a broad reform coalition; the coalition included municipal governments, grassroots organizations, unions, health professionals and academics, and activist bureaucrats. A narrow reform coalition has more homogenous members. For instance, Colombia's participatory planning reform coalition struggled to expand beyond grassroots organizations and NGOs. Alternately, a participatory institution could be created from above without the backing of *any* reform coalition in society, as was the case with Colombia's health councils.

A broad reform coalition can facilitate the institutionalization of participatory policymaking by drawing on diverse resources given the heterogeneity of their members. This is because a range of organizational, symbolic, and informational resources are needed at the creation and implementation stages. Below, I outline the resources needed in the creation and implementation stages to ensure institutionalization (see Table 1.4).

Table 1.4: Resources Needed during Creation and Implementation Stages

	Creation Stage	Implementation Stage
Organizational	X	X
Symbolic	X	X
Informational		X

In the first stage, creation, having a broad reform coalition can support the establishment of a strong institutional design. At this stage, organizational resources are needed to stage large-scale demonstrations. These demonstrations apply pressure on politicians and keep discussions about how to design the councils out in the public sphere. Mobilization will be even more powerful if the coalition can access salient symbolic resources as well. A very broad coalition has legitimacy in claiming to speak for "the people," and therefore can tap into symbols associated with deepening democracy, citizenship, and the public interest. These symbols will hold particular cache at certain periods in time, such as moments of democratic transition – including those experienced by Brazil and Colombia in the late 1980s and early 1990s. Thus, the reform coalition has the opportunity to present its reform project as synonymous with democratic opening. A broad reform coalition could therefore maintain control of the agenda during deliberations about how to structure the participatory institution at hand.

Having a broad reform coalition becomes even more crucial during the implementation stage. The geographic coverage that comes with a broad coalition increases monitoring of subnational governments, while organizational, symbolic, and informational resources are needed to ensure the construction the national system of participatory councils.

First, a reform coalition with broad geographical coverage can monitor policy implementation and hold local governments accountable (Rich 2012). Particularly in the context of weak institutions in Latin America, mandating a major reform does not guarantee its

implementation. Decentralization can exacerbate the challenges of implementation due to the increased number of points where the system of councils could be undermined. Broad reform coalitions provide extra eyes and ears on the ground, thereby enhancing the regulatory capacity of the state. This increase in regulatory capacity is particularly important when the state cannot, or *will* not, monitor subnational governments for compliance with the participatory mandate.

Second, organizational and symbolic resources remain important for sustaining collective action. Even a government that supports participatory policymaking in theory may not always want to invest resources in bodies that challenge government proposals and criticize its performance. The reform coalition will need to apply pressure on the government to fulfill its obligations and continue to invest material, human, and political resources in the councils as they begin operation.

Third, a reform coalition with informational resources can provide positive incentives for the government to invest in the councils. If councilors possess unique information or expertise, they can produce policy proposals needed by the government to achieve its policy objectives. In his study of American bureaucracies, Carpenter (2001) demonstrates that organizations that present themselves as filling an unique role have a greater chance of institutionalization, since they can meet a specific need that no one else can. In the case of participatory policymaking, these informational resources are key in winning the support of bureaucrats. Support from bureaucrats is key in ensuring that councils are included in policy discussions, or at least know when they are not being included. Hostile bureaucrats can easily undermine the councils by withholding material or human resources, concealing information that the councils need to do their jobs, and excluding the councils from informal policy debates and decisions. Therefore, having informational resources that lead the councils to produce valuable contributions to public policy is crucial to the participatory institution's legitimacy, and its overall survival.

6.3 Constructing Broad Reform Coalitions through Sweeping Reforms and Leadership

After identifying the relationship between the breadth of the reform coalition and institutionalization of participatory policymaking, the question remains: Why does a broad reform coalition form in support of participatory policymaking in the first place? Why did Brazil's health and social assistance sectors develop broad reform coalitions, while those in Colombia were either narrow (in the case of planning) or non-existent (in the case of health)?

This study points to two explanatory factors: 1, whether reform is sweeping or procedural – i.e., whether the reform introduces substantive policy changes in addition to the procedural shift of creating councils; and 2, the presence of reform coalition leaders with a vested interest in having strong councils. Table 1.4 reviews the argument as applied to the four sectoral cases of this study. In contrast, institutionalization *can* result when participatory policymaking is embedded in a sweeping sectoral reform and advocated for by reform leaders, as with the Brazilian health and social assistance councils. In contrast, Colombia's planning councils show that institutionalization is difficult for participatory institutions introduced through procedural reforms. If it were not for the leadership of pro-democracy NGOs that mobilized grassroots organizations, the planning councils would not even be partially institutionalized, as they are today. Without the engagement of pro-participation reform leaders, a sweeping policy sector

reform alone is not enough to spark a broad reform coalition that supports councils. This was the case with Colombia's health councils, which failed to institutionalize altogether.

Table 1.4: Argument: Reform Type, Pro-Participation Leadership, and Institutionalization

		PRO-PARTICIPATION LEADERSHIP?	
		Yes	**No**
REFORM TYPE?	**Sweeping Reform: Procedural + Substantive**	**Brazil Health** ▪ Highly Institutionalized **Brazil Social Assistance** ▪ Institutionalized	**Colombia Health** ▪ Not Institutionalized
	Procedural Reform	**Colombia Planning** ▪ Partially Institutionalized	

Explanatory Factor #1: Sweeping Policy Sector Reforms

First, I explain the trajectories of participatory institutions by pointing to their reform origins. This study draws on scholarship from the policy reform literature that highlights how the content of the reform project can give rise to an associated mobilizational politics (Lowi 1964). This literature also emphasizes that reforms will be dead in the water unless stakeholders support or at least acquiesce to the reform (F. Baumgartner and Jones 1993; F. R. Baumgartner and Leech 1998; F. Baumgartner and Jones 2002). Combining these two findings raises the question: what types of reforms are most likely to create the conditions needed for the institutionalization of participatory policymaking?

I contend that participatory institutions only become institutionalized when they are created as part of a larger policy reform that can create enough disruption to upset the existing logic of interest representation. In particular, I point to the depth of the reform, or the degree to which the reform challenges the existing policy paradigm. Hall (1993: 278) argues that "We can think of policymaking as a process that usually involves three central variables: the overarching goals that guide a policy in a particular field, the techniques or policy instruments used to attain those goals, and the precise settings of these instruments." Drawing on Hall's categorization, I distinguish between three types of policy reforms: content reforms, procedural reforms, and sweeping reforms (see Table 1.5).

Table 1.5: Three Types of Policy Reform

Content Reform	Procedural Reform	Sweeping Reform
Changes *content* of public policy	Changes *instruments* of policymaking	Changes *objectives, content, and instruments* of public policy
Example: N/A	Example: Colombia's participatory planning reform	Example: Brazil's health reform

The most basic policy reform, a *content reform*, changes the instrument settings of public policy – in other words, changing the "what" of public policy. Examples of content changes

include an increase in the minimum wage or a new environmental regulation. The policy itself is altered, yet the means of formulating public policy or their core logic remains the same. By definition, content reforms never create participatory institutions, which change the means by which policy is developed, not just its content.

The second kind of policy reform, a *procedural reform*, entails shifting the instruments of policymaking. A procedural reform changes the "how" behind the formation of policy. Participatory institutions are often created through procedural reforms: the instruments of policymaking shift with the introduction of participatory councils, while the underlying objectives of the sector remain the same. Examples include the reforms behind most of Colombia's participatory institutions, including the planning councils, as well as recent legislation in Guatemala and Peru that mandates participatory budgeting for all municipalities. In procedural reforms, participatory institutions are created as a means of redressing some type of democratic deficit. Thus, the instruments of public policy should shift to include new actors in the policymaking process, but there is no need to change the content or objectives of the policy sector. For example, the creation of Colombia's participatory planning councils changed the policy instruments of planning by including civil society groups in discussions for the first time, though the underlying logic and structure behind the planning system remained the same.

Institutionalization is challenging when participatory institutions are established through a procedural reform. This is because procedural reforms only attract a narrow reform coalition of those that have a direct stake in the fate of the participatory institution. Other actors might passively support the councils, but not enough to mobilize resources in defense of the councils. Moreover, procedural reforms are relatively less disruptive than the sweeping reforms described below: changing the instruments of policymaking does not introduce new stakeholders and does not change the agenda at hand, just the sites where the agenda is discussed. Layering a participatory institution onto an existing policy sector fails to mobilize enough supporters and neutralize potential enemies, leading the government to fail to invest the resources needed for institutionalization.

The final type of policy change, a *sweeping reform*, involves substantive shifts in the objectives and content of public policy, as well as its policymaking instruments. A sweeping policy sector reform redefines the "why" behind the policy are, leading to a reorganization of the policy sector as a whole. Like the procedural reforms observed in Colombia, these reforms seek to democratize the state through the creation of participatory councils. Yet these sweeping reforms go a step further by redefining the objectives behind the policy sector. Brazil's participatory institutions, including the health and social assistance councils, arose through sweeping reforms. For instance, Brazil's health reform initiated new preventative health programs (change in content), devolved power to municipal governments and created health councils (change in instruments), and shifted the logic behind the health system from a curative and exclusionary model, to a preventative and rights-based model (change in objectives).

Participatory institutions created through a sweeping reform, such as Brazil's health and social assistance councils, have a greater opening for institutionalization. Provided that the participatory institution is a central component of the reform, reform proponents may band together in defense of the participatory council. This broad alliance can happen even if some members of the reform coalition are indifferent (or even opposed) to the idea of participatory policymaking. There is no guarantee that broad reform coalitions will succeed in their quest for

reform implementation, but they will have a greater chance than the more narrow coalitions that formulate around procedural reforms. Furthermore, sweeping policy sector reforms provide considerable disruption with the creation of new programs, introduction of new stakeholder groups, and shifting frames. These disruptions create openings for the councils to enter the scene.

Explanatory Factor #2: Pro-Participation Reform Coalition Leadership

Nevertheless, sweeping reforms will not *necessarily* lead to the institutionalization of participatory policymaking; the leaders of the reform coalition must also have a vested interest in the success of the councils. These reform leaders play a crucial role in mobilizing stakeholders into a reform coalition, and ensuring that this reform coalition mobilizes behind the construction of participatory councils in particular.

This factor explains the divergence between the Colombian health and planning councils. The procedural nature of the planning reform made it difficult to mobilize stakeholders, yet the NGOs behind the participatory planning reform ensured that at least a narrow reform coalition formed. These reform leaders traveled throughout the country to provide training and technical assistance to subnational councils, and established a shared discourse for members of the reform coalition to use. As a result, the planning councils became partially institutionalized when they might have collapsed altogether.

In contrast, Colombia's health councils lacked reform leaders that favored strong councils, resulting in failed institutionalization. Colombia's universal, marketizing health reform from the early 1990s was a sweeping one that restructured the health sector and created local health councils. Yet unlike in planning, no one in the health reform coalition (largely composed of private sector actors) had a vested interest in the councils. These groups mobilized in support of health reform implementation, but their vision of implementation did not necessarily include councils. Consequently, when the health councils stalled this did not threaten their interests. The Colombian health councils were tacked onto the sweeping health reform, but were not a central part of the sweeping nature of that reform.

7. RESEARCH DESIGN AND DATA

7.1 Case Selection

This project utilizes a nested small-n case comparison to study the institutionalization of participatory policymaking institutions, comparing the national patterns of Brazil and Colombia as well as variation across policy sectors within each country. The small-n method enables the researcher to decipher causal mechanisms in complex political processes that unfold over an extended time period (Brady 2004; D. Collier and Mahoney 1996; George and Bennett 2004: 21-22; Mahoney and Rueschemeyer 2003: 12-14). Moreover, this study's argument points to feedback mechanisms that operate over time, which are best studied through an analysis of a small number of cases (Mahoney 2000; Pierson 2003: 198-203; Thelen 2003).

In selecting the cases for this study, I utilized the most similar systems design, which entails selecting cases that are comparable on many potential explanatory factors, yet have experienced different outcomes. For the national comparison, I selected from the universe of the 11 Latin American democracies that have national legal frameworks for participatory

policymaking, utilizing two criteria: whether the country was an early adopter of participatory policymaking, and whether the country adopted participatory institutions across many policy sectors. First, I narrowed the cases to those that had been early adopters of participatory policymaking (1990s) to have a sufficiently long period of time to analyze the construction and evolution of these institutions. It is still too early to draw conclusions for those countries that established participatory institutions in the past decade, such as Bolivia and Venezuela. Second, I limited case selection to those countries with a broad policy scope for participatory policymaking, defined as having participatory institutions in at least three major policy sectors. A broad scope suggests that the creation of participatory institutions was a coordinated strategy by politicians to restructure interest representation rather than just a passing fad. As Table 1.6 shows, only Brazil and Colombia meet both conditions.

Table 1.6: Country Case Selection

	Broad Scope	Narrow Scope
Early Adopter	**BRAZIL** **COLOMBIA**	*Costa Rica* *Nicaragua*
Late Adopter	*Bolivia* *Venezuela* *Ecuador*	*Argentina* *Dominican Republic* *El Salvador* *Guatemala* *Peru*

For the within-case comparison, I compare the institutionalization of participatory institutions across different policy sectors in each country. I selected policy sectors that vary in terms of civil society mobilization in support of participatory policymaking to highlight the role of bottom-up pressures on institutionalization: health and social assistance in Brazil, and health and planning in Colombia. Moreover, policy sectors merit particular attention as the most well known and prototypical councils for the two countries. Participatory institutions in these policy areas have served as models for those in other sectors within the same country and shape the overall legitimacy of participatory policymaking as a mode of public administration. Thus, these sectors can be considered critical cases in understanding national patterns of participatory policymaking.

7.2 Data Collection

This study draws on quantitative and qualitative data collected during two years of field research in Brazil and Colombia. I observed participatory council meetings at municipal and national levels of government to gain an inside perspective on the institutional practices and dynamics within the councils. To similar ends, I conducted semi-structured, in-depth interviews with over 150 politicians, party leaders, bureaucrats, civil society actors, and academic experts. I also draw on archives from ministries, participatory councils, the legislature, and media sources that recount policymaking processes, and the involvement of councils in these processes. In order to assess the institutional design of participatory policymaking across policy sectors, I

compiled an original dataset of the institutional characteristics of national councils in Brazil; this dataset complements a similar one I used for Colombia (Velásquez and González 2003). Finally, I utilize quantitative datasets of social spending, participatory council characteristics, and government transparency to assess council implementation.

8. OVERVIEW OF DISSERTATION

This dissertation is organized into eight chapters. The second chapter examines the trajectory of participatory institutions in Brazil. Why were participatory institutions adopted in Brazil? And why did they gain such a central role in policymaking? I show that Brazil's national participatory framework has proven successful due to its origins in sweeping social rights reforms that tied participatory policymaking to substantive policy changes. Brazil's participatory institutions were adopted in response to dual legitimacy crises, which linked the country's political exclusion with its social exclusion. These social rights reforms addressed the political exclusion by extending new spaces for participation via councils, while also making substantive changes in the objectives and content of public policy. By the late 1990s participatory policymaking had become part of the logic of appropriateness – the accepted ideas about how policymaking ought to be done. This lowered the costs, and increased the political benefits, of creating and implementing new councils. Participatory policymaking spread into new policy areas, and existing participatory institutions consolidated further.

The third chapter analyzes Brazil's participatory health councils, the most successful case of institutionalization in this study. This chapter traces the institutionalization of Brazil's health councils to the two main explanatory factors of this study: the presence of a sweeping policy sector reform and the active support of elite reform leaders. The health councils were created as part of a sweeping policy sector reform that also made substantive changes to the objectives and content of health policy. This sweeping reform disrupted existing interest group dynamics in the sector, thereby creating a potential opening for the health councils. This opening was seized due to the leadership of pro-participation elites in the sector, who had a vested interest in having strong health councils. These elite reform leaders brought together a broad reform coalition composed of various stakeholders, including public health professionals, community organizations, unions, subnational governments, and progressive politicians from the opposition. The broad reform coalition was able to mobilize diverse resources to support the creation and implementation of the health councils, despite political opposition. Over time, the health councils became focal points for state and civil society interaction as both sets of actors, resulting in positive feedback effects and ultimately institutionalization.

In Chapter 4, I take advantage of variation across policy sectors to test the study's argument. Brazil's social assistance councils provide a surprising case of institutionalization, giving the historical weakness of civil society in the sector and the lack of government support. I argue that the institutionalization of Brazil's social assistance councils can be traced to the sweeping nature of the social assistance reform, which resulted in the mobilization of a broad coalition composed of diverse stakeholders. While many members of the coalition were primarily concerned with the reform's substantive changes, the coalition also mobilized behind the social assistance councils due to the leadership of social assistance professionals who constructed a shared participatory discourse and brought together groups throughout the country.

These stakeholders invested in the new system, and in the councils as a means of securing a seat at the table in decisionmaking, resulting in institutionalization. The social assistance councils were somewhat less infused with value compared to their counterparts in health, a difference that can be explained by pointing to the relative incoherence of the social assistance reform coalition that stemmed from ideological divides between the original reform leaders and service providers. These divisions challenged the social assistance councils' legitimacy as the voice of the public interest, leading to only moderately high infusion with value.

Chapter 5 reviews the Colombian national case of participatory policymaking. Colombia's participatory institutions arose from a series of democratizing reforms that sought to change the *process* of policymaking but not its content or objectives. By the mid 1990s, policymakers established an elaborate framework for participatory policymaking - yet this framework never took root. I demonstrate that participatory policymaking was adopted in Colombia not *in spite of*, but rather *because of*, its legacy of restricted democracy. The reforms that created participatory institutions sought to change the procedures behind policymaking, but not the objectives and content of policy sectors. Early stumbles in implementing participatory institutions damaged the legitimacy of the very idea of participatory policymaking. Both government and civil society investment began to drop off, resulting in a failure to institutionalize the councils.

The sixth chapter examines in greater detail how the procedural – rather than sweeping – nature of Colombia's planning reform failed to attract a broad reform coalition. Since the participatory planning reform made negligible substantive changes to planning, only those that supported participation for participation's sake mobilized in support of the planning councils. The fact that the planning councils became institutionalized at all can be attributed to the actions of pro-participation elites from NGOs, who were instrumental in building up a narrow but potent reform coalition. These elites mobilized grassroots groups throughout the country, provided a shared discourse for those in the participatory planning movement, and constructed a national network of planning councils.

In Chapter 7, I explore the case of Colombia's health councils. At first glance, this case appears to go against this study's argument: the Colombian health reform was a sweeping one, yet these councils are the least successful case of this study. The health councils failed to institutionalize because no reform leaders stepped forward in support of the councils. Whereas Brazil's health and social assistance reform leaders viewed strong councils as crucial to achieving their substantive policy objectives, here the private sector actors that led the reform coalition would benefit more if the councils remained weak or non-existent. The absence of a pro-participation reform coalition meant that the government had few incentives to invest in the health councils. Orphaned by both state and societal actors, the health councils quickly decayed and ultimately failed to become institutionalized.

The final chapter reviews the study's argument, highlighting the importance of substantive sectoral reforms and the role of elite leaders in mobilizing reform coalitions. It also discusses the implications of this study for larger questions of interest representation and democratic quality.

PART I. BRAZIL: BROAD STAKEHOLDER COALITIONS AND INSTITUTIONALIZATION

In the 1990s and 2000s, Brazil constructed an elaborate participatory policymaking framework, establishing councils in dozens of policy areas that range from health to the environment to foreign trade. These councils were assigned broad responsibilities, and a number have formal policymaking and budgetary authority. The councils enjoy a high level of legitimacy and are seen as central and accepted players in the policymaking process. For example, 99% of Brazilian municipalities comply with the mandate for participatory councils in health and social assistance. Indeed, Brazil is the world leader in national participatory policymaking; in no other country are participatory councils so widespread and so important to the policymaking process.

Why were participatory institutions adopted in Brazil, and how did they expand to cover so many policy areas? How and why did Brazil's councils take root, when their counterparts in Colombia faltered? And what explains the different levels of institutionalization of participatory policymaking across different policy sectors? The three chapters in this section examine these questions by analyzing the general Brazilian experience with participatory policymaking, and the construction of councils in the health and social assistance sectors.

Chapter 2 analyzes the trajectory of participatory policymaking in the country as a whole. This chapter demonstrates that Brazil's participatory institutions were adopted in response to legitimacy crises on two fronts: political exclusion and social exclusion. These social rights reforms addressed the political exclusion by creating the councils as new spaces for participation, while also making substantive changes in the objectives and content of public policy. This chapter goes on to show how participatory institutions diffused to new policy areas, beyond those stipulated in the initial legal framework. By the late 1990s participatory policymaking had become part of the logic of appropriateness, or the accepted ideas about how policymaking is supposed to be done. The growing acceptance of participatory policymaking lowered the costs, and increased the political benefits, of creating and implementing new councils.

Chapters 3 and 4 examine the institutionalization process in greater detail for health and social assistance – two policy sectors in which participatory policymaking has become institutionalized. In line with this study's argument, participatory councils in the two sectors became institutionalized due to two factors: a policy sector reform that shifted both the procedures and substance of public policy, and the support of elite reform leaders that helped define the reform agenda and overcome collective action problems. Combined, these two factors sparked the mobilization of powerful reform coalitions that successfully pressured the government to make the investments needed for the participatory health and social assistance councils to become institutionalized.

In both sectors, the sweeping nature of social rights reforms stimulated the formation and persistence of pro-participation reform coalitions. These sweeping policy reforms disrupted existing interest group dynamics, thereby creating a potential opening for the health councils. The reforms also led to alliances among dissimilar stakeholders in the sector that had little in common except their shared interests in the implementation of the sweeping policy sector reform. In health, this reform coalition consisted of public health professionals, community organizations, unions, subnational governments, and progressive politicians – groups that all had

a stake in the implementation of the new health system. Likewise, the social assistance reform coalition was composed of an array of different stakeholders in the sector, including social workers, philanthropic organizations, and beneficiary groups such as movements representing the disabled and the homeless. These broad reform coalitions mobilized diverse resources to ensure the creation of the health councils despite political opposition.

However, the sweeping nature of the health and social assistance reforms is insufficient to explain why these broad reform coalitions mobilized in support of the councils specifically, instead of just advocating for the implementation of the substantive policy changes. In both health and social assistance, and in other policy areas that created participatory institutions in the 1990s, the reform movement was led by elite professionals that saw strong participatory councils as key to ensuring reform implementation on the ground. These leaders brought together the diverse stakeholders under a shared reform agenda that included strong participatory councils, which would serve as the site for battles about reform implementation. These reform coalitions were able to advocate for a strong institutional design for the councils, and successfully pressured governments to invest material, human, and political resources into the health councils, ultimately resulting in their institutionalization.

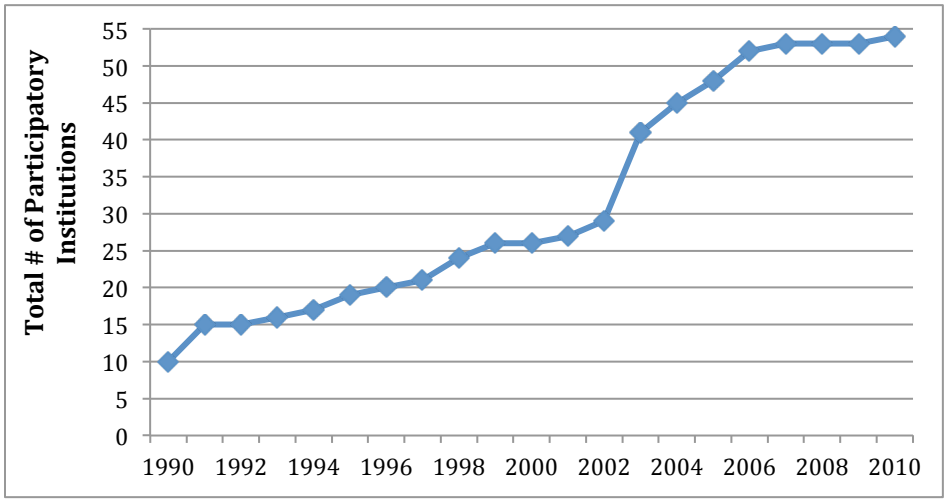
While participatory policymaking became institutionalized in both policy sectors, the health and social assistance councils did vary in their *extent* of institutionalization. While both participatory institutions became routinized, the health councils are more infused with value, with a higher degree of legitimacy and a more central role in the policymaking process than the social assistance councils. Chapters 3 and 4 explain these distinct outcomes by pointing to role that reform coalition coherence plays in value infusion. While the social assistance reform coalition was broad, it lacked the coherence seen in health due to ideological divides between the original reform leaders and service providers. These divisions in the reform coalition challenged social assistance councils' legitimacy as the voice of the public interest.

CHAPTER 2. BRAZIL: LEGITIMACY CRISIS WITH DEMANDS FOR SOCIAL REFORM

1. INTRODUCTION

After struggling to incorporate the popular sectors into politics for most of the 20th century, in the 1990s and 2000s Brazil went on to construct the most expansive and institutionalized participatory framework in the world. Brazil's 1988 Constitution establishes participatory democracy as one of the fundamental pillars of Brazilian democracy, an ideal that was made concrete with subsequent legislation from the early 1990s. As Figure 2.1 shows, participatory policymaking continued to expand into new areas in the two decades throughout the 1990s and 2000s; the number of nationally-mandated participatory institutions skyrocketed from six in 1988, to 53 as of 2010.

Figure 2.1: Growth of National Participatory Institutions – Brazil, 1990-2010

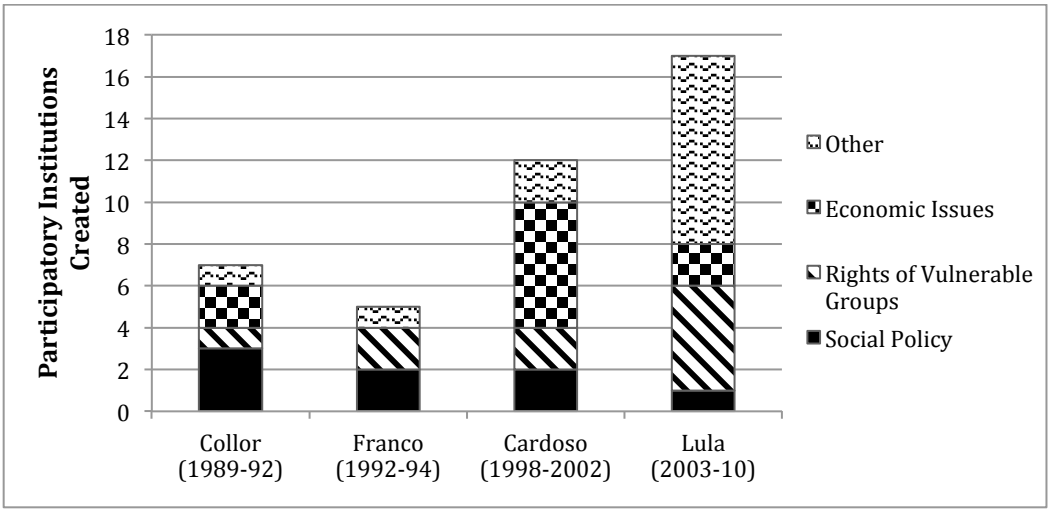


Source: Author's database of nationally-mandated participatory institutions.

Participatory institutions in Brazil have not only grown in sheer numbers – they have also expanded into increasingly diverse policy areas, as shown in Figure 2.2. The first generation of councils created in the early to mid 1990s was largely concentrated in the areas of social policy and the rights of vulnerable groups (e.g. women's rights). This first generation of councils includes some of the most well-known and influential councils, including the National Health Council, the National Social Assistance Council, and the National Council for the Rights of Children and Adolescents. As the councils matured, however, participatory policymaking expanded into additional policy areas, such as agribusiness policy, energy policy, and tourism,

among others. Indeed, by the late 2000s participatory institutions operated in 20 of Brazil's 24 ministries.[1]

Figure 2.2: Expansion of Participatory Institutions into New Policy Areas – Brazil, 1989-2010



Source: Author's database of nationally-mandated participatory institutions.

The explosion of participatory policymaking in Brazil is striking when compared with the Colombian case, where participatory institutions contracted over time. Why were participatory institutions adopted in Brazil? And why did they gain such a central role in Brazilian policymaking?

I argue that Brazil's national participatory framework has proven successful due to its origins in sweeping social rights reforms that tied participatory policymaking to substantive policy changes. I make this argument in two parts. First, I demonstrate that Brazil's participatory institutions were adopted in response to dual legitimacy crises, which linked the country's political exclusion with its social exclusion. These social rights reforms addressed the political exclusion by extending new spaces for participation via councils, while also making substantive changes in the objectives and content of public policy. As we will see in Chapters 3 and 4, the sweeping nature of the health and social assistance reforms sparked the broad reform coalitions needed for councils to become institutionalized.

Second, I show how participatory institutions diffused to new policy areas over time. In response to early successes with participatory policymaking, by the late 1990s participatory policymaking had become part of the logic of appropriateness – the accepted ideas about how policymaking ought to be done. This lowered the costs, and increased the political benefits, of creating and implementing new councils. Participatory policymaking spread into new policy areas, and existing participatory institutions consolidated further. As a result, participatory policymaking became widespread and institutionalized in Brazil.

[1] The only Brazilian ministries without at least one participatory institution are: Communications; Defense; Planning, Budget, and Management; and Transportation. For a complete list of nationally mandated participatory institutions, see Appendix A.

2. PRECURSORS: LEGITIMACY CRISES AND THE NEED FOR REGIME CHANGE

Ironically, Brazil's elaborate participatory framework found its origins in the authoritarian military regime of 1964-85. The idea behind participatory policymaking arose in response to the politically and socially exclusive nature of the military regime. The military had restricted spaces for political participation, while its industrializing policies had led to an increase in inequality and a social deficit. In response to these dual problems, Brazil's democratization movement took on a social rights framework that linked their calls for democratization with the expansion of social rights. This social rights approach led democratization activists to support participatory policymaking: the councils would open up new spaces for political participation in conjunction with social rights reforms that would tackle the country's social deficit. In other words, they supported the creation of participatory institutions as part of sweeping reforms. In this section, I outline the military's political and economic projects and show how cracks in these projects gave rise to proposals for participatory social rights reforms.

2.1 Political and Social Exclusion under Military Rule

The politically and socially exclusive policies of military rule were adopted as part of the military's attempts to restructure the Brazilian government and economy. The military seized power in 1964 following Brazil's first experiment with democratic rule. This first democratic period, from 1945-64, had been chaotic; the military repeatedly intervened in civilian politics and threatened to use force to "stabilize" democratic rule. Between 1963-64, members of the military had grown alarmed at president João Goulart's attempts to mobilize the popular sectors behind his proposed reforms – most notably, land reform. With growing polarization, the Goulart government lost its ability to govern the country and manage the economy. In 1964, factions of the military staged a coup and seized power in the hopes of restoring order to the country.

The military saw itself as filling a temporary but transformative role in which it would make the country "safe for democracy." These military actors saw the polarization and paralysis of Brazil's first democratic period as being a product of dysfunctions in Brazil's democratic institutions and economic model. The country needed to modernize and industrialize, but needed to do so in a way that would not give rise to (what they saw as) mob rule by the masses. Thus, the military pursued two long-term projects designed to transform Brazilian society: a reconfiguration of the political system and a restructuring of the economy.

In terms of its political project, the military reorganized the party system and limited mobilization by the left. The goal was to construct new political institutions that would continue to operate once Brazil transitioned to democracy. The military sought to engineer the political system to construct a more centrist and conciliatory political system – one that could not be hijacked by Marxist politicians, who they saw as threatening the fabric of Brazilian society. In 1966, the military government established a new two-party system in order to restructure political contestation. Although executive offices were appointed by the military, voters could elect representatives for the legislature, choosing between the military's party, ARENA (*Aliança Renovadora Nacional* – National Renovation Alliance) and the loyalist opposition party, the MDB (*Movimento Democrático Brasileiro* – Brazilian Democratic Movement). All other political parties were banned. The military's believed that an institutionalized two-party system

would converge on the center, thereby preventing the polarization and gridlock experienced between 1945-64 under Brazil's multi-party system.

The military cracked down on non-sanctioned forms of political participation. In 1965, the government passed Institutional Act 5, which, among other things, suspended the civil liberties and political rights of citizens and gave the military the right to prosecute political crimes in secret military courts (Moreira Alves 1985: 95-100). The military used imprisonment and torture to target activity by Marxist party activists in particular. Since labor unions were viewed as destabilizing to the political and economic order, the government modified the already restrictive labor relations system to make it nearly impossible to strike and to limit opportunities for collective bargaining (Mericle 1977). These restrictions dampened activity by civil society groups and the political opposition, particularly during the early years of the regime.

In its economic project, the government sought to restore macroeconomic stability and to advance industrialization. The government deepened the country's import substitution industrialization project, investing in heavy manufacturing sectors and bringing in multinational firms to assist with production (P. B. Evans 1979). The result was the so-called "Brazilian Miracle," with double-digit rates of growth. This economic success provided the military regime with its main source of legitimacy. Goulart's government had collapsed largely due to its mismanagement of the economy, which resulted in hyperinflation and economic contractions. After this chaotic period, Brazilians were willing to trade off the loss of civil liberties for the rapid growth rates and the corresponding rise in incomes.

Yet not all Brazilians shared in the benefits of this economic growth and inequality rose dramatically in the 1960s and 1970s. The top decile of the economically active population earned 39.6% of the total national income in 1960 and that number had risen to 47.7% by 1980; in contrast, the proportion going to the bottom half declined from 17.4% in 1960 to 14.2% in 1980 (IBGE Census Data). This increase in inequality was not an accident as the concentration of wealth among the elite was an inherent part of the military's industrialization project. The government sought to increase the incomes of the wealthy so that they could purchase the new, domestically produced heavy manufacturing goods.

In addition to their economic exclusion, poorer Brazilians were also excluded from most social policies. Brazil's welfare state had been built up during the 1930s-1940s as a means of incorporating the newly-unionized workers into the political system (Malloy 1979). The largest area of social policy, the pension system, was restricted to those within the formal sector. And, as described in Chapters 3 and 4, poorer Brazilians had few options in healthcare and received little support via social assistance. The result was that there were two categories of citizenship in Brazil: one in which citizens benefited from the rapid economic growth and generous welfare state, and another for those that did not.

The military's legitimacy unraveled as Brazil's economy began to decline in the 1970s. While the inequalities inherent in Brazil's economic model had been accepted as a necessary evil when the government was able to maintain rapid rates of growth, that acceptance changed as the country entered a recession with the 1974 oil crisis and the exhaustion of the country's heavy import substitution industrialization economic model. Consequently, the military regime faced a dual fiscal and political crisis.

Brazil entered a fiscal crisis as revenues declined and public debt skyrocketed. Tax collection rates fell due to the recession and high unemployment. Meanwhile, the debt grew through a devaluation of the currency and higher interest rates due to the oil crisis. Debt deepened as government spending continued to grow due to the rising costs of the country's

import substitution industrialization economic model, and the lack of cost controls in the social security system. Moreover, there was a growing need for additional resources to serve those hardest hit by the recession; he increase in poverty led to a rise in infant mortality and the spread of epidemics such as meningitis (Paim 2008: 70).

The military's fiscal crisis gave rise to a political crisis. The military did not appear to be more qualified than a civilian government in managing the economy, at least not enough to merit the sacrifice of civil liberties. The regime lost support from domestic business, which had served as its main political base. Private sector elites were upset by the apparent economic mismanagement, as well as the excessive benefits given to state industries and arbitrary rule by the regime. As evidence of the military's shaky standing, the pro-military ARENA party nearly lost the majority in the 1974 Congressional elections. The loyalist opposition MDB party began to act more like a real opposition party, and civil society groups emerged from the woodwork to challenge the regime.

Seeking to bolster its legitimacy, the regime reached out to new constituency groups. With the growing wariness of the private sector, the regime would need to build its mass support through expanded social programs. However, it also faced very real limitations due to the fiscal crisis. Somehow, the government needed to do much more in the area of social policy, and do so with significantly fewer resources. The military adopted a two-pronged strategy of 1) relaxing restrictions on civil and political liberties and 2) reaching out to new constituencies by expanding the social safety net.

First, the military sought support from the public by voluntarily relaxing some political restrictions. This political opening, or *abertura*, would be "slow, safe, and gradual." The military relied less on the state of siege and relaxed restrictions on civil society mobilization were relaxed. The military also restructured the party system to loosen its control on parties. The loyalist ARENA party and official opposition MDB party were eliminated and had to re-register as new parties: the PDS (*Partido Democrático Social* – Social Democratic Party) and PMDB (*Partido do Movimento Democrático Brasileiro* – Party of the Brazilian Democratic Movement), respectively. New political parties – including leftist parties – could now register. The military also opened up subnational elections for mayors and governors for the first time in twenty years. A number of pro-democracy parties won office in key states and cities, such as São Paulo state and Curitiba. Providing access to opposition movements and parties was a risky strategy for them military to adopt. Nevertheless, it believed that a gradual liberalization would placate the public and thereby would enable the military to stay in power for longer.

Second, the military reached out to new constituencies by broadening the social safety net. The government had expanded membership in the state pension and health systems to dampen dissention among groups that had been excluded in the past (Escorel 1998; Fleury and Oliveira 1986; Garay 2010). For example, millions of rural agricultural laborers were included in the social security system (Houtzager 1997; Maybury-Lewis 1994; A. Pereira 1997). Still, the fiscal crisis meant that the government could not simply dramatically expand social spending; it had to find ways to meet social needs while not spending more money. Thus, the government adopted a series of decentralizing reforms and restructured the administration in order to eliminate sources of inefficiency in public administration while expanding coverage.

The dual legitimacy crises of the military regime linked together the projects of political liberalization and social inclusion. The Brazilian case contrasts with that of Colombia, where the crisis was one of *political* exclusion rather than *social* exclusion. These dual crises would give

rise to social rights reforms that changed the objectives, content, and procedures behind public policy – including the creation of participatory institutions.

2.2 The Development of the Social Rights Frame

As the military government reached out to new groups, Brazil's burgeoning civil society began to link their demands for democratization with demands for social rights. The opposition movement brought together a diverse array of social movements, union activists, and leftist party leaders, united behind the push for democratization. Mobilization behind democratization also facilitated the development of a social rights reform project, which sought to amplify Brazilian citizenship to include economic and social rights, in addition to political and civil rights. Advocates of social rights reforms believed that democratization would be incomplete without developing protections for the rights of vulnerable populations and a massive expansion of the welfare state. Democratization of political and state institutions was necessary – but also would need to be accompanied by concomitant shifts in the objectives behind policymaking and the policies pursued by the state.

The *abertura* created a new political space for the opposition by relaxing restrictions on political party, association, and union activity. The opposition brought together a wide array of political parties and civil society groups that varied in socioeconomic and ideological terms. Opposition actors included dissident political and economic elites, the Catholic Church, social movements, students, and labor. The opposition expanded in the 1970s with a surge in civic activity among mothers' clubs, community councils, popular organizations, and movements such as the Cost of Living Movement (*Movimento do Custo de Vida*) and the Popular Health Movement (*Movimento Popular de Saúde*) (Doimo 1995; Jacobi 1993). Many of these organizations initially arose to solve collective social problems in the face of growing inequality and an unresponsive government. When they joined the democratization movement, they framed their social demands through the lens of democratization.

The opposition presented an image of consensus. Politicians from the left and the right, business and labor, rich and poor were all unified in support of democratization. These divergent groups united together behind the master frame of opposition to the military's political and social exclusion, which created a sense of unity and common purpose (Cardoso 1983; Hochstetler 2000). Thus, popular health movements demanding improved sanitation or neighborhood associations protesting inadequate housing framed their demands as part of the larger protest against military rule (Sader 1988). As the democratization process advanced, these social rights proponents shifted their focus from an "opposition to the military" frame to a "social rights" frame (Dagnino 1994; Hochstetler 2000; Telles 1994). One movement leader explained:

> The transition to democracy will not be complete with the institution of a bourgeois democracy. We believe that it needs to go further, looking for a popular democracy […] without losing sight of the final objective, which is a democracy without adjectives that is based in a society without classes. (Machado 1987: 305)

A transformation in citizenship would involve two components: greater political inclusion and greater social inclusion. In terms of political inclusion, the public (*o povo*) needed to have greater access to the policymaking process through both representative and participatory

democratic institutions. In terms of social inclusion, the state had a responsibility to ensure that all citizens were able to live a life free from misery and violence. Social rights reform advocates argued that the two components were inherently intertwined since citizens can only actualize their political and civil rights if their basic subsistence needs are met; the right to the secret ballot is meaningless to a person dying from an easily preventable disease. These activists advocated for an expansive definition of citizenship encompassing political, civil, *and* social rights, including the right to employment, healthcare, education, and nutrition (Beitz 2001; Dagnino 1998; Fleury 1987; Gauri 2004: 465).

In sum, even from the beginning support for participatory policymaking was intertwined with demands for sweeping policy reforms. This linkage stemmed from the political and social exclusion of military rule. As a result, Brazil's political transition happened in response to the dual needs to both democratize the state, as well as transform the objectives and activities of the state. After years of exclusion there was high demand for a more participatory democracy in Brazil. Yet there was also a demand for increased social inclusion, in the form of social rights reforms that would extend universal coverage for social programs to all citizens and would protect the rights of vulnerable groups. In the following section, we will examine the adoption of Brazil's extensive participatory framework as a response to these dual demands.

3. THE ADOPTION OF PARTICIPATORY INSTITUTIONS AS SOCIAL RIGHTS REFORM

Brazil's participatory framework was adopted as part of the democratization movement and social rights reforms that began in the 1980s. Brazil's new constitution presented participatory policymaking within the context of an expansion of social rights. In the 1990s, enabling legislation fleshed out the rights proclaimed in the constitution and created participatory institutions in conjunction with substantive reforms in a number of policy sectors. Of the 11 participatory institutions that were established between 1990-94, nearly all had their origins in a larger sweeping reform that changed the fundamental objectives behind the policy sector. The sweeping nature of these reforms would shake up existing interest representation systems in the sectors, and would ultimately create the conditions needed for the institutionalization of participatory policymaking.

3.1 Democratization, Social Rights, and Early Participatory Initiatives

Brazil's first initiatives in participatory policymaking followed the transition to civilian rule in 1985. The pacted transition to democracy and rise of former regime loyalist and ARENA politician José Sarney to the presidency led to tensions with those in the democratization movement focused on social rights. Sarney hoped to signal a sharp departure from the military regime and promised that social rights reforms would be front and center in the new regime. While the government's support for social rights reforms was inconsistent, a number of early shifts did happen in the late 1980s. The government invested more in social programs, supported the creation of a new universal health system, and backed an expansion of social security coverage. Most relevant for this study, the Sarney government created some of the first national participatory policymaking councils. Below, I sketch the political dynamics behind the creation of the early participatory institutions.

Brazil underwent a gradual and pacted transition to democracy that started with political liberalization (*abertura)* in the late 1970s and ultimately ended with the passage of the 1988 Constitution.[2] The military arranged a deal with the elite political opposition to transition to democracy in a piecemeal way: the military would hand over power to a civilian president in 1985, but this president would be selected through an electoral college and not through a popular election.[3] The Tancredo Neves of the PMDB (*Partido do Movimento Democrático Brasileiro* – Party of the Brazilian Democratic Movement) party was selected to be the country's first civilian president in over 20 years.

Neves reached out to the left and social rights reformers by promising major economic, social, and political reforms. Neves argued that his term would mark the beginning of what he called the "Nova República" (the New Republic), a term that signaled a sharp contrast with the political and social exclusion of the military regime. Neves promised to redress the country's high levels of poverty and inequality and to open up the state to popular participation in policymaking. In particular, Neves called for a "revolution in health" with a series of reforms that reflected the health reform coalition's vision of a rights-based health system (Escorel 1998).

Neves' promises for a new Brazilian regime were interrupted when he died suddenly on April 21, 1988, before he was able to take office. Instead, Neves' vice-president, José Sarney, was inaugurated as president. Those in the democratization movement grew alarmed, believing that their social rights demands – and even the sanctity of the new democratic regime – were under threat since Sarney was a military loyalist and had served as an ARENA politician during the dictatorship.

To maintain legitimacy, Sarney vowed to advance the social rights policy agenda outlined by Neves. Sarney adopted Neves' phrase "Nova República" to describe his time in office. The government argued emphatically that its main objective was to reduce the social debt incurred during the dictatorship and that his administration would follow the motto of "*Tudo pelo Social*", roughly translated as "social inclusion above all else" (Filho and de Araújo Jr. 2002: 99). The *Tudo pelo Social* orientation entailed fighting corruption and governing according to the principles of consensus, transparency, and inclusiveness (Faleiros 1986).

The administration took on a schizophrenic character as Sarney attempted to placate both social rights reformers as well as allies from the right, yet his government *did* implement a number of reforms that would create spaces for participation for civil society groups. The government instituted a number of participatory institutions, including the National Council for

[2] The exact end point of Brazil's democratic transition is murky. Since the military allowed legislatures to continue operating during the dictatorship, electoral competition did not signal a clear break from the past. Some Brazilians, particularly political elites, marked the start of democratic rule with the election of a civilian president in 1985, even if that election was an indirect one. In contrast, others that formed part of the Direitas Já movement argued that the democratic transition would not be completed until a new constitution was passed and all politicians were elected directly. For more information on Brazil's transition to democracy, see Wendy Hunter, *Eroding Military Influence in Brazil* (Chapel Hill: University of North Carolina Press, 1997), Scott Mainwaring, 'Political Parties and Democratization in Brazil and the Southern Cone', *Comparative Politics,* 21/1 (1988), 91-120.

[3] The opposition movement split in its willingness to support the indirect elections. Most political elites saw the indirect elections to be less than ideal but a necessary step in the route to democracy. On the other side, a number of social movements (including those advocating for social rights reforms) and the Workers' Party allied together to form the Direitas Já (Direct Elections Now) movement to protest the indirect elections. Those in the Direitas Já movement argued that the indirect election of the civilian president gave the military the power to unduly influence the new democratic regime. The arguments of the Direitas Já movement were underscored with the selection of Sarney – a politician closely allied with the military – as the vice president.

the Rights of Women (Conselho Nacional dos Direitos da Mulher, CNDM).[4] It also held seven national policymaking conferences during Sarney's administration (1986-1990).[5] The first of these, the 8th National Health Conference, was arguably the single most important policymaking conference in Brazil's history. While national policymaking conferences were not a new development at that time, the 8th National Health Conference broke ground because it provided everyday people access to the policymaking process for the first time. The 8th National Health Conference would serve as the prototype for the dozens of other conferences to come in the future in health and in other policy areas.

Why did Sarney invest in participatory policymaking? One can imagine that the government might prefer to selectively reach out to civil society groups rather than develop a mandatory, formalized space. To explain early initiatives in participatory policymaking, we must look to the transformation of the democratization frame into one centered on social rights and citizenship. Democratization had become associated with a participatory democracy and social rights. Therefore, investing in participatory institutions became a symbolic way for the Sarney government to appease groups from the democratization movement and demonstrate its commitment to the shared goals of social rights. Simply making concessions to individual civil society groups would not have yielded the same degree of legitimation. Moreover, as described in Chapter 3, activists within the state pushed for the early adoption of participatory institutions. For example, the 8th National Health Conference was the brainchild of activist bureaucrats within the Ministry of Health that sought to mobilize a grassroots coalition behind their proposals for sweeping social rights reforms. These early participatory initiatives laid the groundwork for the debates about social rights and participatory policymaking in the 1988 constituent assembly.

3.2 The Mandate for Participation in the 1988 Constituent Assembly

The 1988 Constitution provided the foundation for Brazil's new network of participatory institutions. The 1988 National Constituent Assembly (*Assembléia Nacional Constituinte*) established participatory democracy as a fundamental principle of the Brazilian state. The constitution mandated the need for popular participation in policymaking for a range of policy sectors. Brazil's 1988 constitution is called the "citizen constitution" (*constituição cidadã*) due its emphasis on social rights and the ample opportunities for citizen input. The new charter marks a clear departure from the 1886 constitution, which called for a centralized and elite-centric state.

[4] For more information on the feminist movement in Brazil and the creation of national, state, and municipal women's rights councils, see Heleieth Iara Bongiovani Saffioti, 'Feminismos E Seus Frutos No Brasil', in Emir Sader (ed.), *Movimentos Sociais Na Transição Democrática* (São Paulo: Cortez, 1987), 105-58.

[5] Six of these conferences were in the area of health policy: the 8th National Health Conference (1986), the 1st National Oral Health Conference (1986), the 1st National Conference for the Management of Health Labor and Education (1986), the 1st National Indigenous Health Conference (1986), the 1st National Worker's Health Conference (1986), and the 1st National Mental Health Conference (1987). The seventh council, held in 1985, was the 1st National Science, Technology, and Innovation Conference. For a list of all national conferences held as of 2010, see Secretaria-Geral Da Presidência Da República - Secretaria Nacional De Articulação Social, 'Conferencias Nacionais Realizadas (1941-2010)', (Brasília, 2010).

The social rights framework, including an emphasis on citizen participation in Brazilian democracy, can be seen throughout the charter.[6] The preamble of the 1988 constitution establishes Brazil as "a democratic state designed to ensure the exercise of social and individual rights, liberty, security, well-being, development, equality, and justice." The entire second chapter of the constitution is dedicated to outlining the social rights of citizens, with Article 6 stating that "Social rights include education, health, work, housing, leisure, security, pensions, protection of maternity and childhood, and aid for those in need." Throughout, the Brazilian charter elaborates the core principles and institutional structure underlying the rights-based approach in these policy areas, mandating the participation of the community in policymaking for a variety of sectors, including urban planning (Article 29, section XII); agricultural policy (Article 187); health (Article 198); and social assistance (Article 204). To a greater degree than the Colombian constitution, the Brazilian charter links participatory democracy with major shifts in public policy.

3.3 Enabling Legislation for Sectoral Participatory Institutions

Having achieved success in the constituent assembly, the next main hurdle was establishing a legal framework that would give the constitution teeth. As we will see below, social rights reformers encountered difficulties in advancing their substantive and participatory goals under the neoliberal Collor administration (1990-92). Nevertheless, some participatory institutions were established during the Collor government, and the participatory framework expanded during the subsequent Franco administration.

Creation in a Climate of Hostility: The Collor Government (1990-92)

During the presidency of Fernando Collor de Melo from 1990 to 1992, seven national participatory institutions were created. These included two of the most visible and influential national councils: the National Health Council and the National Council for the Rights of Children and Adolescents. The creation of these participatory institutions is striking given Collor's hostility to participatory policymaking, and to social rights reforms more broadly. Collor sought to block the implementation of the participatory institutions mandated in the constitution. He centralized political power and adopted an economic reform project designed to *reduce* the scope of state activity, rather than expand it through social rights reforms. Therefore, it is remarkable that *any* participatory institutions were established during this difficult period.

Collor's rule was marked by his authoritarian style and centralizing tendencies. Collor was an outsider with few ties to the political establishment. As such, he failed to assemble a governing coalition in Congress and alienated potential allies, such as conservative politicians, that might have supported his economic reforms (Schneider 1991; Weyland 1993). As Weyland (2002: 123) states, "Rather than trying to win supporters, Collor deliberately picked fights."

Collor took office at a time of economic uncertainty and responded with the most ambitious package of structural reforms in Brazilian history (Bresser Pereira 1991: 17-19, 26-30). His reforms were guided by a "Minimal State" (*Estado Mínimo*) approach to public management that aimed to reduce the role of the state in the economy and in Brazilian society.

[6] Scholars universally acknowledge the 1988 constitution as a social constitution, yet many have also pointed out that the document has a schizophrenic and at times contradictory character: even as it outlines expansive social rights, the document provides the foundations for the neoliberal economic policies that would later hamper attempts to guarantee these social rights. For discussion on the dual and contradictory nature of the 1988 constitution, see Vicente De Paula Faleiros, 'Previdência Social E Sociedade: Período 1995-1998', (Brasília: CNPq, 2000).

Collor gained the reluctant Congressional support for most of his reforms through the distribution of political patronage, and because he could claim that he had a clear mandate at that early point in his administration: he won the runoff election with 35 million votes and in March 1990 he had a 70% approval rating (Datafolha 1992; Weyland 2002: 142). When Congress failed to support his proposals, Collor went around the legislature and implemented the economic reforms through decrees, further straining his relationship with Congress (Meneguello 1998: 111-12).

Collor managed to sidestep popular demands for social rights reforms through these undemocratic practices. Rather than the rights-based model established in the constitution, Collor preferred a more centralized, discretionary model of social policy (Rodriguez Neto 1997: 89). The administration attempted to roll back the social rights provisions established in the 1988 Constitution and slashed social spending. When Collor was elected in 1989, Brazil's federal health budget was 10.9 billion U.S. dollars; by 1992, the federal budget had shrunk to 6.6 billion dollars (Cohn and Elias 1996, cited in Faleiros et. al 2006: 115). The health budget contracted precisely at the time when the legal mandate for universal health system required an expansion of its coverage to incorporate the remaining 1/3 of the Brazilian population not already included in the system (Paim 2008: 189). Spending on social assistance also declined; in 1991 the budget of the national social assistance agency was only 53% of the 1989 levels under Sarney (Boschetti 2002: 57).

Given Collor's authoritarian governing style and opposition to social rights reforms, it is perhaps not surprising that he opposed the devolution of authority to participatory institutions. Collor argued that organized interest groups such as unions, professionals, and program beneficiaries should have *less* input into policymaking, not *more*, since these special interest groups would oppose the elimination state waste – an elimination that ultimately was in the public interest.

Collor had limited success in his attempts to halt the creation of participatory councils. He was unable to prevent the creation of the health councils, but he did succeed in blocking the social assistance councils by vetoing the proposed social assistance statute in 1990. Moreover, Collor attacked councils that were established before he took office: he eliminated the national Council for the Defense of Human Rights, and stripped the National Council for the Rights of Women of its policymaking authority.

Despite this hostility, a number of participatory institutions ultimately were created during this period. Notable examples include the health councils, the National Pensions Council, and the councils for the rights of children and adolescents. The councils created during the Collor administration arose as part of sweeping policy sector reforms that introduced substantive changes to the objectives and content of policy, as well as procedural changes with the establishment of participatory councils. For example, Brazil's health councils were established as part of the 1990 Health Statute. As the following chapter will show, Brazil's sweeping health reform included shifts in the objectives of the health system (from a marketized to a rights-based model of health), its procedures (participatory health councils), and the content of health policy (e.g. greater investment in preventative programs).

These participatory institutions were established in the early 1990s due to intense and persistent mobilization by social rights reformers. The health reform movement serves as a vivid example of the resourcefulness of Brazil's social rights movements in the face of high government hostility. Collor utilized the line item veto to eliminate articles related to participatory policymaking in Law 8080 of 1990, which outlined the health system. The health

reform coalition responded with rapid mobilization to lobby Congress and the minister of health. The reform coalition wanted Congress to pass quickly a new law that would reinstate the vetoed articles. The coalition was successful, and Law 8142 was passed in December 1990. Likewise, in 1990 the nascent children's rights movement mobilized in support of the Children and Adolescents Statute - a statute that effectively created a new policy sector that had not previously existed. The Children and Adolescents Statute mandated the creation of municipal, state, and national councils to help create and implement the new system. The children's rights movement staged rallies, launched a media campaign, and lobbied influential politicians to secure strong popular and political support for the statute. The statute gained a moral imperative and few politicians – including Collor – were willing to openly oppose efforts to prevent child abuse and child labor. On July 13, 1990 the Children and Adolescents Statute passed, thereby creating national, state, and municipal councils.

The creation of Brazil's participatory policymaking framework would become easier when Collor was impeached in 1992 in the face of corruption scandals. Once news of these scandals broke, Collor's political capital plummeted. Whereas in March 1990 70% of Brazilians rated Collor's performance as good or very good, by September 1992 this number had fallen to only 10% of the population (Datafolha 1992). Millions of Brazilians joined together to form the largest mobilization ever in Brazil, called the Movement for Ethics in Politics. The movement demanded Collor's resignation as well as fulfillment of the social rights reforms outlined in the constitution (Levcovitz et al. 2001).

Social rights reformers gained visibility and leverage through the impeachment movement. They effectively argued that Collor's corruption went hand in hand with his neoliberal policies; both violated the spirit of democratization and the new social contract constructed with the 1988 Constitution. They also demanded a renewed focus on social rights and popular participation in the policy process. By the time that Collor was removed from office in September 1992, these groups had gained considerable legitimacy and were well-positioned to push for adoption of social rights reforms – and the creation of participatory institutions.

Creation in a Climate of Accommodation: The Franco Government (1992-94)

The government of Collor's successor, Itamar Franco, was shaped by attempts to reach reconciliation with social rights movements. Itamar Franco faced the dual challenges of stabilizing Brazil's macroeconomy and reducing the chaotic political scene. When Franco took office on September 30, 1992, the economy was flailing. Yet reforms to ameliorate the economy were difficult to pass in a highly divided political climate. During the Collor years, Brasília had become paralyzed by gridlock in the legislature and popular protest. Franco needed to reestablish trust and cooperation with politicians in the legislature in order to end this standstill. Franco also needed to develop a solid base of societal support, which would provide the political capital required to undertake these difficult reforms. Weyland (2002: 220) explains that the Franco government "needed both to win support in society and to protect themselves against being undermined from within the government."

Franco faced a difficult balancing act in pleasing his diverse constituents. His government slowed down the implementation of neoliberal policies established under Collor, while still continuing with the economic model in an effort to sustain the political support of right-wing parties in Congress and business groups (Kingstone 1999; Weyland 2002: 213). Meanwhile, Franco tried to maintain a populist relationship with the public to ensure high popular support for his government – and thus space for political maneuvering in Congress (Faleiros 1995).

Franco also sought reconciliation with the social rights movements that had mobilized during democratization and impeachment (Faleiros et al. 2006: 125). He halted the efforts to slash social spending and dismantle Brazil's existing welfare state and backed social rights legislation that had been blocked by Collor. For example, the Social Assistance Statute finally passed in 1993. The number of national participatory policymaking councils increased from eight to 13 during the Franco administration. Among those created during this period were two of the most important councils: the National Food Security and Nutrition Council (CONSEA, *Conselho Nacional de Segurança Alimentar*) and National Social Assistance Council (CNAS, *Conselho Nacional de Assistência Social*). Furthermore, the Franco government convoked six national policy conferences whereas only two national conferences had been held during the three years of Collor's presidency.

Once again, the participatory institutions created during the Franco presidency participatory institutions arose as part of sweeping policy reforms that changed both the substance and procedures of public policy. Two of the councils re-established during this period – the National Council for the Rights of Women and the Council for the Defense of Human Rights – were part of early sweeping reforms that created new policy sectors in defense of the social rights of vulnerable populations. Other councils, such as the social assistance councils and the National Food Security and Nutrition Council, were created as part of sweeping policy reforms that restructured existing policy sectors.

By the close of Franco's presidency in 1994, the infrastructure for a national system of participatory institutions had been created. The next section turns to the question of how this initial participatory framework was put into practice.

4. IMPLEMENTATION AND EXPANSION OF PARTICIPATORY POLICYMAKING

Following the creation of participatory institutions in Brazil, attention turned to the difficult task of implementing the new legal framework. The lack of active political support made the task particularly daunting: Collor had vehemently opposed the new councils, Franco only supported them as a means of keeping the peace, and the technocratic administration of Fernando Henrique Cardoso (1995-2002) seemed to have little electoral reason to invest in participatory institutions. Nevertheless, Brazil's participatory framework was indeed implemented, and it even expanded under Cardoso. Participatory policymaking was entrenched further during the leftist Lula presidency (2003-10), which created dozens of new national councils.

4.1 The Collor and Franco Governments (1989-94): Early Implementation

In the early 1990s, social rights movements found that it had been easier to *create* new participatory institutions than to *implement* them. After unsuccessfully opposing the creation of participatory institutions, Collor sought to stall their implementation, and eliminated others. The Collor government stripped the National Women's Rights Council of its policymaking authority and state resources, effectively disbanding it indefinitely. The government explicitly eliminated the Council in Defense of Human Rights, which had been created under Sarney.

Nevertheless, implementation did not halt completely during the Collor presidency. Following the passage of the Health Statute and the Children and Adolescent Rights Statute in 1990, national councils in the two areas were convoked, began meeting, and developed internal

by-laws. These councils took initial steps in developing their own rules and procedures, and in setting up councils throughout the country. They even managed to insert themselves into policy deliberations. For instance, the National Health Council made significant contributions to debates about the creation of a national community health workers program, and in designing the decentralized financing of the new system. State and municipal councils also began to take shape early on. For example, 6.3% of municipalities had a health council in 1990, with this number rising to 39% by the end of Collor's presidency 1992 (Perfil dos Conselhos de Saúde dataset). Implementation of the health councils was far from universal, yet any advances were remarkable given the president's overt hostility to their very existence.

Implementation became easier when Franco took power. The National Health Council and the National Council for the Rights of Children and Adolescents gained more central roles in the policymaking process. Municipal implementation of the mandatory councils continued to grow. By late 1993, 2108 of Brazil's 4973 municipalities had registered councils with the National Health Council, and all Brazilian states except Rio de Janeiro had registered their state health council (Carvalho 1995).

Crucially, the Franco administration saw the end of the debate about whether participatory policymaking institutions should exist. The combination of strong civil society mobilization and the government's need for reconciliation led the Franco government to accept that councils had a right to exist. Acceptance of decentralization also grew, and participatory councils and conferences were established as intrinsic components of decentralization.

Moreover, the institutional design of participatory policymaking institutions crystallized during this period. The National Health Council, along with the National Food Security and Nutrition Council, provided the reference point for all other participatory councils. According to this model; councils would have formal policymaking authority, would follow the co-governance model, with participation from both government and civil society actors; would be led by civil society groups (rather than directed by the government); and civil society councilors should be selected by civil society groups themselves, not appointed by the government. Thus, the accepted model was one of a strong institutional design that empowered the councils and included safeguards for their autonomy.

Despite these advances, much of the concrete institution building work was left for the future. The Franco government was occupied with its efforts to stabilize the economy and put in place social rights reforms. In practice, the main work of constructing participatory institutions – investing material and human resources, deciding their specific policy responsibilities vis-à-vis other institutional actors, and developing enforcement mechanisms – would be left for the next government.

4.2 The Cardoso Government (1995-2002): Construction

Implementation continued during the government of Fernando Henrique Cardoso (1995-2002). Cardoso hailed from the centrist PSDB (*Partido Social Democrata Brasileira*, Brazilian Social Democracy Party) party. The PSDB was known for its technocratic, decidedly *un*-participatory governing style. The Cardoso government seemed particularly unlikely to invest in the councils, given that participatory policymaking was closely associated with the opposition Workers Party. Thus, we would expect implementation of the participatory policymaking framework to stagnate during the Cardoso years. Instead, considerable advancements in implementation happened during these eight years, and Cardoso even expanded participatory policymaking to new policy areas.

Cardoso's presidency was defined by its attempts to extend the policies of structural adjustment that began under Collor, while applying a renewed focus on social policies to lessen the blows of these neoliberal reforms. Whereas Collor promoted an *Estado Mínimo* and looked to reduce the scope of state activity, Cardoso pursued a third way that would restructure and strengthen state activity in order to complement a globalized, competitive Brazilian economy. Cardoso brought elements of New Public Management into the Brazilian state and shifted the state-civil society relationship by giving NGOs a greater role in directing social policy (Burity 2006). Under this model, the state would act as a facilitator and coordinator of social policy rather than a direct service provider. Its roles would include contracting out service delivery and coordinating state and NGO or philanthropic efforts in social policy areas such as health, education, or poverty alleviation (Faleiros 2004).

Cardoso often came to loggerheads with activists in social rights movement, albeit less so than Collor had. The Cardoso government agreed with social rights activists that the social deficit needed to be addressed. Yet the two sides clashed over questions of expanding social spending, targeting benefits, and privatizing the provision of social services. In particular, the administration argued that the deficit could be reduced through improved public administration and focusing spending on the neediest, rather than by providing costly universal programs for all Brazilians. Overall, social spending rose 19.3% from 1995-2001 – but this rise was largely due to an increase in the minimum wage, which led to greater payouts for the pensions and social assistance systems (IPEA 2003). In fact, spending in some areas, such as food and nutrition and health, actually declined slightly during the Cardoso presidency (Castro et al. 2008: 13).[7]

Despite the PSDB's technocratic reputation, participatory policymaking institutions made major advances during the Cardoso presidency. The national participatory institutions that had been mandated for municipal governments became truly national. By 2001, near the end of Cardoso's second term in office, 97.6% of municipalities had health councils. 93.1% had social assistance councils, 77.4% had councils for the rights of children and adolescents, and 73.2% had education councils (IBGE 2001). In the areas of health, social assistance, and the rights of children and adolescents, inter-governmental transfers were formally linked to council implementation, providing a powerful enforcement mechanism to back the participatory mandate. Moreover, federal funding for both national and subnational councils increased.

The Cardoso administration extended participatory policymaking into new policy sectors. Cardoso's government established 11 new participatory institutions, including the influential National Education Council and National Council for the Rights of the Disabled. The administration also created participatory institutions in different types of policy sectors than those of the first generation of councils. Previously, participatory policymaking had been concentrated in sectors directly related to social rights claims – i.e., social policy and policy to protect the rights of vulnerable groups. While Cardoso extended this trend, he also established a number of councils that focused on issues of economic policy. Key examples include the National Energy Policy Council and the National Tourism Council. These economic policy councils provided a new space for business associations, labor, and other civil society groups to gain access to the state.

[7] Importantly, Cardoso's government did share key policy and political objectives with the social rights reformers. Both sides sought to de-politicize the state, reducing the ability of clientelist politicians to use state resources as patronage. Cardoso might have included the clientelist PFL (*Partido da Frente Liberal* – Liberal Front Party) in his governing coalition out of necessity, yet in the long term his administration sought to limit political parties' access to state patronage. Likewise, clientelism was anathema to a rights-based approach to public policy.

Cardoso's investment in the councils shows the degree to which participatory policymaking had become legitimate. Following the battles of the Collor presidency and the negotiations established during the Franco administration, political actors across the partisan spectrum accepted that the councils would – and *should* – be part of the policymaking process. Providing bureaucratic support for the councils was simply part of good governance. The Cardoso government sought to show its legitimacy and commitment to good governance in new areas, and so logically it invested in the councils. The general idea of participatory policymaking had taken root as a model that should be applied in different areas – and not just in response to extensive pressure by organized civil society groups mobilized behind a social rights reform project.

4.3 The Lula Government (2003-10): Entrenchment

In 2003, the leftist and pro-participation Workers Party gained the presidency for the first time with the election of Luiz Inácio Lula da Silva, known simply as Lula. The Lula continued investment in participatory policymaking, leading to the further consolidation for existing councils and creation of new ones. By 2010 there were 59 national participatory councils, covering 83% of ministries. The number of national participatory conferences, which periodically brought together thousands of stakeholders from civil society, skyrocketed from (a respectable) 17 during the Cardoso administration, to a whopping 55 during the Lula years. Participatory institutions took on a prominent policymaking role during the Lula administration.

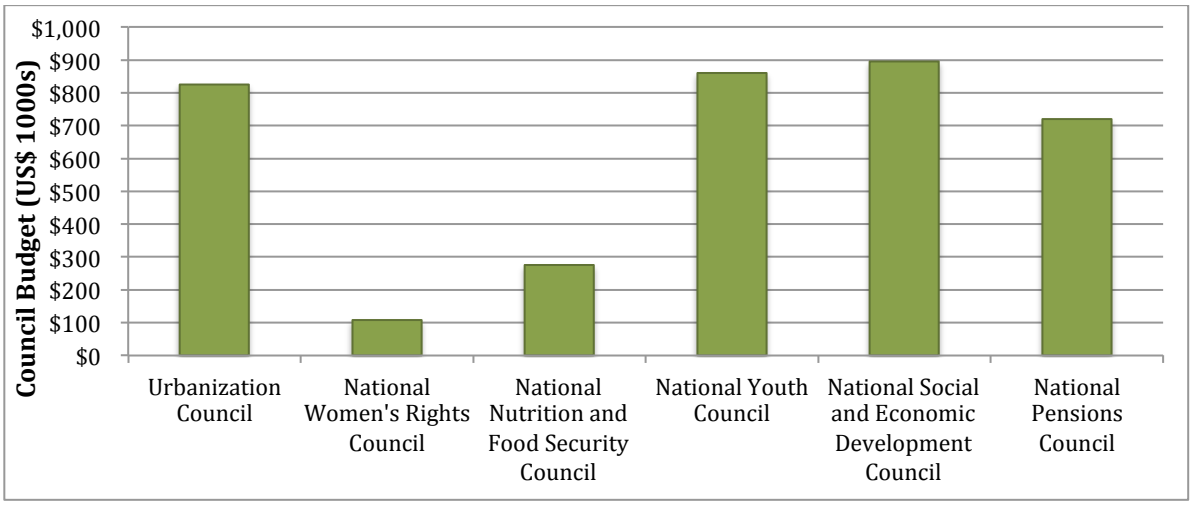
To some degree, the Lula government's investment in participatory policymaking is directly related to the party's ideology and base. The PT has embraced participatory policymaking since the late 1980s with participatory budgeting (Abers 2000; Baiocchi 2003; Goldfrank 2007). The PT is also known for its linkages with social rights groups, including those that had promoted the early participatory institutions (Hochstetler n/d). Nevertheless, participatory institutions were able to take on such a large policymaking role in the Lula government precisely *because* they had been established during non-PT rule. Earlier steps had established the legitimacy of participatory councils as neutral policymaking instruments, not just a partisan tool of the PT.

Once Lula came to power, many of those that had promoted social rights reforms now had direct access to power as the government appointed social movement leaders to top bureaucratic posts (Hochstetler n/d). For example, on his first day in office Lula created a new Ministry of Cities, charged with redressing social inequalities in Brazil's urban areas. The Ministry was framed around the same terms as the Right to the City movement had been, emphasizing pro-poor urbanization strategies and using a rights-based language. Lula named Olivio Dutra, the former mayor of Porto Alegre and governor of Rio Grande do Sul that first implemented participatory budgeting in 1989, as Minister of Cities. Many of the Ministry's staffers were activists from the Right to the City movement that had gained experience during PT administrations in Belo Horizonte, Porto Alegre, and São Paulo. Moreover, within the presidency a new secretariat was created to coordinate outreach to civil society groups, particularly via participatory conferences and councils.

From their new positions within the state, activists across a range of policy sectors sought to deepen further social rights reforms and strengthen participatory institutions. For instance, after its founding in 2003 the Ministry of Cities immediately called a national conference to define a common agenda. Shortly thereafter, the ministry convoked the Cities Council (*Conselho das Cidades*).

The government also provided considerable material support to national and subnational councils. Resource investments from the federal government have ensured a degree of stability for national council operations, as well as outreach and technical support to subnational councils. Figure 2.3 reviews federal spending from 2009 for some of the most important national councils. Despite some variation across policy sectors, overall the federal government invested considerable resources into participatory institutions. On top of the tens of millions of dollars spent on specific participatory councils and conferences, in 2009 the government earmarked additional $US 2.3 million for the "amplification of participatory management practices," and $500,000 was set aside for the "amplification and strengthening of participation and societal mobilization." (Presidência da República)

Figure 2.3: Funding for Select National Participatory Councils in Brazil, 2009

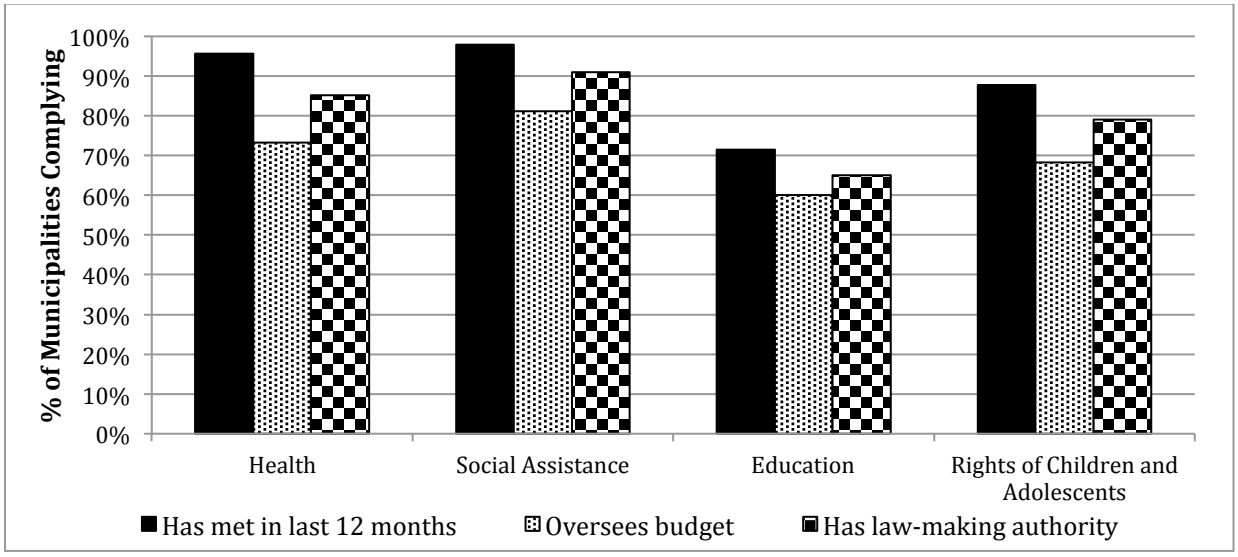


Source: Portal da Transparência do Governo Federal do Brasil. Accessed January 12, 2012.

This federal spending helped boost compliance with mandatory participatory institutions, which is particularly high compared with the Colombian case. Already high near the end of the Cardoso government in 2001, compliance rose even further during the Lula presidency. The vast majority of Brazil's 5565 municipalities implement the mandatory councils in health, social assistance, education, and the rights of children and adolescents. Indeed, Brazil has reached nearly 100% compliance for its health and social assistance councils. Brazil's participatory institutions truly are *national* institutions.

Beyond simply existing, most of Brazil's mandatory councils perform the responsibilities outlined in the legal framework. As Figure 2.4 shows, in around 95% of municipalities, health and social assistance councils have met in the past year. The figure reaches nearly 90% of municipalities for the children's and adolescent's rights councils (versus the 93.5% of municipalities that even have the councils), and over 70% of municipalities for the education councils (versus 90% that have an education council). Compliance is somewhat lower when looking at two of the crucial prerogatives of these councils: oversight of the budgetary process and formal law-making authority. Still, compliance with these more demanding measures is considerably greater than anything we have seen in Colombia.

Figure 2.4: Brazilian Municipal Compliance with Mandatory Features of Participatory Councils, 2009



Source: IBGE Perfil dos Municipios database – 2009. The education councils are not granted formal law-making authority in the national framework, explaining the differential with the other types of councils.

Participatory policymaking expanded into new policy areas under PT rule. The total number of national participatory policymaking councils nearly doubled from 29 in 2002, to 54 by the end of Lula's second term in office in 2010. These councils reached into new and diverse policy sectors, such as urban policy (Cities Council), crime and justice (e.g. National Justice Council, National Public Security Council), and foreign trade (Brazilian Social and Participatory Council on Mercosul). The Lula government also created the National Economic and Social Development Council, which is roughly comparable to Colombia's National Planning Council. This council serves as a space for concertation between the government and major societal actors – business, labor, and civil society organizations – in debating the government's top priorities and policy initiatives.

These new councils follow an already established and legitimate institutional model – that of Brazil's first participatory institutions. Unlike these early councils, however, many of the new councils were *not* established through sweeping policy reforms that introduced substantive changes in the sector. For example, the new Economic and Social Development Council did not accompany a shift in the objectives of policy in the sector, since the relevant "sector" was the government's overarching agenda. Nevertheless, the Economic and Social Development Council was able to take root to a greater degree than the National Planning Council due to government support and the legitimacy of participatory policymaking as a mode of governance.

5. CONCLUSION

This chapter has examined the precursors to, adoption of, and trajectory of participatory policymaking in Brazil. Brazil's participatory institutions have taken root throughout the country, with the vast majority of municipalities implementing the councils mandated across a variety of policy sectors. These councils have established a degree of legitimacy and are seen as

part of "how things are to be done" – in other words, as part of the logic of appropriateness. As the councils developed legitimacy, they also expanded into new and different policy areas. This expansion began even before the pro-participation PT gained the presidency in 2003. The strength of Brazil's participatory framework is particularly striking given then decay and contraction of participatory policymaking in Colombia, as we will see in Part II.

The roots of Brazil's participatory framework can be traced to fiscal and political crises facing the military regime. The military's dual crises shaped the terms of the democratization movement, which linked political opening with the extension of social rights reforms. Consequently, participatory policymaking in Brazil was established through sweeping policy sector reforms that both redesigned the process of policymaking, and introduced substantive changes to the objectives and content of public policy. As we will see in the next two chapters, the origins of participatory institutions in sweeping policy sector reforms would prove crucial for their ultimate institutionalization.

This chapter has outlined *how* participatory institutions were created and took root in Brazil, but has not properly explained *why* they became institutionalized, while those in Colombia floundered. To do so, we need to examine closely the process by which a participatory institution is created, implemented, and ultimately institutionalized. This careful analysis requires is done best when utilized at the level of a specific participatory institution. Thus, in the next two chapters we will turn our attention to more in-depth examinations of Brazil's health and social assistance councils.

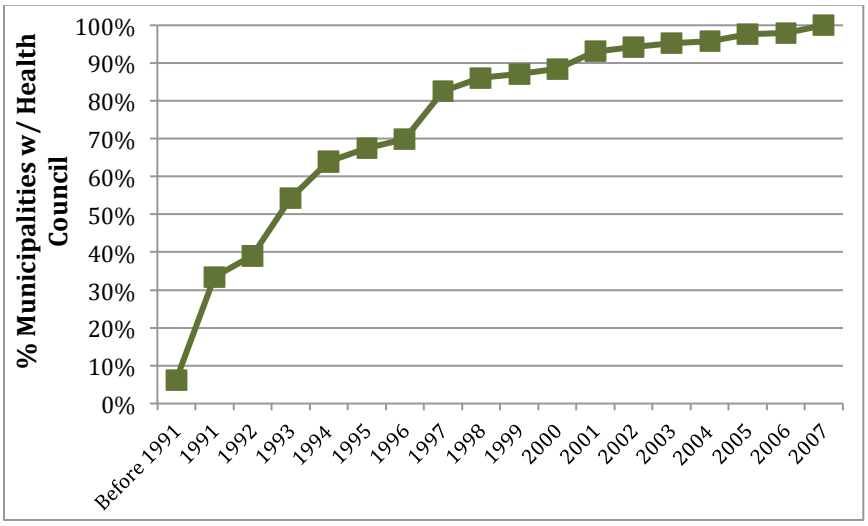
CHAPTER 3. BRAZIL'S HEALTH COUNCILS: HIGH INSTITUTIONALIZATION WITH A BROAD AND COHERENT REFORM COALITION

1. INTRODUCTION

Brazil's health councils have served as the country's model for participatory policymaking institutions. The health councils were formally established as part a larger restructuring of the health sector through the 1988 Constitution and the 1990 Health Statute.[8] Every municipal, state, and national government was required to establish and implement participatory health councils. These health councils were to be central figures in the development, implementation, and oversight of the new health system.

Brazil's participatory health councils are the most successful case of institutionalization in this study. Institutionalization is measured using two distinct criteria: routinization and infusion with value. The health councils are highly routinized: They have a clear regulatory framework with enforcement mechanisms, ample funding, and high levels of compliance throughout the country. Indeed, as Figure 3.1 shows, 5564 of Brazil's 5565 municipalities had established a health council by 2007. Likewise, the health councils have a high level of infusion with value: they are viewed as legitimate among all stakeholders, and are included in the policymaking process even beyond what is formally mandated.

Figure 3.1: Percentage of Brazilian Municipalities Complying with Mandate for Health Councils, 1991-2007



Source: Perfil dos Conselhos de Saúde Dataset, Ministério da Saúde.

The Brazilian health councils serve as a particularly interesting case for this study. First, the health councils are a central component in Brazil's overall participatory framework, since they have served as a model for other councils. Second, the health councils provide an important

[8] Brazil's health statute (*Lei Orgânica de Saúde*) consists of two laws: Law 8080 of 1990 and Law 8142 of 1990.

test of this study's argument. Their successful institutionalization serves as a sharp contrast with that of Colombia's health councils, which failed to institutionalize altogether, and with Colombia's planning councils, which only became partially institutionalized. Brazil's health councils are also more institutionalized than their Brazilian counterparts in social policy, which have become routinized but are less infused with value. Why have Brazil's health councils gained such high levels of institutionalization when other councils have faltered?

The institutionalization of Brazil's health councils also is puzzling given the seemingly hostile political climate for participatory policymaking in the 1990s. A common theme in the participatory policymaking literature is that government will is a necessary condition for participatory institutions to gain a role in policymaking. Yet the health councils first were created during the presidency of neoliberal Fernando Collor de Melo (1990-92), who actively opposed the councils and tried to block their creation. Moreover, the councils continued to face resistance under the technocratic government of Fernando Henrique Cardoso (1995-2002), which had a relationship with the National Health Council that varied from tense to overtly hostile. How did Brazil's health councils become institutionalized, given the apparent lack of political will?

This chapter traces the institutionalization of Brazil's health councils to the two main explanatory factors of this study: the presence of a sweeping policy sector reform and the active support of elite reform leaders. The health councils were created as part of a sweeping policy sector reform that also made substantive changes to the objectives and content of health policy. This sweeping reform disrupted existing interest group dynamics in the sector, thereby creating a potential opening for the health councils. This opening was seized due to the leadership of pro-participation elites in the sector, who had a vested interest in having the health councils succeed. These elite reform leaders brought together a broad reform coalition composed of diverse stakeholders, including public health professionals, community organizations, unions, subnational governments, and progressive politicians from the opposition. The broad reform coalition was able to mobilize diverse resources to support the creation of the health councils, despite political opposition. Following creation, the reform coalition renewed its investments in the health councils, which were now needed to ensure that the health reform was actually implemented in line with its core principles. Over time, the health councils became focal points for state and civil society interaction, resulting in positive feedback effects and ultimately institutionalization.

The chapter proceeds as follows. In the second section, I will compare Brazil's health systems before and after reform to demonstrate the sweeping nature of the health reform. The third section outlines the role of health professionals in forming a reform coalition. Fourth, I review the creation of the health councils and demonstrate the instrumental role of the broad reform coalition in securing a strong institutional design. The fifth section examines the implementation stage. During this stage, government investment in the councils can be traced to continual pressure from the reform coalition. The sixth section looks at the institutionalization stage, during which positive feedback effects from both the government and societal actors ensured institutionalization for the health councils. I conclude by reviewing the role of sweeping policy sector reforms and elite reform leaders in the institutionalization process.

2. BRAZIL'S SWEEPING HEALTH REFORM

This section compares Brazil's pre- and post-reform health systems to highlight the sweeping nature of the health reform that created the health councils. This reform was sweeping in that it changed the objectives behind health policy, its content, and the instruments of how health policy should be formulated (see Table 3.1). The old health system was exclusionary, centralized, hospital-based, and technocratic. In contrast, the new health system would be rights-based, universal, decentralized, preventative, and participatory. As later sections will show, the sweeping nature of the health reform would create space for the health councils by disrupting existing power dynamics and by facilitating the formulation of a broad pro-reform coalition.

Table 3.1: Changes in the Objectives, Instruments, and Content of Brazilian Health Policy[9]

	Policy Objectives	Policy Instruments	Policy Content
Pre-Reform (1940s-1990)	Health as a commodity for those who can pay; curative focus	Centralized; little societal input	Fragmented health system; limited coverage; funding for curative programs
Post-Reform (1990-present)	Health as a right of all citizens; preventative focus	Decentralized; societal input via participatory councils	Unified health system, universal coverage; greater funding for prevention

2.1 The Pre-Reform System: Inequality and Exclusion

During military rule, Brazil's health system reflected the inequality and social exclusion described in the previous chapter. The wealthy and the middle class gained access to medical care via a state-run health system that was part of the social security system. This state-run health system received ample funding and provided broad coverage for its members. Wealthy Brazilians also purchased supplementary private insurance, which gave them access to world-class care. However, options were more limited for the approximately 40% of the population not in the formal sector and thus excluded from the health system (Faleiros 1995: 16).[10]

This inequality in healthcare was reflected in the sharp institutional separation between public health policy (for the poor) and the social security-based health system (for the middle class and wealthy). The formal sector health system was coordinated by a federal government agency, the National Institute for Medical Care and Social Security (INAMPS, *Instituto Nacional de Assistência Médica e Previdência Social*).[11] Health coverage was dependent on paying into

[9] The dividing line between the pre- and post-reform health systems is somewhat arbitrary, since a number of early reforms to decentralize service delivery, increase attention to preventative care, and expand coverage began starting in the late 1970s. I choose 1990 as the year to divide the pre- and post-reform health systems since that is the year the health statute was passed and the reform was codified in national law.

[10] As of 1971, 40% of the population was excluded from the formal health system. See Mónika Dowbor, 'A Trajetória Do Setor De Saúde No Brasil Pelo Prisma De Seus Principais Atores ', (São Paulo: CEBRAP, 2007) at 8.

[11] INAMPS was created as a separate agency under the purview of the National Social Security Institute (INPS, *Instituto Nacional de Previdência Social*) in 1977. Between 1967-77, the INPS itself handled the INAMPS's responsibilities. Prior to 1967, insurance and medical care was fragmented into various agencies, called Retirement and Pension Institutes (IAPs, *Institutos de Aposentadoria e Pensões*).

the social security system, meaning Brazilians working in the informal sector – who tended to be poor – did not have coverage. INAMPS constructed a highly centralized and costly healthcare system based on the curative hospital model. Under this system, the state provided financing via member contributions, while contracting service delivery to private hospitals and purchasing medical supplies from foreign private sector companies. The private sector played an integral role in the health system; in 1975 the government had 3,585 contracts in the provision of medical care; of these, 3,191 were with private companies (Escorel 1998: 55).[12]

Those in the informal sector who did not qualify for health coverage through INAMPS had few reliable options for healthcare. Public health remained the poor cousin of medical care, receiving only 15% of public financing in health in the late 1970s (Mónika Dowbor 2007: 7).[13] These public health programs were insufficient to meet basic preventative care needs. Consequently, the country experienced a number of major outbreaks, most notably the meningitis outbreak of the late 1970s. These outbreaks were more likely to hit the poorer Brazilians – precisely those that lacked health coverage – due to their cramped living conditions and lack of access to clean water sources. When the uninsured did require medical attention, their options were limited to seeking help from philanthropic hospitals, or visiting dilapidated public hospitals, which were few and far between (Mónika Dowbor 2007: 8).

2.2 The Post- Reform System: A Universal Right to Health

Brazil's post-reform, rights-based health system contrasts with the prior system in many respects. The focus shifted from a curative to a preventative model, and the system was redesigned according to four central principles: universality, an integrated and unified structure for the health sector, decentralization, and participation. Importantly for this study, these changes included major shifts in not only the instruments of health policymaking (decentralization and participation), but also the objectives and content of health policy (prevention, universality, and integration).

Changes to the Objectives and Content of Health Policy

The 1988 Constitution and 1990 health statute shift the objectives of health policy by presenting health as a basic social right of all citizens. Article 196 of the 1988 Constitution declares: "Health is a right of all and a duty of the state." In the old health system, those outside the formal labor market had no right to health; under the new system, every Brazilian has the right to health as part of citizenship.

Another shift in the objectives in health can be seen in the emphasis on preventative rather than curative health. This shift in orientation does not simply mean that there should be greater public health spending on preventative programs than before (though there should be). Rather, it entails a different view of how to define "health" altogether. After establishing health as a right of all citizens and a duty of the state, Article 196 of the Constitution goes on to state: "It [the right to health] is guaranteed via social and economic policies oriented towards the reduction of risk for illness and other threats, and to the egalitarian, universal access to services in the promotion, protection, and recuperation of health." This conceptualization of health

[12] Of the remaining contracts, 390 were with unions, 17 with universities, 30 with state governments, 24 with municipal governments, and 33 with other organizations. See Sarah Escorel, *Reviravolta Na Saúde: Origem E Articulação Do Movimento Sanitário* (Rio de Janeiro: Fiocruz, 1998) at 55.

[13] Public health spending increased over the 1970s and 1980s with the gradual adoption of decentralization reforms and preventative health campaigns due to the financial crisis facing INAMPS, described below.

follows a global shift to frame health as an overall state of well-being established through a supportive economic and social environment rather than simply the treatment of ailments. As an example, the preventative approach would view slum upgrading programs as promoting health because they help people thrive in their physical environment.

These changes in the objectives of health policy were matched by corresponding shifts in policy content. Perhaps the most significant shift is the expansion of the health system to include all citizens, regardless of whether they contribute to social security. Millions of Brazilians were added to the health system, resulting in a massive expansion in the health sector.

The content of health policy also shifted with the restructuring of government health agencies. Whereas the prior system was centralized, the new health system would be unified, integrated, and decentralized. In contrast to the past, at each level of government there would be one, and only one, agency responsible for health. These health agencies would operate under one integrated, federal, national system: the Unified Health System (SUS, *Sistema Único da Saúde*). Rules and regulations for the health sector would be established for SUS as a whole, and adapted for the appropriate local context. To avoid the politicization of the past, funding for health would bypass the Congressional appropriations process and instead would go directly from a payroll tax to the National Health Fund. Money in the National Health Fund would then be devolved to state and municipal governments according to standardized, apolitical criteria. The bulk of funding would be transferred to municipal governments, which were charged with managing service provision.

Another key change to the content of health policy involves the role of the private sector. Private sector service providers had been a central part of the prior health system and would still have a role in the new health system. However, the terms of this relationship had changed. Contracts with the private sector would follow new standardized criteria, and service providers would have less discretion than they did under the old contracting system. Moreover, the constitution established that the state had a key role in regulating private sector activity that related to health. For example, the state could regulate healthcare delivered by private sectors to individuals paying out of pocket.

Changes to the Instruments of Health Policy: Brazil's Health Councils

The health reform also involved major shifts in the instruments of policymaking, including a great emphasis on citizen participation in the formulation and implementation of health policy. Article 198 of the 1988 Constitution establishes that the health system will be constructed through participation of the community, and the 1990 health statute clarified that this participation would take the form of permanent policymaking councils.[14] These councils would operate at all levels of government, with the National Health Council (*Conselho Nacional de Saúde*, CNS) contributing to national health policy. Brazil's health councils serve as a space for representatives from the government to come together with key stakeholders in the sector –

[14] Law 8142 for health also mandated that amplified health conferences be held periodically. These conferences operate at the municipal, state, and national level, and include a much greater number of participants from civil society than the health councils. Conference participants deliberate about the top priorities and proposals for the sector, and the councils and government are charged with elaborating these proposals in more detail after the conference ends. As a more amplified participatory institution in terms of number of participants, the conferences were established to redress the problem with representativeness inherent in councils, which engage a small number of councilors from civil society. There are no limits on the numbers of participants in municipal conferences, and thousands of individuals are allowed to participate at the state and national level conferences. Five conferences were held to discuss management of SUS between 1990 and 2010, and an additional 15 conferences addressed more specific issues in the health system, such as mental health and training for healthcare workers.

service providers, health workers, and program beneficiaries – to deliberate and decide on policy. SUS's participatory focus marks a clear departure from the old health system, which was technocratic and provided few opportunities for societal engagement.

Brazil's participatory councils are known as "co-management councils" (*conselhos gestores*), indicating that both government and civil society are to come together in planning and overseeing the policy process. Half of health council seats must be reserved for those acting on behalf of health system users, 25% for health system workers, and the remaining 25% is split evenly among representatives from the government and service providers. Government councilors are appointed by the ministry or secretariat of health, respectively. These councilors will include representatives from that ministry or secretariat, as well as representatives working in policy sectors that have programming that relates to health (e.g., education). On the civil society side, councilors are selected from a forum of their peers. Societal councils must meet basic organizational requirements. For example, prospective councilors for the National Health Council must represent an organization that is officially registered as a non-profit organization and is active in at least two regions and five states.

The structure and primary responsibilities of the health councils mirrors the unified and decentralized design of the health sector. Given the unified nature of SUS, all national, state, and municipal councils are to follow the same guidelines in terms of their composition, how councilors are selected, and responsibilities. Little discretion is granted to subnational governments in how they implement the policymaking councils. Responsibilities include setting priorities in the sector, the design of specific policies and programs to address these priorities, decisions about how funds will be allocated, and the oversight of policy implementation and public expenditures. To execute their rights and responsibilities, all councils have formal policymaking and budgetary authority, meaning that their decisions have actual legal weight and are not mere suggestions.

A closer look at the National Health Council is instructive in getting a clearer sense of what the councils look like in practice. Article 2 of the CNS's bylaws states that the Council's mission is to "contribute to the formulation and oversight of the execution of the National Health Policy as implemented by the public and private sectors, including its economic and financial aspects, its strategies, and in the promotion of societal oversight" (Conselho Nacional de Saúde 2009). During monthly meetings, members of the National Health Council descend on Brasília to deliberate on policies related to the implementation of SUS. Among others, its specific responsibilities include:

- Contributing to the formulation of the National Health Policy, including the financial and economic aspects of the Policy;
- Overseeing the implementation of the National Health Policy;
- Designing the structure of federal resource transfers to subnational governments;
- Proposing the criteria for defining standards and parameters of service delivery;
- Strengthening societal participation and oversight of SUS (Conselho Nacional de Saúde 2009).

In other words, the CNS contributes to all aspects of SUS, and works together with the government in managing the health sector. The CNS, as well as the subnational health councils, has significant responsibilities. Their creation represents a major shift in the instruments of health policy, from a technocratic to a participatory system.

Having contrasted the institutional design behind the old and new health systems, we now turn our attention to the political dynamics involved in constructing the new health system. In the following three sections, I will trace the participatory health reform through its three stages: creation, implementation, and institutionalization. These sections will demonstrate that the sweeping nature of the health reform enabled the formation of a broad and powerful reform coalition that secured institutionalization for Brazil's health councils.

3. THE ROLE OF HEALTH PROFESSIONALS IN OVERCOMING COLLECTIVE ACTION PROBLEMS

Brazil's sweeping health reform arose due to the efforts of a broad reform coalition composed of diverse stakeholders and led by public health professionals. Initial changes in health policy began when the military government's dual fiscal and political legitimacy crises led it to hire reformist public health professionals to implement cost cutting reforms that also expanded access. These public health professionals, which formed the *movimento sanitário* (public health movement), would serve as reform leaders and were instrumental in mobilizing stakeholder support behind the reform, as well as for ensuring that the health councils would be an integral component to reform proposals. After achieving some success by working within the ministries, the *movimento sanitário* sought to deepen reform by building a broad reform coalition composed of diverse stakeholders. Thus, they reached out to new groups such as grassroots associations, unions, and eventually municipal governments. By the mid-1980s, the major stakeholders in health had joined together in support of the reform project – a reform project in which participatory health councils would play a vital role in policymaking. The breadth of this reform coalition would later be instrumental in creating, and then institutionalizing, the health councils.

3.1 The Problem of Collective Action

Collective action was minimal under the prior health system. Health policy during the dictatorship was technocratic and thus isolated from pressures from most civil society interests, particularly those representing patients. The groups that were excluded from the health system had few material resources, thus inhibiting collective action. They also lacked incentives to mobilize, since their exclusion meant that they had little at stake in the sector. Regardless, the military regime limited organizational activity, particularly during its early years, increasing the political costs associated with collective action.

Despite the lack of linkages with patients groups, there *were* strong linkages between INAMPS and representatives of the private sector service providers. Private sector providers were represented by groups such as the National Federation of Health Establishments and Services (FENAESS, *Federação Nacional de Estabelecimentos e Serviços de Saúde*), the Brazilian Medical Insurance Association (ABRAMGE, *Associação Brasileira de Medicina de Grupos*), the Brazilian Medical Association (AMB, *Associação Médica Brasileira*), and representatives from various health industries (e.g., the pharmaceutical industry, medical equipment industry). While private sector associations maintained close contact with INAMPS bureaucrats, the scope of their influence was limited to decisions regarding the terms of state contracts. In other words, they could influence only the aspects of health policy that most

directly related to their material interests. Collective action was negligible among any of the major stakeholders in health, and linkages across stakeholder groups were non-existent.

3.2 The Movimento Sanitário*: Reform Leaders*

The initial push for health reforms stemmed from the Brazilian military government's growing fiscal and legitimacy crises by the mid/late 1970s, as outlined in Chapter 2. These crises discredited the status quo and pushed the military to seek out innovative new health policies – policies promoted and designed by public health professionals that sought a rights-based health system.

The fiscal crisis was particularly acute in the health sector. A faltering economy and declining tax revenues meant fewer resources were available to fund INAMPS. Meanwhile, the curative focus of the health system led to rising costs since patients only sought help once they needed immediate (and costly) medical attention from physicians. The fiscal crisis was exacerbated further by the centralized nature of the health system. With funding decisions made in Brasília, healthcare providers were able to charge high rates and would opt for more expensive procedures when simpler ones could suffice. These fiscal and administrative challenges were exacerbated by the disjointed nature of health policy. Different ministries handled public health and medical care, and programs within each ministry were often uncoordinated with each other, much less with another ministry. The result was high inefficiency: the agencies replicated initiatives in some areas, while leaving other communities underserved.

Solving this fiscal crisis would prove tricky given the government's worsening legitimacy crisis. With the economy in decline, the government needed new sources of political legitimacy among the public. Thus, it could not respond to skyrocketing costs by simply cutting services and coverage. In fact, the military believed that it needed to expand social services to court new constituencies. The government began to focus on the needs of those who remained outside the formal health system to ensure their political acquiescence. In 1974, President Geisel launched the 2nd National Development Plan (*II Plano Nacional de Desenvolvimento*) which included new social investments, which it called "rationalizing policies" (*políticas racionalizadoras*) (Presidência da República 1974). In particular, the military government expanded its investments in public health, including sanitation improvements and vaccinations, to provide coverage to those outside the formal health system (Cortês 2002; Faleiros et al. 2006: 39-40; Paim 2008: 83-87).

These public health initiatives were effective in addressing both the fiscal and legitimacy crises. The programs reached many Brazilians at a low cost, thereby expanding coverage while also controlling health expenditures. The government recognized that a health system oriented towards preventative health programs rather than expensive medical care could enable them to cover more people at a reduced cost – yet needed help putting this idea into practice.

Needing technical assistance, the military government turned to an unlikely source of help: the physicians and public health experts belonging to the *movimento sanitário* (public health movement). Members of the *movimento sanitário*, known as *sanitaristas*, formed the original core of the health reform coalition who would be instrumental in designing the reform project and for ensuring that participation be a core tenet of this reform project. The *sanitaristas* included party activists from the (illegal) Brazilian Communist Party who promoted redistributive policy, a universal welfare state, and democratization – ideas staunchly opposed and even repressed by the military government. Despite these ideological incongruences, the *sanitaristas* were also leading experts in the fields of preventative and community health. For

example, one of the figures most active in the movement was Sérgio Arouca, the director of Brazil's top public health school, Fiocruz. The military had little choice but to reach out to the *movimento sanitário* because the *sanitaristas* were the only ones that had developed potentially viable proposals for a preventative reform of the health system.

The reformers from the *movimento sanitário* sought to reinvent Brazil's health system according to four principles:

> 1) Public health is a matter of social responsibility;
> 2) Health and illness are the products of social and economic conditions;
> 3) Public health measures should be taken to address both the medical and the social conditions that affect health; and
> 4) Under a democratic state, all citizens must enjoy a minimum standard of living in order to actualize their rights (Rosen 1980).

Whereas the pre-reform health system was restricted for those Brazilians that were part of the formal system, the movement sought to make health coverage universal. Whereas INAMPS was based on a curative model of healthcare, they desired a system that prioritized preventative health. Whereas the old health system had little coordination among agencies, the *sanitaristas* sought a system in which all healthcare was integrated into a single, unified system for all levels of government. And whereas the current health system was highly centralized, the *sanitaristas* wanted to construct a decentralized system that granted municipal governments and civil society actors a major role in setting priorities and developing health policies that would be appropriate for their communities.[15]

Given their expertise in public and community health, *sanitaristas* were named to positions in municipal and state secretaries of health, as well as federal posts in the Ministry of Health and INAMPS. The *sanitaristas* opposed the military rule, yet they were eager to work for the government to enact change from within. The movement had adopted a strategy that they called "occupying the state": they would take jobs in the bureaucracy with the aim of dismantling the old health system and advancing their reform vision from the inside.[16] Under *sanitarista* guidance, the military government began a series of policies to decentralize healthcare and promote preventative health. Yet the *sanitaristas*' strategy of pushing reform through their positions inside the state would soon start to show its limits, and the final steps towards a rights-based health system would only come once the health reform coalition expanded to include new allies.

3.3 Conflict Expansion: The Construction of the Reform Coalition

Shortly following the transition to civilian rule in 1985, the *sanitaristas*' strategy of reforming the health system from within began to hit its limits. Undertaking the final push to restructure the sector and create the unified health system entailed taking on powerful political interests. Even top positions in the bureaucracy did not provide sufficient power to restructure

[15] At this point the *movimento sanitário* did not place much emphasis on community participation; participation would become a core tenet later, as they expanded to inclue more groups in the reform coalition.

[16] For an explanation of the *movimento sanitário's* strategy to dismantle the health system from within using the lens of institutional change, see Tulia Falleti, 'Infiltrating the State: The Evolution of Health Care Reforms in Brazil, 1964-1988', in James Mahoney and Kathleen Thelen (eds.), *Explaining Institutional Change: Ambiguity, Agency, and Power* (New York: Cambridge University Press, 2010b), 38-62.

the health system without making compromises with elite politicians and powerful interest groups – compromises that would undermine the spirit of the reform. The *movimento sanitário* looked to expand the reform coalition to include grassroots allies that could bolster their position. It also sought to introduce participatory elements into the health reform to prevent entrenched interests from subverting reform.

The greatest sticking point involved the future of INAMPS, the government agency that administered the previous health system. The *sanitaristas* believed that the agency must be eliminated in order to clear the way for the new health system. They argued that the fundamental logic behind INAMPS – a centralized agency that paid private sector actors for local healthcare service delivery – was incompatible with the universal, integrated, and decentralized nature of the health reform. Instead, the *sanitaristas* wanted to eliminate INAMPS altogether and coordinate all healthcare via the integrated, decentralized, and unified health system under the purview of the Ministry of Health. In other words, they wanted the SUS model.

With the transition to democracy and the shared public commitment to social rights, the moment seemed propitious for a major, final overhaul of the health system. Nevertheless, *sanitarista* bureaucrats were limited in their discretion given the power of INAMPS's supporters, including private sector hospitals that received lucrative federal contracts and bureaucrats employed by INAMPS. *Sanitarista* bureaucrats could not unilaterally dismantle the agency (Faleiros et al. 2006: 47). A change as dramatic as eliminating INAMPS would require sufficient political capital to trump those interests that favored the status quo.

Given these institutional blockages, the *sanitaristas* realized that they would need to shift their focus to what Schattschneider (1960) called conflict expansion: rather than trying to change the system from within, they would need to build a popular movement to exert external pressure. Sweeping reform would be more likely if changes to the health system were debated and decided on in the public sphere and not behind closed doors of the bureaucracy. The *sanitaristas* reframed their efforts: health reform was part of the larger democratization process rather than a problem to be solved by technocratic experts. Thus, the design and content of the health reform should be determined through popular participation.

This new strategy of conflict expansion led the *movimento sanitário* to embrace fully participatory health councils as a central and necessary component of any future health reform. Until the 1980s participatory policymaking had not been a central tenet of their reform project, though the *movimento sanitário* had supported some initial experiments with community participation. Yet as their reform from within strategy became exhausted, the *sanitaristas* came to see that their reforms would be impossible to implement without citizen participation for two reasons. First, bureaucrats were fundamentally limited in their ability to discern the most important health needs for a community. Citizens must be empowered to make decisions about health investments and priorities to actualize their right to health (Fleury 1987: 95; Paim 2008: 106). The second rationale was more strategic: without popular mobilization, the health reform would fail on the ground. Governments and bureaucracies could not be counted on to enact faithfully a rights-based health system – particularly if an opponent of the reform came into power. Eduardo Jorge, a physician from the *movimento sanitário* who later served on the constituent assembly and in Congress, utilized this logic in explaining the need for councils:

> It's a search for institutionalization in formal channels where pressure from the popular [health] movement could take refuge

> and be guaranteed perennial access, in times of flood or times of drought, with the waters always running even when there is little.[17]

Thus, ongoing civil society mobilization via councils would deepen the reform by helping hold governments accountable, while developing a shared vision for health in their community.

The strategy of conflict expansion led the *sanitaristas* to call for a participatory national health conference. In 1986, the 8th National Health Conference brought together thousands of Brazilians to design a new health system. The conference's origins lay directly with the *sanitaristas'* unsuccessful attempts to eliminate INAMPS by decree. Waldir Pires, the director of INAMPS, was sympathetic to the goals of the *movimento sanitário*, but argued that INAMPS was the *patrimônio* (patronage) of Brazilian workers. This meant that a handful of bureaucrats (from the *movimento sanitário*) lacked the authority to eliminate this *patrimônio*. In response, top *sanitaristas* in the bureaucracy agreed that health was indeed the *patrimônio* of the people – not just formal sector workers – and given that health reform of some sort was inevitable, the new health system should be decided directly by the Brazilian people. Sérgio Arouca, a top bureaucrat in the Ministry of Health, proposed doing so via a national health conference. Diverse Brazilians would gather together in Brasília to deliberate how to design the new health system (Paim 2008: 98-99). Arouca agreed to plan and oversee the conference and embraced this monumental task with vigor, seeing a potential opening to create a universal and rights-based health system.

The conference would only have authority in designing a new health system if it was seen as the legitimate voice of the Brazilian people. The conference would have to be participatory, democratic, and representative. This required mobilization by a diverse array of stakeholder groups from throughout the country that spanned a range of partisan affiliations, and not just hail from the left. [18] If the left was overrepresented significantly, the conference would be seen as partisan and thus discredited in developing a health system that would reflect the public interest of *all* Brazilians. In other words, the reform coalition would need to expand far beyond its base of bureaucrats, professors, and physicians to include an array of new groups.

To ensure that the conference be seen as representative and democratic, bureaucrats from the Ministry of Health traveled throughout the country to spur popular mobilization and to facilitate the implementation of pre-conferences at the state and municipal levels. Delegates were selected from these pre-conferences to participate in the national conference in Brasília. These delegates included representatives from patients groups, clinics, hospitals, and community organizations; representatives from unions and other health workers associations; health bureaucrats from the federal, state, and municipal governments; and legislators from the Senate and Chamber of Deputies health commissions.

The legitimacy of the conference also depended on its autonomy. *Sanitaristas* in the government needed to tread lightly and not dominate the conference agenda and proceedings if the conference's findings were to have authority as the will of the Brazilian people. To safeguard the autonomy of participants, the government allowed civil society groups to select the

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[17] From an interview with Eduardo Jorge cited in Vicente De Paula Faleiros et al., *A Construção Do Sus: Histórias Da Reforma Sanitária E Do Processo Participativo* (Brasília: Ministério da Saúde, 2006) at 35.

[18] Importantly, participatory policymaking in 1986 not directly associated with the Workers' Party (PT) as it is today. The famous Porto Alegre experiment with participatory budgeting only began in 1989, and at the time the PT was divided with some factions supporting participatory processes, while others opposed them as inherently co-opting.

delegates for the national conference at the pre-conferences. At the national conference, representatives from the federal government facilitated deliberations and oversaw the logistics but did not set the agenda in advance.[19] Instead, the by-laws of the conference and the agenda were set by a committee of diverse civil society actors (Faleiros et al. 2006: 47).

Devolving this control to conference participants was a risky strategy for the *sanitarista* bureaucrats: ceding control over who participated and the agenda might mean providing access to groups that opposed their objectives. Nevertheless, these risks were outweighed by the potential legitimacy their proposals might gain through this strategy of conflict expansion. This openness to risk is reflected in Arouca's words during the opening of the conference:

> ...this reform can't be a proposal that comes from my mind, or from the minds of health professionals. It has to be constructed, desired, launched, and invented by Brazilian society, even if the final result isn't that which many of us wanted [...] This will be the way that we will construct our shared project, knowing that we will make many mistakes. Yet we will never make the mistake of straying from the path that leads to the construction of a more just Brazilian society. (Arouca 1987: 41-42)

The conference was structured around three core themes: health as an inherent right for citizens, the policy design of the new unified health system, and how this health system would be financed. The conference report established health as a fundamental right of all Brazilian citizens and asserted that the state had an obligation to guarantee this right; argued that all Brazilians should be members of a single, unified, decentralized, participatory, and integrated health system – the Unified Health System or SUS (*Sistema Única de Saúde*); and proposed that SUS be financed through automatic transfers among national, state, and municipal health funds – and thus not be subject to the political machinations of the normal budgetary process (Ministério da Saúde 1987: 382-88). The conference findings closely reflects many of the key principles behind the *movimento sanitário*, which was now being promoted by a broader reform coalition.

The conference advanced the claim that health reform was one of democratization and could not be limited to the experts. Extensive participation had ensured that the conference had a high profile and merited media attention. This participation also underscored the claim that its findings represented the popular will of the Brazilian people. President Sarney attended conference meetings, as did high profile legislators and ministers in the president's cabinet. The conference's final report was described as a "national consensus," and President Sarney and Ministers of Health, Pensions and Social Assistance, and Education made statements that affirmed the legitimacy of the conference in the *Jornal da Reforma Sanitária* (Paim 2008: 139). Whereas the elimination of INAMPS had seemed politically impossible before, it now seemed

[19] While opening up the conference to popular participation, the *movimento sanitário* still helped shape the agenda of the conference. A document produced by Abrasco, a *sanitarista* organization of public health professionals, provided an initial set of topics to be discussed and advanced the case for the rights-based approach to health. See Abrasco, 'Pelo Direito Universal À Saúde: Contribuição Da Abrasco Para Os Debates Da 8a Conferência Nacional Da Saúde', (Rio de Janeiro: Associação Brasileira de Pós-Graduação em Saúde Coletiva, 1985). Nevertheless, the *movimento sanitário* did not simply manipulate popular organizations to serve its own objectives; the final conference report closely matched the document initially presented by Abrasco, but also incoporated propositions and modifications made during debates, roundtables, and working groups.

inevitable because the Brazilian people demanded it. The conference brought health reform into the open and legitimized the idea that it should be decided through popular participation.

One of the most significant effects of the 8th National Health Conference was how it expanded the health reform coalition. Prior to 1986, the reform coalition was primarily composed of health professionals from the *movimento sanitário*. With the conference, however, the reform coalition expanded and gained a broad, popular face. The conference and pre-conference mobilization gave the expanded reform coalition a chance to develop a shared identity, discourse, and conceptualization of health reform (Rodriguez Neto 1988: 35). Moreover, the 8th conference strengthened the interest that the popular sectors had in reforming the health system. As we will see in the next section, the mobilization of these civil society groups would prove essential in the establishing and implementing the legal framework behind the health reform and the participatory health councils.

The health reform coalition expanded and crystallized even further in the following year. Different stakeholder groups, including representatives from popular health movements, the Catholic Church, women's movements, service providers, the labor movement, health professionals' associations, political parties, and subnational governments came together in May 1987 to formalize the health reform coalition in an alliance called the National Health Plenary. The Plenary was formed in the aftermath of the 8th Conference in the hopes of developing consensus among stakeholders in the sector on the details of the new health system. While the 8th National Health Conference established the underlying principles and a skeleton of what the new health system would look like, a more concrete design was needed.[20] The Plenary would work out this concrete design.

Leaders of the reform coalition believed that consensus was critical in establishing the Plenary's legitimacy. As one of the principle organizers of the Plenary explained, this alliance was essential "to guarantee that the country had a health system that is a duty of the state and a right of citizens, and to lay out the general principles needed to construct this system."[21] The reform coalition feared that politicians would pervert the new health system through compromises and adjustments that would undermine its core objectives. Indeed, this watering down process is precisely what happened in the case of Colombia's planning councils, as described in Chapter 6. A united bloc of stakeholder groups could countenance these dangers.

Using the 1986 National Health Conference report as a starting point, the National Health Plenary began developing language on health for the constituent assembly. Earlier in the 1980s, the *movimento sanitário* had allied largely with groups that were already sympathetic with its demands; in contrast, the movement now focused more on expanding the reform coalition and ensuring that all actors felt included in the system. A participant described it as a process of joint struggle and deliberation in developing proposals:

> A particular moment arrived when we focused more on the question of the health reform that we began to feel that we needed a more organic debate. So, what do the nurses think? What do the doctors think? What do the charitable clinics, the rural unions, the workers unions in industry and commerce all think? Everyone

[20] Inteview with Jacinta de Fátima Senna da Silva in Faleiros et al., *A Construção Do Sus: Histórias Da Reforma Sanitária E Do Processo Participativo* at 88.

[21] Interview with Crescêncio Antunes de Silveira, Assesor Especial, Ministério da Saúde and former Coordinator of the National Health Plenary. 16 March 2009.

> who had ideas wanted to express them. The plenary of stakeholders comes exactly from this confluence: it comes from a plural perspective, and from a basis of necessity that the health reform be thought through. We didn't "formulate" the proposal of the health reform that emerged from the 8th National Health Conference and that went into the constitution. Because it wasn't "formulated" in this period between 1986 and 1988. It was instead a process of fermentation…[22]

Indeed, Carlos Mosconi – a politician who was a member of the constituent assembly – argues that the rights-based health reform coalition was so successful in the constituent assembly precisely because it had developed a "very intelligent proposal that didn't exclude anyone."[23]

The largest challenge came would be winning over conservative politicians and private sector insurance companies and hospitals. In an interview, Crescêncio Antunes de Andrada, then-coordinator of the National Health Plenary, outlined the specific language that was altered to gain the buy-in of these private sector actors. For example, members of the Plenary originally proposed language for the popular amendment stating that: "health interventions and services are of a public nature." However, private sector actors were concerned that this "public nature" would threaten the potential role for the private sector in the new system. So, they negotiated a change in the language from "public nature" to "public interest," allowing for private sector participation in the new state-managed health system. These negotiations enabled the reform coalition to gain consensus and support among all stakeholders and enter the creation stage in a strong position to control the reform agenda.

4. CREATION OF THE LEGAL FRAMEWORK: BROAD RESPONSIBILITIES (1988-1990)

The reform coalition drew on substantial organizational and symbolic resources to ensure the creation of a strong institutional framework for the health councils, as summarized in Table 3.2. By expanding the coalition to include popular sector groups and unions, the reform coalition had gained substantial organizational resources, including the organizational infrastructure to mobilize large numbers of people for demonstrations and to lobby Congressmen. Moreover, the reform coalition harnessed symbolic resources stemming from the diversity of its stakeholders and the association between democratization and the health reform process. The reform coalition argued successfully that their proposals represented the public interest and that opposing these proposals would be equivalent to attacking the legitimate democratization process. Thus, attempting to water down the authority of the health councils would be seen as an attempt to subvert the democratic will of the people. Below, I explain how the reform coalition directed the reform agenda and thus managed to secure a strong institutional design for the councils at the two key moments of the creation stage: the 1988 Constituent Assembly and the passage of the 1990 health statute. Later, we will see that this strong institutional design facilitated the implementation and ultimate institutionalization of the health councils.

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[22] Interview with Arlindo in Faleiros et al., *A Construção Do Sus: Histórias Da Reforma Sanitária E Do Processo Participativo* at 90.

[23] Interview with Carlos Mosconi in ibid., at 88.

Table 3.2: Resources Leveraged by Brazilian Health Reform Coalition during Creation Stage

Resource Needed	Resources Available to Reform Coalition
Organizational resources	High
Symbolic resources	High
OUTCOME	**Strong institutional design**

4.1 Defining a Participatory Health System: The 1988 Constituent Assembly

Through a mobilization of symbolic and organizational resources, the health reform coalition was able to ensure that their proposed language was ultimately included in the 1988 constitution's articles on health. The health reform coalition took advantage of the constituent assembly's provision for popularly introduced amendments to the constitution and developed an amendment based on the 1986 conference report and National Health Plenary negotiations. In the end, the National Health Plenary obtained 54,133 signatures from representatives of 167 different civil society organizations. The Plenary's proposal for the constitution carried substantial weight since it was seen as the natural extension of the highly legitimate 1986 National Health Conference, and because of the diversity of organizations participating on the Health Plenary. The high number and diversity of signatories affirmed the Plenary's claim that their proposal reflected the will of the Brazilian people.

Once the popular health amendment had been presented, members of the health reform coalition turned their attention to mobilizing their organizational resources to apply pressure on the politicians in the constituent assembly. An array of different types of actors – such as unions, patients' associations, the church, and municipal governments – descended on Brasília for this purpose. The diversity of actors lobbying on behalf of the popular amendment reinforced their argument that the proposal for a new health system was non-partisan, would serve the public interest, and reflected public will. Thus, the health reform movement was able to tap into valuable symbolic resources related to democratization and social rights. With the democratization project, politicians were particularly attuned to the framing of social rights as part of democratization. In fact, the former coordinator of the National Health Plenary believes that the health reform's radical changes were only possible due to their mobilization at that particular moment of history:

> In the constitution, we achieved fundamental issues that under other circumstances would never have passed. There was the idea, for example, that health is a right of citizenship and a duty of the state. We see this come to be consecrated and written in the constitution. […] And the private sector – the forces that opposed these shifts – did not find room to maneuver. Why? Because this change came from the broader movement… It was not just the health sector, it was all Brazilians. […] The health movement combined with the broader democratization movement, and

> everyone joined together to apply pressure in the corridors of Congress.[24]

Another interviewee that had served in the bureaucracy added that their popular health amendment passed because the Plenary's earlier negotiations with the private sector made the proposal seem non-partisan and thus palatable to all politicians:

> In the final vote it was important that the conservative sectors ended up supporting the creation of SUS, agreeing with its principles. […] We gave up a few things, but the important thing is that in the core of the question we did not cede anything: universal coverage, equity, decentralization and *controle social* [societal oversight via councils]. *Controle social* was the most difficult to achieve.[25]

Some conservative politicians viewed the participatory institutions in the new health system with wariness, fearing that the councils would provide access to the left at their expense. In the end, the mandate behind participatory health councils was able to pass because the reform coalition demonstrated that it had support from a range of different stakeholders – not just the left. In other words, the councils had gained legitimacy as representatives of society and not just of a few narrow groups, and defenders of the public interest and not private or partisan interests.

In the end, nearly all of the final constitutional text for the health system would come from the reform coalition's popular amendment. This included provisions saying that SUS would be governed through popular participation of the community. The coalition won its argument by mobilizing diverse actors and harnessing the salient symbols of democratization and social rights. The constitutional language had not established a clear design for the participatory health councils, but was a major victory in the path towards empowered participatory policymaking in the health sector.

4.2 Creating an Empowered Legal Framework: The 1990 Health Statute

The next step in the creation process was to turn the general principles established in the constitution into a concrete legal framework with a new health statute. The health reform coalition found the task of passing the health statute to be more difficult than that of getting their favored language into the constituent assembly. Nevertheless, the coalition's symbolic and organizational resources were sufficient to overcome the extremely hostile conditions of the Collor presidency and secure the passage of the 1990 health statute (*Lei Orgânica de Saúde*). The health statute consists of two laws: Law 8080/1990 and Law 8142/1990. Law 8080 establishes SUS as a universal, integrated, and unified system that operates at all levels of government. Law 8142, in turn, outlines the specific roles of national, state, and municipal governments, establishes that inter-governmental transfers are to be automatic and based on objective (and not political) criteria, and mandates societal oversight of the health system

[24] Interview with Crescêncio Antunes de Silveira, Assesor Especial, Ministério da Saúde and former Coordinator of the National Health Plenary, 16 March 2009.
[25] Interview with Carlos Mosconi in Faleiros et al., *A Construção Do Sus: Histórias Da Reforma Sanitária E Do Processo Participativo* at 88.

through citizen participation in the form of councils and conferences. Together, these two laws represent a major legal shift in the structure and orientation of health policy in Brazil.

Once the constitution had been passed, the reform coalition had turned its attention to the passage of the health statute. The National Health Plenary continued to meet and developed language that was based on the key principles established in the 1986 National Health Conference, with some changes to accommodate some of the newer members of the reform coalition (namely, the private sector).[26] When Congress began debating the content of the new health statute, the reform coalition had already developed and vetted specific proposals, which entered the agenda. The reform coalition continued the strategy it had used during the constituent assembly: they presented their proposals as the will of the people and the logical conclusion of democratization, and diverse actors from the coalition lobbied members of Congress. The coalition brought in secretaries of health from the members' districts to demonstrate that the health reform was not just an abstract national proposal, but rather something that their constituents demanded. Eduardo Jorge, a *sanitarista* physician and deputy from São Paulo, explained that the reform coalition achieved this success through a combination of popular protest and grassroots lobbying of Congress:

> Members [of the reform coalition] sought out deputies that were in the opposition so that these deputies realized that they had constituencies that were networked and capable of criticizing them… A deputy isn't afraid of a broad-based protest. If his constituency is from [the interior states of] Pernambuco, or Paraíba, or Amapá, then his constituency isn't very affected by this protest, so he is immune and resistant to pressure of this sort… But, when the federal deputy from Ceará [a small northeastern state], for example, receives a visit from state deputies, and from city councilmen, and from municipal secretaries of health from the interior of Ceará, he pays attention because he knows that this issue will have repercussions for his city, for his constituency.[27]

The symbols of democratization and social rights were still salient, amplifying the effect of these arguments. Ultimately, the health reform coalition succeeded in getting most of the key elements of its desired reform approved with the passage of the health statute bill. Among other things, the bill called for the creation of participatory health councils with formal policymaking and budgetary authority, and periodic national health conferences.

While the reform coalition had success in Congress, they were blocked when Collor refused to sign the law in its entirety and vetoed 11 key articles. The vetoed articles included those related to decentralization, integrated service delivery, and societal oversight via health councils and conferences. Collor argued that the provisions related to the health councils and conferences were unconstitutional, since the executive, not the legislature, was granted the authority to create state agencies. More broadly, Collor opposed the creation of the councils

[26] These modifications weakened the dominance of the state in SUS and opened up space for private sector health insurance companies and service providers to provide complementary, private care for those who could afford it.
[27] Interview with Federal Deputy Eduardo Jorge (PT-SP) in Faleiros et al., *A Construção Do Sus: Histórias Da Reforma Sanitária E Do Processo Participativo* at 135.

because they might provide a space for those in the reform coalition to advocate for the health reform, which he had opposed.

Outraged at this veto, proponents of the health reform responded immediately by mobilizing support behind a new bill that would reinstate the vetoed articles nearly verbatim (Faleiros et al. 2006: 116-18, 30-37).[28] Politicians, subnational governments, and civil society groups joined together via the National Health Plenary to coordinate their activities and demonstrate that society wanted the rights-based reform of the health system. Organizing through the Plenary also enabled reform proponents to coordinate directly with Alceni Guerra, the Minister of Health, in developing a new bill that would recoup the vetoed articles from Law 8080 (Carvalho 1995: 72). In other words, the reform coalition mobilized the organizational resources that came with the National Health Plenary's formal organizational structure.

The bill behind Law 8142 was proposed on November 16 and was passed shortly afterwards, on December 28, 1990. The rapid passage of Law 8142 was directly related to the mobilization of the reform coalition via the National Health Plenary. The reform coalition amped up its mobilization efforts to make it clear that Collor was vetoing the health system desired by all stakeholders in the health system, and by the Brazilian people more broadly. Facing intense political pressure, Collor reluctantly signed the second bill into law just two months after the line item veto (Carvalho 1995: 72; Faleiros et al. 2006: 133-37).

With the passage of the 1988 Constitution and the 1990 health statute, the legal framework behind the participatory health councils was in place. This legal framework established that health policy would be developed in a participatory fashion, and that this participation would come in the form of health councils at each level of government. These health councils would have formal authority and were to serve a major role in developing and implementing health policy. Despite these considerable advances in creating the health councils, the regulatory framework behind the health statute remained vague. This left major decisions about how to structure and implement the health system to be determined in the future within the executive branch (Weyland 1996). Passing the health statute was only one step in the broader reform struggle – albeit an important step. As we will see in the next section, the most difficult work in constructing the health councils would come during the implementation stage.

5. IMPLEMENTATION (1991-2002)

With the battles over the creation of the health system settled, attention turned to the thorny issue of implementation. A great deal of work was still needed to make the new health system, and the health councils, operational. As this section will show, the health reform coalition continued to mobilize informational, symbolic, and organizational resources in support of the health councils. The councils' authority expanded with the creation of a regulatory framework that clearly specified the institutional role of councils and established enforcement mechanisms to back the participatory mandate. Funding was guaranteed for councils at all levels of government. As a result, compliance with the national mandate jumped dramatically: whereas only 6% of municipalities had health councils in 1990, this number soared to 94% by 2002.[29] At the national level, the National Health Council began operations and gained a central role in

[28] Together, Law 8080 of 1990 (which was subject to the line item veto) and Law 8142 of 1990 (which reinstated the vetoed articles) serve as the health statute (*Lei Orgânica de Saúde, LOS*.)

[29] Data from the Perfil dos Conselhos de Saúde no Brasil dataset, DCS/NUPES-DAPS/ENSP/FIOCRUZ.

major decisions involving the structure of the new health system – decisions that reinforced the authority of the health councils. Moreover, the legitimacy of the health councils grew steadily as they began to take shape as a focal point in health policy: both civil society groups and government actors recognized the councils as the logical site for engagement between the state and civil society. In sum, by the end of the implementation stage, the health councils were well on their way to institutionalization.

The success of the health councils during the implementation stage can be traced back to their broad reform coalition that formed during the 1980s, which grew even stronger in the 1990s. The strong legal framework established during the creation stage reinforced the commitment of stakeholders in the reform coalition to the health councils. This was largely due to strategic reasons: the councils now provided a real opportunity for policy access and influence. The diverse reform coalition was able to mobilize the resources needed to pressure the government in the implementation stage, summarized in Table 3.3. The coalition harnessed informational resources and expertise to develop proposals that would be valued by the government, used its organizational resources to mobilize mass numbers of people during periodic health conferences, and further applied symbolic resources that linked health council inclusion with democratization and "good governance." As a result, the health councils began to take organizational shape and develop legitimacy throughout the implementation period.

Table 3.3: Resources Leveraged by Reform Coalition during Implementation Stage – Brazil Health

Resource Needed	Resources Available to Reform Coalition
Organizational resources	High
Symbolic resources	High
Informational resources	High
OUTCOME	**Construction of participatory institution**

5.1 Implementation during the Collor Government (1990-92)

A number of advancements in the construction of the health councils were made during the years immediately following the passage of the health statute. National, state, and municipal health councils were established throughout the country, and the outlines of a regulatory framework for the councils began to take shape. Given the government's hostility to the new health system and to the health councils in particular, these advances were possible only due to the health reform coalition's persistent mobilization, both within and outside of the state.

Considerable work was needed to make the health system – and particularly the health councils – operational. The first major step lay in developing the regulatory framework behind SUS. The health reform would be toothless and open to political manipulation without a clear and strong regulatory framework that identified the roles, responsibilities, and rights of different actors at each level of government, including the health councils. These issues would need to be clarified via regulatory orders (*Normas Operacionais Básicas*), which are "rules for the organization and financing of SUS that are mandated by the Ministry of Health, via decrees with appendices that detail the procedures to be observed by states and municipalities interested in receiving federal transfers" (Santos and Andrade 2007: 35).

The hostility of the Collor government to the rights-based health system was reflected in its regulatory orders. Regulatory orders approved in 1991 and 1992 either did not reflect, or directly contradicted, the health statute. For example, the administration failed to dismantle INAMPS, the government agency behind the old health system. Instead, regulatory orders gave the agency new roles in administering SUS, directly violating articles in the constitution and 1990 health statute that mandated a unified organizational structure for the SUS. The Ministry of Health also approved regulatory orders that contradicted the health statute's call for automatic transfers to municipal and state secretaries of health. According to the health statute, subnational secretaries of health would enjoy a basic level of autonomy in designing and implementing programs. Transfers would be determined based on objective criteria, such as population size and the number of children in the municipality. Instead, the regulatory orders declared that resources would be transferred to state and municipal governments via service delivery contracts between the federal government and service providers (Levcovitz et al. 2001: 273-75; Santos and Andrade 2007: 35-43). This model left little autonomy for subnational governments to allocate funds according to local needs, and politicized inter-governmental transfers: money would be allocated based on electoral criteria and not based on need – directly violating the spirit of the rights-based system (Arretche 2002: 448-49; Levcovitz et al. 2001: 274-75).

As with the health system in general, implementation of the mandate for participatory health councils lagged during the Collor administration. Regulatory orders in 1991 and 1992 did reaffirm that subnational governments would need to have councils to receive automatic transfers, but there was little oversight and zero enforcement of this requirement. Besides, most inter-governmental transfers still happened through service delivery contracts and not through automatic transfers.

The number of municipal and state health councils in operation increased somewhat during the Collor period, but council implementation was still far from universal. 6.3% of municipalities had a health council in 1990, with this number rising to 39% when Collor was impeached in 1992 (Perfil dos Conselhos de Saúde dataset). At the same time, these relatively low numbers are overly rosy, given that the increase only reflects the formal existence of health councils. Many of the new councils created failed to comply with the requirements of the health statute: that councils be deliberative, permanent, with 50% of seats dedicated for health system users, and that the council writes and approves its own internal by-laws.

Despite hostilities from the government, the National Health Council made major advancements during this period in developing its new institutional framework. The National Health Council had existed since the 1930s, but was only established in its current form in April 1991. In its previous manifestation, there were only seven councilors, and each had been appointed by the Minister of Health. When the Council was reconstituted in April 1991, the number of councilors expanded to 32. The new Council had parity between health system users and other types of councilors, including workers, service providers, and government representatives. Moreover, these societal councilors would be selected by their peers and not appointed by the government, protecting the Council's autonomy. The National Health Council approved its new by-laws in July 1991 (Conselho Nacional de Saúde 1991).

The National Health Council developed an inconsistent role in the policymaking process during these early years. For example, they made significant contributions to debates about the creation of a national community health workers program, and in designing the decentralized financing of the new system. Yet the National Health Council did not have a major role in deliberating the 1991 and 1992 regulatory orders.

Those in the reform coalition, including national councilors, saw the regulatory orders as evidence that the Collor government was intent on subverting SUS.[30] It became clear that a strategy of concertation with the government would be ineffective in ensuring implementation. Instead, the reform coalition would need to adopt a strategy of confrontation and popular mobilization, to complement the activity of the National Health Council. This mobilizational strategy would ensure that decisions about the health system remained in the public eye and not behind closed doors, where the government would undermine the health reform.

In line with its mobilizational strategy, the reform coalition expanded to include new groups during these years. The expanded reform coalition included various stakeholders that had a vested interest in the health reform, even if they had not mobilized during the legal struggles in 1988 and 1990. For example, at this point in time, you see a growing role in the reform coalition for municipal governments. Municipal governments had very high stakes in the implementation of the health reform and sought the automatic resource transfers from the National Health Fund. The municipal governments would not normally advocate for a participatory mandate at the local level. Yet since the councils would be a central component in how these transfers would happen, municipal governments came to see council implementation as key to their own interests.

To nurture this alliance between the reform coalition and subnational governments, the National Health Council explicitly focused on developing ongoing relationships with municipal and state health councils. One national councilor at the time explained that:

> In the National Health Council, we discussed that in order to make societal oversight [via councils] viable, we had to establish relationships with municipal and state councils. The legislation of SUS applies to all three levels of government – so could a national councilor fulfill his role if he didn't have a relationship with state and municipal councils?[31]

Councilors on the CNS saw the subnational councilors as valuable allies that could facilitate popular mobilization, particularly via the periodic health conferences.

The expanded reform coalition was further strengthened by the strong institutional design established in the health statute. In particular, Law 8142 mandated that municipal, state, and national health conferences were to be held every four years, thereby providing the reform coalition with opportunities for popular mobilization. In the early 1990s, the health conferences were key in facilitating and coordinating popular mobilization in favor of the health reform, and they provided the ideal opportunity to challenge the government's weak record on implementation.

The Collor government (understandably) did not want to hold a national health conference, but it had little means of stopping it. The health statute established that conferences happen every four years, meaning that the 9th National Health Conference should have happened in 1990. Moreover, Law 8142 stated that if the executive failed to convoke the conference, the National Health Council could do so instead. If the Ministry of Health blocked the National Health Council from holding the conference, the Council would have had a strong legal case in

[30] Note that the *movimento sanitário* split to some degree with Conasems, the organization representing municipal governments. Conasems criticized these regulatory orders, but saw them as steps forward.

[31] Interview with Jocelio Drummond, National Health Councilor representing health workers from 1990-2000, in Faleiros et al., *A Construção Do Sus: Histórias Da Reforma Sanitária E Do Processo Participativo* at 141.

the courts. Here, the strong institutional design of Brazil's participatory health councils would prove instrumental in ensuring continued mobilization.

The National Health Council established "Municipalization is the Path" as the theme of the 9th National Conference, which was held in 1992. The conference was to focus on concrete strategies to decentralize financing and administration of SUS – precisely the areas in which the Collor administration had attempted to undermine the health reform. In early 1992, the National Health Council and Conasems (the organization representing municipal secretaries of health) facilitated the implementation of over 3000 municipal health conferences and 27 state health conferences in preparation for the national conference. In August 1992, the 9th National Health Conference was held in Brasília. 3000 delegates and 1500 observers participated, including representatives from half of Brazilian municipalities.

The profiles of those participating were diverse – more so than those from the 8th National Health Conference in 1986. The stakeholders participating in the conference included such groups as the Catholic Church, healthcare providers, and subnational governments (Faleiros et al. 2006: 139). In contrast, the 8th National Health Conference from 1986 primarily counted on participation from grassroots organizations. Thus, the reform coalition had expanded to include more stakeholders. This expansion was important in reaffirming the reform coalition's claim to represent the interests of *all* Brazilians. This symbolic claim was crucial in portraying the government's partial implementation of the health system as going against the will of the Brazilian people and thus undemocratic.

The 9th National Health Conference's final proceedings reaffirmed the Brazilian public's support for SUS, condemns the fiscal reforms promoted by the Collor government, and develops strategies to implement automatic inter-governmental transfers to states and municipalities. Moreover, the proceedings emphasize the importance of strengthening the councils and conferences as a means of deepening democratization (Faleiros et al. 2006: 120). As one set of scholars stated, the conference "was fundamental both in articulating strategies for action as for mobilizing the relevant actors and society" (Faleiros et al. 2006: 120).

The conference's timing heightened its visibility and impact. August 1992 was a particularly weak period for the Collor government. The conference took place the same week as a major protest against the Collor administration from the impeachment movement, which sought impeachment on charges of gross corruption and abuse of power. The impeachment movement channeled not only the Brazilian public's frustration with government corruption, but also the high social costs of the Collor government's neoliberal policies. The health and impeachment movements united their efforts against the Collor government given their shared concerns with corruption and social rights. In addition to its health proposals, the final conference report declared support for the impeachment movement.

By the time Collor was impeached in late 1992, the health reform coalition was in a solid position to further advance their goals, including the construction of empowered participatory health councils. At first glance, the position of the reform coalition might appear weak: the legal framework was still lacking, subnational council implementation was mixed, and the National Health Council had not yet made major contributions to health policy decisions. Nevertheless, the coalition had used this period to nurture ties among members of the health reform coalition, thereby strengthening their organizational and symbolic resources. They had kept health reform on the public agenda, and they had challenged decision-making behind closed doors.

5.2 Implementation during the Franco Government (1992-94)

Implementation of both the health councils and SUS advanced further during the transition government of Itamar Franco. The government of Itamar Franco was defined by attempts to reconcile divergent interests in the wake of Collor's tumultuous removal from office in 1992. Franco collaborated with groups in the health reform coalition to develop the institutional framework behind the new health system. These steps in elaborating SUS reinforced the authority and legitimacy of the health councils, which were woven into the institutional design; establishing a council was a necessary step for subnational governments to receive automatic transfers. The steps towards implementation during the Franco government reflects both the government's interest in appeasing the highly mobilized health reform coalition, as well as the movement's ability to mobilize informational and organizational resources.

Why did implementation of the health councils advance during the Franco government when it had stalled under Collor? Franco's government had a political interest in opening up spaces for civil society participation in the design and implementation of health policy. The government invested in the councils to advance both its political agenda, as well as its policy agenda. In terms of the political agenda, Franco recognized that appeasing the health reform coalition would go a long way in his task of building social peace. The reform coalition had helped to topple Collor and thereby had shown its power in mobilizing symbolic and organizational resources. This social peace would be essential in order for him to have a chance to implement some of the needed economic reforms. Furthermore, including the health reform movement in policymaking advanced the government's policy agenda. While the government was not particularly attached to SUS from an ideological point of view, it clearly needed to do *something* in the area of health. The councils could contribute expertise and help develop policy proposals and thereby help the government with the difficult task of constructing the new health system.

With considerable input from the National Health Council, the government of Itamar Franco oversaw major advancements in the construction of SUS. INAMPS was eliminated finally, clearing the institutional path for SUS to be a truly unified health system. The important family health program, *Programa Saúde da Família*, was established in 1994; this program would come to serve as the centerpiece of primary healthcare in SUS. And, the decentralization process was accelerated with the passage of a new regulatory order in January 1993. This regulatory order outlined the criteria for subnational governments to receive automatic transfers from the National Health Fund. The elaboration of these criteria was a key step in decentralizing and depoliticizing the health system. Subnational governments would now have a major role in administering the health system, and health funding would not be dependent on political allegiances to the president or members of Congress. Importantly for this study, the 1993 regulatory order mandated that municipal and state governments establish permanent health council as one of the criteria to receive automatic transfers – a major institutional step in establishing a national system of health councils. By 1994, 1400 municipalities (out of approximately 5000) had met these criteria and thus would qualify for automatic transfers (Faleiros et al. 2006: 126).

Due in part to the 1993 regulatory order, the prevalence and institutional role of the health councils expanded during the Franco presidency. By late 1993, 2108 municipalities had registered their municipal health council with the National Health Council (Carvalho 1995). The 1993 regulatory order provided institutional teeth behind the mandate that all states and municipalities adopt health councils. The 1991 and 1992 regulatory orders had required that all

governments implement health councils, yet they did not specify any sanctions for governments that were not in compliance. In contrast, the 1993 regulatory order made the creation of a council a condition for the receipt of automatic transfers from the National Health Fund.[32] Moreover, for governments to receive transfers, the health councils also needed to match the institutional design established in national law. For example, health system users must have 50% of council seats, councilors from civil society must be selected by their peers and not appointed by the government, and the council must have formal policymaking and budgetary authority. Linking council implementation to inter-governmental transfers was a powerful carrot, since most municipal governments depended on National Health Fund transfers for nearly all their health budget.

Tying council implementation with automatic transfers provided important symbolic value to the councils. The text of the 1993 regulatory order stated that decentralization "should be understood as a process of redistribution of power," which included "a reformulation of practices of societal oversight (*controle social*)." By including the councils as part of the procedures for decentralization and inter-governmental transfers, the 1993 regulatory order framed the councils as an core institutional design component of the new health system (Faleiros et al. 2006: 129). Decentralization and inter-governmental transfers had been accepted as part of the new health system, and consequently the councils themselves became an unquestioned part of the new health system. Opposition to the implementation of the councils would be seen as resisting implementation of SUS in general – an illegitimate view.

As the legal framework behind the subnational councils developed, the National Health Council's policymaking role also took shape. Council meetings became more routinized, and the Council created various commissions for particular areas of health policy, such as the education of health professionals and health system financing. These commissions enabled the National Health Council to develop specialized policy proposals for diverse aspects of SUS. Moreover, the Franco government reached out to the National Health Council for help with a number of policymaking issues, helping cement the Council's role in the new health system.

As one example of the Council's involvement in policymaking, the proposals and deliberation of the National Health Council led directly to the creation of an information system needed for monitoring and evaluation. Members of the National Health Council had grown frustrated that they were responsible for overseeing the implementation of SUS throughout the country, yet they did not have full access to information about what money subnational governments were receiving, how they spent it, and the results of this spending. The Ministry of Health failed to redress this problem, leading the National Health Council to team up with the Public Prosecutor for Citizen Rights (*Procuradoria Federal dos Direitos do Cidadão*) in developing the Public Health Budgets Information System, or SIOPS (*Sistema de Informações sobre Orçamentos Públicos em Saúde*) (Faleiros et al. 2006: 127-28). This information system not only provided the CNS with valuable information to fulfill their policymaking responsibilities, but it also served as a key aspect in the elaboration of SUS. Furthermore, the Council had undertaken successfully a key task in the development of SUS, thereby reaffirming its ability to contribute valuable policy proposals, and its legitimacy and authority in doing so.

The National Health Council also took a number of steps to nurture the national system of councils and conferences. In the hopes of sustaining the health reform coalition's capacity to

[32] The 1993 regulatory order and subsequent regulatory orders established that in order to receive automatic transfers, states and municipalities must have in place a health fund, a multi-year health plan, and a permanent health council.

mobilize people throughout the country, they convoked several conferences for targeted issues in health, such as the 2nd National Conference for Workers' Health (Faleiros et al. 2006: 127). Moreover, the CNS played a key role in enforcing the new framework established with the 1993 regulatory order. The CNS demanded that states provide evidence that they had created state health councils. It also elaborated enforcement mechanisms to punish states that failed to comply, using their control over the National Health Fund to provide both carrots and sticks to subnational governments. Again, the strong institutional design established during the creation stage gave national councilors the tools to create favorable conditions for health council institutionalization. Without formal policymaking authority and budgetary powers, the CNS would have been unable to provide either carrots or sticks to subnational governments beyond social sanctions.

How did the health councils gain so much ground during this short period? As highlighted above, the administration was in a delicate position and was dependent on civil society acquiescence during this period due to the tumult of the Collor impeachment. And, the health reform coalition was particularly well-suited to take advantage of the government's delicate position to advance implementation of the health reform and the health councils. The health reform coalition was especially effective in mobilizing organizational and informational resources to bolster the health councils.

The health reform coalition's high capacity to mobilize organizational resources gave them political leverage: the government needed to make concessions to the movement if it hoped to advance the social peace. The movement was highly visible and mobilized, and was one of the strongest social rights movements. Thus, any attempt to pacify social rights movements would mean reaching out to the health movement. The organizational strength of the health reform coalition was apparent before Franco even took office. The health movement was known as being highly mobilized due to their success in coordinating and mobilizing thousands of people for the 8th and 9th National Health Conferences in 1986 and 1990, respectively; the 1988 constituent assembly; and the impeachment movement that resulted in Collor's ouster. The reform coalition's reputation made credible its claims to represent millions of Brazilians.

The reform coalition was able to sustain its capacity for mobilization through its organizational resources. In particular, the coalition was still formally organized via the National Health Plenary. This umbrella organization for the health reform movement gave the reform coalition permanent staff, a means for coordinating strategies, and facilitated their ability to mobilize a large base from throughout the country. The different subnational health councils were linked in with the National Health Plenary, making it easier to formulate new councils, populate those councils, and ensure routinized operation according to the regulatory framework. Moreover, the councils' federalized structure meant that if a local government violated the regulatory framework, the local councils could signal this malfeasance up the chain and receive a quick response.

The councils also gained policymaking access – and therefore the ability to ensure that the regulatory code favored council implementation – because the government needed the unique information and expertise possessed by some members of the reform coalition. The government alone did not have the on-the-ground knowledge, experience, and political authority needed to make the health system viable. Participation and buy-in from key stakeholders, including municipal secretaries of health, health professionals, academic experts in health systems design, and service providers, would be needed. The councils, and particularly the CNS, were sites that could aggregate feedback and proposals from these stakeholder groups. Consequently, it was

only natural for the Franco government to reach out to the National Health Council as it developed the 1993 regulatory order. As we will see below, this dynamic would become even stronger during the Cardoso government.

5.3 Implementation during the Cardoso Government (1995-2002)

Despite the major advancements made during the Franco administration, the fate of Brazil's health councils remained uncertain when Fernando Henrique Cardoso took power in 1995. The 1990 health statute stated that councils would have a "permanent and deliberative character" at all levels of government, yet only 67% of municipalities had the "mandatory" councils in 1994. The 1993 regulatory order linked inter-governmental transfers to council implementation, yet there were no enforcement mechanisms in place to ensure compliance. And while the 1990 health statute says that the councils would "act in the formulation of strategies and the oversight of health policy implementation,"[33] many of the specific responsibilities and prerogatives remained fuzzy. The institutional skeleton behind the health councils had been established, but lacked the muscle would enable the system of councils to operate as a political institution.

By the end of the Cardoso administration, it was a different story. Brazil's health councils expanded to nearly universal coverage, with councils in 95% of municipalities (Ministério da Saúde 2009). Moreover, the health councils had developed a clearly defined and concrete role in the policymaking process. The regulatory framework for the new health system and councils was elaborated during this period. The regulatory framework further specified the composition, practices, and responsibilities of the councils. The development of this regulatory framework was essential to provide a common model of what the councils should do, and to ensure that council implementation did not simply depend on the discretion of local politicians. The 1996 regulatory order established that councils at all levels of government must be involved in major decisions related to health financing and cost controls; human resources; and the implementation, monitoring, and evaluation of health programs. The same order also specified that each state and municipality must have a health council in place to receive a federal transfer from the National Health Fund and that this council must also approve the health budget. If a municipality did not comply, it would not receive its inter-governmental transfer – a step not taken with earlier regulatory orders. Thus, subnational governments now had a financial incentive to comply with the participatory mandate; indeed, we see a major increase in the percentage of municipalities with participatory health councils from 70% in 1996 to 83% 1997. One public health scholar currently employed by the Ministry of Health argued that these orders were essential to flesh out the basic idea of participatory policymaking in health:

> These regulatory orders provided the institutional structure for the health councils to make them match what is in the legislation. Every municipality and every state had to establish a council as a condition of receiving financial resources from the health system – they have to have their council in operation. It means they have to comply with what is laid out in the legislation. So, these regulatory orders were largely responsible for the advancement and

[33] The Brazilian health statute is composed of two laws, Law 8080 and Law 8142 of 1990. The sections on participatory policymaking are outlined in Law 8142.

> expansion in the implementation of municipal and state councils in this country.[34]

The Cardoso government provided material and human resources to support this regulatory framework. For example, the Secretariat of Institutional Development established a training program for councilors from throughout the country. This program, run by the Federal University of Minas Gerais, provided councilors with information on institutional design of the health system, the budgetary process, and the legal instruments available to hold their governments accountable. The national government also sponsored two national health conferences and provided a permanent meeting space, full-time staff, and a basic operations budget to support the National Health Council (CNS – *Conselho Nacional de Saúde*). The Cardoso government's material support stands in stark contrast with the experience of Colombia's health councils, which have no dedicated staff and negligible financial support.[35]

Perhaps most surprising, the health councils – particularly the National Health Council – gained a role in the policymaking process during the Cardoso years and were able to help shape the construction of the new health system. The National Health Council deliberated major questions related to the structure of the health system, including financing, decentralization and implementation in the federal system, coordination with other policy sectors, the establishment of policies targeted at specific diseases (e.g. HIV and Hansen's disease), and mobilization of civil society (Faleiros et al. 2006: 169). These deliberations resulted in the passage of regulatory orders structuring the health system in 1996, 2001, and 2002.

Moreover, the health councils were instrumental in mobilizing at the grassroots level and lobbying Congress. This organizational capacity for mobilization enabled national councilors successfully mobilized to block a proposed constitutional amendment in 1995 that would have tempered the constitution's language in establishing health as a right of all citizens and duty of the state.[36] The Council was also key in advancing Constitutional Amendment 29 in 2000, which guarantees separate sources of health financing, outside of the Congressional appropriations process. One CNS staff member explains:

> Civil society and the National Health Council were very important, not because of the mobilization of the council itself. The Council only had 32 councilors that don't have much weight in and of themselves. But when these councilors went to the organizations they represent, they mobilized the labor unions, the national organizations of people with disabilities and chronic illnesses, they mobilized the Brazilian National Congress of Bishops that was on the council, the organizations representing businessmen from industry, agriculture, and commerce. Everyone was mobilized in the halls of Congress, from the grassroots, so much so that it

[34] Interview with Ana Costa, Director, Departamento de Apoio à Gestão Estratégica e Participativa, Ministério da Saúde, October 15, 2008.

[35] Colombia also has a system of nationally-mandated health councils, which I examine in my dissertation. These councils have become deinstitutionalized and only exist in a few municipalities, exemplifying the broader Colombian pattern of deinstitutionalization.

[36] Interview with Maria Luiza Jaeger, former Municipal Secretary of Health for Porto Alegre and former State Secretary of Health for Rio Grande do Sul, in Faleiros et al., *A Construção Do Sus: Histórias Da Reforma Sanitária E Do Processo Participativo* at 182.

> [Constitutional Amendment 29] was approved.[37]

The Cardoso administration seems to be an unlikely government to invest in the health councils. Many members of the administration, including Cardoso, opposed several of the objectives of the health reform coalition. Moreover, most national councilors had voted for Cardoso's opponent, Lula from the PT, in the 1994 presidential election. We would not expect Cardoso to invest resources into the councils and thereby grant additional access to his political opponents.

In the health sector, the Cardoso administration supported the implementation of the programmatic, integrated health system established by the health statute. Cardoso came from the center-right PSDB, a programmatic political party that presented an alternative to the clientelist agendas of most Brazilian parties. The government sought objective, evidence-based criteria behind health policy. Consequently, his administration supported the continued development of SUS; the new health system presented a potentially more efficient and effective alternative to the flawed health system of the past.

While supporting the rationalized nature of SUS, however, the administration did not support the social rights precepts behind the new system.[38] Instead, the government used the language of efficiency and improved quality of services for clients of SUS. Indeed, the administration proposed a constitutional amendment in 1995 that would have weakened the language in the constitution establishing health as a "right of citizens and a duty of the state." The proposed amendment added a clause qualifying that state had a duty to provide health only as established in the law (rather than as a fundamental social right) – effectively weakening the state's responsibilities. (This constitutional amendment was ultimately defeated following a period of intense mobilization by the right to health movement.) The Cardoso government viewed poor management, not the lack of resources, to be the main problem facing SUS. Economists, and not physicians, should be in charge of structuring the health system in order to enhance effectiveness and efficiency.

Given this technocratic focus, it is perhaps not surprising that Cardoso and the PSDB have not been known for embracing participatory policymaking (Raichelis 1998; Yazbek 2004).[39] Indeed, Cardoso's first Minister of Health, Adib Jatene, failed to install the National Health Council when he took office in 1995, arguing that the Council was no longer necessary (Faleiros et al. 2006: 191-92). The National Health Council had been dominated by organizations that staunchly opposed the government's policy agenda in health. Few of these participants had linkages to the ruling PSDB, and most were sympathetic to the opposition center-left Workers' Party. The administration's ideal reform package would prioritize market incentives designed by economists and would limit societal engagement, which should be seen as "special interests" that would hamper efficiency in the sector. The Cardoso government seemed

[37] Interview with Nelson Rodrigues Santos, professor of preventative medicine, ex-CNS staff, and former president of the National State Secretaries of Health Council, in ibid., at 183.

[38] It is important to note that there were divisions within the Cardoso administration. Cardoso's first minister of health – Adib Jatene – had served on the National Health Council during the Franco administration and in private sympathized with many of the arguments made by the right to health movement. However, in the first Cardoso administration the fiscally conservative minister of health and the architect of the *Reforma do Estado*, Luiz Carlos Bresser Pereira, held more sway in determining the administration's policy agenda in health.

[39] During interviews, most councilors from health and social assistance councils described the PSDB as anti-participation.

more likely to dismantle than build up the health councils – and yet the councils became institutionalized during this government.

Why did the Cardoso government invest resources in the participatory health councils, when doing so seemed to directly contradict many of its political and policy objectives? I argue that this investment came due to the unique informational resources of councilors from the National Health Council. These national councilors had valuable expertise and understanding of health on the ground. These informational resources helped the CNS to construct policy proposals needed by the government, and to ensure stakeholder buy-in for regulatory framework it constructed in conjunction with the government. Including the CNS in policy debates strengthened the health councils in two ways. First, the CNS took advantage of its privileged position to further clarify and strengthen the policymaking prerogatives of councils at all levels of government. Second, providing the CNS with policymaking access in the sector affirmed the council's legitimacy as the voice of stakeholders in the sector, and its legitimacy as a player that deserved a seat at the table in policy deliberations.

Over the course of the Cardoso presidency, health became an increasingly important policy sector for the government. Implementation of the health system reform had stalled during the Collor presidency and was in its early stages following the tumultuous Franco administration. With the health system only partially constructed, health indicators remained stagnant and corruption was rampant. By 1996, only about 40% of Brazilian municipalities had undertaken all the necessary administrative reforms needed to take on the new responsibilities associated with decentralization[40] (Mendes 1998: 37). In 1994, just 1.1% of municipalities had the preventative Family Health Program in place.[41] Funding for the health system was not guaranteed. According to a 1995 survey of Brazil's 11 largest cities, the main problem facing the country was the crisis in the health system – even greater than the perennial problem of unemployment.[42]

Upon taking office, the Cardoso government had immediate technical needs in developing what Bardach (1977) would call the "policy machine" required to implement the health reform. In particular, the government needed information and proposals about how to decentralize administrative responsibilities and resources to the municipalities in a way that would not also lead to an increase in graft, mismanagement, and inefficiency. The government sought to develop new policies for improving service delivery that would meet public needs while keeping costs down. It also required revised human resources policies and a program for the education of healthcare workers. In addition, the administration needed to develop a system of monitoring and evaluation to ensure the nascent health system ran efficiently and that emerging problems could be tackled at an early stage. In sum, the Cardoso administration faced a number of technical challenges associated with the construction of a universal, integrated, decentralized, and rationalized health system.

The government itself was somewhat limited in collecting the information and developing proposals required to address these technical gaps. The administration's technocratic experts in the Ministry of Health and other ministries were not the top experts in the field of

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[40] A total of 2323 municipalities had undertaken all the needed reforms. Additionally, 618 municipalities had undertaken partial reforms and 137 had undertaken semi-complete reforms. For more on regional variations, as well as variation across different policy sectors, see Marta Arretche, 'Políticas Sociais No Brasil: Descentralização Em Um Estado Federativo', *Revista Brasileira de Ciências Sociais,* 14/40 (1999), 111-41.

[41] Data from Ministério da Saúde – Sistema de Informação da Atenção Básica.

[42] Folha De São Paulo, 'Saúde É Problema No. 1, Diz Pesquisa Realizada Pelo Datafolha Em 11 Capitais', *Folha de São Paulo,* July 22, 1995 1994.

preventative health and health systems design. Instead, the top scholars with expertise in public health came from the health reform coalition (Escorel 1998; Falleti 2010b). Stakeholders in the reform coalition had been the legal infrastructure and policy proposals behind SUS since the late 1970s. The Cardoso administration could not exclude these actors from deliberations if it hoped to make meaningful advances in implementing health reform.

The Cardoso government also faced political needs in the health sector: successful reform implementation would require acceptance, or at least acquiescence, by the main stakeholders involved. The challenges to implementation were exacerbated by the structure of the new health system: SUS involves many stakeholders and, consequently, there were a high number of points where the system could be undermined. State and municipal governments would be charged with coordinating and implementing health programs; public and private hospitals and clinics would administer healthcare; and health system workers would ultimately provide healthcare services. These diverse stakeholders were in a position to undermine the reform through resistance, tokenism, delay, and outright subversion.

In sum, the Cardoso administration had a political need to speed up implementation of the new health system, and was dependent on some members of the health reform coalition to do so. The government clearly needed to include these stakeholders, and would do so through the health councils. However, this reliance on the councils, and investment in them, should not be mistaken for actively supporting participatory policymaking – indeed, the Cardoso government did not.

Nevertheless, this inclusion could have taken a variety of different forms *instead* of the health councils. Inclusion might have come through informal consultations, or the government might have simply granted targeted concessions to the different groups in order to secure support. Instead, the Cardoso government invested human, material, and political resources in developing the institutional infrastructure behind the health councils. These councils were granted formal policymaking authority that was backed by enforcement mechanisms, and the national government included the National Health Council in developing the regulatory framework behind SUS and designing specific policies.

To understand why stakeholder engagement would have to happen through the councils, we should look to the previous political battles fought during the Sarney, Collor, and Franco administrations that had ensured that implementation of the health councils as inextricably linked with implementation of decentralization. These battles had helped cement the allegiances among members of the reform coalition behind a common vision of societal inclusion via the health councils. As IPEA researchers argued:

> [National Health Councilors] sought the construction of a discourse based in the common interest. This discourse would be efficient if it more or less was found to be representative of the positions of a significant portion of stakeholders, or at least was a discourse that did not threaten any stakeholders. This efficiency, on the other hand, guaranteed the Council symbolic capital, alliances and support that in an ideal situation would enable them to intervene, mobilize, and exercise influence. (Silva and Abreu 2002: 33)

National health conferences had helped to deepen these ties by providing an opportunity for stakeholders from different segments of society and disparate parts of the country to come together to develop a common agenda and collective identity.

Moreover, through earlier political victories, the health reform coalition had shifted the terms of policy debate: if the government opposed the operation of these councils, it would be violating the law and the constitution, and stood to face legal sanctions for doing so. These legal sanctions became apparent as the Public Prosecutor's office (*Ministério Público*) intervened to hold the government accountable for fulfilling the constitutional mandate stating that all citizens had the right to health. In so doing, the Public Prosecutor allied with the right to health movement and bolstered the authority of the health councils. Humberto Jacques de Medeiros, the former Public Prosecutor, explained:

> The constitution says that the Public Prosecutor is the guardian of the democratic regime […] and societal oversight of the health system is a privileged space for participatory democracy. So, I have to protect this space so that democracy can function. Supporting societal oversight [via the councils] is, at a minimum, supporting a rationalizing tool of service delivery. But, beyond this, societal oversight is one of the pillars of the health system. If I am not taking care of [the councils], I am not complying with the constitution. Community participation is a constitutional imperative."[43]

Thus, the terms of the health reform debate had shifted since the early proposals of the 1980s. If Cardoso hoped to comply with the constitutional and legal mandate for health reform, this compliance would necessarily entail implementing the health councils. Alternative modes of stakeholder engagement had effectively been taken off the table. Since the Cardoso government was committed to implementing health reform and as a result needed to gain some input from key stakeholders in the sector, it faced no other option than to support the expansion of health councils throughout the country and engage the National Health Councils in major decisions related to the design and regulation of the health system.

The government's need for stakeholder input and corresponding investment in the health councils can be seen with the 1996 regulatory order, which provided the most significant advancement to date in elaborating the institutional framework behind SUS. The passage of this order was essential in order to move beyond the fragmentation of the system in place when Cardoso took office.

Gaining consensus among all the major stakeholders – the federal, state, and municipal governments; service providers; health workers associations and unions; and patient groups – appeared daunting at this period. Tensions between the federal government and the health reform coalition were high. 1996 was just one year after the health reform coalition clashed with the federal government over the proposed constitutional amendment to temper the right to health. 1995 had also been the year that the government had stated publicly that the National Health Council was unnecessary, leading to alarmist pronouncements from the reform coalition that the government sought to dismantle the health reform and subvert the constitution.

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[43] Interview with Humberto Jacques de Medeiros in Faleiros et al., *A Construção Do Sus: Histórias Da Reforma Sanitária E Do Processo Participativo* at 186-87.

To ensure that the new regulatory order succeed in making major changes in deepening decentralization and enhancing efficiency, it was essential that these divides be narrowed. Thus, the Ministry of Health oversaw a long process of discussion and negotiation among major stakeholders to develop a consensus proposal for the regulatory order (Levcovitz et al. 2001). Importantly, these negotiations took place within the National Health Council, legitimating its authority and role as the arbiter of societal disputes on the health system. The government and stakeholders ultimately succeeded in developing and approving a consensus proposal for the regulatory order. The 1996 regulatory order affirmed the role and clarified the responsibilities of the councils at different levels of government, and introduced enforcement mechanisms for governments that did not comply with the participatory mandate.

In the end, the 1996 regulatory order was highly effective in advancing the implementation of SUS. Whereas less than half of all municipalities had undertaken the reforms needed to take on their new responsibilities prior to the 1996 regulatory order, this number soared to 99% of Brazilian municipalities by December 2000 (Levcovitz et al. 2001: 280). Similarly, municipal participation in the *Programa de Saúde da Família* went from a scant 1% in 1994 to 80% of all municipalities when Cardoso left office in 2003.[44] Despite the many clashes between the Cardoso administration and the National Health Council, the two sides *were* able to work together in developing a plan for reform implementation.

Brazil's health councils began to take root during the implementation stage. The strong institutional design that was established during the creation stage provided a favorable starting point for the reform coalition. This strong institutional design gave the National Health Council the right to convoke national health conferences, which were key in expanding and sustaining the organizational and symbolic resources of the coalition. The institutional design also established that the councils were to have formal policymaking authority and would be mandatory, effectively taking some debates off the table.

The reform coalition that coalesced during the creation stage took advantage of this strong institutional design and was able to secure investment in the health councils due to its ability to mobilize organizational, symbolic, and informational resources. The reform coalition was able to mobilize large numbers of people and effectively frame their agenda as part of the democratization project, thereby legitimating their proposals for strong councils. The coalition also benefited from having informational resources that were needed by the government, which ensured them the policymaking access to strengthen the institutional design of the councils. Toward the end of the Cardoso government, positive feedback effects began to operate. The councils had begun to be seen by state and societal actors as a focal point in state-society relations. These positive feedback effects would continue and deepen during the institutionalization stage, as described next.

6. INSTITUTIONALIZATION (2003-2010)

When the leftist Workers' Party (PT) gained the presidency in 2003, Brazil's health councils were en route to full institutionalization. A number of leaders of the reform coalition, particularly some of the old *sanitaristas* that had started the reform coalition in the first place, were named to key positions inside the bureaucracy. The PT government further invested in the health councils in terms of human and material resources, and it reached out to the CNS in

[44] Data from Ministério da Saúde – Sistema de Informação da Atenção Básica.

developing policy. Moreover, the government and CNS convoked a staggering nine national conferences in health.[45] Nevertheless, the high visibility and policymaking role for the health councils today is *not* a PT phenomenon, since the real legwork of their construction had been completed during the Franco and Cardoso presidencies.

The institutionalization of Brazil's health councils can be seen in both of this study's dimensions of institutionalization: routinization and infusion with value. Routinization refers to the extent to which councils throughout the country have comparable structures and roles in the health policy process. By the institutionalization stage, the necessary conditions for routinization – a clear regulatory framework, meaningful enforcement mechanisms, and guaranteed funding – were in place. As a result, health councils operated in all Brazilian municipalities and states. The other aspect of institutionalization, infusion with value, entails the degree to which the participatory institution is valued intrinsically, meaning that the councils are seen as legitimate and are included in policymaking processes. Below, I demonstrate the high institutionalization of Brazil's health councils according to each of these two criteria.

6.1 High Routinization

As described in the previous section, the health councils had already become fairly routinized during the implementation stage: they had a clear regulatory framework, enforcement mechanisms, funding, and high compliance by subnational governments. This routinization would deepen during the institutionalization stage with PT investments in participatory governance. The Lula government focused more intensely on strengthening subnational capacity in the health sector, including capacity for participatory processes.

One key prerequisite for routinization, a clear regulatory framework, had already been established by the start of the institutionalization stage. Enforcement mechanisms had also been established to back this regulatory framework. In the institutionalization stage, we see these enforcement mechanisms in operation. While it remains rare for health councils to block inter-governmental transfers, this power is widely acknowledged and seen as a source of strength for the councils. More concretely, the National Health Council uses its informal powers to ensure that subnational governments respect the rights of the health councils. For example, in 2009 the governor of Rio Grande do Norte disbanded the state health council due to tense relations between the government and the council. The National Health Council named a delegation to go to Rio Grande do Norte to investigate the claims and write a report. The CNS delegation's involvement led the governor to back down. Thus, the federal structure of the health councils has led to a sort of "boomerang effect" (Keck and Sikkink 1998), by which local movements appeal to the CNS for backup and support in applying pressure on their governments.

As one critical step, the Ministry of Health created a separate secretariat to support participatory health processes: the Secretariat for Strategic and Participatory Management (Secretaria de Gestão Estratégica e Participativa). Influential figures were named to head this Secretariat: its first director was to be Sérgio Arouca, the former director of Fiocruz and the mastermind behind the 1986 8th National Health Conference; Dr. Crescêncio Antunes, the former director of the National Health Plenary, took on the position when Arouca unexpectedly passed away. Having an entire secretariat dedicated to monitoring, evaluating, and providing technical

[45] Conferences held during the two Lula administrations include two National Health Conferences (2003, 2008) and more targeted national conferences in the areas of oral health (2004); workers health (2006); indigenous health (2005); environmental health (2009); science, technology, and innovation in health (2004); management of labor and education in health (2006); and medication and pharmaceutical care (2003).

assistance for subnational health councils was crucial in ensuring the ongoing operations of the health councils, and providing them with the tools to be effective players in the policy process.

The Secretariat for Strategic and Participatory Management undertook a number of initiatives that strengthened routinization on the ground. The secretariat produced a number of documents that provide practical guidance to municipal secretaries of health and local health councils. Staff from the Secretariat also conducted numerous site visits and training sessions. Working in conjunction with Fiocruz (Brazil's top public health school), they undertook a massive data collection effort to survey all municipal health councils. The survey included logistical questions, such as whether the council had internet, or a permanent office, or employed staff. Other questions focused on the practices of the councils, including those on the frequency of council meetings and whether the councils made proposals to the government. The survey also asked municipal councils what type of support they would like to receive from the federal government.

This data collection effort strengthened routinization in two ways. First, the Ministry would now have a better sense of the needs and interests of local councils, and thus could provide better support to them. Second, they gained a greater sense of actual compliance rates with the regulatory framework. While the dataset was not designed to be a monitoring and enforcement tool, it does signal which municipalities might deserve more careful oversight.

These efforts by the Secretariat for Strategic and Participatory Management have been made possible by government funding. Resource investments from the federal government support routinization by ensuring a degree of stability in council operations. In 2009, Brazil's federal government spent a total of $5.5 million to support participatory institutions and civil society engagement in health.[46] This money has funded the technical support and data collection activities by the Secretariat for Strategic and Participatory Management. It has also been used to sponsor regional fora for civil society groups to network with one another (Rich 2012).

The National Health Council enjoys particularly generous support from the federal government. This support pays for nearly 60 full-time staff members for the CNS. The federal government also allocates money to support ongoing council operations, including travel for councilors to attend Council meetings in Brasília, as well as meetings with subnational governments and councilors throughout the country. Additional funding is allocated to sponsor periodic national health conferences, which have been key in sustaining the shared identity for those in the health reform coalition. The conferences also provide the health councils with clear visions about what health policy should look like and thus their roles in safeguarding its implementation. In addition to this budgetary support, Brazil's Ministry of Health provides permanent office space for the CNS. The National Health Council's ongoing funding has made it possible for national councilors to stimulate networking among participatory councils at all levels of government – a key factor in facilitating the institutionalization of subnational councils.

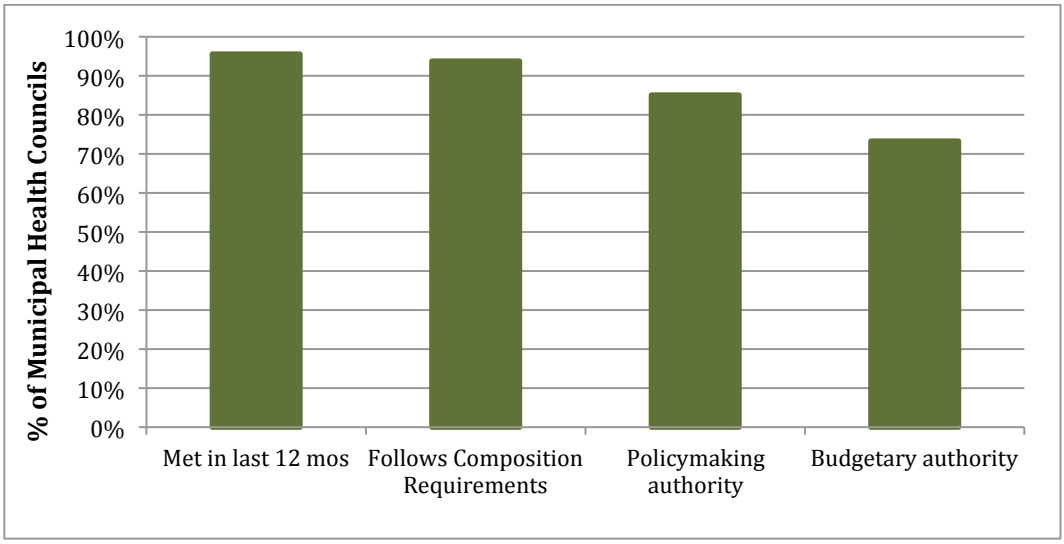
With the greater investments of the institutionalization period, compliance with the regulatory framework has risen in recent years. According to Ministry of Health data, 100% of municipalities and states have created health councils.[47] Most of these councils perform the

[46] In 2009, the federal government spent R$4,542,222.26 on the National Health Council, R$1,015,922.16 on strengthening participation and civil society mobilization in health, and R$5,654,618,65 to support participatory public management, societal oversight, and education in health. Currency conversion using a 2 reais to 1 US dollar exchange rate. For detailed information, see Presidência Da República, 'Portal Da Transparência Do Governo Federal', <http://www.portaltransparencia.gov.br/>. Accessed January 12, 2012.

[47] Ministério Da Saúde, 'Participa-Net Sus', (Brasília, 2009).

basic responsibilities outlined in the legal framework, as Figure 3.2 shows: around 95% of health councils have met in the past year; 94% follow the composition requirements, including reserving 50% of seats for patients' groups. To a lesser degree, most councils also fulfill two of the crucial prerogatives of these councils: having formal policymaking authority (85%) and overseeing the budgetary process (73%). As a point of contrast, barely half of Colombian municipalities have even created the "mandatory" planning councils and compliance is more dismal for stricter measures (see Chapter 6).

Figure 3.2: Compliance with Mandatory Features of Brazil's Health Councils, 2009



Source: IBGE Perfil dos Municipios database – 2009. The education councils are not granted formal law-making authority in the national framework, explaining the differential with the other types of councils.

In sum, Brazil's health councils were already fairly routinized by the end of the implementation stage, and became highly routinized during the institutionalization stage with investments made by the Lula government. The national mandate for participatory health councils is, in fact, a national mandate that is respected and observed.

6.2 High Infusion with Value

Brazil's participatory health councils developed a high level of institutionalization on the second measure, infusion with value. Different stakeholders may not always agree with the agendas promoted through the councils, but no major actors call into question the idea that Brazil's health councils advocate the public interest and are an essential component of democratic rule. In the early 1990s, conservative politicians – including then-president Fernando Collor de Melo – opposed the devolution of policymaking authority to health councils. By the institutionalization period, however, that perspective had become marginalized. Among the 40 politicians, bureaucrats, councilors, and other experts interviewed about the health councils for this study, not a single person questioned whether the councils should exist or the claim that their operation deepens Brazilian democracy.

At its core, the legitimacy of Brazil's health councils stems from their association with democratization. One Ministry of Health bureaucrat explained that that the participatory health

councils are "at the core of democratization processes in this country," [48] while the confederation of state secretaries of health asserts that "citizen participation in the form of councils and conferences […] is part of the political struggle for effective democratization in Brazil." [49] Even politicians critical of the councils' political agendas described them as the "voice of civil society"[50] and a "great advancement of our democracy."[51]

The legitimacy of the councils is underscored by the fact that councils are considered to be a central component of democratic public administration in health. Numerous interviewees described the councils as being a crucial part of the state apparatus, and not part of any one government. Administrations across the ideological spectrum should equally provide technical support and respect the autonomy of councils. Following this logic, Conasems has developed a national strategy to aid small municipal governments in implementing participatory health councils. Their 2007 strategy document states:

> The importance of health councils is undeniable in Brazil. [...] They permit greater oversight of public health expenditures, and more broadly enhance accountability. They should be considered to be a social obligation in terms of good governance, in terms of democracy, and in terms of respect for the citizen. [52]

This quote shows that Brazil's health councils are portrayed as enhancing democracy in Brazil while improving the quality of governance. They are accepted without question, in the way that it is now accepted that local governments must collect basic service delivery statistics for oversight.

Even conservative politicians – previously opposed to participatory policymaking – have accepted the role that councils have in the policymaking process. One conservative federal deputy stated: "When we saw that the councils were gaining force, that they were gaining muscle in policy, everyone realized that they had to participate too [to prevent the left from dominating.]"[53] In other words, the role of participatory institutions in policymaking does not just depend on whether pro-participation politicians are in power; all political actors recognize the legitimacy of the health councils. If more *petistas* participate in the health councils, that does not mean that the councils are biased – it just means that other parties should get their acts together.

Infusion with value can also be assessed by examining the extent to which health councils are included in the policymaking process in practice. In particular, councils that are highly infused with value will be included in informal policy debates and decisions, going beyond what is formally required. Brazil's health councils indeed have become an important part of the health policymaking process. The influence of councils may vary over time, but across the board Brazil's health councils have gained a role in the determination of policy priorities, development of the budget, and the oversight of policy implementation.

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[48] Interview with Ana Costa, Diretora do Departamento de Apoio à Gestão Estratégica e Participativa, Secretaria de Gestão Estratégica e Participativa, Ministerio da Saúde, October 15 2008.
[49] Conasems, 'Tese 6a Do Conasems', (Brasília: Conasems, 2007).
[50] Interview with Darcisio Perondi, Federal Deputy (PMDB/Rio Grande do Sul) and President of the Frente Parlamentar de Saúde, 11 May 2009.
[51] Interview with Armando Abilio, Federal Deputy (PTB/Paraíba), 19 March 2009.
[52] Conasems, 'Tese 6a Do Conasems'.
[53] Interview with Armando Abilio, Federal Deputy (PTB/Paraíba), 19 March 2009.

The inclusion of participatory institutions in policymaking is especially visible with the National Health Council. Top government officials attend council meetings; as of 2012, the Minister of Health regularly attends the monthly National Health Council meetings. The government councilors serve as the liaisons between the council and the government, ensuring that councils have some sort of institutionalized access to the bureaucracy.

Brazil's participatory councils are included in the policymaking process via more informal channels as well. Through their participation on the National Health Council, councilors develop authority as experts in their designated field and participate in government working groups for specific programs. For example, the councilor representing the LGBT community on the National Health Council was also invited to participate in the ministry's working group on lesbian health to develop specific proposals to present to the Council.[54] Likewise, the representative of the Brazilian Celiac Association gained state access and grew an activist network through her participation on the National Health Council. Through this access, the councilor was able to spearhead an initiative to develop a national celiac policy – a policy that had no support in the Ministry before her efforts, due to the disease's low profile.[55]

The CNS is also engaged in lobbying of Congress, in contrast to the negligible contact between Colombian councilors and national politicians. I interviewed nearly a dozen politicians that serve on the Social Security and Family Issues Commission (which is responsible for both health and social assistance policy) and members of the Congressional Health Caucus. Even though I did not inform them that I was studying participatory institutions, *all* respondents voluntarily mentioned interacting with the National Health Council when asked about their contact with citizens and civil society groups. Top leadership from the Congressional Health Caucus periodically attends council meetings to discuss legislative developments. Council representatives will attend and participate in Congressional seminars and hearings. Moreover, these politicians described having regular informal meetings with the National Health Council President.

In sum, Brazil's health councils have become highly institutionalized, both in terms of routinization and in terms of infusion with value. The advances made by the reform coalition during the creation stage and implementation paid off during institutionalization. While facilitated by the support of the Lula government, the true roots of institutionalization can be traced to the broad and content-based nature of the health reform project.

7. CONCLUSION

As this chapter has shown, Brazil's health councils became highly routinized and legitimate, gaining a considerable role in the policymaking process. Yet the institutionalization of the health councils is surprising given the hostile political environment they faced in the 1990s. It was not until 2003 that ardent supporters of the health councils gained the presidency. The original idea behind the participatory health system arose during the right-wing military dictatorship that ruled from 1964-85, and the legal framework that created the councils was approved during the neoliberal and anti-social rights Collor government. The political climate

[54] Interview with Carmen Luiz, Councilor, National Health Council representing Liga Brasileira Lésbica, 11 February 2009.

[55] Interview with Nildes Oliveira de Andrade, Councilor, National Health Council representing Associação dos Celíacos do Brasil, 6 December 2008.

did not improve when implementation began under Collor, and the later technocratic Cardoso government could hardly be described as a supporter of participatory policymaking.

I have shown that the institutionalization of Brazil's health councils can be traced to the sweeping nature of Brazil's health reform. This sweeping reform stimulated the mobilization of diverse groups that were instrumental in the institutionalization of the health councils. The health councils became embedded in the overall reform project over time, meaning that stakeholders with an interest in having the new health system take root had an interest in having the health councils take root as well. Thus, the reform coalition in favor of the health councils expanded beyond the public health activists, grassroots organizations, and unions that had mobilized early on. The expanded reform coalition also included some unusual supporters, such as municipal governments, that might not normally support increased popular participation in the policymaking process.

Importantly, the sweeping health reform mobilized this expanded reform coalition in favor of the participatory health councils precisely because council implementation had become deeply embedded in the health reform itself. The health councils were seen as a key element in the decentralization of health funding and administration, and therefore subnational governments advocated for the implementation of these councils. As we will see in the case of Colombia's health councils in Chapter 7, a sweeping reform that does not effectively link participatory policymaking to the overall integrity of the reform's implementation will not lead to the mobilization of a pro-participation reform coalition. In this case, the vested interests of diverse groups is not tied up with council implementation, and thus the councils will only be advocated for by those who actively support the idea of participatory policymaking.

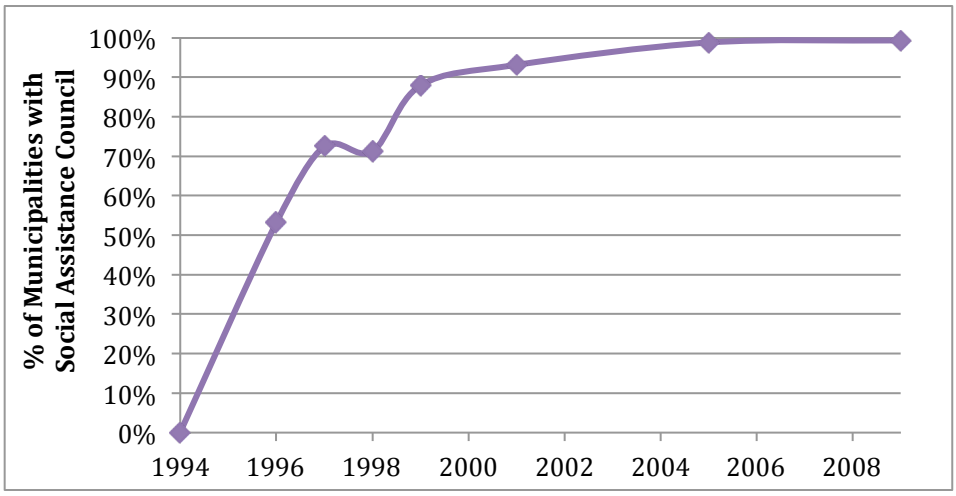
In the next chapter, we apply the study's argument to a more difficult case: Brazil's social assistance councils. In contrast to what we have seen with the Brazilian health case in this chapter, a reform coalition did not exist before the sweeping reform was proposed, and civil society in general has been hard to mobilize in the sector. Yet, as with the Brazilian health councils, the social assistance councils were also interwoven with implementation of the sweeping reform. Despite low mobilization prior to the creation of the social assistance councils, a reform coalition *did* form in response to the sweeping nature of the social assistance reform – just as we saw with the health reform coalition. Also as we saw in this chapter, that broad reform coalition would be successful in securing the unlikely institutionalization of the social assistance councils.

CHAPTER 4. BRAZIL'S SOCIAL ASSISTANCE COUNCILS: MODERATE INSTITUTIONALIZATION THROUGH SWEEPING REFORM AND REFORM COALITION INCOHERENCE

1. INTRODUCTION

With the passage of the 1988 Constitution and the 1993 Social Assistance Statute (LOAS, *Lei Orgânica de Assistência Social*). Brazil transformed the social assistance sector into a rights-based framework modeled on the health system. As with health, governments at all levels were required to establish a social assistance council, which was to play a major role in designing and overseeing the sector. Also like health, the social assistance councils had formal policymaking and budgetary authority. Over time, Brazil's social assistance councils have become institutionalized. The social assistance councils are highly routinized: the councils are funded by the government and have a clear regulatory framework that is enforced. As a result, compliance is high, as shown by Figure 4.1. The councils also have a somewhat high level of infusion with value, meaning that they are seen as legitimate by major stakeholder groups and are included in the policymaking process. While having a somewhat lower level of infusion with value than the Brazilian health councils, the social assistance councils have become far more institutionalized than the Colombian councils.

Figure 4.1: Percentage of Brazilian Municipalities Complying with Mandate for Social Assistance Councils, 1994-2009



Source: IBGE 'Perfil dos Municipios Brasileiros – Pesquisa de Informações Básicas Municipais' Dataset, 2001, 2005, 2009; Balanço Geral da União v. 1, exercicio de 1999, cited in (de Resende Chagas et al. 2003)

The Brazilian social assistance councils are an important case for two reasons. First, much of the scholarship on participatory policymaking suggests that participatory institutions are doomed without the early and continued backing of vibrant civil society organizations, yet there was little civil society activity around social policy until the 1990s, after the councils were established by the constitution. Moreover, the sector faces structural obstacles to collective action. Its main beneficiaries include the disabled, the elderly, vulnerable children, and the

homeless – groups that typically lack resources and a shared identity, crucial factors in sustaining mobilization. Second, while the existing literature emphasizes that participatory institutions are doomed from the start without substantial buy-in from politicians, this support was not forthcoming. Indeed, the social assistance councils enjoyed even less backing from politicians than the health councils.

Why and how did Brazil's social assistance councils become institutionalized, given these obstacles? In this chapter, I argue that the institutionalization of Brazil's social assistance councils can be traced to the sweeping nature of the social assistance reform. The social assistance reform was modeled on the health reform and adopted a rights-based approach to reframe social assistance as a right of all citizens, rather than as scattered acts of charity. This sweeping policy sector reform led to the mobilization of a reform coalition composed of diverse stakeholders, including social workers, hospitals, philanthropic groups, subnational governments, and academics – groups that all stood to benefit from the new social assistance system. While many members of the coalition were primarily concerned with the reform's substantive changes, the coalition also mobilized behind the social assistance councils due to the leadership of social assistance professionals, who helped construct a shared discourse and brought together groups throughout the country. These stakeholders invested in the new system, and in the councils, as a means of securing a seat at the table in decisionmaking.

Nevertheless, the social assistance reform coalition was less successful in advocating for the councils than that of health, resulting in lower infusion with value for the social assistance councils. This sectoral difference can be explained by the relative incoherence of the reform coalition. While social assistance reform coalition was broad, it lacked the coherence seen in the case of Brazil's health councils due to ideological divides between the original reform leaders and service providers. These divisions in the reform coalition challenged social assistance councils' legitimacy as the voice of the public interest, leading to only moderate infusion with value.

This chapter proceeds as follows. In the second section, I compare social assistance policy before and after reform to highlight the sweeping nature of the reform. In the third section, I describe the role that professionals in the sector had in advocating for reform, mobilizing a diverse reform coalition, and linking the success of the reform with the success of the social assistance councils. Fourth, I review the creation of the social assistance councils and show how the reform coalition's breadth was fundamental in overcoming political opposition. The fifth section outlines government and civil society investments in the councils in the implementation stage, during which the councils took shape. In the sixth section I look at institutionalization, highlighting how positive feedback effects resulted in high routinization and fairly high infusion with value. I conclude in the seventh section with a discussion of alternative explanations.

2. BRAZIL'S SWEEPING SOCIAL ASSISTANCE REFORM

This section shows that Brazil's social assistance reform was a sweeping one. The social assistance system pre-reform operated under a fundamentally distinct logic than the post-reform system. In the past, social assistance was motivated as charity or patronage. In the current, rights-based model, however, social assistance is viewed as protection for vulnerable groups excluded from the market. Moreover, the current policymaking instruments – including participatory social assistance councils – and content of social assistance are very different.

Below, I outline the objectives, instruments, and content of social assistance policy under the two models, as summarized in Table 4.1. As we will see later in this chapter, the sweeping nature of the social assistance reform facilitated the creation of a reform movement that would successfully advocate for strong social assistance councils.

Table 4.1: Changes in the Objectives, Instruments, and Content of Brazilian Social Assistance Policy

	Policy Objectives	Policy Instruments	Policy Content
Pre-Reform (1942-1993)	Social assistance as charity and/or patronage	Centralized; little societal input	Scattered and uncoordinated programs
Post-Reform (1994-present)	State protection for vulnerable groups as a right of all citizens	Decentralized; societal input via participatory councils	Coordination among three levels of government; new cash transfer programs

2.1 The Pre-Reform System: Charity and Patronage

Before reform, Brazil's social assistance policy followed a centralized and charity-oriented model. Social assistance was established as a national policy in 1942 with the creation of the Brazilian Social Assistance League (*Legião Brasileira de Assistência* - LBA), which directed federal funds to needy families, particularly the widows and children of Brazilian soldiers that had died in World War II. Over the coming decades, LBA came to have a broad presence throughout the country; by the mid 1980s, local LBA offices were present in 80% of Brazilian municipalities (Fleury 1985: 80). The federal government administered social assistance funds primarily by contracting with philanthropic groups, often those affiliated with the Catholic Church. When these charitable organizations then administered the aid, the recipients often did not know that they were receiving public funds. The result was low visibility and consequently low accountability in the sector. Throughout this earlier period, there were no formally established performance targets in the sector and few guidelines about how to prioritize and allocate spending. As some have argued, social assistance was not a social policy as much as it was a collection of disparate programs (P. Pereira 1996; Sposati et al. 1985).

In addition to its direct support of philanthropic organizations through social assistance contracts, the Brazilian state's social assistance policy also involved supporting the philanthropic sector by granting tax breaks to groups that qualified as non-profit organizations with philanthropic aims. Philanthropic organizations benefited from these tax breaks, but also needed certification because many state contracts in social assistance, health, and education could only be granted to certified non-profit organizations. To certify and oversee the philanthropic sector, the government created the National Social Welfare Council (*Conselho Nacional de Serviço Social* - CNSS), which was comprised of key figures from the Church and other philanthropic groups.[56] This certification function made the CNSS an important institution for politicians that sought to use state contracts to deliver political patronage.

[56] The CNSS differed from the National Social Assistance Council, created with the 1988 Constitution and 1993 Social Assistance Statute, in that it only consisted of elite groups; social assistance workers and beneficiaries were not included.

Social assistance was used widely as patronage. The absence of a national social assistance policy to provide objectives and targets in the sector combined with the high discretion for non-state actors (the philanthropic groups) in administering programs to create prime opportunities to do so. In fact, social assistance was literally synonymous with clientelism: in Portuguese, *clientelismo* and *assistencialismo* are used interchangeably, and many use the term *assistência social* to mean political patronage. Philanthropic organizations received state contracts with the implicit understanding that they would use these resources to provide political support for the sponsoring politician (Yazbek 2004). Maintaining poorly defined objectives and loosely organized programs in the sector facilitated the use of social assistance as political patronage, which could be targeted according to the electoral needs of politicians. High levels of discretion also meant that beneficiaries were dependent on the investments of their local political patron rather than having the right to social assistance benefits.

In sum, Brazil's social assistance system pre-reform was dominated by a logic of clientelism and charity, with little conception of citizens' right to social assistance. The policymaking instruments were centralized and provided little access for societal organizations outside of determining which groups would be designated philanthropies. Programs were not coordinated across levels of government, or across locations; each community had their own idiosyncratic social assistance programs in line with the electoral needs of local *coroneis* (political patrons).

2.2 The Post-Reform System: Rights-Based Social Policy

Social assistance policy was reinvented with the reforms of the 1988 Constitution and 1993 Social Assistance Statute (LOAS). The objectives of social assistance were shifted to reflect the social rights approach; the first article of LOAS asserts that social assistance is a "right of citizens and a duty of the state." Social assistance would be integrated into the Social Security system, along with health and pensions. Including social assistance in Social Security represented a major shift and signified that social assistance was an entitlement that came along with citizenship – not merely charity for the needy. Before, only contributors received Social Security benefits. Under the new model, all citizens were entitled to Social Security, including social assistance.

The new model of social assistance centers on the concept of vulnerability and social exclusion. Social assistance policy would establish a basic social safety net through an integrated set of programs and services. In this new model, social assistance is often described as the social policy sector that fills in the cracks of Brazil's social safety net that are not addressed through other social policies. Some individuals or groups of individuals (e.g. the disabled, child laborers, the homeless) face systematic obstacles to integration into society and/or the market economy. The state has a duty to step in and either take care of these individuals, or provide them with the tools to ameliorate their situation.

These new objectives logically led to major changes in the content of social assistance policy. One such change came with the creation of the Non-Contributory Pension (*Benefício de Prestação Continuada*, BPC), which provides a monthly minimum wage to impoverished elderly and disabled people. Established in the Constitution, the BPC defines a guaranteed income floor for the elderly and disabled, which is not subject to the political will of politicians. With the BPC, the state has a responsibility to take care of those who are squeezed out of the labor market due to old age or disability. The BPC represents much of social assistance funding, and is itself

one of the largest social programs offered by the Brazilian state. As a point of comparison, $5.8 billion was spent on the BPC in 2007, versus the $4.5 billion spent on the internationally famous Bolsa Família program (Ministério de Desenvolvimento Social e Combate à Fome 2007b: 10; 2007a).

In addition to these changes in the objectives of social assistance, policy would also be decided through new instruments. The new system was to be implemented in a decentralized fashion, with the input of civil society via mandatory social assistance councils. While decentralized, the sector would also be federally integrated. The main principles, institutional design, and priorities are set at the national level and specific programs planned and implemented at the municipal level. The rights-based approach demands that social assistance be applied using a universal and rationalized approach, with the allocation of social assistance funds determined using objective criteria. This contrasts with the old social assistance system in which programs were implemented in an ad hoc fashion according to the political needs of the elite.

The social assistance reform also changed the roles of state and philanthropic actors in the sector. Social assistance is now to be planned and designed by the state, with philanthropic organizations restricted to bidding for government contracts to carry out projects that have been clearly defined and delimited. In contrast, the prior model gave more discretion to the non-profit and philanthropic groups that received government contracts, with social assistance funding often resembling government subsidization of the charitable efforts of the philanthropy, rather than a principal-agent relationship. Philanthropies can still shape social assistance policy – but only as participants providing input to the state on social assistance councils, not as those ultimately responsible for the design and implementation of social assistance. Social assistance policy is managed via "public participation, through representative organizations in policy formulation and oversight (*controle*) of activity at all levels." (Art. 204)

Participatory policymaking councils would be engaged in the decentralized management of the new social assistance system. The institutional design of the social assistance councils is nearly identical to that of the health councils, and intentionally so. As with health, council seats are split between state and societal actors. The government has more seats than in health however. The government occupies 50% of the seats, 25% of social assistance council seats are reserved for program beneficiaries, and the remaining 25% are split evenly between workers in the sector and service providers (philanthropic and non-profit organizations receiving social assistance contracts). Councilors representing societal stakeholder groups must belong to a formally-registered organization with legal personhood, and each set of societal councilors are to be selected by a forum of their peers. The ruling administration appoints government councilors from a range of ministries or secretariats.

The social assistance councils operate at all levels of government and have substantial policymaking prerogatives. The councils' input is overarching for the whole sector and is not limited to just one or two aspects of social assistance policy. At each level of government the councils are charged with overseeing the design, implementation, and oversight of all major policy decisions in the sector. Thus, the social assistance councils are charged with specifying the objectives and priorities of social assistance policy, designing specific policies and programs, and overseeing public spending in the sector.

A look to the National Social Assistance Council (*Conselho Nacional de Assistência Social*, CNAS) can provide a better understanding of the councils' policymaking responsibilities. The official mission of the CNAS is to "formulate, regulate, approve, and monitor social

assistance policy, in conjunction with other policy sectors; exercise societal oversight (*controle social*); and ensure the realization of the Unified Social Assistance System (*Sistema Único de Assistência Social* – SUAS)" (CNAS 2007). The Council contributes to decisions about how federal social assistance funds are to be transferred to subnational governments – specifically, the conditions guiding automatic transfers; the creation of different programs and the associated funding streams, such as the Program for the Eradication of Child Labor (*Programa da Eradicação do Trabalho Infantil)*; and eligibility criteria to receive the BPC (non-contributory pension) cash transfer. The CNAS also approves the annual social assistance budget of the Ministry of Social Development, and is responsible for overseeing the implementation of social assistance policy. The council conducts this oversight by forming linkages with subnational councils. A key tool establishing these ties is the National Social Assistance Conference, which brings together government and civil society actors from all levels of government to discuss national priorities and potential improvements to the social assistance system.

In addition to these policymaking functions, the CNAS is also responsible for the certification of non-profit organizations – a bureaucratic responsibility that was transferred to the CNAS when the CNSS was eliminated. As mentioned earlier, all organizations that receive state contracts in health, education, and social assistance must register with the CNAS and be certified as non-profits by the Council.[57] The requirement extends to all religiously affiliated universities, schools, hospitals, and clinics throughout the country. To provide an indication of the size of this responsibility, as of 2006, there were 33,076 organizations that had applied for and received certification. Only 48.4% are even involved in social assistance, with the remainder operating in health and/or education (IBGE 2006). The CNAS is responsible for establishing the criteria for certification, as well as assessing all new and renewing organizations for compliance with these criteria.

Having reviewed the institutional designs of the prior and current social assistance systems, I have demonstrated that the social assistance reform was a sweeping policy change that made substantive changes to the objectives and content of social assistance policy. The sweeping nature of this reform would later prove key to the formation of the pro-participation reform coalition needed for the social assistance councils to become institutionalized. Yet where did this new social assistance system come from? In the next section, I review the creation of social assistance councils with the passage of the 1988 Constitution and LOAS in 1993.

3. THE ROLE OF SOCIAL WORKERS IN OVERCOMING COLLECTIVE ACTION PROBLEMS

As in health, in social assistance elite professionals took the lead in constructing and leading a reform coalition that advocated for the social assistance reform and its associated councils. Prior to the 1990s, civil society in social assistance was virtually non-existent due to the design of the policy sector and structural barriers to mobilization by beneficiaries. With the social assistance reform, however, this began to change. Social workers and social work professors sought to adapt the rights-based approach of the health sector for the social assistance

[57] This certification is also required for organizations to receive contracts for the *emendas parlamentares*, which are funds that each member of Congress has to spend in his or her home district. The funds, typically seen as pork, can only be implemented by either a municipal government or a certified organization.

sector. These reform leaders would be instrumental in defining what the social rights approach to social assistance would mean and bringing together a number of diverse actors to form a broad reform coalition. As we will see later in the chapter, this broad reform coalition was instrumental in institutionalization.

The coalition's success in pressing for institutionalization of the councils would be limited, however, by the coalition's lack of cohesion. In this section, I also show that while social workers succeeded in mobilizing diverse stakeholders into the reform coalition, they failed to gain consensus among all stakeholders in the coalition on a shared vision of what the policy sector should look like. In contrast, the health reform coalition unified behind a common reform vision. While both health and social assistance councils became institutionalized, relative lack of cohesion in the reform coalition explains why the social assistance councils ultimately became infused with value to a lower degree than the health councils.

3.1 The Problem of Collective Action

Before the 1988 Constitution, there were few groups in civil society mobilized around social assistance policy (Monika Dowbor 2008). Whereas a strong reform coalition had developed in the mid-1980s in Brazil's health sector, in social assistance there were few civil society organizations at all, much less a coordinated reform coalition. The philanthropic organizations that received social assistance contracts were atomized and not organized hierarchically into a peak association, making collective action unlikely. These organizations were only linked into social assistance policy through their individual connections with the local politicians sponsoring their social assistance program; they did not become involved in shaping the underlying policy behind these contracts.

Current and potential social assistance beneficiaries – including the elderly, the disabled, the homeless, child laborers, and victims of domestic violence – were even less organized. By definition, these groups rank among the most marginalized individuals and therefore face considerable collective action problems. In fact, the first organizations representing beneficiary groups in policy only arose in the 1980s, with the rise of the disabled persons movement.

Among stakeholders in the sector, only the public sector social workers engaged in collective action related to social assistance policy. The social workers were unionized and were represented by the peak association ANASSELBA (Associação Nacional dos Servidores da Legião Brasileira de Assistência – National Association of LBA Workers). Yet ANASSELBA did not mobilize around issues related to the design and management of the social assistance sector as a whole. Instead, their collective action was limited to labor relations concerns, such as wage increases and fringe benefits.

In sum, mobilization in the social assistance sector was negligible prior to the 1988 Constitution. A reform coalition would only develop later, in response to leadership from social workers and substantive policy changes in the reform.

3.2 Social Workers as Reform Leaders

Social workers and social work professors would emerge as the main advocates for reform and leaders of the social assistance reform coalition. As we will see in the following section, the social assistance reform coalition would not emerge prior to the start of reform, but rather after the 1988 constitution had been approved. This contrasts with the experience of the

Brazilian health reform coalition, which had crystallized by the time reform began in with the constitution and 1990 health statute.

Social work professors (and some of the social workers they trained) were the core leaders behind the social assistance reform coalition. Many of these social work professors had not been involved in the area of social assistance, focusing instead on other social policy areas, including education, health, and pensions. Indeed, they typically saw social assistance as synonymous with patronage, and consequently believed that the sector undermined other social rights efforts.[58] Following the passage of the 1988 constitution, however, they saw an opportunity to reinvent social assistance as a social safety net for society's most vulnerable.[59]

The social assistance professors and social workers that led the reform coalition in that sector were inspired by the health reform and health reform coalition, which had taken preliminary steps in the 1980s and was under construction in the early 1990s. Many of these social work professionals had also been involved in the health reform. They sought to apply the policy reform model adopted in health to the social assistance sector. Policy details would be modified, but the core objectives behind the system – a universal, rights-based approach that granted a considerable role to the state – would be the same.

The social assistance professors behind the reform coalition could mobilize a number of valuable resources that would advance the proposed reform. They possessed considerable expertise on social policy in general, and the sector in particular. They also were effective at linking the struggle for social assistance reform with the larger democratization struggle, amplifying the symbolic resources of the coalition. Nevertheless, these elites were limited considerably in their ability to mobilize other key resources, including the organizational resources needed to stage major demonstrations and to lobby Congressmen. Moreover, their symbolic resources could only go so far without being able to point to beneficiaries that would gain from these expanded rights. In other words, the reform leaders needed to construct a diverse reform coalition to ensure the passage and implementation of the social assistance reform.

3.3 Conflict Expansion: The Construction of the Social Assistance Reform Coalition

In addition to drawing on the policy framework established in health, social assistance reform leaders also drew on the health reform's political lessons. As the *movimento sanitário* discovered in the 1980s, an elite-based reform effort that attempted reform from within the state could make some changes but could not achieve the deep changes needed to create a rights-based system. The social assistance reform would need to be backed by a coalition of different stakeholders in the sector that could counteract reform opponents. Moreover, this reform coalition would need to have an institutional role within the state – the councils – from which it could contribute to the ongoing definition of the new social assistance system and monitor reform implementation.

Thus, the social workers that led the reform coalition reached out to stakeholders representing beneficiary groups, workers in the sector (including social workers as well as

[58] Interviews with Potyara Pereira, Professor of Serviço Social, Universidade de Brasília, June 30, 2009 and Vicente de Paula Faleiros, Professor of Serviço Social, Universidade de Brasília, May 15, 2009.

[59] Interviews with Potyara Pereira, Professor of Serviço Social, Universidade de Brasília, June 30, 2009; Vicente de Paula Faleiros, Professor of Serviço Social, Universidade de Brasília, May 15, 2009; and Aldaíza Sposati, ex-Secretary of Social Assistance, São Paulo, April 14, 2009

lawyers, psychologists, and other professionals), and the charitable organizations that provided social assistance services. This task would prove more complicated than in health, however, due to the paucity of existing civil society organizations involved in the social assistance sector. They would need to both nurture the expansion of civil society as well as bring these different groups into the fold – all during the construction of the social assistance reform itself.

Needing broad stakeholder support, the social workers leading the reform coalition reached out to diverse groups, which did not share a common vision of what social assistance should look like. While there was consensus the pre-reform model of social assistance was overly politicized and did not protect the rights of vulnerable populations, there remained a sharp division between two camps regarding the objectives of social assistance policy, its target populations, the relative roles of philanthropic organizations and the state, and the ultimate purpose of participatory policymaking councils.

The social workers that led the reform coalition viewed social assistance as a distinct social policy, not merely a space for intersectoral programming, and a fundamental right of all Brazilians and not simply of the poor. They emphasized how social assistance is a social right, and thus the state must be responsible for the design and implementation of social assistance programming; philanthropic organizations should provide a supporting but subordinate role. The social assistance councils would be essential to guarantee that the government did not misuse social assistance resources for political aims, and to ensure that the state protects the rights of all citizens.

In contrast, many subnational governments and service providers favored greater continuity with the pre-reform model. For these stakeholders, social assistance's primary objective is poverty alleviation, and is an inherently intersectoral policy area that coordinates the anti-poverty programs of other sectors. The government and philanthropic sectors are both engaged in these poverty fighting efforts, and can amplify their impact by coordinating – but both sides remain equal partners. In this context, councils should provide the means to coordinate these efforts and a space for the philanthropic sector to self-regulate. This perspective remained despite the persistent efforts of the reform coalition leaders to raise awareness of their new and "correct" interpretation of social assistance.

Thus, diverse stakeholders came together behind the leadership of social assistance professors. The broad nature of this reform coalition would enable it to pressure effectively the government to implement the social assistance reform and construct the new councils. Nevertheless, a lack of coherence would limit these efforts in the long run.

4. CREATION OF THE LEGAL FRAMEWORK: BROAD RESPONSIBILITIES (1988-1990)

The creation of the legal framework behind Brazil's social assistance councils was more complicated than for the health councils. Prior to the early 1990s, there was no reform coalition mobilized behind a rights-based social assistance reform. Indeed, there was negligible civil society mobilization of any sort in the sector at this time. Thus, the 1988 Constitution's rights-based framework and mandate for participatory policymaking councils was not the result of grassroots mobilization, nor was it the product of politicians' strategies. Instead, it was copied from the health reform without deliberation.

Political mobilization for, and opposition to, the reform only formed during the development of LOAS. A small reform coalition of bureaucrats and scholars formed in support

of the sweeping, rights-based social assistance reform. This early and small reform coalition clashed with the government of Fernando Collor de Melo (1990-92), which opposed participatory policymaking and the expansion of social policy. Whereas the health reform coalition had been strong enough to overturn Collor's veto of the Health Statute, the social assistance coalition was considerably weaker and Collor vetoed LOAS in its entirety. The reform coalition was only able to persevere after it undertook a mobilization campaign in which the reform coalition expanded to include social assistance workers, beneficiaries, and, to a limited extent, the charitable organizations engaged in service delivery of social assistance programs. Substantive changes included in the social assistance reform facilitated the formation of alliances among these diverse groups. An important implication is successful institutionalization of the social assistance councils was *not* simply due to prior mobilization, given the atomization of stakeholders prior to reform.

4.1 Defining a Participatory Social Assistance System: The 1988 Constituent Assembly

The 1988 Constitution provided the foundation for a radical rights-based reform of the social assistance system, yet there was little debate about the structure and content of social assistance policy during the constituent assembly.[60] When writing articles 203 and 204, which define the institutional design and objectives of the social assistance sector, members of the Sub-commission on Health, Social Security, and the Environment largely copied the language and framework used in article 198 for health. The paucity of debate about social assistance reflected the complete absence of stakeholder mobilization, as well as the lack of interest among politicians: members of the social security commission had joined in order to shape pension and health policy, not social assistance policy.[61]

After the 1988 Constitution was passed, the government of José Sarney (1986-90) was charged with developing the legal charter for the new social assistance system.[62] Yet the administration faced an obstacle: no one knew what the universal, participatory, decentralized social assistance system mandated in the constitution might look like. The Sarney administration assigned the task of designing the new social security system (including social assistance) to the government's policy research institute, IPEA and the Universidade de Brasília (UnB), which was home to some of the top scholars on social policy in Brazil.

UnB was charged with coordinating working groups of stakeholders to elaborate the legal framework for each sector. However, it was not clear exactly who these stakeholders should be. In designing the health framework, the health ministry, health experts, members of the right to health (*movimento sanitário*), and the healthcare industry were involved. Likewise, bureaucrats, academic experts, unions, and representatives of pensioner groups contributed to the development of the pension system. In social assistance, however, the social assistance sector

[60] While there was little debate about the design of the sector, the proposal to provide a Non-Contributory Pension (BPC) to the elderly and disabled was a contentious issue. Ana Maria De Resende Chagas et al., 'A Política De Assistência Social E a Participação Social: O Caso Do Conselho Nacional De Assistência Social (Cnas)', in Ipea (ed.), *Textos para Discussão* (Brasília, 2003) at 24..

[61] Interviews with Potyara Pereira, Professor of Serviço Social, Universidade de Brasília, June 30, 2009 and Aldaíza Sposati, ex-Secretary of Social Assistance, São Paulo, April 14, 2009.

[62] Article 59 of the 1988 Constitution stated that the executive was to introduce bills structuring the three sectors of Brazil's social security system (pensions, health, and social assistance) within six months of the constitution's ratification, and a total of two years to implement the new system. In violation of the constitution, this process took over five years for social assistance.

itself remained undefined, and there were no mobilized groups of stakeholders (Boschetti 2002). Consequently, the social assistance group had arguably the most difficult task yet the least input from stakeholders.[63] Nevertheless, UnB assembled a working group of top scholars and policy analysts in the area of social policy, including representatives from IPEA and the Ministry of Pensions and Social Assistance (MPAS, *Ministério de Previdência e Assistência Social*).[64] The working group would develop the conceptual underpinnings of the new social assistance policy, and then to elaborate the specific policy framework to actualize this new policy.

Over the course of several meetings, the working group established a consensus that social assistance was defined as aid to prevent and ameliorate situations of vulnerability (and thus is not just a catch-all category for anti-poverty programs), and that it should be designed and implemented in a decentralized, participatory fashion. Many of the working group's participants were also involved in the right to health movement and they explicitly modeled the structure of social assistance on the successful Brazilian health system. Thus, there should be one institutional actor responsible for social assistance policy at each level of government, and these institutional actors would implement a national social assistance policy, albeit adjusted for local needs. In this model, philanthropic organizations would be involved in the implementation of social assistance, but would have a secondary importance and were to be subordinated to public sector actors. This working group also conceived of the conference and council system, and argued that councils should have formal policymaking authority (Boschetti 2002) – yet they themselves developed the rights-based framework for social assistance without stakeholder participation.[65]

Thus, the design of Brazil's social assistance reform was the vision of a small group of bureaucrats and academics – hardly a broad-based reform coalition. Whereas there had been ample debate and struggle in developing the contents of the health reform, for social assistance matters were determined by few actors behind closed doors. This technocratic exercise defined the terms of the social assistance reform, but the arguments of an elite few would soon prove insufficient to restructure social assistance – particularly given the sector's importance in distributing patronage.

4.2 Creating an Empowered Legal Framework: The Social Assistance Statute

Passing the enabling legislation behind the constitutional mandate would prove challenging for social assistance reformers, which primarily consisted of members of the IPEA-UnB reform coalition at this point. The initial social assistance reform bill was amended heavily in committee to remove many of the most important features of the new rights-based system, and

[63] Interviews with Potyara Pereira, Professor of Serviço Social, Universidade de Brasília, June 30, 2009 and Vicente de Paula Faleiros, Professor of Serviço Social, Universidade de Brasília, May 15, 2009. For more information, consult Ivanete Boschetti, 'As Forças De Apoio E De Oposição À Primeira Proposta De Regulamentação Da Assistência Social No Brasil', *Cadernos CEAM - Conflitos de interesses e a regulamentação da política de assistência social,* 3/11 (2002), 13-62, Comissão De Saúde Previdência E Assistência Social Da Câmara Dos Deputados, 'Anais Do Simpósio Sobre Assistência Social', (Brasília, 1990a), Comissão De Saúde Previdência E Assistência Social Da Câmara Dos Deputados, 'Anais Do Simpósio Sobre Previdência Social', (Brasília, 1990b), Comissão De Saúde Previdência E Assistência Social Da Câmara Dos Deputados, 'Anais Do Simpósio Sobre Saúde', (Brasília, 1990c).

[64] The LBA was invited on several occasions to participate, but did not respond. The MPAS representatives participated somewhat inconsistently, and refused to sign the final document produced by the IPEA-led working group. For more information, see Boschetti (2002).

[65] Interview with Vicente de Paula Faleiros, Professor of Serviço Social, Universidade de Brasília, May 15, 2009.

even this watered-down bill was vetoed by the new president, Fernando Collor de Melo. This initial failure can be traced to the very limited nature of the original reform coalition, which had few supporters. It was only when the reform coalition reached out to new stakeholders and mobilized them behind the shared goal of the rights-based social assistance reform that LOAS finally passed in 1993. Table 4.2 outlines the shift in organizational and symbolic resources during the creation stage that ultimately resulted in the creation of a strong institutional design. Below, I explain how the reform coalition expanded and their struggles to create the new social assistance system, which would include participatory social assistance councils.

Table 4.2: Reform Coalition Resources during Creation Stage – Brazil Social Assistance

Resource Needed	Reform Coalition Resources: 1990	Reform Coalition Resources: 1993
Organizational resources	Low	Medium/High
Symbolic resources	Medium	High
OUTCOME	**Failed reform**	**Strong institutional design**

From the start, support was weak for the new social assistance bill, which was based on the principles and proposals of the IPEA-UnB working group. The government delayed its introduction of the new social assistance bill due to internal divisions about how to structure social assistance. Given the government's reticence to act, Federal Deputy Raimundo Bezerra – the president of the Health, Pensions and Social Assistance Commission in the Chamber of Deputies – introduced a bill that closely resembled the UnB-IPEA plan. As the bill moved through committees, however, politicians from clientelist parties on the right amended it beyond recognition. The amendments all but eliminated decentralization and participatory policymaking and preserved the old social assistance system with only minor changes. The "new" social assistance proposal used some language of rights, but in practice this language was not backed by changes that would protect citizens' right to social assistance. For instance, the revised bill emphasized the need for political discretion in setting social assistance policy – directly contradicting the idea that social assistance funds should be allocated based on objective criteria, not the needs of politicians (Boschetti 2002; Raichelis 1998).

Reform proponents were unable to block these amendments. The experience in social assistance contrasts with that of the health reform, in which the reform coalition was so legitimate and strong that their proposal was able to sail through committees and floor votes virtually untouched. In social assistance, however, would-be reformers had not mobilized stakeholders in society and thus had few resources to leverage when clientelist politicians seized political control of the process. Nevertheless, the social assistance bill *did* contain some important changes – namely, the creation of the non-contributory pension for the elderly and the disabled living in poverty. The heavily amended bill was approved by both houses of Congress in August 1990 and was sent to the president for his final signature.

The fate of the social assistance reform was threatened because by that time, the conservative Fernando Collor de Mello had assumed the presidency. As described in Chapter 2, Collor implemented a number of neoliberal reforms. He also opposed the expansion of social policy, which would inevitably require additional resources – and might threaten his ability to buy votes. While Sarney had appeared ambivalent about the new social assistance framework,

Collor was overtly hostile. Collor slashed the budget of the old social assistance agency, the LBA; in 1991 it was only 53% of the 1989 levels under Sarney (Boschetti 2002: 57). When the social assistance bill reached Collor to be signed into law, the president vetoed the bill in its entirety. The numerous amendments made along the way by Congress were insufficient to weaken the new social assistance system, in Collor's view. Notably, the president declined the less severe option of using the line-item veto (as he had done with the health statute) and struck down the social assistance reform entirely, claiming it to be unconstitutional.

For three more years, the fate of social assistance policy in Brazil remained uncertain since the country lacked the enabling legislation needed to comply with the new constitutional mandate for social assistance. It seemed quite possible that this new constitutional mandate would never be implemented and would be forgotten over time.

The efforts of the growing social assistance reform coalition were bolstered by the collapse of the Collor government due to the weight of hyperinflation, policymaking gridlock, and allegations of egregious corruption. By late 1992, Collor had a complete lack of legitimacy among the public. He was impeached by the Congress in September of 1992 and was replaced by Itamar Franco, his vice president who was seen as more honest than his predecessor. Franco was charged with restoring both economic and political stability to the country.

When Franco came to office, the social assistance reform coalition had a much greater capacity to stage protest than in 1990. The small group academics and experts that had developed the new social assistance framework recognized that without the support of stakeholders, they would never be able to push back against the president and the traditional party politicians in the Congress.

They needed to expand their reform coalition to include new supporters from diverse backgrounds and began a nation-wide campaign. They traveled throughout the country to meet with social workers in all states. The reform coalition also reached out to the nascent disabled persons movement, which was growing in size and political influence. As of late 1992, the social assistance movement had expanded beyond academics to include a greater diversity of members that could be mobilized for protest and marches on Brasília.[66] In contrast, in 1990 the reform coalition was powerless to do anything but provide their expert opinions. Nevertheless, this movement did not include some of the major stakeholders in the sector; notably underrepresented were the philanthropic organizations that provide social assistance services and the majority of potential beneficiaries.

In addition to these new organizational strengths, the social assistance reform coalition was also better positioned to wield symbolic resources. In particular, they were more skilled at linking their proposals with the larger democratic and social rights norms behind the constitution, which was widely popular.[67] Moreover, their ability to use these symbolic resources was heightened due to the overwhelming disgust with the Collor administration: since Collor opposed the social rights guarantees established in the popular 1988 constitution and had vetoed the first social assistance bill, activists were able to assert that the rights-based social assistance system was the obvious heir to the constitution. The movement was able to harness symbolic resources of the constitution: they established legitimacy by virtue of being the enemy of the reviled Collor.

[66] Interview with Valéria Gonelli, Directora de Proteção Especial, Secretaria de Assistência Social, MDS, October 18, 2008.

[67] Interview with Valéria Gonelli, Directora de Proteção Especial, Secretaria de Assistência Social, MDS, October 18, 2008.

After the scandalous Collor administration, Franco sought to heal the battered economy and find conciliation with social movements, particularly those mobilized around social rights that were angered by Collor's flagrant refusal to actualize the social rights reforms mandated by the 1988 Constitution. As part of this attempt to mollify social movements, Franco pushed for the rapid passage of the Social Assistance Statute, known as LOAS (*Lei Orgânica de Assistência Social*). Franco tasked four cabinet members – the Minister of Social Welfare, the Minister of Pensions, Minister of Planning and Budgeting, and the Minister of the Treasury (future president Fernando Henrique Cardoso) – with developing a compromise bill. The compromises changed some of the content of the new social assistance system – namely, by making it more difficult to receive the non-contributory pension. However, they did not alter the rights-based orientation, or the participatory and decentralized design, of the new system. This bill was ushered through Congress under the guidance of Federal Deputy and social worker Fátima Pelaes and passed easily. Five years after the passage of the Constitution, LOAS was finally signed into law on December 7, 1993.

5. IMPLEMENTATION (1994-2002)

Implementing the new social assistance framework would prove just as difficult as creating it. Following Collor's impeachment, social assistance reformers no longer faced roadblocks from a president that sought to slash social policy to the bone. Nevertheless, the subsequent Cardoso administration appeared to have little interest in putting into place the social assistance sector – much less in developing social assistance councils with policymaking authority. During later years of the administration, however, the government invested in the construction of social assistance councils (and the sector in general).

This construction happened due to the persistent efforts of a social assistance reform coalition. Substantive changes to the content of social assistance policy had attracted a number of different of stakeholder groups – academics, social workers, the elderly, the disabled, and some philanthropic organizations. Reform leaders united these groups behind a participatory vision of reform. Still, the reform coalition had failed to mobilize the philanthropic sector as a whole behind its vision of a new rights-based social assistance system. While supporting the construction of councils and participating on them, stakeholders in the sector could not unify behind one shared vision of the public interest, as we observed with the Brazilian health councils. This lack of cohesion limited the symbolic and organizational resources available to apply pressure on the government, when compared to the health reform coalition. Informational resources were higher due to the National Social Assistance Council's unique competency in the regulation of the philanthropic organizations, meaning the Cardoso government needed the council's input (Table 4.3). As a result, implementation was more fraught than we saw with Brazil's health councils, but still more successful than Colombia's planning and health councils.

Table 4.3: Resources Leveraged by Reform Coalition during Implementation Stage – Brazil Social Assistance

Resource Needed	Resources Available to Reform Coalition
Organizational resources	Moderate/High
Symbolic resources	Moderate
Informational resources	High
OUTCOME	**Construction of participatory institution**

Following the passage of the Social Assistance Statute in December 1993, there was a delay in beginning implementation. The Franco government was busy attempting to broker bargains among polarized groups and passing the statute was investment enough in that one particular sector. The National Social Assistance Council convened in early 1994, but had little to discuss during its first year. The implementation of the new social assistance system and its attendant councils fell to the president that succeeded Franco: Fernando Henrique Cardoso of the centrist and technocratic PSDB.

The start of the Cardoso government was a period of great frustration for the advocates that had designed the new social assistance system, including those on the National Council. As described in Chapter 2, the government's top social policy priority was the Comunidade Solidária anti-poverty program. The presidency concentrated it efforts in this area and made few investments in the social assistance sector. Likewise, the Minister of Pensions and Social Assistance focused almost solely on the pensions part of his position and gave short shrift to the social assistance part. According to one of the founding CNAS councilors in a 2001 interview, "From 1995 until today [2001], the Ministry of Pensions and Social Assistance has been in turmoil about whether the Ministry was for pensions, or social assistance… It isn't clear who is directing policy." (de Resende Chagas et al. 2003: 19)

Government indifference to the social assistance sector manifested in the government's five month delay in naming a National Secretary of Social Assistance (de Resende Chagas et al. 2003: 19). Without a National Secretary, necessary reforms to construct the institutional infrastructure and regulatory framework for the new social assistance system could not begin.[68] These decisions included the specific roles for each level of government; the conditions guiding inter-governmental transfers of the National Social Assistance Fund, which was to distribute money to subnational government based on objective, non-political criteria; and the top policy priorities in the sector.

Lacking a functioning Secretariat, the CNAS could not oversee the implementation of social assistance policy for the basic reason that social assistance itself had not yet been outlined. They could not contribute proposals without knowing the government's initial starting point, and could not pressure the Secretariat to act if no one was responsible for the Secretariat. Likewise, the subnational councils lacked a clear purpose, since there was no national social assistance system in place that they could monitor for compliance.

At this point social assistance reform coalition was unable to apply sufficient pressure on the government and command implementation of the new system. The social assistance reform

[68] In Brazilian politics, the legislature provides general mandates and the executive has great authority in determining how these mandates will be implemented.

had attracted a number of advocates in recent years, but the coalition was still nascent. Whereas the health reform coalition began to form in the late 1970s, a decade before the constituent assembly, the social assistance coalition only developed *after* the reform had already begun in 1988. Thus, the coalition's shared identity was in construction, and many potential beneficiaries had not yet signed on because they were unaware of what the sweeping changes would entail. Moreover, the coalition faced the persistent challenge of mobilizing social assistance beneficiaries, who are by definition extremely vulnerable populations.

The CNAS was nevertheless able to begin operations because its councilors had a unique area of expertise needed by the government: the certification of non-profit organizations. Prior to 1995, certification had been handled by the CNSS, which had been eliminated. A backlog of thousands of applications began to grow, and it became apparent that this crucial responsibility needed to be met as soon as possible. Since the CNSS had historically been responsible for the certification function, no one in the bureaucracy totally understood the requirements and procedures of certification, and there was a vacuum. Yet a number of the new national councilors were representatives of philanthropic organizations that had served on the CNSS. These councilors laid out the processes and requirements of certification to the government and to the new councilors, and undertook this task.

The CNAS's early experiences confirm the argument of this study that institutionalization is facilitated when participatory institutions have a monopoly on some kind of needed expertise. Maria Carmelita Yazbek, a top expert in social assistance policy and one of the original CNAS councilors, argued that the specialized certification expertise proved essential in establishing a role for the CNAS in policymaking:

> It was this bureaucratic function that also enabled the Council to gain permanency. There were moments in which the Council was so fragile, in terms of political will of the ministry, that it only continued on because it had the power to say "this organization can sign government contracts, that one cannot." To tell the truth, we realized that one of the bases of the CNAS's power was exactly this ability to authorize or not these non-profit organizations.[69]

The certification function enabled the CNAS to secure investments from the Cardoso government, including human and monetary resources. The CNAS also gained an increased public profile since certification was so important for non-profit organizations. Indeed, some of the most important philanthropic groups in the country joined the CNAS due to its certification function. The early investments and increased visibility and legitimacy took the CNAS from existing on paper and inserted it into the institutional structure of the Ministry of Pensions and Social Assistance, placing it in a better position to later act in social assistance policy.

After months of delays, the Cardoso government eventually named a Secretary of Social Assistance and began investing in the process of constructing the social assistance sector. Still, its investments were slow to arrive. The government kept the CNAS at arm's length, and consulted only minimally with them on how to construct the sector. The councilors representing the government that the administration named to the CNAS that were not senior officials and

[69] Interview by Raquel Raichelis with Maria Carmelita Yazbek, CNAS councilor/Conselho Federal de Serviço Social (Raichelis 1998: 137).

lacked the ability to speak on behalf of their ministries. A councilor from ABONG, the national federation of NGOs, explained that:

> The government doesn't have social policy as a priority, and doesn't have as a priority the expansion of social rights, like social assistance. This is true, and it causes big problems. If [social assistance] were a priority, obviously everything would fall into place. The council *has* the capacity to operate, and it does, including the capacity to present alternatives, to propose solutions. But, when the government doesn't want these alternatives and solutions, nothing happens as a result. (Raichelis 1998: 141)

CNAS councilors – including not only the leftist, pro-participation activists, but also those representing the more conservative philanthropic organizations – grew frustrated with their exclusion and manipulation. The councilors believed that the CNAS needed to have a greater role in policymaking in order to ensure that the social assistance reform would be followed.

The councilors decided to turn to a strategy that had proven successful in health: mobilization of the base via a national conference. The reform coalition would need to expand further and develop greater mobilizational resources. As allowed in the Social Assistance Statute, the CNAS called for a National Social Assistance Conference in 1995. The national conference would mobilize stakeholders throughout the country in support of the social assistance reform. It would also produce proposals and establish priorities for how to construct the sector since the government appeared unwilling to do so. These proposals would be strengthened politically by the legitimacy attendant with a participatory process that mobilized thousands of people from throughout the country. In 1995 municipal conferences were held across Brazil, and then state conferences, leading finally to the First National Social Assistance Conference in Brasília. As planned, the conference produced a number of clear proposals and priorities for the sector. In response, the government finally passed the first administrative orders (*Norma Operacional Básica*) to establish a regulatory framework in the sector. These administrative orders also formalized the structure and responsibilities of the social assistance councils.

Given the success of the 1995 national conference in mobilizing new groups into the reform coalition and applying pressure on the government, the CNAS decided to call another conference for 1997. The municipal, state, and national social assistance conferences were charged with developing an official National Social Assistance Policy. The National Social Assistance Policy would explicitly establish the rules, regulations, and structure of the sector. The conferences were meant to apply pressure on the government, but also served to construct a shared understanding among stakeholders of social assistance as a social right. As a result of the conferences, many more stakeholders became mobilized, and the potential of the pro-participation activists to apply pressure on the government increased due to its enhanced organizational resources. A CNAS councilor who had been one of the activists involved in constructing the social assistance system explained that:

> The great success of the conferences is that they caused debate on the question of social assistance and reconstructed the vision of social assistance in society. So, I think that this was a great

> success. You had representatives of very small municipalities, of neighborhood associations, insisting that social assistance could not be conflated with clientelism, with *assistencialismo.* The conferences facilitated a process of the re-conceptualization of social assistance, and this left the [National] Council stronger – so much so that that the Presidency had to start recognizing its contributions. (Raichelis 1998: 144)

Following the second conference, in 1998 the government approved the National Social Assistance Policy - five years after the passage of LOAS. The National Social Assistance Policy clarified the roles of different levels of government – and the councils – in the policy process for social assistance. It also established guidelines about how to implement social assistance policy on the ground, and how municipal governments should develop priorities and policies.[70]

These conferences proved effective in increasing pressure on the government to develop a social assistance policy. Yet, when compared with health, the social assistance reform coalition's capacity to apply pressure was more limited. Indeed, some of the national councilors worried that if they pressured the government too much, it would respond by dismantling the social assistance sector – demonstrating the relative weakness of the stakeholders promoting a more expansive policymaking role for participatory institutions.

Despite the fragility of the social assistance sector and councils in the initial years following the passage of LOAS, the situation had stabilized by the end of the 1990s due to pressure from the reform coalition. With the National Social Assistance Policy in place, the CNAS was able to define a concrete role for itself and subnational councils overseeing the administration of social assistance policy throughout the country. Subnationally, the National Social Assistance Policy provided a (relatively) clear set of guidelines for the implementation of social assistance, and also solidified enforcement mechanisms. The social assistance councils relied on the same enforcement mechanisms used in health: inter-governmental transfers would be blocked if local governments failed to institute councils, or did not respect their formal authority. At the federal level, additional funds went to support the training and operation of councils at the state and municipal levels. Furthermore, the conferences had established linkages among councils throughout the country, and with the CNAS. These linkages facilitated the sharing of information, and the National Council came to have a greater role in providing technical and organizational support to subnational councils. By 2001, the vast majority of municipalities – 93% – had established the mandatory social assistance council (IBGE 2001).

Institutionalization of the participatory social assistance councils rose in the late 1990s for another reason: the Cardoso government and the PSDB started to place increased emphasis on social programs as part of its electoral strategy (see Chapter 2). With this shift towards social programs, social assistance went from being a neglected policy sector to a more central one in the Cardoso administration – particularly given the size of the BPC income transfer as well as other income transfers in the sector, such as the Program for the Eradication of Child Labor. Given the specialized expertise of many members of the National Social Assistance Council, the

[70] Even this National Policy failed to resolve many of the questions about the how national social assistance policy would be implemented at each level of government. These issues were not fully resolved until 2004, with the creation of the Unified System of Social Assistance (SUAS), which addressed the lingering questions from the 1998 National Social Assistance Policy.

Cardoso government began to include the CNAS in decision-making more, and the social assistance councils grew more established and legitimate.

The sweeping nature of Brazil's social assistance reform had attracted diverse supporters, and the reform coalition was successful during the implementation stage in attracting additional supporters. Nevertheless, there remained faultlines for the reform coalition. In particular, the reform coalition had a less coherent vision of the public interest, and diverged on what they thought an ideal social assistance system would look like. Many philanthropic groups never fully supported the rights-based framework proposed by the IPEA-UnB working group in 1990, preferring a model that gave philanthropic groups greater autonomy and placed less of an emphasis on social assistance as a citizen right. The diverse stakeholders allied together during the 1990s due to their shared interest in ensuring that social assistance policy actually was implemented and funded by the government. Yet as we will see in the following section, tensions across different stakeholder groups ultimately limited the reform coalition's unity and thus its ability to push for strong social assistance councils with high legitimacy and a central role in policymaking.

6. INSTITUTIONALIZATION (2003-2010)

The path to institutionalization had been rocky, but by the time Luiz Inácio Lula da Silva assumed the presidency the institutional infrastructure was already in place for the social assistance councils. Substantive policy changes in the social assistance reform had mobilized a number of different stakeholder groups behind the councils. With the election of the leftist Workers' Party of these actors now gained key positions in the national social assistance secretariat. From these positions of power, the new bureaucrats stepped up government support for the social assistance councils. However, it is key to note that the infrastructure behind participatory policymaking in the sector was already in place; the Lula government just sought to deepen it.

During the institutionalization stage, it became clear that Brazil's social assistance councils had taken root. Virtually all municipalities, and all states, had a social assistance council. Routinization was high, with councils fulfilling more or less the same roles and following the same structure throughout the country. Nevertheless, it also became apparent that the social assistance councils are less institutionalized than their counterparts in health. While both are highly routinized, the social assistance councils are less infused with value: they lack the strong legitimacy of the health councils, and are more secondary players in the development of social assistance policy. Despite these limitations, Brazil's social assistance councils have proven to be more institutionalized than even the strongest participatory institution in Colombia, the participatory planning councils discussed in Chapter 6. During the institutionalization stage, we see that the advances and setbacks of the social assistance councils result from the reform coalition that developed in the sector. Given the sweeping nature of the reform, this reform coalition is fairly broad and includes a number of stakeholders. Yet with only partial buy-in from philanthropic organizations, the councils' claims to represent all stakeholders and to defend a shared vision of the public interest falls short, leading to a limited infusion with value.

As demonstrated in Chapters 2 and 3, the Lula government was programmatic and promoted the social rights discourse; this tendency was particularly pronounced in social assistance policy. The Ministry of Pensions and Social Assistance was restructured in 2003 to form the Ministry of Social Development and Combating Hunger (*Ministério de*

Desenvolvimento Social e Combate à Fome, MDS), which housed national social assistance policy, anti-hunger programs, and the famed Bolsa Família conditional cash transfer program. The MDS became one of the most visible and significant ministries of the Lula administration, serving to showcase the leftist party's efforts to alleviate poverty and create a political climate of social rights.

The national Social Assistance Secretariat was staffed with subnational bureaucrats from the social assistance reform coalition. These reformers had gained practical experience administering rights-based social assistance policy during their tenure in municipal secretariats of social assistance – particularly the *petista* exemplars of Belo Horizonte and São Paulo. Other senior staff in the MDS included academics and civil society activists from the reform coalition, including several that had served on the CNAS during the Cardoso years.[71] In sum, the national social assistance program was taken over by members of the reform coalition. One such activist turned senior bureaucrat stated, "The Ministry of Social Development is an activist ministry."[72]

Now in power, these activists embraced the opportunity to deepen implementation of the rights-based social assistance system. Great strides had been made over the past decade: LOAS had passed and a new social assistance system had been constructed throughout the country. The new social assistance system was more or less legitimate and accepted by political actors of all ideological stripes: no one called for the elimination of social assistance, as Collor had. Nevertheless, considerable work needed to be done. The new bureaucrats from the reform coalition believed that the Cardoso government had dragged its feet and had resisted constructing fully the rights-based system. One MDS bureaucrat stated: "We were delayed for those ten years [1993-2003] debating what exactly 'social assistance' means" – but now in power, they could realize fully the rights-based approach.[73]

According to these activist bureaucrats, the Social Assistance Statute itself is not enough to actualize a rights-based framework for social assistance. The Social Assistance Statute established the skeleton of how the social assistance system would operate, but did not specify the details of this operation. The law called for an integrated and decentralized system that mandated the implementation of local social assistance plans, councils, and designated social assistance funds to receive inter-governmental transfers – but did not clarify how these institutions would relate to one another, or across different levels of government in the federal system. In other words, the regulatory framework behind the social assistance system was not clearly established. It is difficult to ensure that the government fulfills its obligations in protecting the rights of its citizens when these obligations have not been clearly defined in the first place.[74]

In developing the institutional framework behind the rights-based social assistance system, Ministry staff turned to the example of Brazil's Unified Health System (SUS). Brazil's

[71] While these bureaucrats were typically members of the PT, they were hired to support the objective of professionalizing social assistance policy, not to distribute ministry jobs as patronage for political support. Interviews with Renato dos Santos Paula, Coordinator, Apoio às Instâncias do SUAS, Secretaria de Assistência Social, Ministerio de Desenvolvimento Social, 13 October 2008 and Valéria Gonelli, Directora de Proteção Especial, Secretaria de Assistência Social, MDS, October 18, 2008.

[72] Interview with Valéria Gonelli, Directora de Proteção Especial, Secretaria de Assistência Social, MDS, October 18, 2008.

[73] Interview with Renato dos Santos Paula, Coordinator, Apoio às Instâncias do SUAS, Secretaria de Assistência Social, Ministerio de Desenvolvimento Social, 13 October 2008.

[74] Interview with Jaime Rabelo Adriano, Coordinator, Regulação da Gestão Intergovernmental, Secretaria de Assistência Social, Ministerio de Desenvolvimento Social, 15 October 2008.

health system was seen as a successful model of a decentralized, participatory, and universal federal policy. Attempting to replicate the experience of SUS, the government focused on developing and institutionalizing SUAS. Yet, given the administration's focus on social rights and participation, SUAS could not be developed in isolation, and the MDS turned to the social assistance councils for input in constructing the system.

6.1 High Routinization

Ministry officials saw the social assistance councils and periodic conferences as having a central role in facilitating their political agenda in social assistance. As mentioned above, many of these activist bureaucrats had served on the CNAS during the Cardoso administration as representatives of workers or beneficiaries, or on subnational social assistance councils. Given their experience as councilors, they saw the councils as instrumental in elaborating the social rights discourse and mobilizing groups in civil society behind this framework.

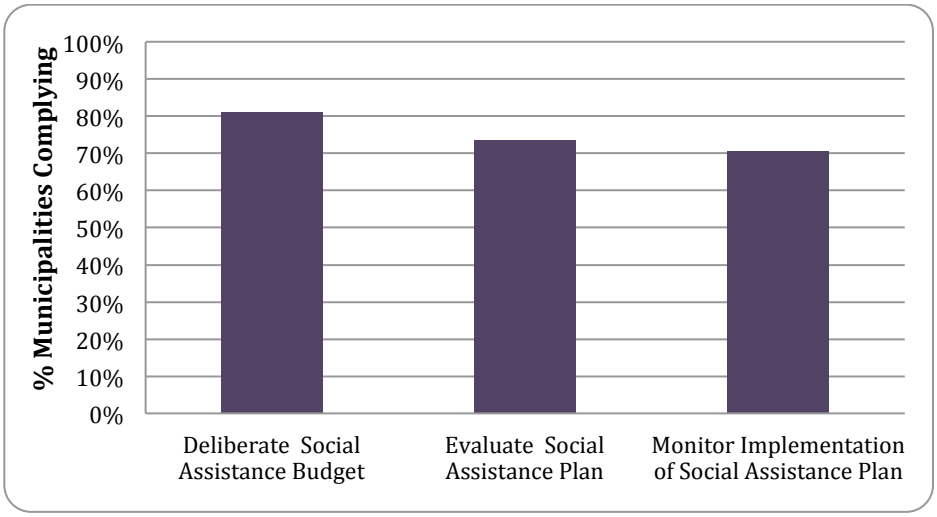
The basic infrastructure for the social assistance councils had been put into place during the implementation stage. In other words, the councils were more or less routinized by the time the PT came to power and the reform coalition was able to take over the ministry. The regulatory framework behind the councils had been established through regulatory orders and with the 1998 National Social Assistance Policy. Enforcement mechanisms had been duplicated from the health model and were in place. Building on this foundation, the regulatory framework and enforcement mechanisms were further elaborated with additional regulatory orders – most notably, with the 2005 regulatory order that established the Unified Social Assistance System (NOB/SUAS 2005). Routinization of the social assistance councils throughout the country was further supported through government spending: in 2009, the federal government spent $1.6 million to support social assistance councils throughout the country.[75] This is in addition to the money that subnational governments themselves spend on their councils, which comes directly from the National Social Assistance Fund and thus does not come out of the governments' discretionary funding.

Finally, there is high compliance with the participatory mandate in social assistance. Governments at the national, state, and municipal levels meet the core institutional requirements established in the regulatory framework in both sectors. By 2009, 99% of Brazilian municipalities had established participatory social assistance councils (IBGE 2009). These subnational councils do not only exist on paper; most exercise the range of responsibilities established by the legal frameworks. In 97.3% of municipalities, social assistance councils meet the requirement of equal representation for government and civil society actors; councils met at least once in the previous year for 97.9% of all municipalities (IBGE 2009). However, a somewhat smaller percentage of councils fulfill the broader range of responsibilities, which include deliberating and monitoring the municipal health or social assistance budget, evaluating the municipal health/social assistance plan that is developed every year, and monitoring the implementation of these plans. Nevertheless, as Figure 4.2 demonstrates, compliance with formal requirements is still fairly high, with between 70-80% of municipal councils performing the aforementioned responsibilities. This inclusion of civil society groups via councils is

[75] In 2009, the federal government spent R$3,147,572.73 to directly support social assistance councils and R$1,533,382.59 to support the organization and administration of SUAS. The government spent R$4,542,222.26 on the National Health Council, R$1,015,922.16 on strengthening participation and civil society mobilization in health, and R$5,654,618,65 to support participatory public management, societal oversight, and education in health. For detailed information, see Presidência Da República, 'Portal Da Transparência Do Governo Federal',

particularly remarkable given the paucity of any civil society activity in the sector just 20 years earlier.

Figure 4.2: Percent of Municipal Social Assistance Councils that Exercise Mandated Responsibilities



Source: IBGE Perfil dos Municipios database – 2009.

6.2 Moderate/High Infusion with Value

While the social assistance councils became clearly routinized during the Lula administration, their degree of institutionalization as measured by infusion with value proved more mixed. On the one hand, the councils were generally regarded as legitimate, and no major stakeholders question whether they should exist and whether they deepen Brazilian democracy. Both MDS officials and members of Congress regularly consult with the CNAS about major policy decisions. Thus, Brazil's social assistance councils have considerably greater infusion with value than even their counterparts in Colombia. On the other hand, the social assistance councils are *less* legitimate and *less* included in policymaking than Brazil's health councils. This mixed outcome can be traced back to the reform coalition that formed in support of the sweeping social assistance reform. The substantive policy changes included in the reform explain why Brazil's social assistance councils have become (comparatively) routinized and infused with value. However, the social assistance reform coalition was never as unified or coherent in its ideas as the health reform coalition. Thus, the reform coalition's ability to mobilize symbolic and organizational resources was relatively limited, and consequently their ability to press for a strong, autonomous, and respected role for the social assistance councils was also limited.

As in health, Brazil's social assistance councils have become a focal point for state-society engagement in social assistance policy. The broad reform coalition that developed with the sweeping social assistance reform has meant that the social assistance councils can effectively claim to represent all major organized stakeholder groups. For policymakers from both the executive and legislative branches, any discussion of how to include civil society in the design and implementation of social assistance policy centers on the councils. This became apparent during interviews conducted for this project. The 14 politicians and party leaders interviewed were informed that the project centered on interest representation in the health and

social assistance sectors, but were not made aware that the project centered on participatory councils in particular. Yet every one proactively mentioned the councils during interviews and talked about their connections to them, at both the national level and in their home districts. Policymakers hoping to reach out to civil society groups do so via the social assistance councils. Likewise, civil society groups that seek to influence social assistance policy do so via the councils, more so than via lobbying or other strategies.

One reason that the social assistance councils have become a focal point is due to their legitimacy in representing stakeholders. Brazil's social assistance councils are now taken for granted and unquestioned. In the early 1990s, conservative politicians – including former president Fernando Collor de Melo – opposed the construction of this system and the devolution of policymaking authority to social assistance councils. Today, that perspective has become marginalized and is not articulated. Among the 32 politicians, bureaucrats, councilors, and other experts interviewed about social assistance for this study, not one questioned whether the councils should exist. The bureaucrat at MDS charged with coordinating technical assistance to subnational governments stated:

> In this country, we have created a current that is in favor of SUAS - no, a current that *defends* SUAS. Today, no one still opposes [SUAS] or resists it, saying that it's terrible to organize the system in this way – that doesn't exist anymore. For policymakers at the three levels – national, state, and municipal – there is consensus that this model of public administration… is appropriate for social assistance.[76]

Interviewees uniformly described the social assistance councils as a space for civil society to contribute to policy, and something that was beneficial for social assistance policy and for democracy more broadly.

While the social assistance councils have established a basic level of legitimacy, they still lack the high legitimacy that we observed with Brazil's health councils. The major challenge to their legitimacy stems from the fact that the social assistance councils represent the most organized civil society groups in the sector rather than *stakeholders* in the sector. While many have argued that this question of representativeness will always trouble participatory policymaking council (e.g. Tatagiba 2000), this challenge seems particularly acute for the social assistance councils. Many see the civil society councilors on the social assistance councils – and in particular on the CNAS – as defending their own interests, rather than the larger public interest. All MDS officials interviewed expressed extreme frustration with the CNAS and described many of its members as self-interested individuals that seek to advance their own interests and not the public interest.

These problems with representativeness limits the ability of social assistance councils to accuse the government of disrespecting the will of the people if it excludes the councils; council backing of a proposal does not necessarily mean that this proposal reflects the public interest and/or the will of Brazilian society as a whole. In fact, this problem of representativeness has proven so problematic that the CNAS convoked a National Social Assistance Conference in

[76] Interview with Renato dos Santos Paula, Coordinator, Apoio às Instâncias do SUAS, Secretaria de Assistência Social, Ministerio de Desenvolvimento Social, 13 October 2008.

2009 to develop strategies to increase participation and improve representation on councils at all levels of government.

Social assistance councilors themselves do not even see their fellow councilors as the legitimate embodiment of civil society in the social assistance sector, and are highly critical of one another. Some complained that the government councilors try to monopolize control of the council and are looking to concentrate power in the sector by coopting the council; others argued that their fellow councilors did not represent the public interest and were hurting the cause of social assistance.[77] For example, one councilor representing social assistance workers stated that "the logic is that philanthropic organizations, who are overrepresented on the Council, defend their corporatist interests, of certification of non-profit organizations, and not to define social assistance policy."[78]

One of the core reasons that the social assistance councils are not seen as representing "the public interest" is that the reform coalition itself does not share a common vision of "the public interest" to project and defend via the councils. The absence of a common vision can be traced to the reform origins of the social assistance councils. Substantive policy changes included in the social assistance reform brought together a range of stakeholders that had a vested interest in reform implementation, yet not all of these groups were in agreement about what reform implementation would look like. Because the reform coalition developed *after* the creation process had begun, the different stakeholder groups did not have the time to hammer out their differences and design the reform to reflect a consensus about what the sector should look like. While there is consensus that the pre-LOAS model of social assistance was overly politicized and that it did not protect the rights of vulnerable populations, there is a sharp division between two camps regarding the objectives of social assistance policy, its target populations, the relative roles of philanthropic organizations and the state, and the ultimate purpose of participatory policymaking councils.

Those from one camp – what I call the statists – follow the ideas and proposals initially established by the IPEA-UnB working group in 1990. The statists see social assistance as a distinct social policy, not merely a space for intersectoral programming, and a fundamental right of all Brazilians and not simply of the poor. Adherents to this approach emphasize how social assistance is a social right, and that the state must be responsible for the design and implementation of social assistance programs; philanthropic organizations should provide a supporting but subordinate role. Councils, including the CNAS, are essential to ensure that the government does not misuse social assistance resources for political aims, and that the state is protecting the rights of all citizens. Advocates of the statist perspective include those from the original reform coalition: academics, social workers, and some bureaucrats (including those in the MDS). While members of this perspective designed the Social Assistance Statute as well as SUAS, the statist approach remained a minority among the broader universe of social assistance stakeholders.

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[77] Interviews with Samuel Rodrigues, national social assistance councilor representing Movimento Nacional da População da Rua, 12 March 2009; Daniel Avelino, national social assistance councilor representing the Ministry of Education and Culture, 11 May 2009; Marisa Furia Silva, national social assistance councilor and national health councilor representing Associação Brasileira de Autismo, 2 July 2009; Margareth Alves Dallruvera, national social assistance councilor representing Federação Nacional dos Assistentes Sociais, 3 July 2009; and observation of CNAS plenary meetings in October 2008, March 2009, April 2009, May 2009.

[78] Interview Margareth Alves Dallruvera, national social assistance councilor representing Federação Nacional dos Assistentes Sociais, 3 July 2009.

The state-society collaboration perspective, which is dominant among many subnational governments and service providers, sees more continuity with the pre-1993 model. In contrast to the statist perspective, this approach was not elaborated in a series of meetings among experts. Instead, it is simply the way that many actors involved in the sector view social assistance, despite the persistent efforts of bureaucrats and academics from the statist perspective to raise awareness of their new and "correct" interpretation of social assistance. This view sees the government and philanthropic sectors as both engaged in fighting poverty, able to amplify their impact by coordinating – but both sides remain equal partners. In this context, councils should provide the means to coordinate these efforts.

These clashing perspectives ensure that it is impossible for councils to defend the public interest, since the public interest would be defined differently for the two approaches. During the creation and implementation stages, these conflicts only occasionally came to the surface, because the two camps *did* share a number of commonalities. Both sides seek additional or at least stable social assistance funding, and both sides believe that social assistance should be distributed according to objective needs and not political agendas. More broadly, the two camps wanted the Social Assistance Statute passed and implemented because they believed that it would help advance their own visions of the public interest. Yet when time came to deepen the social assistance reform in the institutionalization stage, conflicts began to emerge. These clashes and inconsistent visions have undercut the legitimacy of the social assistance councils with policymakers, and among stakeholders in the sector as a whole.

In sum, the social assistance councils have a minimal level of legitimacy and no one challenges their existence – yet this legitimacy has limits and the social assistance councils lack the moral authority we observed with the health councils.

Likewise, the social assistance councils also are mixed in the degree to which they are included in the policymaking process. The politicians most engaged in social assistance policy frequently attend CNAS plenary meetings to update the councilors on the status of impending legislation.[79] Government proposals in the sector go through the social assistance councils for reactions and suggestions. For example, the CNAS' approval of a resolution establishing the Unified Social Assistance System was one of the most important steps in its creation. The CNAS was involved in all discussions and debates on the regulatory order from the MDS that finalized the creation of SUAS. Moreover, much of the content of SUAS was determined during a national social assistance conference convoked by the CNAS.

The consistent engagement with the CNAS in major policy decisions provides a sharp contrast with the experience of Colombia's National Planning Council, described in Chapter 6. The National Planning Council is not included in deliberations about the National Development Plan; instead, it can only react *after* the government outlines policy. Moreover, the National Planning Council's proposals and critiques are only rarely taken into consideration at all. In contrast, the CNAS is included at all steps of the policymaking process – from agenda setting to designing policy to monitoring its implementation to evaluating its impacts.

Nevertheless, the extent of inclusion in policymaking is limited when compared to the health councils in Brazil. A number of interviewees, including councilors themselves, expressed frustration that the councils have more of a reactive rather than proactive role in proposing and deliberating on policy. Thus, they are part of decisions about how to divide up the social

[79] Namely, Federal Deputies Raimundo Gomes de Matos (Ceará-PSDB) – the president of the Congressional Social Assistance Caucus – and Eduardo Barbosa (Minas Gerais-PSDB) – a politician active in the disability rights movement and generally regarded as Congressman most involved in social assistance policy.

assistance budget, but are more likely to respond to existing proposals from the government rather than present new ideas themselves.

While the MDS regularly consults with the CNAS, its relationship is less intimate than the one between the Ministry of Health and the National Health Council. The MDS only consults with the CNAS when doing so seems necessary, and the ministry has not involved the CNAS in its strategies vis-à-vis Congress. This distant relationship is not new with the Lula administration; during Cardoso's government, the CNAS and ministry had an even more strained relationship and the ministry left the Council out of most decisions. The politicians in the National Congress who are involved in social assistance policy view the social assistance councils as flawed and are more critical of them than are politicians linked to the health councils. In interviews, several politicians stated that the CNAS is only passively involved in legislative policymaking discussions, making an explicit comparison with the more engaged National Health Council.

In contrast to the Ministry's rhetoric in support of social rights and participatory policymaking in social assistance, in practice the Ministry took steps to restrict the autonomy and policymaking role of the CNAS. For example, in 2009 MDS issued a decree that restructured the CNAS composition on the government side, replacing representatives from the Ministry of Health and the Ministry of Health and Education with additional representatives from the MDS. This decision altered the CNAS' internal bylaws and is the type of decision that is supposed to be undertaken by the CNAS itself, not the Ministry – yet they did not respect these formal channels, and moreover it did not even inform the CNAS councilors that had been removed from their positions. Indeed, the councilor that had represented the Ministry of Education and Culture learned that he had been removed from the CNAS when discovering the change in the Public Record (*Diário Oficial da União*).[80] Other councilors contended that the MDS infringes on CNAS autonomy by ensuring that the agenda for discussion reflected the government's priorities, and that the MDS only reached out to the Council when it served their interests.[81]

While the Lula government had a poor record of respecting the autonomy and policymaking role of the social assistance councils, it pursued alternate strategies that could give the social assistance councils a more expansive and institutionalized role in policymaking in the future. The Lula government and the PT stood to benefit from increased civil society mobilization by program beneficiaries in the sector as part of its strategy to reach out to voters in the informal sector (see Chapter 2). Thus, the problem with the current social assistance councils was that the wrong types of civil society groups were participating: philanthropic groups could not (or would not) produce the political resources sought by the government.

To redress this problem, the government began efforts to transform the councils by mobilizing beneficiaries. Bureaucrats from the MDS explicitly recruited and backed the candidacy of one councilor, who represents the homeless person's movement, in order to encourage greater representation of social assistance beneficiaries themselves (and not simply NGOs speaking on behalf of the beneficiaries). The theme of the 2009 National Social Assistance Conference was participation and societal control to encourage the development of

[80] Interview with Daniel Avelino, national social assistance councilor representing the Ministry of Education and Culture, 11 May 2009.

[81] Interviews with Daniel Avelino, national social assistance councilor representing the Ministry of Education and Culture, 11 May 2009; Clodoaldo de Lima Leite, national social assistance councilor representing Federação Espírita Brasileira/REBRAS, 3 July 2009; and Marisa Furia Silva, national social assistance councilor and national health councilor representing Associação Brasileira de Autismo, 2 July 2009.

strategies to induce mobilization by beneficiaries at the local level. Moreover, the government has established thousands of social assistance reference centers throughout the country as a means of facilitating collective action by program beneficiaries. According to this strategy, if the poor receive social assistance benefits directly from the state via these reference centers – and not from philanthropic organizations – they will come to recognize social assistance as a right and not a political favor. Moreover, they will come into contact with other social assistance beneficiaries, enhancing social capital and their ability to engage in collective action, including the councils.

In sum, during the institutionalization stage the social assistance councils were subject to both positive and negative feedback effects. Positive feedback effects, which stemmed from the origins of the social assistance councils in a sweeping sectoral reform, came as organized stakeholders mobilized into the councils, and in turn governments consulted with the councils as proxies for society as a whole. However, these positive feedback effects were limited. The reform coalition that had formed in favor of the social assistance reform had failed to resolve its underlying fissures. Thus, the councils were unable to fully claim to represent the public interest and the voice of the people, because a common vision of the public interest had never been articulated and agreed upon, and many stakeholders were not represented by the councilors.

7. CONCLUSION

Overall, the social assistance councils are fairly institutionalized. They have proven to be highly routinized: the social assistance councils exist throughout the country, with roughly the same structure and prerogatives in their different locales. Moreover, the councils have been infused with value enough that no one questions whether they should exist and should be involved in policymaking. The social assistance councils are less institutionalized than the health councils in Brazil, which are seen as the voice of the people and the defenders of the public interest, and have a significant role in the policymaking process. Despite their limitations, however, the social assistance councils can be described as institutionalized – particularly when compared with Colombia's participatory institutions.

This outcome is surprising given the paucity of civil society mobilization prior to the early 1990s. Few stakeholder groups even recognized their potential interest in social assistance, much less mobilized behind policy in the sector. Scholars uniformly argue that vibrant civil society activity is a prerequisite for participatory institutions. Thus, the social assistance councils seemed doomed from the start – and yet they managed to become standard throughout the country, recognized as a legitimate and central part of the policymaking process in the sector.

This chapter has shown that the surprising institutionalization of Brazil's social assistance councils can be traced to their origins in a sweeping sectoral reform. The social assistance councils were not imposed on existing interest representation dynamics in the sector, but rather emerged as the objectives, instruments, and content of the sector were all in flux. During this moment of change, a reform coalition formed in support of the social assistance councils, and the social assistance reform more broadly. The reform coalition brought together diverse actors, who were able to mobilize sufficient resources to pressure the government effectively for investment in the nascent councils. By the institutionalization stage, the social assistance councils had become focal points for both state and societal actors, leading to further investments in the councils.

Still, institutionalization was not as deep as that of Brazil's health councils. The sweeping policy sector reform *did* mobilize a diverse reform coalition, but the reform coalition had not worked out its disagreements about what the public interest might look like in the new social assistance system. The weaknesses of civil society in the sector did not disappear overnight with the sectoral reform. Thus, the reform coalition was more limited than that of health in wielding symbolic and organizational resources in defense of the councils. Clearly, sectoral reform alone is insufficient to yield institutionalization. Nevertheless, a sweeping reform can create the necessary conditions for such a reform coalition to emerge in the first place – conditions that were absent for many of Colombia's struggling participatory institutions, as we will see in the following chapters.

PART II. COLOMBIA: THE LIMITS OF PROCEDURAL REFORM

Like Brazil, Colombia established an extensive array of participatory policymaking institutions across diverse policy sectors in conjunction with its 1991 Constitution, which emphasized popular participation as a fundamental tenet of Colombian democracy. Despite early enthusiasm, however, Colombia's participatory councils failed to develop the broad policymaking responsibilities or achieve the same authority as their Brazilian counterparts. The national mandate behind participatory policymaking was largely ignored; municipal governments failed to implement the councils. Participatory councils in Colombia enjoy little legitimacy and are excluded from the policymaking process. Colombians now view their experiment with participatory policymaking as an overly idealistic venture that never had a chance of succeeding.

How did Colombia change from being a highly restricted democracy to having one of the most expansive legal frameworks for participatory policymaking in the world? Why did the implementation of Colombia's participatory framework stall, while Brazil's thrived? And what explains the different levels of institutionalization of participatory policymaking across policy sectors? The three chapters in this section examine Colombia's overall experience with participatory policymaking, and the trajectories of participatory councils in the planning and health sectors.

Chapter 5 analyzes the trajectory of participatory policymaking in the country as a whole. I argue that participatory policymaking was adopted not in spite of, but rather because of, its legacy of restricted democracy. By the 1980s, public consensus was that the existing political system needed to be thrown out and restructured as a more participatory democracy. The focus of the participatory reforms was on changing the procedures behind policymaking instead of also transforming the objectives and content of specific policy sectors, as happened in Brazil. I trace the fecklessness of participatory policymaking to the procedural nature of these participatory reforms. The procedural participatory reform attracted the support of only those with an inherent interest in participatory policymaking. Consequently, there was insufficient pressure on policymakers to make the political and material sacrifices needed to construct strong participatory institutions. As implementation stalled, the legitimacy of participatory policymaking also declined, leading to a negative feedback effect as both civil society and state actors pulled away from the councils.

Chapters 6 and 7 focus on the fate of Colombia's planning and health councils. While the participatory planning councils struggled to become even partially institutionalized, institutionalization failed altogether in health. In both sectors, the struggles to become institutionalized can be traced to the lack of a broad reform coalition composed of diverse stakeholders that could pressure the government to invest political, material, and human resources into the councils. The reform coalition mobilized behind the planning councils was limited due to its narrow composition of grassroots organizations and NGOs; missing were other powerful stakeholders such as economic associations and labor. In health, a reform coalition failed to formulate altogether, resulting in low levels of institutionalization.

Colombia's planning councils highlight the consequences of failing to implement a sweeping reform that links the creation of participatory councils with substantive policy changes, as we saw with the Brazilian cases. In contrast, Colombia's planning councils were established through a procedural reform that shifted which actors would be involved in the planning process, but not the substance of planning itself. In contrast to Brazil, the reform coalition was led by a

group of NGOs primarily focused on deepening democracy. These NGOs pushed for the creation and construction of the planning councils, mobilizing community organizations in the process. Other stakeholder groups, such as unions, planners, economic associations, and subnational governments did not mobilize behind the planning councils. Thus, the reform coalition was narrow and limited in its ability to pressure the government to invest in the planning councils, leading to incomplete routinization and infusion with value.

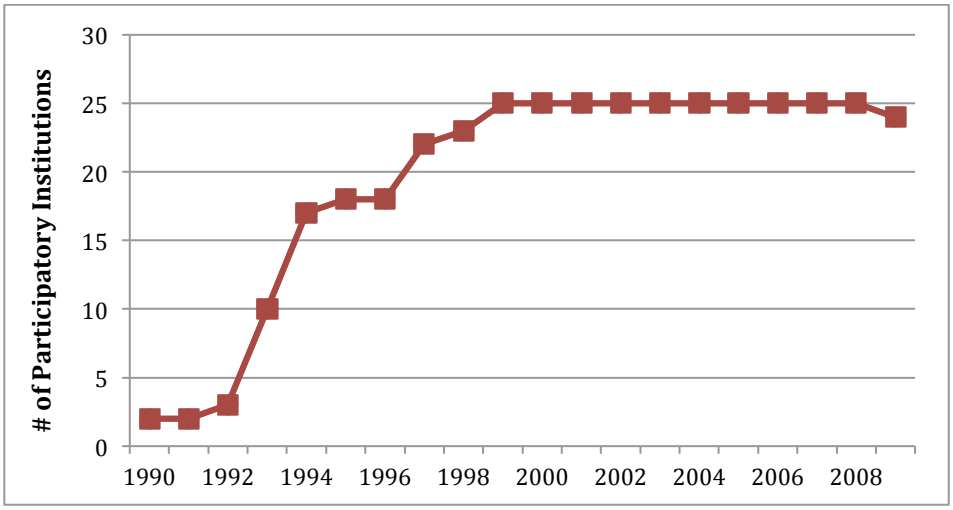
The case of Colombia's health councils underscore the importance of this study's second explanatory variable: the presence of reform leaders with a vested interest in strong councils. Colombian health councils were created in conjunction with a sweeping reform that established a universal, market-based health system. In contrast to the other three cases, there were no pro-participation reform leaders to advocate for the construction of the health councils. The reform was designed by technocrats (namely, foreign economists) contracted by the government that included councils in the reform as a means of enhancing efficiency – but not as a site of contestation about the design and implementation of the reform. Private sector service providers, the main supporters of the reform, did not advocate for strong health councils since they were the ones that would be overseen by the councils. Without leaders and a reform coalition mobilized in support of the health councils, the government failed to invest, giving rise to negative feedback effects and ultimately low routinization and low infusion with value.

CHAPTER 5. THE CONSTRUCTION OF PARTICIPATORY POLICYMAKING IN COLOMBIA: LEGITIMACY CRISIS WITHOUT DEMANDS FOR SOCIAL REFORM

1. INTRODUCTION

Before the 1991 Constitution, Colombia had one of the *least* participatory democratic systems in Latin America. Whereas most other major Latin American countries incorporated the popular sectors into democratic politics via state corporatism in the mid-20th century, Colombia's political parties sought to demobilize them altogether (R. B. Collier and Collier 1991; Hartlyn 1988). The regime grew even more restricted during the 1950s-70s with the formation of a consociational government that made voting a mere formality. The creation of participatory institutions in the 1990s signified a sharp reversal from this pattern of exclusion. The 1991 Constitution established Colombia as a participatory democracy. Colombian policymakers followed up by establishing 26 distinct national participatory institutions (see Figure 5.1). By the mid 1990s, Colombia had one of the most elaborate participatory frameworks in the world.

Figure 5.1: Nationally-Mandated Participatory Institutions – Colombia, 1990-2010



Source: Velásquez and González (2003); Author's database of nationally-mandated participatory institutions.

However, participatory policymaking stagnated by the late 1990s. As Figure 5.1 illustrated, no additional participatory institutions were created after the mid-1990s. In fact, one participatory institution – the National Health Council (*Consejo Nacional de Seguridad Social en Salud,* CNSSS) – was eliminated in 2007. Unlike in Brazil, Colombia's participatory institutions failed to expand into new policy areas. For example, Colombia has four participatory institutions in health, yet none at all in labor, energy policy, agricultural policy, industrial policy, or foreign trade – all areas in which Brazil has participatory institutions. Only 38% of Colombian

ministries are subject oversight by any participatory institution, in contrast to 83% of Brazil's ministries.[82]

The participatory institutions that do exist failed to become an important part of the policymaking process. Many municipalities ignore the mandate to implement participatory institutions. They face no consequences for doing so. Others go through the motions of creating participatory councils, yet exclude these councils from deciding on or even debating policy. Not surprisingly, participatory policymaking has little legitimacy: neither state nor civil society actors see the councils as valuable spaces of interest representation worth their attention.

This chapter outlines the origins and trajectory of participatory institutions in Colombia, looking at two questions. How did Colombia go from being a restricted democracy with few spaces for participation, to having one of the world's most expansive participatory frameworks? And why did this participatory framework stagnate, while Brazil's consolidated and expanded?

First, I argue that participatory policymaking was adopted in Colombia not *in spite of*, but rather *because of*, its legacy of restricted democracy. With the escalating violence of the 1980s, the political legitimacy of democratic institutions had reached abysmally low levels. Public consensus grew to replace the existing political system with a more participatory democracy. The focus of this transition was to reinvent democracy, and as such the reforms behind participatory institutions sought to change the procedures but not the substance of policymaking.

Second, I demonstrate that from the beginning policymakers had few incentives to invest heavily in the new councils due to the lack of reform coalitions mobilized in support of participatory institutions. Early stumbles in implementation led Colombians to view participatory policymaking as an unrealistic idea. Consequently, state and civil society actors withdrew investments, weakening the councils.

The chapter proceeds as follows. In the second section, I outline the legitimacy crises that gave rise to proposals for participatory policymaking. The third section examines how a legitimacy crisis facing the political regime led to the creation of participatory institutions across a range of policy sectors. The fourth section explores the anemic implementation of participatory policymaking in the 1990s, and its ultimate decay in the 2000s. The fifth section concludes with a discussion of how legitimacy crises shape the reform coalitions formed for participatory policymaking.

2. PRECURSORS: LEGITIMACY CRISIS UNDER RESTRICTED DEMOCRACY

Colombia's exclusionary political regime in place in the 1960s-80s set the stage for the dramatic expansion in participatory policymaking that would come in the 1990s. This regime was designed to demobilize the popular sectors and mute political competition. Eventually, this system gave rise to a major legitimacy crisis, as representative institutions seemed incapable of responding to their constituents and governing in the face of a security crisis. As we will see in the next section, this crisis would lead to calls for procedural reform, including the creation of new participatory spaces.

2.1 Political Exclusion during the National Front Governments (1958-74)

Colombia's restricted democratic regime can be traced to 1958. In that year, Colombia emerged from a bloody decade-long civil war known simply as *La Violencia* (The Violence). *La*

[82] For a list of participatory institutions in Colombia, see the appendix.

Violencia pitted partisans from the country's two traditional political parties, the Liberal and Conservative Parties, against each other and left between 100,000 and 300,000 Colombians dead (Bejarano and Pizarro Leongómez 2005; Palacios 2006; Roldán 2002). To quell the partisan conflict, in 1958 elites from the Liberal and Conservative Parties formed a consociational government known as the National Front (*El Frente Nacional*).[83] Under the National Front, which operated until 1974, the two parties rotated the presidency every four years and divided positions in the executive branch.

The National Front regime can be considered what Collier and Levitsky (1997: 439-41) call a "restricted democracy" (Bejarano and Pizarro Leongómez 2005: 238-39). During the National Front, Colombian citizens enjoyed many freedoms, including universal suffrage and the protection of civil liberties. However, elected authorities governed without being subject to external controls or vetoes by non-elected actors. Moreover, Colombians had few opportunities for political participation or voice. Voting options were restricted; mayors and governors were appointed rather than not elected. In practice, presidents were not chosen through competitive elections, since the Conservative and Liberal parties agreed to rotate the presidency and thus restricted contestation.

While voters could elect senators and deputies to Congress, legislators had only a small role in policymaking. National policymaking was not done through legislative bargains, since the National Front regime was designed to minimize conflict between the two main parties. Instead, the national executive negotiated directly with the country's powerful *gremios*, the peak associations for different economic sectors (Bagley 1984; Bailey 1977; Hartlyn 1988: 78-82). Some of the most powerful *gremios* include the National Federation of Colombian Coffee Growers, the National Association of Industrialists, and the National Association of Financial Institutions.[84]

Legislative elections also provided little opportunity for political voice. The Liberal and Conservative Parties sought to deemphasize their policy differences during this period. Rather than drawing on partisan identities and appeals, they ran clientelist campaigns. Party brokers grew in strength and influence, while party organizations and labels decayed (Archer 1995: 1970-79). Politicians became more and more dependent on brokers' patronage networks since the candidates had little (or no) contact with voters themselves. Legislators focused primarily on securing state resources for the party brokers to distribute as patronage rather than making partisan and programmatic appeals that might attract voters (Leal Buitrago and Dávila 1990).

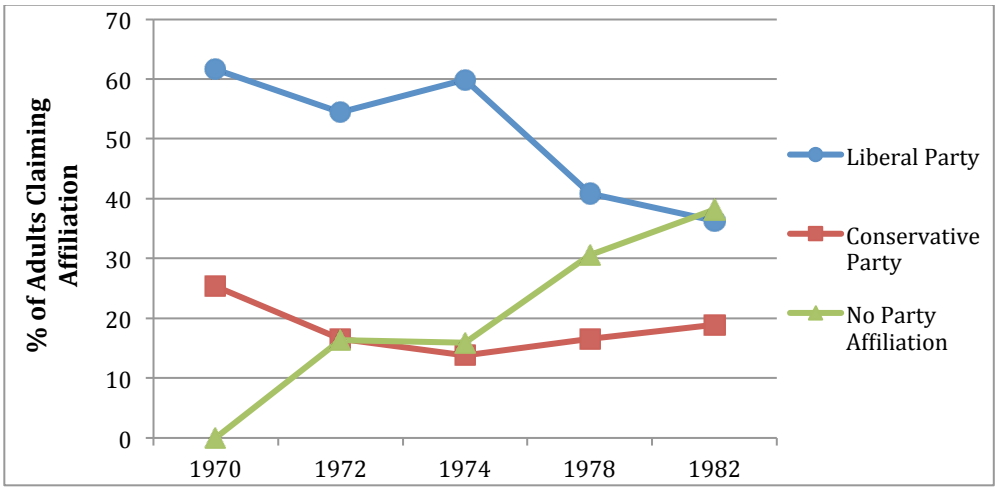
The rise of clientelist machines and decline of partisan appeals led to the erosion of partisan identities, as seen in Figure 5.2. As of 1970 nearly 90% of *Bogotanos* claimed affiliation with one of the two traditional political parties. Yet during the 1970s, a new post-*La Violencia* generation came of age that lacked affective attachments to either party. In Bogotá in 1982, identification with either of the two traditional parties had fallen to just around 50%. Nearly 40% of those surveyed claimed no partisan affiliation at all. This detachment would have

[83] The most exhaustive and authoritative treatment of this period can be found in Jonathan Hartlyn, *The Politics of Coalitional Rule in Colombia* (Cambridge: Cambridge University Press, 1988).

[84] In analyzing the *gremios* and interest representation during the National Front period, Bailey (1977) argues that Colombia differs from the dominant pattern of state corporatism in the region. This difference arises due to the lack of state controls on participating organizations and absence of popular sector organizations from negotiations. Bailey claims that the Colombian case more clearly reflects the pattern of state pluralism proposed by Schmitter (1979), in which the state regulates but does not manage civil society groups. See John J. Bailey, 'Pluralist and Corporatist Dimensions of Interest Representation in Colombia', in James Malloy (ed.), *Authoritarianism and Corporatism in Latin America* (Pittsburgh: University of Pittsburgh Press, 1977).

been unthinkable just 25 years earlier, when partisan loyalties had been so deep-seated that they resulted on a civil war on party lines.

Figure 5.2: Party Affiliation in Bogotá, 1970-82



Source: Hartlyn 1988: 164, drawing from (Gómez Gómez 1982: 43; Hoskin 1979: 29; Murillo and Williams 1975: 25; Williams and Losada Lora 1972: 12, 33).

Outside of the electoral arena, the National Front government established institutions to restrict and control popular sector participation. Popular mobilization was seen as destabilizing for the regime's delicate balance of power (Bagley and Edel 1980; Hartlyn 1988: 167-70). The regime channeled popular participation through two types of state-sponsored organizations: the community action boards (*Juntas de Acción Comunal*) and the National Association of Peasant Users (ANUC – *Asociación Nacional de Usuarios Campesinos*). These bodies ostensibly encouraged participation, yet in practice they served to co-opt rather than mobilize Colombians.

The *juntas de acción comunal* are state sponsored neighborhood associations. The *juntas* were first established as a means of defusing conflict in the countryside in the wake of *La Violencia*. The *juntas* quickly became the most widespread type of association in the country: according to a 1978 census, 21,752 *juntas* were in operation with 2.2 million Colombians participating.[85] In 54.1% of municipalities, the *juntas* were the *only* association operating.

Typically, the *juntas* lacked autonomy. A number of *juntas* were actually established under the "facilitation" of state bureaucrats and priests (Hartlyn 1988: 167-68; Henderson 1985: 232).[86] Over time, many *juntas* served as vehicles for the distribution of patronage, rather spaces for community cooperation and contestation. According to the 1978 census, approximately half of *junta* resources came from the state, particularly from Congressional pork-barrel earmarks (Ungar 1981: 17-18).

Like the *juntas*, the ANUC was established to mobilize Colombia's *campesinos* in a way that would mobilize support for the political regime but without providing real policymaking access (Zamosc 1986). ANUC membership had grown to 600,000 in March 1968 and to

[85] Hartlyn (1988: 170), citing Elizabeth Ungar, 'Las Juntas De Acción Comunal En Colombia: Un Diagnóstico Sobre Su Desarrollo, Actividades, Logros Y Necesidades', (Bogotá: Universidad de los Andes, Departamento de Ciencia Política, 1981).

[86] Historically, the Colombian government has had close ties with the Catholic Church. The Church was a conservative figure that was little influenced by Marxist liberation theology seen in other Latin American countries.

989,000 by October 1971 (Hartlyn 1988: 168). Yet when the ANUC began to radicalize in the 1970s, the government responded by cutting off public funding (Zamosc 1986: 68-96). The lack of state support crippled the ANUC. Its influence and membership declined, and many *campesinos* abandoned the ANUC for the co-opted *juntas de acción comunal* (Hartlyn 1988; Zamosc 1986: 169-70).

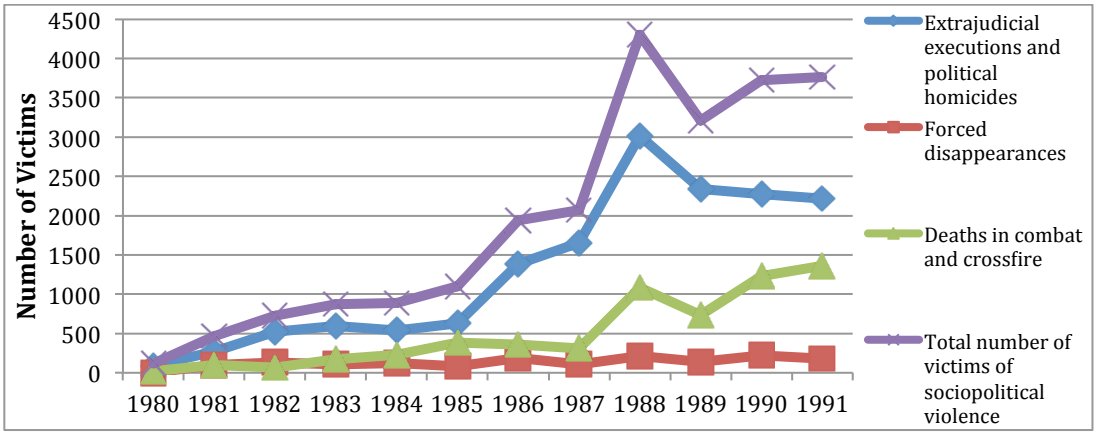
In sum, Colombians lacked opportunities for autonomous participation during the 1950s-1970s. Voters had few meaningful choices at the ballot box. As we saw with the experiences of the *juntas de acción comunal* and the ANUC, Colombian governments only permitted mobilization when it reinforced the current system, and had little tolerance for collective action that challenged the status quo. The exclusionary nature of this system began to crack in the 1980s, leading to a legitimacy crisis that threatened the regime.

2.2 Colombia's Political System in Crisis and a Growing Interest in Participation

The unresponsive nature of Colombia's political system led both the state and democratic institutions in Colombia to the verge of collapse by the 1980s. The crisis of the state arose as the growing strength of both the guerrilla movements and the violent drug cartels incapacitated the Colombian state. The crisis of democratic institutions emerged as voters rejected the feckless and unrepresentative political system.

During the 1980s, illicit activity increased to the point that the Colombian state was on the verge of becoming a failed state. Rising consumption of cocaine in the United States and Europe in the 1970s-80s had made Colombia's cocaine trade extremely profitable. The powerful Cali and Medellín drug cartels challenged the state's monopoly on violence. Colombia's guerrilla groups also expanded in the 1980s. The most important of these included the FARC (*Fuerzas Armadas Revolucionarias de Colombia*), the ELN (*Ejército de Liberación Nacional*) and the M-19 (*Movimiento 19 de Abril*). The FARC, in particular, was engaged heavily in the drug trade. The influx of drug money fueled the FARC's explosive growth: while the FARC had only 1200 combatants in 1978, this number soared to approximately 8400 by 1990 (Ortiz 2006: 325-26). The combined growth of the drug cartels and the guerrilla groups led to skyrocketing levels of sociopolitical violence, including extrajudicial executions, forced disappearances, and deaths in armed combat (Figure 5.3); in 1988, there were 4304 victims of sociopolitical violence.

Figure 5.3: Socio-political Violence in Colombia, 1980-1991

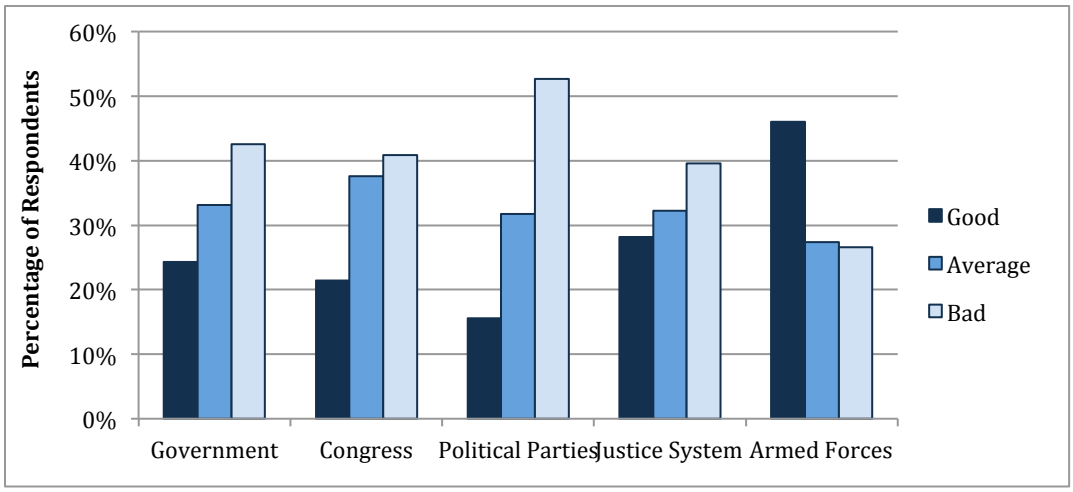


Source: (Gallón 2007: 358-59).

Even beyond the security threats from the drug cartels and guerrilla movements, rule of law deteriorated in Colombia. Homicides increased dramatically: on average, a staggering 79.1 people were murdered each day in 1991, up from 25 per day in 1980 (Gallón 2007: 358). With The judicial system nearly had collapsed and the vast majority of these homicides were carried out with impunity; only 20% of homicides led to arrests and less than 6% of homicide cases went to trial by the early 1990s (Bejarano and Pizarro Leongómez 2005: 256). These security threats revealed a Colombian state paralyzed and in crisis.

By the 1980s, Colombia's representative institutions also faced a legitimacy crisis. Approval ratings of political institutions were abysmal, as shown by Figure 5.4. In a 1988 survey, 43% expressed disapproval of the quality of the government overall. 41% expressed disapproval for Congress, 40% for the judiciary, and a whopping 53% for political parties.

Figure 5.4: Public Opinion on the Quality of Political Institutions, 1988

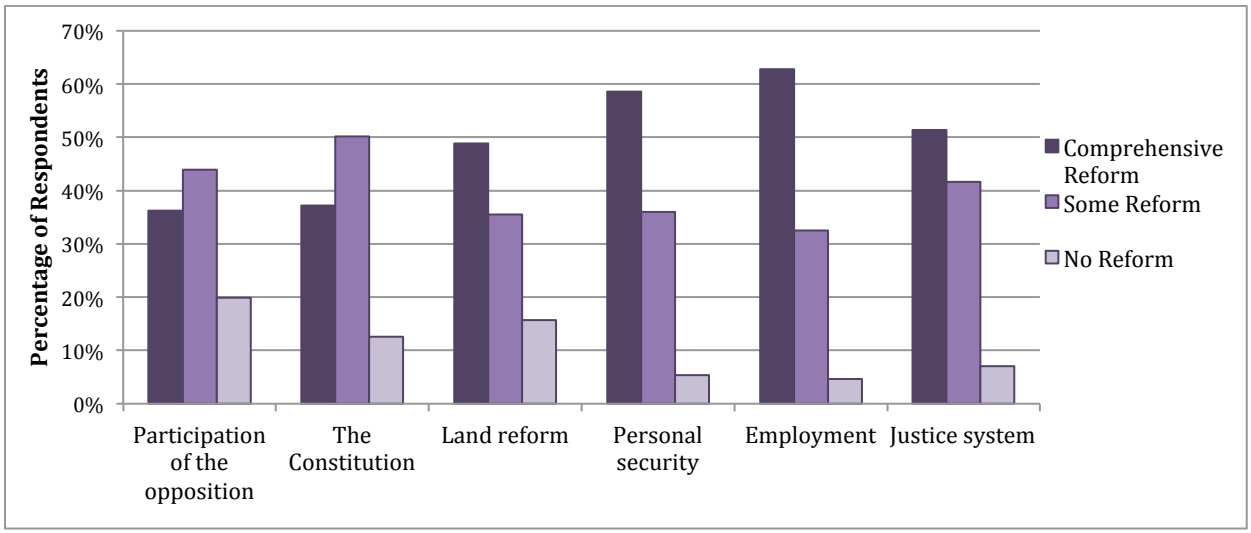


Source: (Archer 1995: 195).

One major factor leading to the public's dissatisfaction with the political system was its unrepresentativeness. Leftist parties were banned from participating in electoral competitions, thereby closing off alternatives for disaffected voters. Moreover, there were few spaces for autonomous civil society groups to influence policy. The result was a growing sense that the democratic system could not represent the people and was broken.

Another reason behind the legitimacy crisis with democratic institutions was that these democratic institutions simply did not function. Policymakers' allegiance to party brokers over voters made it impossible to pass reforms. Major reforms were needed to tackle Colombia's weak state, stagnating economy, and political gridlock. According to a 1988 survey, most Colombians believed that either partial or comprehensive reforms in a wide range of areas were long overdue (see Figure 5.5). For example, 51% of respondents agreed that comprehensive reform was needed to restructure the judiciary, with an additional 42% wanting partial reform; only 7% believed that no reform was needed. In the area of employment, 95% believed that either comprehensive or partial reform was needed, while 85% of respondents wanted some sort of land reform. The outcry for these changes went unheeded.

Figure 5.5: Public Opinion on the Need for Policy Reform, 1988



Source: (Archer 1995: 188).

Colombian presidents in the 1970s and 1980s responded to these demands for change by attempting institutional and policy reforms, yet faced roadblocks in Congress. The proposed reforms would have rationalized the state and limited the use of state resources as political patronage. While in the public interest, these reforms would have attacked the source of party brokers' political power. Congress repeatedly failed to advance reforms that might upset those party brokers that controlled patronage networks and thereby controlled legislators' future political careers.

In sum, Colombia's prior political order was notable for its lack of participation. Colombia's restrictive democracy ultimately led to a crisis of the state and a legitimacy crisis for its feckless representative institutions. As the next section will show, these crises sparked the adoption of participatory reforms in hopes of opening up the political system to new voices.

3. THE ADOPTION OF PARTICIPATORY INSTITUTIONS AS DEMOCRATIC REFORM

In this section, I show that participatory policymaking in Colombia was adopted to redress the legitimacy crisis of the 1980s. Given that this crisis stemmed from political exclusion, the solution involved opening politics to new actors and new forms of participation. Thus, Colombia's participatory institutions were established as part of procedural reforms to enhance the legitimacy of the political system by deepening democracy. This origin contrasts with that of Brazil's participatory institutions, which were created through sweeping policy reforms that also introduced substantive policy changes.

3.1 Political Liberalization and Early Participatory Initiatives

Presidents Belisario Betancur (1982-86) and Virgilio Barco (1986-90) used their considerable executive authority to pass a series of reforms designed to enhance democratic representation. These reforms included decentralization, which allowed for the direct elections of mayors for the first time in the country's history, and early experiments with participatory

institutions. While making important steps, these initial reforms ultimately would prove insufficient to restore democratic legitimacy; the country would need deeper reforms, such as those that created the national participatory framework.

The most important of these initial reforms was the decentralization reform of 1986. By the 1980s, Colombia was one of the most centralized countries in Latin America. The decentralization reform reversed this pattern by establishing direct elections for mayors for the first time in Colombian history, increasing inter-governmental transfers, and expanding responsibilities for subnational governments. The dysfunctional Congress managed to pass the decentralization reform because it limited the political power of the national executive rather than the national legislature. The Barco administration was able to secure support among legislator through the promise of new opportunities for political power at the local level.[87] Jaime Castro, the former Minister of Government under Barco and mastermind behind decentralization, explained that both the administration and Congress understood that decentralization and participation reforms were needed if political elites hoped to have any future in politics:

> It was clear that we needed to create new spaces for citizen participation and for new political groups. We thought that we could transform the political map of the country – but it wasn't that we wanted to eliminate the traditional parties. No, it was clear that the traditional parties were going to have to change their strategies and practices because otherwise they would end up replaced by new political forces.[88]

Academic observers concurred with this assessment; one described decentralization as the "oxygen needed by the political establishment to survive."[89]

The Betancur and Barco administrations also passed a number of decrees that supported greater citizen participation in policymaking. For example, Decree 1306 of 1980 stated that local development plans "will be prepared with participation of community organizations, business groups, professional associations, cultural groups, and the citizenry in general." In the area of the environment, the National Renewable Resources and Environmental Protection Code established "green councils," which were composed of interested citizens and municipal employees (Iderena-Fescol 1986). In the area of health, one of the most important developments during this period was the creation of community health committees (copacos) and health users associations. Later, these spaces for participation would be incorporated into the new health system established in 1993 (see Chapter 7).

These early initiatives in decentralization and participation were the first step in opening up political institutions to popular participation – but were only a first step. The participatory initiatives of the 1980s failed to give clear responsibilities to participatory institutions and were implemented inconsistently. For example, the aforementioned planning decree failed to specify the form that this civil society participation should take and thus it served as more of a symbolic

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[87] Interview with Jaime Castro, Minister of Government under Barco administration and former mayor of Bogotá, 29 January 2010. For more information on the 1986 decentralization reform, see Tulia Falleti, *Decentralization and Subnational Politics in Latin America* (New York: Cambridge University Press, 2010a), Fabio Velásquez, 'El Sistema Nacional De Planeación En Colombia: Notas Y Propuestas', *Revista Foro,* 28 (1996).

[88] Interview with Jaime Castro, Minister of Government under Barco administration and former mayor of Bogotá, 29 January 2010.

[89] Interview with Fabio Velásquez, Director, Foro por Colombia, 17 September 2009.

than concrete shift in planning. And, a number of green councils and copacos were created, yet their coverage was spotty and their role in policymaking remained unclear. Thus, the significance of these early participatory experiments was not in how they expanded popular participation, as much as the symbolic shift in asserting that the popular sectors *should* be included in policymaking. As the 1980s progressed, it became clear that these limited reforms were insufficient to fix the legitimacy crisis facing the Colombian political system. The rules of the political game needed to be more than just adjusted – they needed to be rewritten entirely.

3.2 The Mandate for Participation in the 1991 Constitution

By the early 1990s, there remained an overwhelming sense that the political system served the interests of politicians at the expense of the public and needed to be restructured from scratch (Buenahora Febres-Cordero 1995: 39; Hoskin 1998: 48). In response, President Virgilio Barco called for a constituent assembly in January 1988. Barco's proposal gained momentum with the mobilization of the *Séptima Papeleta*, a student movement that formed to support a constituent assembly. Barco used his extraordinary executive powers to call a referendum on whether or not to have a constituent assembly. In May 1990, 89% of participating voters cast their ballots in favor of the proposal for "strengthening participatory democracy through a constituent assembly" (Cepeda 1998: 71; Hoskin 1998: 59). The moment was one of great optimism, as one activist from the time recalled:

> The setting was very different at that moment in 1990-91. We lived in what we called the great democratic euphoria. The country was convinced that in this moment we were sealing a peace pact, and that we were inaugurating a new democratic era, eliminating the State of Siege, putting rights in place. [90]

Given that the purpose of the constituent assembly was to reestablish the legitimacy of Colombian democracy, it was crucial that the constituent assembly itself be seen as fair, open, and representative. To this end, current legislators were banned from participating in the constituent assembly, and the selection process was opened to new political parties and figures without any partisan affiliation. Elections for constituents took place in December 1990. While many of those elected represented the two traditional parties, new voices were included as well; approximately 1/3 of constituents were from leftist parties that until recently had been banned. Some of these leftist politicians included those from the ADM-19, the party of the recently-demobilized M-19 guerrilla organization. Others hailed from Unión Patriótica, the political party branch of the still-active FARC guerrilla group. Non-politicians were elected as well, including indigenous leaders, a former professional soccer player, and the sociologist Orlando Fals Borda.

As in Brazil, civil society groups and citizens could directly submit proposals for debate in the constituent assembly. NGOs and other activists recognized this as an opportunity to shape their country's new democracy. Eight Colombian NGOs united forces to form the *Campaña Viva la Ciudadanía*, or Citizenship Campaign, with the objective of mobilizing Colombians to participate in the formation of the new constitution. The *juntas de acción comunal* also mobilized community members to participate in the process, taking advantage of their presence

[90] Interview with Antonio Madariaga, Executive Director, Corporación Viva la Ciudadanía, 18 December 2009.

in essentially every Colombian municipality. Citizen proposals were submitted in a wide range of areas, including utilities, indigenous rights, and planning.

Importantly, there was consensus among constituents that participatory institutions would be needed to complement (but not supplant) representative institutions. Support for participatory policymaking did not solely come from leftist parties, which are typically associated with the push for participatory democracy. Constituents from the traditional Liberal and Conservative parties agreed about the necessity of establishing greater citizen participation the Colombian democracy. Indeed, the leader of the Conservative Party, Álvaro Gómez Hurtado, was one the most vocal proponents of participatory policymaking.

Colombia's constitution was promulgated on July 4, 1991. The charter establishes participation as a founding principle for the Colombian state, and a right of all citizens. The Colombian constitution gives even more attention to citizen participation in politics than the highly participatory Brazilian constitution. Articles 1 and 2 mandate that the Colombian state should be organized in a decentralized and participatory structure, and declare that the state is to promote and support community participation throughout all levels of government. Article 270 goes on to state: "The law will organize the forms and systems of citizen participation that enable the oversight of public administration implemented at the various administrative levels." Additional articles of the constitution call for the incorporation of societal participation in specific sectors, including health (Article 49), education (Article 68), the environment (Article 78) and public utilities (Articles 106, 369). Despite the extensive references to participatory democracy, the institutional form of this participation was left largely unspecified and would need to be developed through enabling legislation.[91]

3.3 Enabling Legislation for Sectoral Participatory Institutions

While the 1991 Constitution provided a clear mandate for greater participation in Colombian democracy, it was considerably less clear about the institutional form that participatory democracy should take. When Congress reconvened in 1992, the establishment of Colombia's elaborate participatory framework was anything but certain. Yet Congress passed a slew of laws creating dozens of participatory institutions and processes in the years immediately following the constituent assembly. Some of the most important examples include the planning councils, created by Law 152 in 1994 and profiled in Chapter 6; and the community health committees, established by Law 100 of 1993 (see Chapter 7).[92] Moreover, another law (Law 134 of 1994) passed easily that created additional mechanisms for citizen participation, including legal standing for citizen watchdog groups; the referendum; the right to call a popular consultation with the president, governor, or mayor; and the power to remove elected officials from office for failing to deliver on campaign promises. Indeed, these legal initiatives went far beyond what was in the 1991 Constitution.

Compared to the constituent assembly, citizen engagement in developing the legislature behind participatory policymaking was more restricted. Proposals for different participatory institutions did not originate in proposals from civil society, and for the most part civil society did not mobilize on behalf of participatory institutions. While there was great popular support for participatory policymaking, this support was passive. Instead, the creation of participatory

[91] Articles 339-344, which discuss planning and the National Planning System, contain the most explicit and extensive discussion of participatory institutions. These articles mandate the creation of the National Planning Council and of the territorial planning councils for each department and municipal government.

[92] For a complete list of the participatory institutions created in Colombia, see the appendix.

institutions reflected an effort by legislators to restructure democratic institutions in the interest of revitalizing the political system and proactively addressing the legitimacy crisis.

The laws behind participatory policymaking were passed with high levels of consensus. The dominant parties had recognized the deep-seated need for political reform. One academic expert and advocate for participatory planning during this period explained that politicians sought more than a mere cosmetic change:

> This explains why the next ten years were dedicated to the creation of participatory spaces. You can't create participation laws if you don't find consensus in the Congress to do so. It would be a huge leap to assume that all the legislators that were in office and creating the legal infrastructure for participation during those ten years were doing it just as a cosmetic change, as window dressing.[93]

A political aide during the constituent assembly and subsequent legislative sessions agreed, arguing that legislators agreed that "we needed more participation, and participation couldn't work until we built up a legal framework."[94]

In contrast to Brazil, in Colombia most participatory institutions were adopted as procedural changes that changed *how* policymaking was done, rather than making substantive changes to the content or objectives behind public policy. The planning system (or the education system, or cultural policy, etc.) itself was not fundamentally broken; new voices just needed to be included in the policymaking process. For example, the procedural planning reform mandated that the planning bureaucracies incorporate civil society engagement via participatory councils, while failing to shift the objectives and content of planning policy. Planners would now need to develop local development plans in consultation with municipal planning councils, whereas in the past planning had been highly insulated and technocratic. Yet the components of these development plans remained the same, as did the objectives of planning: to stimulate economic growth and social development. As we will see in the next section, Colombia's procedural participatory reforms attracted many passive supporters, yet few were willing to make the political sacrifices needed to build up strong participatory institutions.

4. IMPLEMENTATION AND DECAY OF PARTICIPATORY POLICYMAKING

Despite early enthusiasm, putting Colombia's participatory framework into practice proved challenging. Going back to the 1980s, all presidents have declared their support for participatory policymaking in their national development plans. Yet when it comes to taking concrete steps, these governments have not followed through. Initially, both politicians and civil society groups had seen participatory institutions as potentially valuable. However, few actors on either side had a strong vested interest in having strong councils, meaning that the councils attracted only scattered investments. Over time, a negative feedback effect developed as neither side saw the councils as yielding political rewards. Many councils existed in name only, while others simply rubber stamped government policy. Still others became sites for the distribution of

[93] Interview with Fabio Velásquez, Director, Foro por Colombia, 17 September 2009.
[94] Interview with Luis Emiro Valencia, ex-aide at the National Constituent Assembly, 16 September 2009.

patronage. Few, however, served as meaningful spaces of co-governance. Participatory policymaking grew discredited as a model of public administration, leading to the contraction of participatory institutions, rather than the expansion seen in Brazil.

4.1 The Samper Government (1994-98): Early Implementation

Of all the post-1991 presidents, Ernesto Samper appeared most committed to the construction of participatory policymaking in Colombia. Yet in practice, the administration invested insufficient material and institutional resources to back its participatory rhetoric.

Samper placed a major emphasis on citizen participation in governance in his national development plan, *El Salto Social* (The Social Leap). The introduction to the plan states:

> The strengthening of civil society and the definition of real democratic spaces for participation… are necessary complements to economic and social strategies in the essential objective of constructing a new society in which we can live together in peace (Departamento Nacional de Planeación 1995b: 2-3)

The plan promotes participatory policymaking as a core component of good governance that should be backed by a national legal framework. It also promotes specific policies oriented to the development of civil society, the diffusion of capacities and information needed for participation, and the consolidation of an institutional infrastructure that nurtures civil society.

The government followed up on the national development plan with an inter-sectoral national strategy to promote citizen participation in policymaking.[95] The strategy sought to "develop the postulates of participatory democracy enshrined in the 1991 Constitution" (Departamento Nacional de Planeación 1995a: 493). It outlined a number of initiatives to support participatory policymaking on the ground. For example, the strategy created a Fund for Citizen Participation to provide grants to civil society groups that sought greater involvement in the policymaking process, as well to municipal governments to help set up local participatory councils. While a useful development, these funds were a tiny fraction of the resources needed to construct the dozens of participatory institutions established in the national framework. The strategy also called for information campaigns to raise awareness about the existing spaces for participation; support for research on the causes and effects of citizen participation; and technical support for civil society groups, participatory councils, and municipal governments. The Samper government developed this strategy in a top-down effort to develop the most technically sound policies that would support participation. Just as with the creation of the participatory framework, the strategy for council implementation was developed with little civil society input.

Unfortunately, the strategy document changed little on the ground. A number of the initiatives outlined in the document never happened. Others had insufficient funding to have their proposed impact. The document had not identified the funding streams to pay for the programs outlined in the strategy. It also failed to specify which agencies would be responsible for many programs, effectively leaving them orphaned. The bureaucrat currently responsible for

[95] Departamento Nacional De Planeación, 'Promoción De La Participación De La Sociedad Civil: Del Derecho a Participar a La Particpación Efectiva', (Documento CONPES #2779; Bogotá: Departamento Nacional de Planeación, 1995a).

implementing the Fund for Citizen Participation – one of the few programs from the 1995 strategy document actually implemented – explained:

> The [strategy document] from that time was not established as a responsibility of any agency. So that left very fuzzy the question of who is responsible to coordinate programs and monitor implementation, of who will verify that X sector is carrying out the processes outlined for their sector.

Another bureaucrat responsible for promoting participation across government agencies agreed, adding:

> They didn't manage to consolidate what was in the 1995 [strategy document]. There was a solid effort from some to have coordination across different sectors and levels of government to make citizen participation effective. But in practice, [the strategy] was crippled due to the lack of resources, the lack of political will, and the lack of coordination among the different agencies.[96]

Samper's participatory policymaking strategy also suffered from an additional flaw: it failed to recognize the inherently political nature of participatory policymaking. To explain the causes of weak political participation in Colombia, the strategy document pointed to a lack of information and capacity by municipal governments and civil society groups. Consequently, its policy prescriptions centered on increasing awareness and training – relatively easy fixes. More entrenched challenges, such as political exclusion, clientelism, and the co-optation of civil society groups, were ignored entirely (Restrepo 1997). Samper's government overlooked the considerable political capital needed to effect real change and truly include new actors in the policymaking process. Thus, the government's support proved hollow: it promoted participatory policymaking as long as doing so incurred few political costs.

Despite these problems, the strategy document *did* reflect to modest steps in implementing the new participatory framework. These efforts slowed, however, as Samper's government began to unravel in the face of charges that his 1994 presidential campaign had accepted illegal contributions from the powerful Cali drug cartel. Governing ground to a halt, and programs to promote citizen participation took a backseat to the increasingly impossible task of keeping the government afloat.[97] Ultimately, Samper was impeached in 1998.

Importantly, the advances made during the Samper presidency happened at the behest of the government and not in response to pressure from a reform coalition. Except in the area of planning, civil society groups failed to mobilize behind the councils and did not pressure the government to invest in the new councils. Thus, the government had little incentive to go beyond the symbolic proclamations of support for participatory policymaking.

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[96] Interview with Elsa Yanuba, Director, Dirección de Empleo Público, Departamento Administrativo de la Función Pública, 2 February 2010.

[97] Interviews with William Gaitán Medina, Coordinator of the Grupo para el Fortalecimiento de la Democracia, Dirección de Democracia y Participación Ciudadana, Ministerio de Justicia y Interior, 3 February 2010; Marta Tamayo, program officer with GTZ, former staff of international NGO, former advisor to the Defensoría del Pueblo and Ministry of Culture, 26 October 2009.

4.2 The Pastrana Government (1998-2002): Stagnation

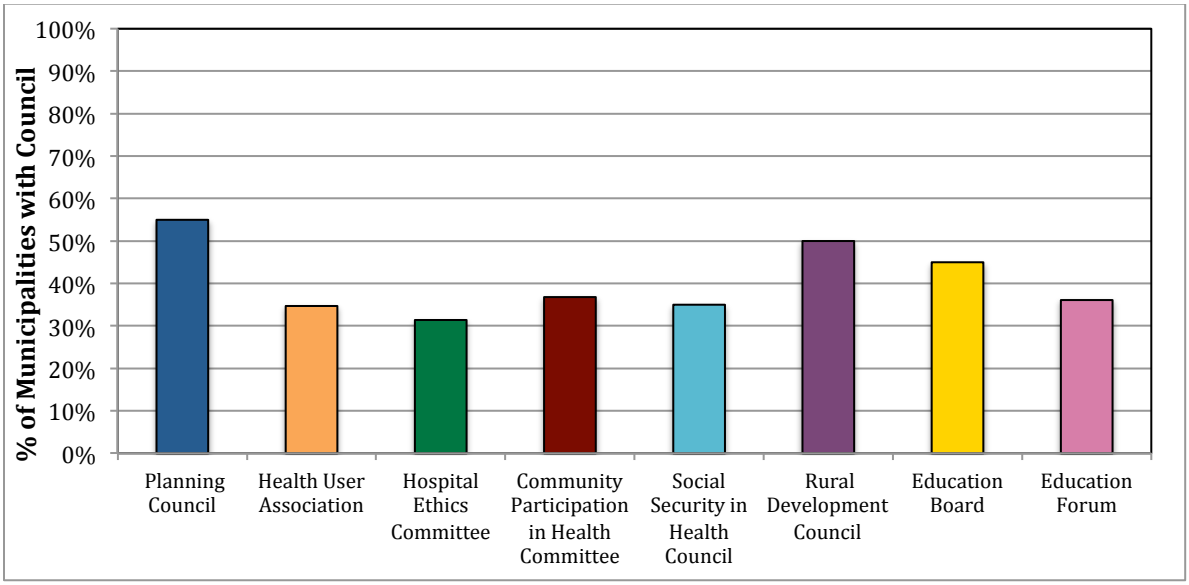
The conservative Andrés Pastrana succeeded Samper. Pastrana pledged support for citizen participation, but in practice this support remained superficial. Once again, the absence of strong reform coalitions meant that no external groups pressed the government to invest in the councils. Without pressure, the Pastrana government dedicated only modest material, human, or political resources to constructing the national participatory framework.

By 1998, participatory policymaking had entered the standard parlance of good government, ensuring that the Pastrana government did not neglect the new participatory institutions altogether. Pastrana's national development plan, *Cambio para Construir la Paz* (Change to Construct Peace), emphasized the need for popular participation in the policymaking process. The document makes an explicit link between participatory democracy and the prevention of violence and argues that participatory institutions could be a solution to the country's civil conflict (Departamento Nacional de Planeación 1999). In this vein, Pastrana established the Peace Councils, a new participatory institution for conflict zones.

The Pastrana government took some strides in implementing Samper's participation strategy. Additional material and human resources were dedicated to build capacity for local governments and civil society groups. For example, the Contraloría de la República (Comptroller of the Republic) expanded the responsibilities of the newly created Citizen Participation Division, which took strides to raise awareness about participatory spaces and build capacity for participation. The government also received a grant of $1.6 million from the Inter-American Development Bank to promote citizen participation and freedom of information (Velásquez and González 2003: 121). Still, these efforts failed to address the endemic, political obstacles, such as clientelism and co-optation. After all, addressing these obstacles would mean shifting overall patterns of interest representation, and thus would involve real political costs.

Data from the Pastrana presidency reveals the mixed progress in constructing the new councils. For nearly all participatory institutions, only a minority of Colombia's nearly 1100 municipal governments had established their respective councils as of 2002 (see Figure 5.6). Municipalities that had created the required participatory institutions did so more in response to local political factors than because of a national mandate. Compliance was higher for some types of councils, such as the planning and rural development councils. Yet even for these more successful cases, only about half of Colombia's municipalities had established the supposedly "mandatory" councils.

Figure 5.6: Municipal Compliance with National Mandate to Establish Participatory Councils - Colombia



Source: Balance de la Participación Ciudadana en Colombia – Foro Nacional por Colombia. Data collected in 2002 survey. (Velásquez and González 2003: 434)

By the end of the Pastrana government in 2002, Colombia still had not yet developed a truly national system of participatory institutions, as we saw in Brazil. The participatory policymaking framework was being put into practice in some places – yet even these councils seemed to have little role in policymaking. Whereas in 1991 many hoped that participatory institutions would deepen democracy, dismantle clientelism, and root out corruption, proponents of participatory policymaking had now scaled back their expectations. Pessimism would grow further still during the Uribe administration to come, when the government actively opposed the councils.

4.3 The Uribe Government (2003-10): Retrenchment

When Álvaro Uribe entered the presidency in 2003, Colombia's participatory policymaking councils were in a state of limbo. Implementation was not negligible, yet insufficient political, material, and human resources had been dedicated to ensure institutionalization. Already in a weak position, the councils further declined under Uribe as a negative feedback effect began, in which civil society organizations began to pull back from the councils, giving state actors even less reason to invest.

Uribe's government concentrated power in the national executive away from subnational governments and away from participatory councils. With re-centralization, local governments had fewer discretionary funds to dedicate to participatory councils. Moreover, national government support for the subnational councils evaporated – in terms of both direct financial support as well as human resources. One frustrated bureaucrat in the Ministry of Social Protection noted:

> The infrastructure behind participatory policymaking is much more fragile than it was 10 years ago… Throughout the government, in

> different ministries and secretariats, at all levels, you see a reduced emphasis on participation. Ministries and subnational governments have cut Participation Bureaus, and there is less of an investment overall by the central government to support participation. In health, the Ministry used to have a Participation Bureau. Then it was downsized to a department, and then an office, and now there is nothing. Our department would like to do more to engage citizen participation but this costs money. Leonardo [Cubillos, director of the department] has tried to get Ministry support for participation but with no results...[98]

While a number of state and civil society actors expressed frustration at the declining support from the government, these groups had insufficient power to push back against this trend. As a result, the Uribe government was able to slowly dismantle participatory institutions.

Rather than investing in the participatory policymaking institutions created in the 1990s, the Uribe government instead established parallel "community councils" (*consejos comunales*). These new councils followed a fundamentally distinct logic than the participatory policymaking councils examined in this study. Unlike the participatory councils, Uribe's community councils were not permanent bodies that deliberated and contributed to policymaking. Instead, they were occasional meetings between the president and local communities. Uribe traveled throughout the country, visiting a new location every weekend. A meeting would be called in which community members could voice their complaints and requests to the president. (Any civil society leaders critical of the president were blocked from attendance.) Following the meeting, the president would respond to the community's concerns using the national state apparatus. For example, a community member might discuss the need for a bridge to help bring her crops to market. The president would then provide that community with a bridge, by-passing the normal policy procedures: the project would not go through the municipal planning secretariat (much less the planning council), or even the mayor's office. Rather, it would be funded directly by the Ministry of Transportation, or by the presidency. Critics contend that these councils were a thinly-veiled vehicle for distributing patronage and buying votes. Moreover, many argue that the community councils directly threatened existing participatory institutions by discouraging collective action and reducing the discretion of local governments and local councils.[99] Why should community members spend long hours in the process of mobilization and participating on participatory councils, when they can achieve their objectives in one afternoon by simply asking their patron, the president?

In the face of these challenges, the legitimacy of the participatory institutions declined in the 2000s. Even its proponents began to see participatory policymaking as a fatally flawed proposal, and perhaps even damaging to the quality of democracy. One such activist expressed this pessimistic viewpoint, arguing that:

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[98] Interview with Janette Bonilla, Dirección de Gestión de la Demanda en Salud, Ministerio de Protección Social, 21 October 2009.

[99] Interviews with Fabio Velásquez, Director, Fundación Foro por Colombia, 14 September 2009; Janette Bonilla, Dirección de Gestión de la Demanda en Salud, Ministerio de Protección Social, 21 October 2009; Carlos Alberto Garzón, ex-Coordenador General of the Consejo Nacional de Planeación, 28 October 2009; among others.

> Colombians are disillusioned with participation because we believed so much in the possibility of participation. We thought that participation could solve many of the problems of our political system. We have become disillusioned because it just wasn't possible – it's not possible because corruption continues in this country."[100]

Other disheartened respondents described the national participatory system as "too ambitious" and opined that it "should never have been mandated into law."[101]

An important critique of the councils is that rather than deepening democracy, they only serve to legitimate corrupt governments under the fiction of participation. One expert pointed to the role of citizen watchdog groups in actually facilitating massive corruption in contracting for the expansion of Bogotá's public transit system:

> …Since the watchdog groups only have a consultative role, no one actually has to listen to them and the government doesn't take into account what they say. And then the district can say, "No, everything is democratic here because we formed a watchdog group! So you can't say we didn't include the community in these decisions."[102]

The belief that participatory policymaking only serves a legitimating function has led the most important and influential civil society groups to give up on participatory institutions. An academic expert on participatory policymaking and civil society engagement in Colombia argued that: "People have begun to see negatively these formal participatory institutions and look for other routes to have an impact on policy – ones that are generally *not* formal and institutional."[103]

Despite this dismal depiction, participatory policymaking in Colombia has not faded away entirely. One expression of its legitimacy is that participatory policymaking has become a standard part of the political discourse. As one respondent explained, "today, everyone in the government talks about participation and societal oversight. […] That this discourse exists is in and of itself an advancement."[104] Since 1982, all of Colombia's presidents have included a section on stimulating popular participation in their national development plans. Support for participatory policymaking may be mainly lip service, but at least most politicians feel the need to pay this lip service to appear legitimate.[105]

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[100] Interview with Marta Tamayo, program officer with GTZ, former staff of international NGO, former advisor to the Defensoría del Pueblo and Ministry of Culture, 26 October 2009.
[101] Interviews with Salvador Mendoza, Vice-veedor, Veeduría Distrital de Bogotá, 12 April 2010; Gabriel Torres Andrade, councilor, Puerto Berrio Municipal Planning Council, 30 October 2009.
[102] Interview with Juana Patarroyo, directora, Oficina de Participación, Veeduría Distrital de Bogotá, 9 April 2010.
[103] Interview with Fabio Velásquez, Director, Fundación Foro por Colombia, 14 September 2009.
[104] Interview with Salvador Mendoza, Vice-veedor, Veeduría Distrital de Bogotá, 12 April 2010.
[105] Interviews with Salvador Mendoza, Vice-veedor, Veeduría Distrital de Bogotá, 12 April 2010; Marcela Restrepo, Coordinator, Equipo de la Estrategia Territorial y Control Ciudadano, Transparencia por Colombia, 19 October 2009; Gabriel Torres Andrade, councilor, Puerto Berrio Municipal Planning Council, 30 October 2009, among others.

5. CONCLUSION

Colombia's participatory institutions were adopted in a democratizing spirit by politicians seeking to salvage the legitimacy of a political system in crisis. Politicians sincerely sought to restructure political competition, and proactively undertook participatory reforms. Yet when the time came for implementation, few actors had enough of a vested interest in the councils to go beyond minimal, symbolic investments. Colombia lacked reform coalitions that could be part of the debate about how to design participatory institutions, and how to put them into practice. The absence of reform coalitions meant that the governments could implement participatory institutions in ways that were convenient for their own objectives. The Samper and Pastrana governments had an incentive to promote a participatory discourse, yet preferred to reserve valuable material and political resources for other battles more central to their political and policy agendas. By the time the anti-participation Uribe came into power, the promise of participatory policymaking had become tarnished, making it easy for Uribe to fracture the already weak participatory framework.

This chapter presents a macro perspective to see explore where participatory institutions come from, and how they can decline over time. Understanding *why* and *how* institutionalization happens in some contexts and not others, however, requires a more focused analysis. In the following two chapters, we will use a micro approach to examine why Colombia's planning councils managed to gain at least partial institutionalization in this hostile environment, and why its health councils failed to institutionalize altogether.

CHAPTER 6. COLOMBIA'S PLANNING COUNCILS: WEAK INSTITUTIONALIZATION UNDER PROCEDURAL REFORMS

1. INTRODUCTION

Participatory planning lay at the heart of Colombia's participatory policymaking reforms of the 1990s. In Colombia, planning is the process by which the government sets its medium- and long-term priorities, and develops policy strategies to reach these goals. In other words, the planning includes virtually everything the government would do. This broad scope made planning a logical site for reformers seeking to open up the policymaking process as a whole. According to the 1991 Constitution and the 1994 Planning Statute (Law 152/1994), all municipal, departmental, and national governments must incorporate civil society into the planning process via participatory planning councils with consultative power. The new participatory planning councils would bring together diverse societal actors to debate, construct, and evaluate the development plans established by their governments.

The planning councils serve as a critical case in understanding the challenges facing participatory institutions in Colombia. At the time of the 1991 Constituent Assembly, the planning councils were the instance of participatory policymaking with the greatest degree of civil society mobilization and the most support from politicians. As the centerpiece of participatory policymaking in Colombia, the planning councils merit careful examination for anyone concerned with the overall fate of participatory institutions in Colombia.

While the most successful of Colombia's participatory institutions, the planning councils still are considerably less institutionalized than the Brazilian health and social assistance councils. As outlined in the introduction, this study follows Levitsky (1998) in conceptualizing institutionalization along two dimensions: routinization and infusion with value. Routinization entails the extent to which the rules of the game for the institution consistently are applied and enforced. Colombia's planning councils are only partially routinized: the regulatory framework remains somewhat vague and lacks enforcement mechanisms; funding exists but is uncertain; and compliance varies widely throughout the country. The second dimension of institutionalization, infusion with value, is the degree to which the participatory institution is valued intrinsically. High infusion with value would mean that the councils are seen as legitimate and are included in policymaking processes. Using qualitative data from dozens of interviews, participant observation of planning council meetings, and document analysis, I demonstrate that the planning councils have a low to moderate degree of infusion with value. Thus, on both dimensions the planning councils prove somewhat institutionalized – better outcome than that faced by Colombia's health councils, but far behind the Brazilian cases.

The planning case provides a propitious test for this study's argument. As we saw with the Brazilian cases, institutionalization is possible under two conditions. First, councils must be created as part of a sweeping policy sector reform project that introduces substantive changes along with creating the participatory institution. As Colombia's planning councils show, institutionalization will prove difficult when participatory policymaking is established as a procedural reform. Since the participatory planning reform made negligible substantive changes to planning, only those that supported participation for participation's sake mobilized in support of the planning councils. In contrast, a sweeping policy reform project, like those seen in Brazil, can attract a broad reform coalition composed of diverse stakeholders that may have little interest

in participation but support reform for other reasons. These opportunistic members of the reform coalition often bring resources that would be absent otherwise and are vital for institutionalization.

As the second factor needed for institutionalization, elite reform leaders must have a vested interest in having strong councils. The planning councils benefited from the presence of these elite leaders. Indeed, the fact that the planning councils became institutionalized at all can be attributed to the actions of pro-participation elites from NGOs, who were instrumental in building up a narrow but potent reform coalition. These elites mobilized grassroots groups throughout the country, provided a shared discourse for those in the participatory planning movement, and constructed a national network of planning councils.

This chapter reviews the trajectory of participatory planning in Colombia. The next section compares the old planning system with the new, participatory one to demonstrate the procedural nature of the reform. The third section highlights how pro-participation elites came to support participatory planning, and their role in constructing a reform coalition. Fourth, I examine the establishment of a relatively weak institutional design for the councils during the creation stage, which would hamper the potential for institutionalization in the future. The fourth section turns to the implementation stage. In this stage, the government made only scattered investments of money, human, and political capital into the participatory planning process. The reform coalition's resources were sufficient to ensure a piecemeal and partial construction of the planning councils, but were not enough to garner the investments needed for institutionalization. The fifth section's overview of the institutionalization stage highlights how the planning councils only became moderately routinized and infused with value. The sixth section concludes by reviewing the limitations of procedural participatory reforms.

2. COLOMBIA'S PROCEDURAL PLANNING REFORM

In this section, I outline the main features of planning in Colombia before and after the participatory planning reform in the early 1990s to demonstrate the procedural (rather than sweeping) nature of the reform, as summarized in Table 6.1. The participatory planning reform made major changes in the procedures of planning by devolving some responsibilities to subnational governments and including civil society organizations in the process via the planning councils. However, the objectives of the sector – to advance economic and social development by coordinating policies across sectors – did not change. Likewise, the content of planning was and remains highly variable by the nature of the sector, which is more about the process of coordinating than a clearly defined set of programs. Later in this chapter, I will show that the procedural nature of Colombia's planning reform made difficult the formation of a strong reform coalition, and ultimately inhibited the institutionalization of the participatory planning councils.

Table 6.1: Changes in the Objectives, Instruments, and Content of Colombian Planning Policy

	Policy Objectives	Policy Instruments	Policy Content
Pre-Reform (1950s-1994)	Coordinate medium- and long-term policies across sectors to advance economic and social development	Centralized; little societal input	Highly variable
Post-Reform (1994-present)	Coordinate medium- and long-term policies across sectors to advance economic and social development	Decentralized; societal input via participatory councils	Highly variable

2.1 The Pre-Reform System: Technocratic Planning

To understand the significance of the participatory planning reform of the early 1990s, we must first examine the centralized and technocratic nature of planning before the reform. The original planning system was established in the late 1950s in an attempt to modernize and rationalize the Colombian state through long-term strategic planning. Velásquez and González explain:

> …planning was considered to be essentially a technical procedure, a specialized practice, oriented to control change in a specific system or universe (society, territory, population, economy, organization, etc.) Thus, the planning exercise fell to a few specialists (the "planners"), supposedly trained to apply the technologies developed in this area. There was a clear distinction made between the subject and the object of planning. The former was considered to be the driver of the process; the latter as the passive receiver of such action and the beneficiary of the results. (Velásquez and González 2011: 7-8)

In both the old and the current planning systems, the planning process would be coordinated by the National Planning Department (*Departamento Nacional de Planeación*, DNP), which was established in 1958.[106] The DNP was established to be a highly technical and capable agency that would coordinate the efforts of all other agencies and ministries in assessing the country's well-being; coordinating programs across policy sectors; overseeing the use of public funds through analysis, supervision, and monitoring; and advising on public credit, foreign investment, and international cooperation.

The national development plan is at the heart of both the prior and current planning systems. At the start of every presidential administration, the DNP would draft a national development plan that assess the greatest problems facing the nation, constructs overarching

[106] Before a 1963 administrative reform, the agency was originally called the Departamento Administrativo de Planeación y Servicios Técnicos.

policy proposals to redress these problems, and identifies how state resources would be allocated to implement these policies. The proposals would span different policy sectors, and the DNP was charged with coordinating the efforts of the different ministries to ensure coherence and cooperation in policy implementation.

By granting the DNP these wide-ranging responsibilities, Colombia's planning system concentrated political authority into the hands of the national executive. The old planning system was developed at the height of the National Front governments (1958-72) described in the previous chapter. The National Front governments sought to de-politicize the policy process by reserving the policymaking role to the unbiased and technocratic experts that were concentrated in the DNP (Hartlyn 1988). Consequently, Congress would play a relatively small role in making policy. Within the executive, power was further concentrated away from the ministries and into the hands of the DNP, in the interest of insulating the policymaking process from special interest groups that might have cozy relationships with ministerial bureaucrats. In a message to Congress in 1968, President Alberto Lleras Camargo justified concentrating power in the DNP since "… the need to plan Colombia's development implies dividing the available resources and applying them in the most useful manner to look for the greatest and quickest route to productivity for those investments, in accordance with reasonable priorities" (Cano Motta 1972: 12).

The old planning system also concentrated power away from subnational governments and towards the central government. Prior to 1986, Colombian mayors were appointed rather than elected, and municipal governments few responsibilities in governing. The planning system reinforced this centralization by charging the DNP – rather than subnational governments – with promoting local and regional development.[107] Even planning initiatives with specific regional or city targets would be led by the DNP, rather than by subnational governments. For example, Misael Pastrana's 1972 national development plan, "The Four Strategies," identified the promotion of exports and construction as top priorities, and in this vein elaborated projects to advance coffee production and sales from the coffee growing areas of the Caldas department. The Caldas departmental government, in contrast, played little role in these initiatives.

Since planning was to be a technocratic exercise in pursuit of Colombia's public interest, the process was left in the hands of the experts, particularly economists and statisticians. These experts were seen as having the technical tools needed to diagnose and develop solutions to the major problems facing the country. Civil society groups had little access to the planning process. The insulation of planning from popular forces was not seen as a problem with the planning system since insulation would give planners the freedom to conduct their analyses in the pursuit of the public interest. Indeed, allowing societal input or lobbying would be seen as harmful because special interest groups would take advantage of this access to push for programs in their narrow interest and not in the interest of the country as a whole.[108]

By its nature, the exact content of planning would vary dramatically across different administrations. This is because planning is more about the process of coordinating across

[107] Towards the end of the 1970s and in the 1980s, subnational governments took on additional roles in the planning process and became more involved in urban planning as rural to urban migration skyrocketed. For more on the centralization and subsequent decentralization of power, see Tulia Falleti, *Decentralization and Subnational Politics in Latin America* (New York: Cambridge University Press, 2010), Fabio Velásquez, 'Descentralización Y Modernización Del Estado En Colombia: Balance De Una Experiencia', *Revista Nómadas,* 3 (1995b). For more on early planning experiences in the 1980s, see Chapter 1 of Fabio Velásquez and Esperanza González, *¿Qué Ha Pasado Con La Participación Ciudadana En Colombia?* (Bogotá: Fundación Corona, 2003).

[108]

sectors and levels of government than it is about the design and implementation of specific programs. The policy content of a health system might include programs targeted to different populations, or guidelines about who receives coverage and who does not, or the creation and management of health clinics. For planning, the policy content cannot be identified in the same way because the content entails everything that the government does. The high variability in the content of planning is a definitional one for the sector, and remains constant in both Colombia's prior and current planning system.

2.2 The Post- Reform System: Participatory Planning

Colombia's planning system was reformed in the 1990s as part of the decentralization of the Colombian state and the creation of new spaces for popular participation. On net, the objectives and content of planning remained fairly constant across the old and new planning systems; the real difference lies in *how* planning would happen and which actors would be involved in the process. The overarching motivation for planning remained the same: defining the long-term public interest of society in terms of social and economic development, and coordinating policies and spending across sectors to reach this vision of the public interest. As before, each new presidential administration would draft a national development plan. Likewise, the national development plans would follow the same structure as before, containing both a strategic/theoretical component and a public investment component.

While the objectives and content of planning remained constant, the procedures behind planning shifted significantly to make planning decentralized and participatory. Whereas under the prior system planning was a centralized activity carried out by the national executive, the new system also granted municipal and departmental governments a role in planning. Just like the national government, every municipal and departmental government would formulate its own development plan. This multi-level planning system complemented other decentralizing reforms established through the 1991 Constitution, including those that established new roles for municipal governments in social policy, infrastructure, utilities, and local economic development.

In another procedural shift, the planning system expanded the types of actors involved in the planning process. As described in the previous chapter, the constituent assembly was convoked to open up new spaces for popular participation in Colombian democracy, particularly at the local level. Planning would be one of the main spaces in which Colombian citizens could shape public policy.

Importantly, expanding the universe of players involved in planning did *not* signal a shift away from using rationality as a means of achieving the public interest. Both the prior and new planning systems sought to rationalize the government, but following different logics. In the prior system, rationalization would come from giving experts full authority to define the public interest and the policies to reach the public interest. Under the new system, experts are not the only actors capable of assessing the public interest; indeed, experts often tend to have a bias towards projects that benefit elite interests. Rather than having a technocratic project, diverse actors from society should construct a shared vision of the community's future through a process of concertation. Thus, the new planning system would engage both experts from the bureaucracy, as well as civil society groups as a means of both rationalizing and democratizing the process (Velásquez 1995a: 14).

Article 340 of the 1991 Constitution specifies that this participation is to happen in the form of planning councils at the municipal, departmental, and national levels. In contrast with

the Brazilian councils, which reserved seats for both state and civil society representatives, participation on the planning councils is restricted to civil society actors alone. Article 34 of the 1994 Planning Statute states that councilors are to come from the economic, social, environmental, education, cultural, and community sectors.[109] To qualify to serve on a planning council, a prospective councilor must be active in the sector they claim to represent, have technical knowledge or personal experiences about that sector, and represent an organization that has legal standing (*personería jurídica*). Councilors serve eight-year terms, with half the councilors replaced every four years.[110] Unlike the Brazilian councils, planning councilors are appointed by the executive and are not directly selected by their peers. Upon coming into office, the elected executive (i.e. mayor, governor, or president) appoints new councilors to replace the councilors that have completed their eight-year term.[111]

Colombia's planning councils are also distinct from the Brazilian councils due to their lack of formal policymaking or budgetary authority. In this consultative capacity, the councils' main responsibilities are to provide feedback on the government's proposed development plan every four years, monitor and evaluate government progress in implementing the development plan, and to serve as the liaison between civil society and the government. Their primary function is to produce a document called a *concepto*, which is an assessment of the government's proposed development plan, every four years. The planning council is to coordinate civil society and public input on the proposed plan and incorporate these diverse perspectives into a *concepto* that critiques the plan's objectives, goals, benchmarks, and projects, and provide policy suggestions to be included in the final draft. Yet the council has no authority to make the government incorporate any suggestions from the *concepto*, or to even react to the *concepto*'s findings.

Having highlighted the procedural nature of Colombia's planning reform, we now turn our attention to the political dynamics involved in creating this legal framework and implementing it. In the following three sections, I will trace the participatory planning reform through its three stages: creation, implementation, and institutionalization. These sections will demonstrate that the procedural focus of the participatory planning reform made it difficult to develop a durable reform coalition that could leverage the diverse resources needed for institutionalization.

[109] The National Planning Council also reserves seats for representatives of departmental and municipal governments. Councilors representing additional sectors of society may also be named to the council; for example, the CNP includes representatives from indigenous and afro-Colombian groups.

[110] Councilors cannot serve consecutive terms in representing their segment to ensure a renovation of the council. This norm implies that councilors will step down from the council entirely after eight years, but often councilors continue on by changing the sector that they represent. For example, someone representing the community organizations sector could switch over to serve as a representative of the social sector.

[111] According to formal guidelines, civil society groups are to nominate a list of potential councilors representing their sector and the executive will select from these lists. This selection process is similar to the one used to select health and social assistance councilors in Brazil, which is overseen by the Public Prosecutor. Unlike in Brazil, however, in Colombia the executive makes the final decision on who will serve as councilors, and is not required to go through the aforementioned consultation process.

3. THE ROLE OF NGOS IN REDUCING COLLECTIVE ACTION PROBLEMS

NGOs and individual activists that would go on to serve as councilors on the National Planning Council sparked the formation of a reform coalition in support of the participatory planning reform. Prior to reform, planning was highly technocratic and not a site for collective action. The NGO reform leaders sought to change this through the construction of planning councils across Colombia. They constructed a theoretical framework behind participatory planning, mobilized elite resources on behalf of the councils, and brought together grassroots organizations throughout the country. Despite their impressive accomplishments, these reform leaders struggled to expand the coalition beyond grassroots organizations – those that would directly benefit from access to the state. Thus, compared to the Brazilian cases we see that the participatory planning reform coalition was narrower. Nevertheless, the planning councils contrast with the Colombian health councils in that a reform coalition *did* form due to the leadership of these NGOs, which ultimately would enable the planning councils to become at least partially institutionalized.

3.1 The Problem of Collective Action

Prior to reform, participation in the planning process was limited due to its technocratic nature. As described in Section 2, professional planners were to diagnose the main problems preventing economic and social development, develop solutions to these problems, and implement the solutions insulated from popular pressure.

Still, collective action in planning was not non-existent. Informally, the country's powerful economic associations (*gremios*) provided key input into the formulation and adjustment of national development plans. The *gremios'* inclusion was seen as justified because they had unique information and expertise that would be crucial in developing plans for economic growth (Hartlyn 1988). Following this logic, it would not make sense for the government to develop a strategy to promote exports in the coffee sector without consulting the top experts on the coffee sector – the Colombian Federation of Coffee Growers.

Collective action in the sector would have been limited even without this technocratic focus due to low overall levels of mobilization. As outlined in Chapter 5, the government sought to control and co-opt grassroots organizations throughout much of the 20th century. Colombia's labor unions are among the weakest in Latin America, and thus unions could not be a potential vehicle mobilization in planning. In sum, the opportunities for collective action in planning were minimal prior to reform – which is precisely why the planning councils were established.

3.2 NGOs as Reform Leaders

Pro-democracy NGOs backed early proposals for participatory planning. These NGOs would develop the theoretical framework behind participatory planning, given the sharp contrast with the standard technocratic planning model. Moreover, they brought together groups throughout the country in support of the new councils to form a real participatory planning movement that would act as a reform coalition.

In 1990, a number of prominent NGOs took a leadership role in coordinating the reform coalition. These NGOs formed an alliance called Viva la Ciudadanía, which promoted citizen inclusion in drafting the constitution and pressed for the establishment of participatory planning councils. The NGOs behind Viva la Ciudadanía had diverse profiles, including foundations,

service delivery NGOs, and those explicitly focused on rights and participation. Some were funded by international donors, while others received funding from domestic philanthropic sources or through corporate social responsibility. Despite their differences, these NGOs were united by their shared interests in fighting corruption, promoting transparency, and stimulating popular participation. They believed that the key to resolving Colombia's domestic conflict, poverty, and inequality lay in empowerment, which could be achieved by creating participatory institutions. These participatory institutions would endow communities and citizens throughout Colombia with voice in the policy process, and would thus provoke positive social change through public deliberation. Much like in Brazil, these groups used a Habermasian framework that sought to expand the public sphere to deepen democracy.

Viva la Ciudadanía traveled throughout the country to hold collect input from diverse organizations and citizens. Antonio Madariaga, the current president of the organization, describes their campaign:

> We launched a very strong media campaign, which used TV, radios, pamphlets, and had national coverage. It was a very intense exercise – close to 12,000 roundtables throughout the country. […] Our organization combined deliberations with territorially-defined groups and deliberations with groups representing different social sectors [e.g. women's organizations, environmental groups, professional associations, etc.], with national networks, with processes of articulation."[112]

These early meetings did not seek to mobilize the public as much as gather information. Viva la Ciudadanía sought input that could be translated into articles for the new constitution, since civil society groups were allowed to submit proposals for consideration once they had gained a minimum threshold of signatures. Of particular interest to the organization was the development of language behind the participatory planning system to ensure that "this participatory democracy would, among others, be expressed in the form of planning – in overseeing, monitoring, and co-managing the public."[113] To this end, Viva la Ciudadanía led an elite-targeted effort to provide technical input for constituent assembly members on planning and to lobby for the establishment of a strong institutional framework for participatory planning that would grant the planning councils formal policymaking authority, as is the case in Brazil. Madariaga went on to outline this elite-targeted strategy:

> Simultaneously, we undertook diverse activities with the members of the constituent assembly to present them with the proposals that resulted from this deliberation. We also undertook technical work in drafting proposals for constitutional articles. And then we returned to those sites of citizen deliberation to report on the discussions that we were having with members of the National Constituent Assembly. [114]

[112] Interview with Antonio Madariaga, Executive Director, Corporación Viva la Ciudadanía. 18 December 2009.
[113] Interview with Antonio Madariaga, Executive Director, Corporación Viva la Ciudadanía. 18 December 2009.
[114] Interview with Antonio Madariaga, Executive Director, Corporación Viva la Ciudadanía. 18 December 2009.

Thus, NGOs advanced the participatory planning reform by drawing on their capacity to collect information, produce reports, and lobby. Nevertheless, these efforts would not be enough. The NGOs also needed to mobilize grassroots groups throughout the country to not only contribute information, but to participate actively in the creation and construction of the new planning councils.

3.3 Conflict Expansion: The Construction of the Planning Reform Coalition

NGO staff from Viva la Ciudadanía traveled throughout the country to mobilize grassroots organizations. For the most part, these were organizations that historically had been denied policy access, such as neighborhood associations, women's groups, and environmental movements. A number of these groups supported the deliberative democratic vision promoted by Viva la Ciudadanía, though others were more concerned with gaining policymaking access than with the utopian visions of expanding the public sphere and empowerment through deliberation.

Missing from the reform coalition were groups that did not have a vested interest in the intrinsic benefits of having participatory planning councils. This initial reform coalition were organizations such as business associations and unions that *already* had access to power and did not need planning councils to become involved in policymaking. The unions continued to rely on their formal spaces for negotiation and focused narrowly on issues that directly affected unions, in contrast with the unions in Brazil that allied with popular movements in support of participatory health councils.[115] Likewise, business associations had historically enjoyed high access to the state – indeed, as the previous section described, these business associations were considered to have more power than legislators in Congress. These societal organizations with secure access did not oppose the creation of planning councils, but refrained from intense mobilization in their support.

Also missing from the reform coalition were the insiders and experts that had supported participatory processes in Brazil: bureaucrats and professional associations, such as the Colombian Planning Association. In Brazil, bureaucrats from municipal governments as well as those from the Ministry of Health were vital players in constructing the national network of health councils, while experts from the bureaucracy and professional health associations reaffirmed the legitimacy of the councils as viable spaces for policymaking. In Colombia, bureaucrats and planning professionals were either disinterested in or opposed to the planning councils. Indeed, as the next section will show, bureaucrats from the National Planning Department lobbied *against* the creation of strong planning councils. These insiders did not ally with the civil society groups in the participatory planning reform coalition because the reform promised few concrete gains. The procedural nature of the reform was a direct assault on the authority of the DNP and professional planners, which resisted sharing power with civil society organizations. While subnational governments *did* stand to gain with the decentralization reforms that accompanied the participatory planning reform, the councils were not a key prerequisite to this decentralization and consequently subnational governments were removed from debates on the planning reform.

The narrowness of the reform coalition made it difficult to mobilize the material, organizational, and symbolic resources needed to establish a strong institutional design of the

[115] Interviews with Antonio Madariaga, Executive Director, Corporación Viva la Ciudadanía, 18 December 2009; Fabio Velásquez, Director, Foro por Colombia, 17 September 2009.

councils. First, material resources are needed to pay for the logistical costs of contentious strategies and lobbying. Particularly in a country with a dispersed population and geographic barriers to travel, as in Colombia and Brazil, it is costly to assemble people for a march on the capital, yet these demonstrations are key to apply pressure. Likewise, lobbying requires money not only for transportation but also to produce reports and other materials needed to convince policymakers. In this area, the reform coalition had sufficient resources for their objectives due to the leadership role of NGOs, which were backed by wealthy corporations and foreign donors and dedicated considerable resources to these efforts. At least in the creation stage, the reform coalition's inability to secure a strong institutional design was not due to a lack of material resources.

Second, the reform coalition must have organizational resources beyond these material resources to apply pressure on policymakers via popular mobilization. Lacking this popular pressure, politicians may establish participatory planning, while modifying its institutional design in a way that will make the councils toothless. In particular, planning reform coalition would need to have many participants are linked together through an organizational network, such that the coalition can call quickly demonstrations and be guaranteed high levels of participation by members of the coalition. A high capacity for mobilization can ensure that discussions over the design of planning councils remain in a very public venue, rather than lost in narrow legislative committees.

In terms of organizational resources, the participatory planning coalition presents a mixed result. Mobilization capacity was not negligible because the movement *was* quite broad, with ties to thousands of organizations in all 32 departments. NGOs representing Viva la Ciudadanía traveled throughout the country to hold meetings with diverse organizations and citizens. Antonio Madariaga, the current president of the organization and one of its founders, describes their campaign:

> We launched a very strong media campaign, which used TV, radios, pamphlets, and had national coverage. It was a very intense exercise – close to 12,000 roundtables throughout the country. […] Our organization combined deliberations with territorially-defined groups and deliberations with groups representing different social sectors [e.g. women's organizations, environmental groups, professional associations, etc.], with national networks, with processes of articulation."[116]

Thus, the participatory planning reform coalition could lay claim to a large number of participants that could hypothetically be mobilized for contentious strategies.

Nevertheless, the large number of participants in the reform coalition did not translate into a high capacity to stage demonstrations. Participation was low-intensity for most members of the coalition, with only the NGOs engaged in the intense work of providing input to the constituents. Local organizations would attend a meeting or two and sign the petition behind proposed constitutional language. Yet few were called on to actually come to Bogotá to demonstrate or personally lobby those constituents drafting the constitution. When the constituents debated the specific design of the planning councils and began to favor the weaker

[116] Interview with Antonio Madariaga, Executive Director, Corporación Viva la Ciudadanía, 18 December 2009.

institutional design, the participatory planning coalition was not able to respond with contentious strategies.

The moderate (but limited) organizational resources of the Colombian planning coalition contrast with those of the Brazilian health reform coalition. In the Brazilian case, a diverse array of activists were involved integrally in securing their preferred institutional framework. A key difference is that in Brazil, municipal governments and unions formed a central core of the participatory health reform coalition. These actors were able to mobilize people from all throughout the country to come to Brasília and apply pressure on legislators and members of the constituent assembly. These actors were missing from the planning reform coalition in Colombia, a more dispersed group.

Third, the reform coalition must be able to utilize salient symbols that would make opposing politicians appear illegitimate. In particular, the reform coalition may be able to secure a strong institutional design if they can successfully harness symbols that position participatory institutions as fundamental to the exercise of citizenship and uniquely positioned to protect the public interest. When these symbols are effectively applied, policymakers lose control of the agenda in designing participatory institutions. Their hands are tied because opposing the reform coalition will make them appear undemocratic and/or more interested in their personal power rather than interested in the public interest. To secure these symbols, the content of the reform coalition matters greatly. It is helpful to have diverse groups of people in the same coalition in order to claim that this is the will of the people and not just a handful of narrow interests. Particularly key here is to have groups that normally would not be allied united behind the idea of participatory planning – for example, uniting business groups with unions.

The reform coalition was limited in their ability to frame the planning councils as the guardians of the public interest and the voice of the people. On the one hand, they were able to harness these symbols due to the high public association in the public between participatory planning and the project of deepening democracy, which was the main objective of the constituent assembly. Moreover, Viva la Ciudadanía's campaign to gain support and input from organizations throughout the country bolstered their claim to be speaking on behalf of Colombian civil society. On the other hand, the campaign had mobilized only a portion of Colombian society and organizations and thus could not truly claim to speak for everyone. Missing were key groups such as the *gremios* and unions. Having a broader swath of Colombian society would have reaffirmed the movement's claim of consensus among Colombian society in favor of a strong participatory planning model.

4. CREATION OF THE LEGAL FRAMEWORK: NARROW RESPONSIBILITIES (1990-1994)

A combination of grassroots mobilization and support from politicians led to the creation of participatory planning councils in the 1991 Constitution and the 1994 Planning Statute. Despite this broad political support, the planning councils were created with a fairly toothless institutional design that made the planning councils mandatory for all governments, yet granted them no formal policymaking authority. This weak institutional design would make it more difficult to mobilize supporters in the implementation and institutionalization stages. Why were the planning councils given a weak formal institutional design, given that Brazil's councils *were* able to gain policymaking and budgetary authority? To answer this question, this section points to the narrowness of the participatory planning coalition.

As explained in Chapter 1, pro-participation reform coalitions need diverse resources during the creation stage to maintain control of the agenda and ensure a strong institutional design for the councils. Two types of resources are of particular importance: organizational and symbolic resources. First, the coalition needs access to organizational resources, including a dense network of members and the capacity to mobilize these members for contentious strategies. Second, the reform coalition must be able to access symbolic resources that assert participatory policymaking institutions as fundamental to the exercise of democratic citizenship, as well as the institution best suited to achieve the public interest. These symbolic resources facilitate conflict expansion by giving the reform coalition authority to set the agenda, thereby preventing politicians from watering down the institutional design of participatory institutions.

In the case of Colombia's planning councils, only those actors that favored participatory planning for its inherent value joined the reform coalition; missing were those actors that had proven crucial in Brazil, such as subnational governments, professional associations, unions, and business associations. Thus, the reform coalition faced difficulties in assembling the organizational and symbolic resources needed to ensure a strong institutional design during the creation stage, as summarized in Table 6.2. Still, the institutional design for the planning councils was not as weak as we will see with the Colombian health councils, for which a reform coalition failed to mobilize altogether.

Table 6.2: Resources Leveraged by Colombian Participatory Planning Reform Coalition during Creation Stage

Resource Needed	Resources Available to Reform Coalition
Material resources	High
Organizational resources	Medium
Symbolic resources	Medium
OUTCOME	**Somewhat weak institutional design**

During the constituent assembly, both politicians and the reform coalition supported the creation of a participatory planning system that included municipal, departmental, and national planning councils.[117] Diverse politicians supported the creation of planning councils in hopes of establishing new ties with community organizations. The traditional Conservative and Liberal parties had few linkages with voters and civil society groups beyond their decaying clientelist machines, while the leftist ADM-19 was an elite group of former guerrilla fighters that had little reach outside of the capital, and even had few ties with the poor *Bogotanos* that they claimed to represent. In other words, no one party would clearly benefit from the creation and inclusion of the new planning councils, while each of the main political parties believed that it *could* benefit from expanding their linkages with community groups – particularly given the shift to local

[117] The 1991 Constituent Assembly was composed of three loose blocs: the Conservative Party, the Liberal Party, and an amalgamation of leftist politicians and civil society leaders, coordinated by the AD-19, the party of the now-demobilized M-19 guerrilla group. The inclusion of these figures from the left was one of the ways in which traditional politicians from the Conservative and Liberal Parties demonstrated their willingness to include new voices in Colombia's new democracy; Marxist parties previously had been outlawed. The Conservative and Liberal Parties each had approximately 30% of the constituents, with the remaining 40% representing the leftist factions – a sharp contrast from the old system, which had been dominated by the two traditional parties.

politics with fiscal, administrative, and political decentralization. Municipalities would be important sites for governing and political mobilization in the future, and the parties were interested in capitalizing on these new institutional shifts. The question was not whether or not to create planning councils – the real question was what these planning councils would look like and what they would do in the planning process.

The resource limitations of the participatory planning reform coalition weakened its ability to advocate for and buffer a strong institutional design for the planning councils. In Colombia, the politicians in the constituent assembly had a much heavier hand in adapting the popular proposals into articles for the Constitution, as compared to Brazil. The proposals submitted by civil society groups would have established a system of planning councils similar to the Brazilian model with joint participation by the government and civil society and formal policymaking authority. As the initial proposals went through the process of debate and deliberation during the constituent assembly, politicians called for compromise and a rival proposal gained greater support. The rival proposal accepted the demand to create planning councils, but limited the councils to a consultative role and restricted their membership to civil society representatives. An NGO leader that had mobilized on behalf of the initial proposal explained:

> We lost in terms of how the planning councils would operate. Namely, in that participation is merely consultative. […] Our proposal was that regional and local planning councils be real actors in the process, not just bodies that would produce a document but rather actors in all spheres of the process: in the legislative sphere and in the administrative sphere. [118]

The reform coalition's inability to secure a strong institutional design for the participatory planning councils can be traced to their organizational and symbolic resource limitations. The absence of bureaucrats from the reform coalition would prove key. Clemente Forero, who would later go on to be the first president of the National Planning Council, added that elites from the traditional parties and National Planning Department negotiated away the political authority of the councils and "left it as a weak body with the hope that it would never operate."[119] Whereas Brazilian health bureaucrats had been instrumental in pushing for the creation of strong participatory health councils, in Colombia the planning bureaucrats sought a toothless system of councils. Since the planning councils were adopted to signal a shift towards greater democratic opening, politicians and bureaucrats had a vested interest in creating councils – but they did not have a vested interest in ensuring that the councils had great policymaking authority.

The reform coalition was unable to stage demonstrations to prevent this dilution, and the limited symbolic resources undercut their insistence that the councils needed to not only be created, but also endowed with policymaking authority. Participatory planning was indeed tied to the symbols of democratic citizenship and pursuit of the public interest, but these symbols was insufficiently strong to make politicians that watered down the original proposals seem illegitimate and undemocratic. As a result, the planning councils would enter the implementation stage disadvantaged with a weak institutional framework.

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[118] Interview with Antonio Madariaga, Executive Director, Corporación Viva la Ciudadanía, 18 December 2009.
[119] Interview with Clemente Forero, founding president of the National Planning Council, 15 December 2009.

5. IMPLEMENTATION (1994-2002)

Once the 1991 Constitution was ratified and the 1994 Planning Statute was passed, attention turned to the implementation of the new participatory planning system. During the eight years of the implementation stage, significant progress was made in establishing the institutional framework behind the planning councils. Nevertheless, the planning councils had mixed results in some of the key tasks of the implementation stage: developing a regulatory framework, creating councils throughout the country, and building up the legitimacy of the planning councils.

In this section, I highlight how the narrow composition and limited resources of the planning reform coalition inhibited council implementation. While expanding to some degree, reform coalition remained fairly narrow during the implementation stage. First, the procedural nature of the reform lowered the stakes of reform implementation for many stakeholder groups. Furthermore, the planning councils' weak institutional design made it difficult to mobilize new allies in support of participatory planning, since councils without policymaking authority would never yield much access to power. Despite its relatively narrow composition, the planning reform coalition was able to mobilize moderate organizational and symbolic resources in support of the planning councils. Thus, the coalition had only a moderate capacity to pressure the government to invest in the councils. The coalition was less successful in mobilizing informational resources, meaning the government did not depend on the councils to provide a unique service. Table 6.3 summarizes the resources mobilized and outcome of the implementation stage, which will be described below.

Table 6.3: Resources Leveraged by Reform Coalition during Implementation Stage – Colombia Planning

Resource Needed	Resources Available to Reform Coalition
Organizational resources	Moderate
Symbolic resources	Moderate
Informational resources	Low
OUTCOME	**Limited construction of participatory institution**

5.1 Implementation under the Samper Government (1994-98)

As the first step in implementation, the new Samper administration convoked the National Planning Council in late 1994 and named its founding councilors. The CNP met in late 1994 to discuss the Samper's proposed national development plan, The Social Leap (*El Salto Social*) (Departamento Nacional de Planeación 1995). The CNP's involvement was historic in that it was the first time that civil society groups would have a say in a national development plan. The stakes were high: "The Social Leap" established an investment plan for about $40 billion resources for the 1994-98 period.

In accordance with the 1994 Planning Statute, the CNP had 55 days to develop a *concepto* (evaluation of the proposed plan) after receiving the government's proposal on November 15, 1994. In the beginning, the government provided the CNP with the resources needed to operate and produce the *concepto*. Support included office space, operational funding,

and temporary personnel on loan from the DNP. The CNP used these resources to travel throughout the country to solicit input from diverse communities and civil society groups. In the two-month period, they held over 40 public audiences in all 32 of the country's departments. The councilors met with groups ranging from local governments to environmental movements to afro-colombian organizations. In total, over 3000 individuals participated in these meetings to suggest changes and proposals to the draft development plan. The Council also solicited additional analysis from academic experts in a range of fields. These findings were compiled into the final *concepto* released in January 1995, entitled "We are All One Nation" (*"Todas y Todos Somos Nación*") (Consejo Nacional de Planeación 1995b).

The Samper government, including the DNP, included a few of the CNP's suggestions in the final version of "The Social Leap" presented to Congress. For example, the revised development plan included language calling for the recognition of ethnic, cultural and regional diversity. It also named education as a foundational element of the plan. Nevertheless, the *concepto* did not have a large impact on the national development plan overall. Government conciliations were primarily in the first, strategic component of the plan rather than the public investment component. In other words, the government was willing to tinker with some of the plan's symbolic language, but not the proposals for how money would be directed. Likewise, civil society's involvement was more symbolic than substantive.

Ultimately, the participatory planning reform coalition lacked a unique contribution to a persistent technical problem. The "problem" that the planning councils were designed to solve was one of weak democratic quality and a paucity of political participation. This problem is not a technical one but rather a political one. Moreover, the planning councils were not the only institutional solution to this problem. Many other democratic institutions – including representative institutions themselves – could also be leveraged to address the problem of weak democratic quality. Consequently, there was little urgent reason that politicians would need to grant the planning councils strong, formal policymaking authority if they could get away with establishing weaker councils that would give civil society groups a site for mobilization and political activity, thereby making the symbolic effort towards deepening democracy that was required.

The relationship between the CNP and the Samper government soured after the *concepto* was released. The President's General Council reinterpreted the 1994 Planning Statute to argue that producing the *concepto* was the CNP's sole function. Thus, the government attempted to disband the CNP. Yet both the 1991 Constitution and the Planning Statute clearly state that the National Planning Council would be charged with not only producing a *concepto* of the national development plan, but also with monitoring and evaluating the implementation of that plan.

The CNP's councilors – top figures on Colombian civil society – rejected this minimalist interpretation of their duties and refused to give up what they saw as a monumental opportunity to forge a more participatory democracy in Colombia. Clemente Forero, the CNP's founding president, described the clash with the government:

> The government didn't recognize [the CNP] as a permanent body. They wanted it to be something that met, approves the National Development Plan, and then went away. […] We looked at the articles approved during the constituent assembly. There, the Council was conceived as a permanent organization to oversee the government. So, the Council rejected the government's vision and

> subsisted without any government support whatsoever for at least a year.[120]

Lacking government funding, the CNP was left without a headquarters, staff, or any operating funds. The participatory planning coalition had insufficient resources to compel the government to invest in the CNP and the rest of the councils. Nevertheless, they did manage to take advantage of the personal networks of the national councilors, and their symbolic resources that linked the planning councils with deepening democracy and defending the public interest. Thus, the CNP looked to non-state actors for support. The Bogotá Chamber of Commerce and later the National University provided office space for the Council.[121] Individual councilors provided some basic materials such as office supplies out of their own pocket, and Hernández solicited in-kind donations from business groups. For example, she convinced a friend at the national coffee growers' federation (*Federación Nacional de Cafeteros*) to donate coffee for the office.[122]

These linkages with groups in society were key in setting up the planning councils, and during this period the reform coalition expanded to include some of these private sector actors; nevertheless, the ties with these groups were tenuous. The private sector groups were willing to make donations for the CNP, but their support was passive and did not include using their considerable weight to pressure the government to invest in the councils. Still, gaining private sector backing did expand the diversity of their coalition and thus bolstered the claim that the planning councils would represent *all* Colombians.

With the core material resources secure, the National Planning Council undertook two broad tasks necessary for the construction of participatory planning in Colombia: monitoring the national government's implementation of the national development plan, The Social Leap, and constructing the subnational councils within the National Planning System.

In late November 1995, the CNP produced its first oversight report of The Social Leap (Consejo Nacional de Planeación 1995a). The very first sentence of this report asserts the authority of the CNP in overseeing the planning process, "which does not end with the printing of the National Development Plan" (Consejo Nacional de Planeación 1995a: 6). To prepare the report, CNP councilors had traveled extensively throughout the country to meet with various subnational governments and civil society groups to discuss progress (and the lack thereof) in achieving the goals and promises of The Social Leap. In this first report, the Council focused its attention in particular on the question of job creation: whereas the Plan had promised that the government would create approximately one million jobs during the administration, in practice job creation was stalled. The CNP's reports also highlighted government shortcomings in the areas of education and health.[123]

The National Planning Council's diligent and critical oversight of implementation of The Social Leap drew rancor from the government. Jeanneth Hernández, the founding Executive Director of the CNP, explained:

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[120] Interview with Clemente Forero, founding President of the National Planning Council, 15 December 2009.
[121] Interview with Clemente Forero, founding President of the National Planning Council, 15 December 2009.
[122] Interview with Jeanneth Hernández, founding Executive Director of the National Planning Council, 21 January 2010.
[123] Interview with Jeanneth Hernández, founding Executive Director of the National Planning Council, 21 January 2010.

> For the DNP, the Council was always a rock in their shoe. It was a pain. The Council is an organization that monitors, supervises from civil society what they're doing and what they are accomplishing. And the Council was emitting reports that say "There are only 28 but you said that we would have 35, that the budget is X but you are only spending Y." And assessing what the government is doing and comparing that to the stated objectives and goals that the government promised and *didn't* achieve.[124]

The DNP urged the CNP to limit their activities to "neutral" policy analyses that did not actually critique the government. The CNP ignored these demands and continued to exasperate the government by publishing another document in 1996, Towards an Ethics of the Public (*Hacia una Ética de lo Público*) that lambasted the government for allegations of corruptions that threatened to (and eventually did) bring down the president in disgrace (Consejo Nacional de Planeación 1996). Each year, the CNP wrote reports assessing the government's progress and providing proposals for improvement (Consejo Nacional de Planeación 1997, 1998b). These reports were the product of countless trips throughout the country to collect input from subnational governments and civil society groups outside of Bogotá.

These reports had the result of enhancing the legitimacy of the National Planning Council in two ways. First, the critical but balanced tone of the reports signaled that the council had not been co-opted by the government, nor by opposition parties. The CNP continued to proclaim that it was supra-partisan and acted in defense of the public interest, not private interests. Second, the extensive groundwork done by the councilors to collect input from organizations and communities throughout the country reinforced their claim to be the voice of civil society, writ large. These reports did not merely reflect the perspectives of the councilors – they reflected the perspectives of millions of Colombian citizens.

During these early years, the CNP sought to bolster further its visibility and thus its access to symbolic resources by building relationships with those in the media. The CNP disseminated widely its reports on the government's performance, rather than simply delivering the reports to the government. Moreover, Hernández and Forero developed ongoing relationships with individual reporters from print, radio, and television media.[125] By the late 1990s, the CNP had secured a foothold with the national and local media and frequently gave quotes or were mentioned in news articles or op-eds. The main periodical in the country, *El Tiempo*, mentioned the CNP 24 times in 1995, but this number great to 42 times by 1999.

The national councilors had two goals with this publicity campaign. First and most simply, they hoped to effect change through their reports. Gaining greater publicity would add extra weight to their arguments. Second, they sought ties with the media in order to increase the visibility of the Council itself and augment their reputation as neutral, unbiased defenders of the public interest. This reputation would secure their political access in the future. It might also increase public expectations on the government to include the CNP.

Beyond the CNP's activities directed at the national government, it also took responsibility for building up the National Planning System of subnational planning councils. As

[124] Interview with Jeanneth Hernández, founding Executive Director of the National Planning Council. 21 January 2010.
[125] Interview with Jeanneth Hernández, founding Executive Director of the National Planning Council, 21 January 2010.

of 1995, the institutional framework behind the National Planning System was far from clear. The constitution and statute had called for the creation of a National Planning System, yet had failed to specify what, precisely, this system *was*. Was it an umbrella group with a concrete organizational form, or was it simply the name for the planning councils as a collective? Beyond developing *conceptos*, what precisely would be the role of the councils in the different stages of the planning process? Who would fund the councils? What monitoring and enforcement mechanisms would be put into place to ensure that subnational governments actually complied with the legal and constitutional mandate? These questions remained unanswered.

Institutionalization would require the establishment of a regulatory framework to address these questions, yet the national government was disinterested in elaborating and enforcing such a regulatory framework. No agency within the national executive claimed responsibility for the planning councils. The logical agency to do so would have been the National Planning Department. Yet the planning statute had not explicitly stated that the DNP would be in charge of the National Planning System, and no bureau within the DNP accepted this responsibility. Neither human nor financial resources were dedicated to the task of constructing the National Planning System.

Given the Samper government's ambivalence (and at times hostility) towards the construction of the National Planning System, it quickly became clear that the councilors would have to do it themselves. Thus, the planning councils would be tasked with establishing the regulatory framework and developing local capacities for participatory planning. The CNP took leadership in this effort given its national profile, as its Assistant Director at the time explains:

> The government didn't want to implement the councils, nor did it want to regulate the System. So, the CNP decided to make itself responsible for this regulation – that the councils would be self-regulating. If the government is against participatory planning, civil society and the councils themselves would have to construct the system, especially since they were the ones that had the willingness and interest that the System actually work.[126]

This sentiment was echoed by Clemente Forero, the CNP's founding president: "In practice, the (National Planning) System was our creation alone. The constitution talks about the System but… [shrugs] We had to take on the authority ourselves to convene the system."[127]

To begin the process of constructing the National Planning System, the CNP convoked the First National Congress of Planning Councilors to be held November 27-28 1995. The primary purpose of the Congress was to bring together planning councilors from throughout the country to establish the regulatory framework for the National Planning System – a key step in institutionalization. The CNP raised funds from private donors to cover the costs of the Congress, including supplies for the meeting itself, as well as lodging and food for the approximately 200 councilors in attendance.[128] At the Congress, the planning councilors debated the institutional structure and by-laws for the National Planning System, ultimately

[126] Interview with Carlos Córdoba, Director, Bogotá Cómo Vamos and former Assistant Director of the CNP, 20 October 2009.
[127] Interview with Clemente Forero, founding President of the National Planning Council, 15 December 2009.
[128] Interview with Jeanneth Hernández, foudning Executive Director of the National Planning Council, 21 January 2010.

approving the Social Constitution of the National Planning System in which the councilors accepted responsibility for constructing the system and self-regulation:

> Colombia's planning councilors, brought together in the first National Congress, have assumed the responsibility to consolidate and extend the National Planning System whose conformation is ordered by the 1991 Constitution. […] The National Planning Council, the subnational planning councils, the planning authorities, and the leaders of civil society present here declare open the spaces of association, concertation, and participation of the National Planning System. We assume the responsibility of promoting the principles of participatory democracy, which we will execute with autonomy, respecting diversity and difference and privileging the interest of the Nation. (Sistema Nacional de Planeación 1995)

Another key objective for the Congress was to build up the capacity of councilors. The Congress gave councilors a space to discuss their early experiences with participatory planning and provided them with technical assistance and training. Most of those early councils t faced a number of challenges. For example, many municipalities failed to follow the established procedure for selecting councilors. According to the official process, the government makes a selection from a list of names presented by that segment of society: to fill the two spots allocated for community organizations, the mayor would select two names out of the six presented by the community organizations. The mayor is *not* permitted to select two the leaders of two community organizations of her choosing. Yet often, this is precisely what happened. In other cases, planning officials, councilors, or both were unclear about the logistics of doing participatory planning. At the Congress, participants received some basic training to overcome these gaps, drawing on the expertise of the CNP councilors.

After the Congress was over, the CNP continued their work of building state and civil society capacity to do participatory planning. While the Samper government had publicly stated that it would support the construction of the National Planning System, it was doing little to aid in the process of creating municipal planning councils throughout the country. Given this vacuum, CNP councilors traveled throughout the country. The councilors set about helping set up councils, training councilors and planning bureaucrats, and providing legal assistance with the help of law students from the National University.[129]

The CNP also produced a number of documents to support the technical capacity of the councils and disseminated these documents widely. The councilors developed and distributed sample subnational council by-laws to be adapted locally, as well as templates for the legal decrees to formally establish a local planning council. They also produced a number of pamphlets and monographs that could serve as references for local planning councils. For example, the CNP released a book entitled *Participatory Planning: Strategy of Peace*. This book developed a theoretical framework behind participatory planning; compiled the relevant

[129] Interview with Jeanneth Hernández, founding Executive Director of the National Planning Council, 21 January 2010. Regions in this context refers to communities and economies that extend beyond the boundaries of a single municipality. Regional councils, composed of representatives of the various municipalities, are not mandated by national law or the constitution. Their spread indicates the growing legitimacy of the planning councils.

constitutional articles, laws, and decrees related to participatory planning; included answers to a list of frequently asked questions; and outlined step-by-step guidelines on the logistics of council formation, the drafting of development plans, and the councils' role in overseeing implementation (Consejo Nacional de Planeación 1999).

The CNP placed particular emphasis on communicating the logic of participatory democracy behind the planning councils. The national councilors sought to strengthen the symbolic resources of the reform coalition by disseminating a shared vision and ideology, and creating linkages among civil society groups and among different councils. In addition to training sessions, National Planning Congresses would be held annually in order to tighten the linkages among the different groups in the movement. Constructing a common vision, uniform practices, and a shared identity would make concrete the claim that these councils were defenders of the public interest and not merely spaces for special interest groups to lobby or politicians to distribute patronage.

Despite these important steps, however, by 1997 both national as well as subnational councilors had become somewhat disillusioned with the potential of participatory planning to yield real voice. As the CNP councilors traveled throughout the country, they heard a consistent complaint: the planning councils had put in considerable effort and time in writing their *conceptos* of the municipal government's development plans, only to have the government ignore their suggestions altogether. This experience mirrored that of the National Planning Council as well, which had seen the Samper government only superficially incorporate their input into its final draft of The Social Leap. The planning councils seemed to be window dressing and not real spaces for community engagement in the planning process.

Rather than reacting to the government's development plan once it has already been drafted, the councils would need to be an integral part in drafting the development plan in the first place. To this end, the CNP developed the concept of rights-based planning, which is "the participatory process of elaboration, evaluation, and oversight of development plans in which civil society (citizens and organizations) has the possibility of presenting initiatives to policymakers." (Consejo Nacional de Planeación 1998a: 15) The instrument to put rights-based planning into practice would be a process that they called the "*trocha ciudadana*" (citizenship path), during which the community would present proposals *before* the incoming mayor/governor/president had even been elected (Forero et al. 1999: 13-14). The *trocha ciudadana* consisted of two phases. In the first phase, the planning council would begin a consultation with the community to assess its needs, aspirations, and potential projects. In the second phase, the planning council would translate these findings into a series of concrete policy proposals, which would be presented to candidates for mayor/governor/president to include in their electoral platform. Once elected, the new executive would include the community's proposals in the development plan rather than relying solely on the analysis of the planning agency.

The innovation of the *trochas* was that they provided a route to formal authority for the councils, even as the 1991 Constitution and the 1994 Planning Statute failed to do so. Political candidates would have a clear incentive to incorporate the *trocha* proposals into their platforms (*plan de gobierno*) as a means of wooing organized voters during the election. Article 259 of the 1991 Constitution states that the candidate's platform serves as the basis for the administration's development plan. The linchpin of the *trocha* process lies in the fact that governments can be held legally accountable to the promises made in these platforms: Law 131 of 1994 establishes the principle of *el voto programático* (the obligatory vote), which gives citizens the right to

remove politicians from office if they fail to enact their platforms. Thus, the *trochas ciudadanas* provided an institutional route to real policymaking authority for the planning councils.

The first experiment with the *trochas ciudadanas* was launched in May 1997. Approximately 300 municipalities were involved in this first round of *trochas*. Participants included more than 10,000 organizations representing diverse sectors of society, including business groups, community associations, and universities produced supporting documents and participated in 61 meetings, regional and departmental forums, and public audiences. Moreover, they solicited and received suggestions via email and post from hundreds of citizens. Whereas the initial reform coalition had been narrow due to the limited scope of the participatory planning reform, the coalition thus expanded through the *trocha* process. Following this study's argument, the reform coalition was able to attract new and more diverse actors with an institutional design that conferred real policymaking authority. These new groups may not have originally cared about the participatory planning reform, but supported its implementation once they stood to gain from the process.

The high levels of participation and outreach of the *trocha* process contributed to the legitimacy of the planning councils by strengthening their claim to represent the voice of the people. By including many, diverse municipalities and civil society groups from throughout the country, the *trochas* could be credibly seen as the voice of organized civil society in Colombia. Forero and other key leaders in the CNP at the time explained:

> Through participatory planning… civil society has become a central figure in the public life of the nation, and a channel for the democratic aspirations of the Colombian people. In the meetings [of the *trochas ciudadanas*] it became clear that planning councils were not simply NGOs, nor community organizations… they are spaces that belong to everyone. They are spaces where we all come together, where we can enter into a relationship with the state and where we can better direct our attentions in service of the public and in pursuit of the pubic interest of the nation. (Forero et al. 1999: 30)

At the end of the *trocha* process, analyses and proposals were compiled for municipal and departmental governments. The CNP also aggregated these proposals up to the national level to produce the *Trocha Nacional Ciudadana.* A preliminary edition of this report was presented to the presidential candidates in 1998, and a final version was sent to the newly elected Pastrana government upon taking office in July 1998. At each of the national, departmental, and municipal levels, a number of the proposals identified in the *trocha* documents were incorporated into the development plan. While still nascent, the 1998 *trocha* process was a key first step in developing a concrete institutional role for the planning councils and building their legitimacy. In other words, the planning councils were making clear advances towards institutionalization.

5.2 Implementation under the Pastrana Government (1998-2002)

In 1998, voters elected Andrés Pastrana, a member of the Conservative Party and the son of a former president, to serve as their new president. The change in office did not lead to a considerably friendlier environment for the planning councils than that of the Samper years. Pastrana's national development plan, Change to Construct Peace (*Cambio para Construir la*

Paz) mentioned the importance of participation in sustaining Colombia's democracy and countering the long-running civil conflict (Departamento Nacional de Planeación 1999). However, the government was reluctant to back these words with actions – or resources.

Despite a lack of government support, the policymaking role of the National Planning Council consolidated during the Pastrana administration. Whereas during the Samper years the CNP faced the initial challenges of developing an institutional form and acquiring the basic resources needed to operate, by 1999 these basic issues had been addressed. The CNP had developed a reputation as a capable, neutral, and publicly-minded organization. No one challenged the right of the CNP to exist. A number of the policy recommendations established in the 1998 national *trocha* document had been incorporated into the National Development Plan, bolstering the legitimacy of the CNP even more. The CNP's legitimacy manifested in a more secure budget; to develop the 1999 *concepto*, the government gave the CNP resources to cover basic costs, such as computers, desks, a travel allowance, and staff salaries. In sum, by 2000, the CNP had made major steps towards institutionalization. Hernández, the former Executive Secretary of the CNP, explains:

> By this point we were people that mattered. We had a staff working to support the Council, an administrative structure that was clear. I didn't have to do everything because I had a team of people that could help. We had a spectacular headquarters, the *Trocha Ciudadana* process underway throughout the country. We were releasing *conceptos* and publishing, writing on an ongoing basis.[130]

Forero agrees, noting: "It was perhaps during the Pastrana government that we reached their strongest point, because that was when our activities became normalized."[131]

Nevertheless, at this point the CNP's institutionalization still was weaker than that of Brazil's national health council. Through the *trochas,* the CNP had gained a seat at the table in policy discussions. Yet the Pastrana government still incorporated few of their policy recommendations. Their access was greater than it was during the Samper presidency but was still insecure. The CNP's procedures were routinized and it had developed a modicum of legitimacy – but not enough to secure high levels of access.

During the Pastrana administration, the CNP continued to travel throughout the country to provide technical and legal assistance to municipal and departmental planning councils and governments. The subnational planning councils were becoming more routinized, though key, structural problems remained. It remained unclear which government entities were responsible for supporting the National Planning System, and government funding continued to be negligible. Thus, the CNP sought financial support elsewhere to support the System. The CNP had secured grants from donors such as the Inter-American Development Bank, ASDI (the Swedish development aid agency), and the Corona Foundation. The CNP also began to collaborate with the Human Rights Ombudsman (Defensoría del Pueblo) in training subnational planning councilors.

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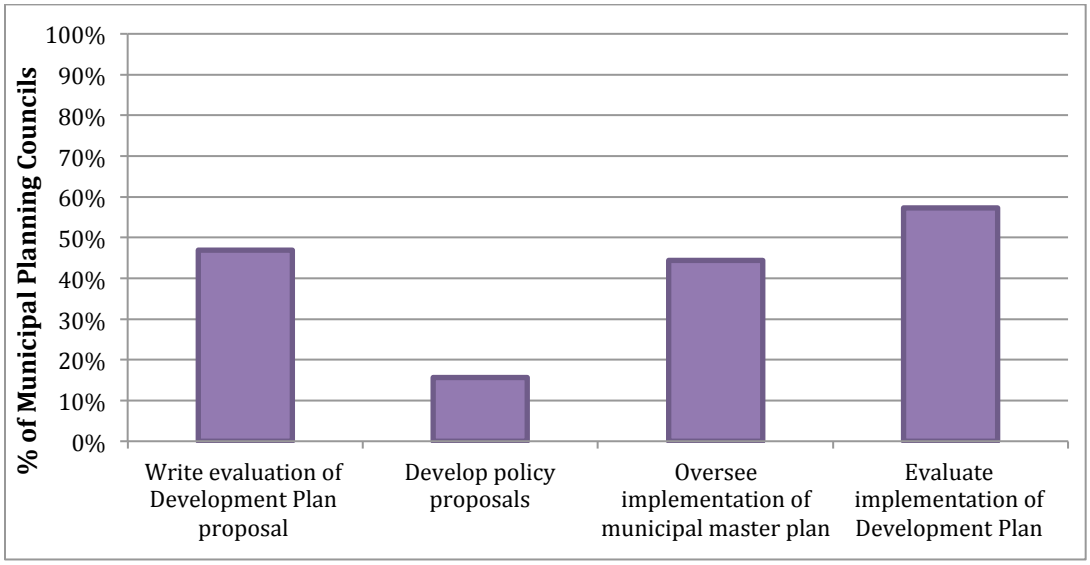
[130] Interview with Jeanneth Hernández, founding Executive Director of the National Planning Council, 21 January 2010.

[131] Interview with Clemente Forero, founding President of the National Planning Council, 15 December 2009.

Another problem with routinization was the lack of a clear regulatory framework that established the specific roles and responsibilities of the councils, and outlined enforcement mechanisms. Nevertheless, the *trochas* had provided a way around this weak regulatory framework. In 2000, the National Planning System launched the second *trocha* process, with even more widespread participation. At the municipal level, the Planning councils sought formal accords with the candidates to give the *trocha* process greater institutional weight. In 50 municipalities candidates signed accords with the planning council related to the *trocha* documents. Most of these candidates were elected in the October 2000 mayoral elections, and included aspects of these accords in their development plans. In 2001, they began the process of the second national *trocha*. This time, participation was even greater, with about 70% of municipalities participating in the process.

Despite these advances, compliance with the participatory planning mandate stagnated in the absence of a formal legal framework and support from the national government. In 2002, only 55% of municipalities had a planning council (Velásquez and González 2003: 434). Moreover, as Figure 6.1 shows, many of councils that had been established were not fulfilling their formal prerogatives. Fewer than half of planning councils had completed a *concepto* for the local development plan, and a scant 15.6% of councils actually made proposals to be included in the plan.

Figure 6.1: Percentage of Colombian Municipal Planning Councils Performing Formal Prerogatives



Source: (Defensoría del Pueblo and ASDI 2002). Based on 2001 survey of all municipalities

Key strides had been made towards infusion with value, but here institutionalization was also incomplete. The legitimacy of the CNP, and the planning councils in general, had been boosted through the *trocha ciudadana* process, the National Planning Congresses, and the CNP's ties to planning councils in all 32 departments. These efforts strengthened both their claim to speak for Colombian civil society writ large, and their assertion that the planning councils were neutral organizations that sought to defend the public interest over private interests. However, the ties between these diverse organizations and the planning movement were tenuous: groups

such as business associations and unions supported the *trocha* process and the planning councils, but their commitment was new and thus potentially fragile. The planning councils' success was more limited on the second indicator of infusion with value: inclusion in policymaking. Inclusion was clearly higher than it was during the early days of the planning councils, and the *trocha* process had strengthened their inclusion. Still, the weak institutional design of the planning councils limited the extent to which governments truly had to grant the planning councils a seat at the table, and the *trochas* were still nascent experiments that were only starting to yield real access.

In sum, by the end of the initial implementation stage the planning councils had made major advances towards institutionalization, but the process was still unstable due to structural problems with the institutional design of the planning councils and the originally narrow reform coalition. As we will see in the next section, the tenuousness of these advances became glaringly obvious during the institutionalization stage, during which Colombia's participatory planning system began to unravel.

6. INSTITUTIONALIZATION (2003-2010)

While considerable progress had been made over the past eight years, the underlying fragility of the planning councils became apparent starting in 2002, when Álvaro Uribe was elected president. The initial steps taken during the implementation stage had not fully taken root and the supporters of participatory planning were left with insufficient resources to challenge a hostile government. The decline in access and legitimacy during the Uribe years gave rise to negative feedback effects that discouraged both government and civil society actors from investing time and resources into the planning councils. The result is an outcome of weak institutionalization, in which the planning councils emerge as only partially routinized and have experienced an incomplete infusion with value. In terms of infusion with value, the CNP was included in the planning process less and less, and its legitimacy as the defender and voice of the public interest suffered. A similar trend occurred with the subnational councils in the National Planning System, which increasingly was seen as irrelevant and a flawed experiment. Routinization was also somewhat weak for the planning councils: funding was even less secure than in the 1990s, the regulatory framework remained vague and without meaningful enforcement mechanisms, and overall compliance stagnated at the levels of the late 1990s. Still, the planning councils did not collapse altogether during the institutionalization stage and continue to operate, despite their flaws.

6.1 Moderate Routinization

Turning to the subnational planning councils, we see the incomplete institutionalization of participatory planning via weak routinization. Routinization entails the degree to which the planning councils have comparable structures and functions throughout the country. Colombia's planning councils certainly prove more routinized than its health councils, which effectively do not exist. Nevertheless, the routinization of participatory planning in Colombia is lacking according to this study's measures: stable funding, a clearly elaborated regulatory framework, and compliance with that regulatory framework.

One of the key characteristics of routinized participatory policymaking is access to sufficient and stable funding. Institutionalization was damaged during the institutionalization

stage due to the growing financial insecurity of the planning councils, particularly at the subnational level. During the second Uribe administration, the DNP centralized control over the National Planning Council's budget. One of the major boons to the Council in its first decade was its ability to raise funds from external sources to support the construction of the National Planning System. Complementing the governmental support obtained in 1997 was funding from foundations and bilateral aid agencies. This external funding made it possible for the CNP to host annual Congresses for all planning councilors and to provide technical assistance to subnational governments and councils. Yet in 2007, the government released a decree stating that the CNP could only receive funding directly the National Planning Department. Moreover, the Council lost full discretion over its budget. Previously, the CNP had received public funding automatically and had autonomy over how to spend this money. Now, it needs to go through the DNP to gain access to funding.

These funding restrictions have also left the National Planning System in an uncertain position. Previously, the CNP provided considerable aid to subnational councilors and had facilitated coordination among the planning councils. The withdrawal of funding has left a looming gap, as one NGO leader describes:

> Three years ago we asked the CNP to do some consultations and training sessions [with the Planning councils]. They couldn't simply because the government did not release the money for them to do so, because the government isn't interested in this kind of participation. […] And with a few exceptions, like Medellín or the case of Barrancabermeja, the subnational planning councils operate with very low capacity to influence policy.[132]

The System is now currently without a stable source of funding, relying only on contributions from those (few) subnational governments willing to invest their own discretionary funds into the nation-wide network of planning councils. The CNP still provides some support for the annual National Planning Congresses, yet the subnational councilors must now rely on their governments to pay for travel and lodging costs for the Congresses. In other words, only councilors that receive financial support from their local governments are able to attend the (nominally) national congress. In contrast, the Brazilian federal government earmarks hundreds of thousands of dollars to cover the full cost of comparable health and social assistance conferences. Indeed, establishing guaranteed funding to support the National Planning System is the top policy priority for leadership of the National Planning System, which argues that dedicated funding is a precondition for institutionalization of the participatory planning system in

[132] Interview with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010.

Colombia.[133] Advocates of participatory planning have presented proposals to establish a system of dedicated funding for the councils 17 times, to no avail.[134]

One direct effect of the reduction in CNP support was the death of the popular and successful *trocha ciudadana* process. The second *trocha* process in 2002 had involved 70% of Colombia's municipalities and had resulted in a number of instances in which the planning councils were involved in drafting the development plan – not just reacting to it after the fact. Yet once the CNP was no longer in a position to coordinate this process, it fizzled away and was not repeated.

Turning to another measure of routinization, the regulatory framework behind the planning councils remains unclear. Until a 2003 Constitutional Court ruling,[135] it was not even clear if the planning councils should have a permanent existence or if their role was limited to providing input on the new development plan every four years. In this ruling, the Court determined that the planning councils were indeed permanent bodies engaged in the process of formulating *and* monitoring the implementation of development plans, yet what that would entail precisely remained vague. For example, the regulatory framework states that planning councils are to develop evaluations of each administration's proposed development plan that provide policy recommendations to ensure that the development plan matches existing law and community priorities. However, the regulatory framework remains silent about what happens after these evaluations are delivered to the government, leaving the governments free to throw away the evaluations without reading them.[136]

Moreover, without the CNP's leadership, compliance with the (weak) regulatory framework behind participatory planning has stagnated. A number of interviewees described the common occurrence of councils that fail to perform any functions. Others described councils that meet a few times, produce an evaluation of the mayor's development plan, and then disappear for the next four years.[137] In other cases, the absence of government cooperation makes it impossible to perform their functions of overseeing and evaluating the implementation of the development plan. For example, the government may fail to deliver vital information and data about policy performance.[138]

The institutional weakness of the planning councils is further demonstrated by the continued lack of enforcement mechanisms. Formally, the offices of the Comptroller (*Contraloría*) or Public Prosecutor (*Procuradoría*) are responsible for preventing and sanctioning improper usage of public funds and abuse of power in the public sector. These

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[133] Interviews with Carlos Alberto Garzón, ex-Coordenador General of the Consejo Nacional de Planeación, 28 October 2009; Javier Corrales Villegas, councilor, Bolívar state planning council; president, Cartagena municipal planning council, 29 October 2009; Luis Giraldo, councilor representing community organizations, Maní Municipal Planning Council, 30 October 2009; Miguel Correa, councilor representing the juntas de acción comunal, Lorica Municipal Planning Council, 29 October 2009; Carmenza Ospina Ospina, councilor representing tourism sector, Calareá Municipal Planning Council, 29 October 2009; and Guillermo Cardona, Executive Director, Confederación de Juntas de Acción Comunal, ex-Secretary General and ex-president of the National Planning Council, 4 February 2010.

[134] Interview with Antonio Madariaga, Executive Director, Corporación Viva la Ciudadanía, 18 December 2009.

[135] Sentencia C-524 of 2003.

[136] Interviews with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010; Diego Bejarano, Director of Participation, Bogotá Municipal Planning Secretariat, 18 April 2010; Javier Corrales Villegas, councilor, Bolívar state planning council; president, Cartagena municipal planning council, 29 October 2009; Carlos Alberto Garzón, ex-Coordenador General of the Consejo Nacional de Planeación, 28 October 2009; among others.

[137] Interview with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010.

[138] Interview with Salvador Mendoza, Vice-veedor, Veeduría Distrital de Bogotá, 12 April 2010.

agencies could theoretically ensure that local governments dedicate sufficient funding to the planning councils and comply with the regulatory framework. Yet these bodies have not focused on ensuring the implementation of the planning councils, or of other participatory institutions in Colombia. During interviews, bureaucrats from the Federal Comptroller and the Federal Public Prosecutor explained that they are charged with ensuring municipal compliance yet lack the staff to do so.[139] For instance, the Federal Public Prosecutor that would be responsible for participatory institutions is composed of only two bureaucrats. These bureaucrats have chosen to prioritize the creation of training materials rather than more comprehensive monitoring and enforcement.

The absence of enforcement mechanisms is exemplified through the case of the planning council in the coastal city of Cartagena.[140] When a reformist mayor came to power in 2008, she dismissed the old planning council on the grounds that the councilors were part of the old political machine and did not represent democratic civil society. However, the 1994 Planning Statute states councilors are to serve eight-year terms and that the executive has the right to appoint half of the councilors to replace the 50% at the end of their eight-year terms. The executive does *not* have the right to replace all the councilors, even if she deems them to be undemocratic. In other words, the mayor had violated the rights of the council and was violating the law. The planning council refused to be disbanded and continued to operate parallel to the new planning council named by the mayor. Tellingly, the members of the disbanded planning council knew that their rights had been violated, yet could not identify any legal avenues that would lead to reinstating the planning council. The president of the disbanded planning council – a top leader in the National Planning System and thus very knowledgeable about the planning councils' rights and responsibilities – told me that they had no legal options.[141]

Despite all the evidence of the planning councils' weakness, it is important to note that they have *not* deinstitutionalized entirely. The institutional framework behind the National Planning System, established in the 1990s, remains in place. The subnational councils and the CNP come together once a year for a congress of the System. For example, in November 2012 the 16th National Participatory Planning Congress was held in Pereira, the capital city of the Risaralda department. The CNP continues to operate and has regular meetings (even if many national councilors are absent). The CNP receives government funding, unlike in 1995 and 1996, and has a permanent office and staff. Moreover, the idea of participatory planning – that representatives from the community have the right to at least present their opinion on the proposed development plan – has taken root. In fact, most interviewees stated that the spread of the participatory idea is the most significant advance in participatory planning over the past twenty years. Jeanneth Hernández summarized the current weakness of the CNP, and its hope for the future:

> The Council lost a lot that we had gained, it lost at the internal level a lot that we had gained in terms of its structure. But it didn't lose everything – it didn't lose the construction of the participatory

[139] Interviews with Diana Bravo, Delegada para la Vigilancia Preventiva de la Función Pública, Procuradoría General de la República,13 April 2010; Carlos Mora, Verónica Caro, and Diego Álvarez, Contraloría Delegada para la Participación Ciudadana, Contraloría General de la República, 6 April 2010.

[140] Interview with Carlos Alberto Garzón, ex-Coordenador General of the Consejo Nacional de Planeación, 28 October 2009.

[141] Interview with Javier Corrales Villegas, councilor, Bolívar state planning council; president, Cartagena municipal planning council, 29 October 2009.

> planning process that we generated through the National Planning System. The seeds that we planted are giving fruit.[142]

The narrow reform coalition behind participatory planning has limited its institutionalization – first through the development of a weak institutional design, and later through insufficient mobilization to include the planning councils. Yet the leadership of key members of the participatory planning movement has ensured that the planning councils have carved out a role in the planning process, albeit a vague one.

6.2 Low/Moderate Infusion with Value

In 2002, the CNP lost its founding councilors, the leaders that had embraced the task of constructing the National Planning System. As provided in both the 1991 Constitution and the 1994 Planning Statute, there was a renovation in planning councilors with the new president. Councilors serve one (and only one) 8-year term, and the individuals that had taken such a leadership role in constructing both the CNP and the National Planning System completed their terms. These were the councilors described by Jeanneth Hernández, the Executive Director of the CNP, as the "crazy dreamers" who were willing to travel constantly throughout the country on their own dime. They did so out of a conviction that participatory planning was crucial for the fate of Colombian democracy. The founding CNP councilors were highly respected and influential civil society leaders, which had conferred a degree of initial legitimacy on the Council. They were also willing to battle with the Samper and Pastrana governments, and did not hold back in criticizing the governments' shortcomings.

Nearly anyone replacing these councilors would likely be less effective in their efforts to construct participatory planning, but the councilors appointed in 2002 were particularly weak. These councilors were selected in part based on their political loyalty to the new president. As described by Carlos Córdoba, the Assistant Director of the CNP during its early years, the result was a decline in the CNP's autonomy and overall legitimacy:

> The original councilors were very passionate and had a strong commitment to participatory planning, and they did so much in just a little time. The next batch to come in was not as committed to this ideal. They were less likely to stand up to the government, were more conciliatory, had less of a vision, and were less willing to take an active leadership role in constructing the System. This new group saw their role less in terms of civil society oversight of the government (*control social*) and more in terms of providing technical consultation and input to the government.[143]

Even with this decline in autonomy, the Uribe government was hostile to the Council's request for information, funding, and access – even more so than the unfriendly Samper and Pastrana administrations. Jeanneth Henández, who had served as the Council's Executive Director from the beginning, found herself and her staff in constant conflict with the DNP:

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[142] Interview with Jeanneth Hernández, founding Executive Director of the National Planning Council, 21 January 2010.

[143] Interview with Carlos Córdoba, Director, Bogotá Cómo Vamos and former Assistant Director of the CNP, 20 October 2009.

> At that point, I began to notice that what everything we had fought for, that we had constructed was been trampled on and it would be very difficult to sustain it alone. […] I began to find that this was going against my principles. I was starting to give in to things against which I had fought for my whole life. I saw in that moment that I was just banging my head against a wall. I spent 8 years advancing a process that I think was ethical and absolutely transparent, and to turn it into *this?* […] I said to myself: 'For my mental health and that of my team, I should leave.' [144]

Hernández resigned from her post on January 10, 2003, the day the CNP submitted its *concepto* of Uribe's development plan. By the end of March, the DNP had fired every person who had served on the CNP staff under Hernández – even woman who made the coffee.

In 2003, the CNP's fragility and weak infusion with value became even clearer after it had submitted its *concepto*. This *concepto* was less critical than prior ones had been since most councilors were loyalists to the president. Nevertheless, the document *did* raise a number of concerns and suggested changes to the proposed plan. When the CNP originally presented the *concepto* to President Uribe, he was full of praise for the document – yet this praise would prove hollow. The President of the CNP between 2003-10, Adolfo Atehortúa, explained: "when we went to discuss it with the National Planning Department, to highlight the points we thought should be modified, and they practically threw us out of the meeting." [145] In particular, the Council challenged the government's education proposal and objected to the name that the government had given it – "Revolutionary Education" – because the proposals were just an extension of previous education programs. Yet as Adolfo Atehortúa notes, the DNP overtly was hostile to all of their suggestions:

> **Adolfo**: The response was: "That was the name that we are going to give the program, because that's what 7 million people voted for." And I replied, "But how you make those claims about these new charter schools you propose? How can you promise this expansion of coverage without also increasing the education budget?" And they said: "Look, to repeat, this is a program that 7 million people voted for. This is the president's proposal to them and we have to respect the votes of those 7 million people." I said, "Well, we could discuss some of the issues that you have here about higher education. There's a lot to discuss in terms of funding for universities." The reply: "We repeat, this is the proposal that Uribe presented as a candidate, and 7 million people voted for him for president."
> **Lindsay**: And *was* the education proposal a major part of Uribe's presidential campaign in 2003?

[144] Interview with Jeanneth Hernández, founding Executive Director of the National Planning Council, 21 January 2010.
[145] Interview with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010.

Adolfo: No, not at all! That's exactly the point![146]

Every time the councilors raised a concern that they had with the government's development plan, they received the same response: The government could not change the plan because 7 million Colombians had voted for it. There appeared to be no possible role for the CNP to influence the development plan. The government had not consulted the CNP when formulating its platform during the campaign, nor when formulating the development plan proposal. The administration then claimed that its hands were tied when the CNP finally had the opportunity to provide input. The CNP had enough infusion with value to gain an audience with the president and later the top leadership of the DNP – but insufficient to actually have any of their ideas considered or even discussed by the administration.

This disheartening experience discouraged the national councilors from investing time and effort in their oversight of the 2003 national development plan. The CNP *did* continue to produce reports that assessed the implementation of the plan.[147] Yet these reports were not as extensively researched, nor as combative, as those produced by the Council during the Samper and Pastrana administrations. Rather than traveling extensively throughout the country to collect input from councilors in the regions, these documents took on the character of technical, expert-based policy briefs. The government continued to prove unresponsive and continued to exclude the CNP from major planning discussions and decisions.

The institutionalization of the planning councils also appeared weak according to the other aspect of infusion with value: legitimacy. Legitimate councils are seen by all major societal and government stakeholders as the voice of the people and defenders of the public interest. This legitimacy secures a stable policymaking role for the participatory councils because their existence is no longer challenged. During the 1990s, the planning councils made considerable strides in bolstering their legitimacy, in large part through the *trocha* process that bolstered their claim to speak for Colombian civil society as a whole. During the institutionalization stage, however, to the autonomy of the councils undermined the legitimacy of the councils, and the CNP in particular.

The legitimacy of the planning councils has been further strained by a shift in the symbols used by the CNP to justify its role in policymaking. As mentioned above, the original CNP framed its work as one of mobilizing and coordinating all of Colombian civil society. This mobilization process was needed to ensure that the planning process would be democratic and would reflect the interests of *all* Colombians. In contrast, the current councilors see their job as more one of providing input to the government based on their particular expertise or points of view.[148] Thus, the job of the CNP is *not* one of ensuring that all Colombians have a voice through participatory processes.

In the search for legitimacy, the new, informational framing is a weaker one than the prior, democratizing frame. In its prior framing, the CNP presented itself as the voice of civil society and the organization uniquely capable of aggregating the interests of diverse organizations from throughout the country and across different social sectors. Consequently,

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[146] Interview with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010.
[147] See, for example, Consejo Nacional De Planeación, 'Balance General Del Plan Nacional De Desarrollo, 2006-2010', *Reflexión para la planeación* (Bogotá: Consejo Nacional de Planeación, 2009b), Consejo Nacional De Planeación, 'Seguridad Democrática Y Política Antidrogas', *Reflexión para la planeación* (Bogotá: Consejo Nacional de Planeación, 2009a).
[148] Interviews with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010 and Carlos Córdoba, Director, Bogotá Cómo Vamos and former Assistant Director of the CNP, 20 October 2009.

they traveled throughout the country collecting input for their oversight evaluations, and ensured a great diversity of organizations in the *trocha* process. The CNP was not fully successful in harnessing this symbol, yet it had made important strides. In contrast, the new framing presents the planning councils as a source of technical input – a function that certainly is not unique to the planning councils.

The declining legitimacy of the planning councils can be seen in their reduced coverage by media outlets. During its first eight years, the CNP developed media contacts and when they wrote critical reports, they received press coverage. Clemente Forero, the former president of the CNP, explained that "before, the media was interested in our work because the CNP was critical and said things openly. The CNP gave credit for advances, but we also spoke with force when criticizing the shortcomings of the development plans."[149] Yet the CNP's reduced autonomy starting in 2003 left it "completely neutralized, an organization without the capacity to be critical of the government. Consequently, it did not have the capacity to mobilize the media."[150] Adolfo Atehortúa, the CNP's president from 2002-10, agreed with this assessment:

> The CNP has done reports, has overseen the government, but only on paper, not in a real or concrete way. So, I don't know. It isn't taken into consideration. For example, we wrote a critical text on anti-drug policy. We did not receive a single response from *any* government agency. Of course, it was covered in the press, but the less important actors in the press – not in RCN nor Caracol [the country's top news radio channel], nor in El Tiempo [the country's most influential newspaper].[151]

The CNP's weak legitimacy and low inclusion in policymaking became clear during the 2010 election. The CNP sought to host a forum with the presidential candidates in which the candidates would answer questions about their plans for regional development. The proposed forum would be transmitted on regional channels throughout the country and would also be covered by El Espectador, one of the top two newspapers in the country. Despite the potential for free publicity, no candidates would commit to the event. The CNP scaled back its request, suggesting instead a 10 minute interview with each candidate at the time and location of their choosing. Yet even this minimal commitment with the CNP was deemed not worth it by all the campaigns. This experience signals the weakness and lack of legitimacy of the planning councils: "If the won't give a 10 minute interview with the CNP that will be transmitted throughout the country when they are candidates, how is the CNP going to have the attention of a president once elected?"[152]

The combination of low inclusion in policymaking and weak legitimacy has led to negative feedback effects, causing both civil society groups and the government to invest less in the councils. On the civil society side, a lack of access and influence causes many councilors to stop attending the council meetings, which they now see as a waste of time. One municipal councilor explains: "When you get out into the country, you find that public officials have put up barriers to keep the councils from having access. And this makes people unmotivated and saps

[149] Interview with Clemente Forero, founding President of the National Planning Council, 15 December 2009.
[150] Interview with Clemente Forero, founding President of the National Planning Council, 15 December 2009.
[151] Interview with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010.
[152] Interview with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010.

up the will that we bring to these spaces."[153] This dynamic can even be seen on the National Planning Council, acknowledged to be the most institutionalized and influential planning council. Atehorúa describes:

> This is what happens: they go to the first, the second session. They participate in the discussions on the *concepto*. But once they realize that they don't take what we do into consideration, they say "Forget it, this is a waste of time." And they don't come back. This is what happens with most. Those of us that have a personal commitment to bringing our message to a certain number of people, to at least get it written down and disseminated, well, we dedicate a bit more time. But the rest of the people that are more pragmatic, people that are looking to advance a certain interest, those people say: "Nothing is going on here, they don't get anything done here."[154]

Thus, participation is left to those who have a strong ideological or personal commitment to the idea of participatory planning, a belief that carrying on is crucial for the country even if it yields no discernable impacts on planning. Yet ideology and patriotism by themselves are weak incentives to sustain broad participation in planning councils throughout the country. Consequently, many influential civil society groups will opt out of the planning councils in favor of alternate strategies that are more effective. As a case in point, Jeanneth Hernández – the founding Executive Director of the CNP and perhaps the individual who contributed most to the institutionalization of the national council and the National Planning System, no longer works in the area of participatory planning. Nor do any of her staff from those formative years.

Negative feedback effects operate on the government side as well. With fading interest from the most qualified and influential civil society organizations, the councils are less capable of producing valuable proposals that might be of interest to the executive in designing its development plan, and the planning councils no longer able to claim to speak for civil society writ large. Not surprisingly, then, no politician interviewed said that the councilors had any or much contact with the planning councils, with the exception of a former mayor of Bogotá. As one politician noted, "It's a lot more important on the books than it is in reality, isn't it?"[155] Many of the politicians interviewed did not have a clear understanding of the functions of the planning councils, and they certainly did not describe frequent contact with the National Planning Council as we saw in Brazil for the National Health Council and the National Social Assistance Council.

7. CONCLUSION

The case of Colombia's planning councils demonstrates the importance of developing a broad reform coalition in support of participatory policymaking – the kind of reform coalition that cannot come from a procedural change alone. Colombia's planning councils were only able

[153] Interview with Miguel Correa, councilor representing the juntas de acción comunal, Lorica Municipal Planning Council, 29 October 2009.
[154] Interview with Adolfo Atehortúa, president of the National Planning Council (2003-10), 23 July 2010.
[155] Interview with Representative Germán Navas Talero (PDA/Bogotá), 1 August 2010.

to attract the firm support of those actors who actively supported participatory planning for the sake of participation; unlike Brazil's councils, the planning councils lacked allies that were only interested for instrumental reasons. The procedural nature of the planning reform project attracted a comparably narrow reform coalition that had insufficient symbolic and organizational resources to ensure a strong institutional design for the planning councils. During the implementation stage, creative leadership from national councilors helped the planning councils overcome some of their initial difficulties, including government hostility. The number of councils spread and became somewhat routinized. Moreover, the councils became more institutionalized in terms of infusion with value, as the national councilors nurtured a growing participatory planning movement that represented a highly diverse set of Colombians. Nevertheless, these advances were tenuous. During the institutionalization stage, the planning councils became less institutionalized with a change in CNP leadership and increasing hostility from the government.

Might another explanation account for the only partial institutionalization of Colombia's planning councils? In this chapter, I have pointed to how the procedural nature of the planning reform made it difficult to attract and sustain the kind of reform coalition needed to ensure institutionalization. Below, I review two alternative explanations related to political will and civil society strength and demonstrate that these explanations fail to account for the outcome of semi-institutionalization observed with Colombia's planning councils.

One explanation for the partial institutionalization of Colombia's planning councils might be related to political will. As outlined in the first chapter of this dissertation, a number of scholars have emphasized the centrality of political will to creating and sustaining participatory institutions. Perhaps the politicians who created Colombia's participatory planning councils never intended for these councils to operate. Instead, the planning councils might have been created as part of a cynical attempt to feign openness and transparency while keeping politics as usual. After all, the legitimacy crisis had arisen because people believed that there were few opportunities to influence politics. Resolving the legitimacy crisis would mean that politicians would have to convince the public that there were additional opportunities in the new democratic regime – but they need not actually provide these opportunities if the symbolic efforts suffice.

There is little evidence to support this pessimistic interpretation. First, politicians' support for participatory policymaking went beyond just the moment of the constituent assembly. In the years following the constituent assembly, Congress passed a slew of laws that created participatory institutions and processes in planning and in other areas. These legal initiatives went far beyond what was in the constitution. Congress created this expansive participatory infrastructure because the dominant parties had recognized the deep-seated need for political reform and did not seek to simply make a symbolic change. One academic expert and advocate for participatory planning during this period explained:

> I don't think it was just a cosmetic change. […] This explains why the next ten years were dedicated to the creation of participatory spaces. You can't create participation laws if you don't find consensus in the Congress to do so. It would be a huge leap to assume that all the legislators that were in office and creating the legal infrastructure for participation during those ten years were doing it just as a cosmetic change, as window dressing.[156]

[156] Interview with Fabio Velásquez, Director, Foro por Colombia, 17 September 2009.

A political aide during the constituent assembly and subsequent legislative sessions agreed, arguing that there was consensus among legislators that "we needed more participation, but participation couldn't work until we built up a legal framework."[157]

Second, support from politicians continued even after the planning councils had been established. These politicians, who included some of the most important figures in the county, continued to promote participatory planning past the exciting moment of creation and during the slog of implementation. When the Samper government insisted that the CNP shut down after submitting its 1995 *concepto* and refused to fund the planning councils, these political leaders applied pressure on the Samper government. In early 1995, Álvaro Gómez Hurtado – one of the presidents of the 1991 Constituent Assembly and the head of the Conservative Party – stated "Planning, as we wanted it, would have become a powerful opportunity for participatory democracy. Yet planning was interrupted and still has not come to exist in its full form." (Forero et al. 1999: 7) Horacio Serpa Uribe, another president of the Constituent Assembly as the head of Samper's own Liberal Party, agreed and asked the Samper government to respect the functions of the CNP and acknowledge their role in the ongoing planning process (Forero et al. 1999: 7-8). Samper's own vice president praised the planning councils as the 1991 Constitution's "most concrete advancement in terms of expanding democracy" and advocated for the permanent oversight of the CNP and the National Planning System "to allow that citizens directly identify their needs, signal their priorities, put in place goals for state action; and to ensure that the people feel more like protagonists than spectators" (Forero et al. 1999: 3). Thus, we can see that there *was* a core level of political will among at least some politicians in support of the planning councils. And, as shown in Chapters 3 and 4, politicians in Brazil were reluctant investors in participatory policymaking. Political will was mixed for the sectoral cases in both countries, and thus cannot account for their divergent outcomes.

Another alternative explanation is that the planning councils failed to institutionalize fully because civil society organizations in Colombia are simply too weak to participate effectively and autonomously in the planning councils. Thus, the councils could never develop the legitimacy needed in institutionalization. The procedural nature of the planning reform is irrelevant; a content-based planning reform would have faced the same challenges.

Civil society resources play a central role in the institutionalization process, yet the outcome is not because Colombian civil society writ large is weaker than that of Brazil. Nor is it due to the inherent weakness of civil society in the planning sector when compared with Brazilian civil society in health and social assistance. Indeed, as Chapter 5 demonstrated, civil society in Brazil's social assistance sector was virtually non-existent at the time of the social assistance reform. Yet Brazil's social assistance councils are comparatively more institutionalized than the planning councils.

The successful experience of the Bogotá Cómo Vamos initiative demonstrates that Colombian civil society is indeed *capable* of acting autonomously and holding the government accountable, meaning that the stagnation of the planning councils is not simply due to the inherent weakness of Colombian civil society. Founded in 1998, Bogotá Cómo Vamos is an initative composed of the most influential societal figures in Bogotá, including the newspaper *El Tiempo*, the Bogotá Chamber of Commerce, and the Corona Foundation, among others. The organization collects data on policy implementation and policy outcomes, summarizes this data and makes it publicly available, and evaluates the municipal government's performance in

[157] Interview with Luis Emiro Valencia, ex-aide at the National Constituent Assembly, 16 September 2009.

implementing the local development plan and achieving other policy objectives. In other words, the functions of Bogotá Cómo Vamos are very similar to those of the Bogotá planning council – except Bogotá Cómo Vamos carries out these functions in an elite-centered, non-participatory fashion.

Bogotá Cómo Vamos is seen as a successful initiative in enhancing accountability, so much so that it has been replicated in nine other Colombian cities and in national health policy. Bogotá Cómo Vamos' success is particularly notable as a contrast with that of the planning councils, given their comparable purviews. When Bogotá Cómo Vamos issues its annual report evaluating the capital city's municipal government, they immediately have high levels of press attention. Moreover, the mayor's office demands that each secretariat produce a formal response to the criticisms lodged in the report. They mayor ignores the critiques and proposals included in this report at his/her own peril, since doing so would signal unresponsiveness and potentially corruption.[158] In other words, Bogotá Cómo Vamos has the legitimacy and inclusion in policymaking that has eluded the planning councils.

Why has Bogotá Cómo Vamos gained legitimacy and policymaking inclusion when the planning councils have not? In line with this study's argument, the initiative's success can be traced to its ability to mobilize resources. Bogotá Cómo Vamos has access to greater resources than the planning councils do. These resources afford them the expertise and man-hours needed to collect data and oversee government performance. Moreover, Bogotá Cómo Vamos is composed of organizations that have a high level of access and high legitimacy as pillars of public life in the capital. Participation of actors such as the Chamber of Commerce and *El Tiempo* confer legitimacy to the initiative and signal that its findings are to be taken seriously. Figures from the private sector and the press supported the planning councils during the 1990s, yet their support was passive. These elite organizations are central figures in Bogotá Cómo Vamos, and thus their backing carries more weight. Carlos Córdoba, the former Assistant Director of the CNP and current Director of Bogotá Cómo Vamos, attributes the divergence between the two initiatives to these factors:

> To do accountability work, you need to have a very high level of technical capacity. The participatory institutions don't work this way. They lack the autonomy and the institutional capacity to be effective in doing society oversight work. But Bogotá Cómo Vamos, composed of elite entities with many resources, with autonomy, and with a very high profile has this capacity. We are able to do a complete analysis of the government, and we have the public influence to guarantee that the government responds. […] In an ideal world, participatory institutions – which are much closer to the people – could do this kind of analysis and societal oversight. But this world doesn't exist in Colombia. You can only have societal oversight through elite organizations, those that have resources and influence. They are not democratic nor are they representative, but they are the only ones that have the capacity.[159]

[158] Interview withCórdoba, Director, Bogotá Cómo Vamos and former Assistant Director of the CNP. 20 October 2009.
[159] Interview with Carlos Córdoba, Director, Bogotá Cómo Vamos and former Assistant Director of the CNP, 20 October 2009.

The success of Bogotá Cómo Vamos signals that there *are* societal actors in Colombia that are strong enough to hold the government accountable – these actors just aren't doing so via the planning councils. The main problem for the planning councils was not that Colombian civil society is so weak that the resources needed for institutionalization did not exist. Bogotá Cómo Vamos was able to mobilize vital resources that were lacking from the participatory planning reform coalition.

These elite organizations and those in the participatory planning reform coalition shared the common objectives of reducing corruption and enhancing accountability. Why did the organizations contributing to Bogotá Cómo Vamos prefer to follow the route of an elite initiative rather than throwing their weight behind the fledgling planning councils? This study's emphasis on the substance of the reform project provides insights to explain this outcome. The broad and procedural nature of the planning reform provided few incentives for these elite organizations to join forces, since they did not *need* the planning councils to achieve their objectives. Unlike the organizations interested in the overall success of the health reform in Brazil, the only groups that had anything at stake with the planning reform were those interested in the planning councils themselves. Preferring to not be saddled down by the messy logistics of facilitating popular participation throughout the country, the elite organizations opted for the non-participatory but more effective Bogotá Cómo Vamos.

This chapter has demonstrated one way in which reform content can make later institutionalization difficult. For the planning councils, the procedural nature of the reform made it difficult to attract a broad reform coalition. Nevertheless, the planning councils were notable among Colombian participatory institutions for the presence of an active and engaged reform coalition. In fact, most Colombian participatory institutions were created in the absence of civil society mobilization. In the next chapter, we will examine the fate of Colombia's health councils, which lacked a reform coalition and ultimately failed to institutionalize altogether. That chapter will show that substantive policy reforms do not *necessarily* lead to the institutionalization of participatory experiments if the councils are not an integral component of that reform.

CHAPTER 7. COLOMBIA'S HEALTH COUNCILS: FAILED INSTITUTIONALIZATION WITHOUT PRO-PARTICIPATION REFORM LEADERS

1. INTRODUCTION

In addition to planning, health was recognized in the early 1990s as the area with the greatest potential for participatory policymaking in Colombia. The cities of Cali and Medellín already had experimented with participatory, community-based health projects in the 1980s. Sweeping health reforms in 1990 and 1993 extended these experiments to the rest of the country, mandating the creation of various participatory councils. These health councils included the community participation in health committees (copacos - *comités de participación ciudadana en salud*) and the National Health Council (CNSSS – *Consejo Nacional de Seguridad Social en Salud*). According to their design, these councils would incorporate civil society in designing and regulating health policy.

Colombia's health councils would prove even more difficult to institutionalize than the planning councils. After tepid investments in the 1990s, government support and civil society interest evaporated. The local-level copacos only existed in any meaningful way in handful of municipalities, and the CNSSS was eliminated entirely in 2007. Both government and civil society actors viewed the health councils as a colossal failure and a waste of time.

At first glance, this case appears to go against the argument that sweeping policy reforms facilitate institutionalization: the Colombian health reform was a sweeping one, yet these councils are even less institutionalized than the Colombian planning councils that arose through procedural reform. The case of Colombia's health councils reveals that a sweeping reform will not necessarily facilitate the institutionalization of participatory policymaking. Rather, institutionalization will only happen when the leaders of the reform coalition have a vested interest in having strong councils. Whereas Brazil's health and social assistance reform leaders viewed strong councils as crucial to achieving their substantive policy objectives, in Colombia the private sector actors that led the reform coalition would benefit more if the councils remained weak or non-existent.

Reform leaders are needed to ensure that the councils are embedded in the reform project, such that a failure to implement the councils would cripple the overall health of the reform in some way. This happened in Brazil, where surprising bedfellows came together in support of the health councils because doing so was key to achieving other reform goals. In Colombia, however, the health councils were tacked on to the broader health reform as a means of enhancing efficiency and not as a means of safeguarding the health reform itself. In fact, a reform coalition in support of the councils failed to form altogether without the backing of leaders that could bring together diverse stakeholders, thereby solving collective action problems. The absence of a pro-participation reform coalition meant that the government had few incentives to invest the material, human, and political resources needed for institutionalization. Orphaned by both state and societal actors, the health councils stalled and ultimately failed to become institutionalized.

This chapter reviews the creation, feeble implementation, and ultimately failed institutionalization of Colombia's health councils. The next section will compare Colombia's health systems before and after the reforms of the 1990s to demonstrate the sweeping nature of

the health reform. In the third section, I review the creation stage to show how Colombia's sweeping health reform was developed in isolation from civil society groups. Fourth, I examine the implementation stage, showing how construction of the health councils stalled in the years following reform in the absence a reform coalition to advocate for the new councils. The fifth section looks at the institutionalization stage where, we see the tepid support for the health councils disappear almost entirely. The result was a negative feedback effect in which both government and civil society actors withdrew their investment in the councils. The chapter concludes in the sixth section.

2. COLOMBIA'S SWEEPING HEALTH REFORM

Like Brazil's health and social assistance reforms, Colombia's health reform was a sweeping one. Prior to the reforms of the early 1990s, the Colombian health system shared a number of similarities with Brazil's old, centralized health system. Healthcare was restricted to those in the formal sector that contributed to social security and those that could pay out of pocket; the poor had few options for preventative healthcare and even fewer options for medical treatment. As summarized in Table 7.1, the reform of the early 1990s made health a right of all Colombians and restructured the health system around a market-based logic. This reform project would also provide a limited role for the health councils. The health system was supposed to be regulated by the market itself, leaving relatively few issues up for debate by the councils. Given the restricted scope of these councils under a market-based system, it is perhaps not surprising that the councils would not prove central for reform success, as we will see later in this chapter.

Table 7.1: Changes in the Objectives, Instruments, and Content of Colombian Health Policy

	Policy Objectives	Policy Instruments	Policy Content
Pre-Reform (1940s-early 1990s)	Health as a commodity for those who can pay; curative focus	Centralized; little societal input	Fragmented health system; limited coverage
Post-Reform (early 1990s-present)	Health as a commodity for all citizens	Societal input via participatory councils; health policy driven by market factors	Unified health system; universal coverage; greater role for private sector

2.1 The Pre-Reform Health System: Inequality and Exclusion

Before reform, Colombia's health system was characterized by massive inequalities. On one side were those who were part of the formal labor market. These Colombians either were included in the country's public social security framework or could afford to purchase their own health insurance. On the other side was the poor majority that depended on the country's second-rate public clinics and hospitals. They often paid large out-of-pocket expenses for health care, despite their limited means. Among the poorest quintile, more than half had no access to care whatsoever because they could not afford it. One quarter of the total population lacked access to health care because of limitations in the health infrastructure, human resources, and availability of medicines and other medical goods (Barón Leguizamón 2007). The health system was not a "system" in the sense of providing a coordinated series of programs and funding to

meet the overarching goal of providing health care to Colombians. Instead, it was a mishmash of uncoordinated and overlapping efforts that was regressive and provided few incentives for risk pooling, quality care, and broad coverage (Hernández 2002: 992).

The instruments of policymaking were centralized with little societal input. The Colombian state remained highly centralized until the decentralization reforms of the 1980s and 1990s. Consequently, Colombia's departments and municipalities had few responsibilities and little funding in health. Instead, health policy was designed and administered by the national government.

Health policy was also fairly insulated from societal pressures. The health system that operated in the 1970s and 1980s was the result of negotiations among a handful of organized economic and labor groups looking out for their particular interests. The result was a system that excluded the majority of Colombians (Hernández 2000). Once the system was set up, there was scant civil society input into the design of health policy. Historically, there has been little popular mobilization in health, in contrast to Brazil (Echeverry López 2000: 18). When a civil society group *was* involved in health policy, it was in narrow matters related to that group's self-interest. For example, health workers' unions advocated for higher salaries and better benefits for health workers, but did not mobilize behind questions related to the financing of the health system, or the development of public health initiatives, or how to improve emergency care. Instead, technocrats from the central government tackled these and other policy issues, buffered from popular pressures.

2.2 The Post-Reform Health System: Universal Coverage under Structured Pluralism

Reforms in the early 1990s introduced major substantive and procedural changes to Colombia's health system. The objectives of health policy shifted with the shift to universal coverage and a logic of marketization. The content of health policy also transformed as more Colombians were enrolled in the health system and market-based mechanisms were established. And, the instruments of policymaking changed, at least on paper, as civil society groups were given new roles in developing and regulating health policy.

Changes to the Objectives and Content of Health Policy

Colombia's health reform created the General System of Social Security in Health (*Sistema General de Seguridad Social en Salud* – SGSSS), which follows a fundamentally distinct logic than the old health system through its emphasis on universal coverage and a market-based logic. All Colombians – not just those in the formal sector, as before – would now be members of the SGSSS, with those who could afford to do so paying into the system and subsidizing the poor.[160] Both subsidized and contributing members select their insurance companies from a list of options, and also select their healthcare providers from within the insurer's provider network. This model, called "structured pluralism" (Londoño and Frenk 1997), is designed to harness the competitive pressures of the market with the goal of improving efficiency and the quality of care. The role of the state is restricted to investing in public health, setting the terms of competition for insurance companies and service providers, and regulating

[160] While all SGSSS members are unified under one system, there are distinct regimes for those that contribute and those that do not: the Contributory Regime and the Subsidized Regime. The national health plan is more limited for those in the subsidized system, and the two regimes each have distinct insurance companies (*Empresas Promotoras de Salud* – EPS) and service providers (*Instituciones Prestadoras de Salud* – IPS).

these entities. The focus on market mechanisms transforms the role of the state from one of service provision to one of market regulation.

SGSSS relies on market-based competition to expand coverage to the general population, increase the quality of services, and improve efficiency. Like other privatization schemes throughout the Latin American region, Colombia's SGSSS sought to increase competition among service providers. Unlike most other models, Colombia's SGSSS also stimulates competition at the level of insurance coverage. SGSSS members select their insurance providers from the list of approved insurers, choose service providers within their insurer's network, and receive a benefits plan that is purchased by their insurer from public and private service providers through contracts. Insurance companies earn money by enrolling as many individuals as possible into their network, and receive a set payment for each enrollee. Reimbursement rates for health care equipment, medication and services are set by the national level, so service providers should compete with one another on the basis of quality and not by cutting costs. Likewise, insurance companies should have an incentive to find the best quality service providers in order to attract the greatest number of enrollees in their insurance network.

The state also coordinates quality control mechanisms. This responsibility is carried out by the Superintendencia Nacional de Salud (SuperSalud), which monitors the activities of all insurance companies and service providers throughout the country. SuperSalud is charged with uncovering and investigating corruption and fraud, gaps in quality and healthcare access, and any other inappropriate health practices that violate the laws and SGSSS guidelines. According to the design of the SGSSS, there should be few problems with fraud and other types of malfeasance since market mechanisms will provide such strong incentives to provide high quality services. (As we will see later on, this optimism was misplaced.)

The government has a much more limited role in direct healthcare provision, and even in planning public health interventions – particularly when compared with Brazil. For example, Brazil might develop a national HIV/AIDS policy to plan HIV prevention and awareness, a distribution strategy to provide anti-retrovirals to HIV-positive individuals, and a national model of palliative care for those individuals in whom the disease has advanced. Colombia's efforts would be limited to some HIV prevention programs handled by the Ministry of Health, discussions about which HIV medications to include in the national health plan and reimbursement rates for these medications to insurance companies and service providers, and monitoring insurance companies and service providers to ensure that they provide this medication to their HIV-positive patients. The state plays an important role in both models, but its policymaking scope is broader under the Brazilian model.

Changes to the Instruments of Health Policy: Colombia's Health Councils

The health reform also changed the instruments of health policy by creating an array of participatory health councils at the local and national levels. The 1991 Constitution established the right to participation in health by the community. Article 2 of Law 100 of 1993 goes on to establish participation as one of the integral principles of the SGSSS. Moreover, Article 153 Defines participation as one of the fundamental precepts of public health and "the General Social Security System will stimulate the participation of beneficiaries in the organization and oversight of entities in the SGSSS. The national government will establish community oversight mechanisms over the entities that compose the System, and participation of community representatives will be obligatory in the executive boards of public entities."

To put this participatory component in place, the health reform created several different types of councils, in contrast with the other three sectoral cases. These councils work at different

levels of government and perform different functions, though there is considerable overlap in their areas of responsibility and prerogatives. Table 7.2 reviews the four main participatory institutions created in health, outlining the jurisdiction, composition, and responsibilities of each.

Table 7.2: Colombia's Overlapping Participatory Health Institutions[161]

	Jurisdiction	Composition	Responsibilities
Committees for Community Participation in Health (copacos)	Municipality/ neighborhood	• Local government • Community organizations • Service providers	• Contribute to the planning, budgeting, and oversight of public health and healthcare services • Mobilize community participation
National Health Council (CNSSS)	Nation	• National, subnational governments • Service providers • Health workers • Rural sector	• Determine services, medicines included in Obligatory Health Plan • Set reimbursement rates • Regulate insurance companies, service providers
Hospital Ethics Committees	Hospital/clinic	• Service provider • Health workers • Health system users	• Develop health promotion, prevention programs for service provider • Monitor service delivery quality • Aggregate, voice community complaints and demands
Municipal Health Councils	Municipality	• Local government • Service providers • Health system users	• Advise service providers on community needs, opportunities • Monitor implementation of programs defined by CNSSS

The main health councils, and the focus of this chapter, are the Committees for Community Participation in Health, known as copacos. The copacos were designed to be spaces of concertation that engage both state and societal actors. Participants include representatives from the secretary of health, community health organizations, and public hospitals and clinics. The copacos were charged with contributing to all aspects of local health policy, including planning, budgeting, and oversight of public health and healthcare in hospitals and clinics. The copacos also are charged with mobilizing the community and aggregating popular input. These general responsibilities have not been elaborated into more specific prerogatives in the regulatory framework.

It is important to note that the health reform created health councils, yet did not give these councils a key role in the continued elaboration of health policy. Whereas Brazil's health and social assistance councils had been granted central roles in safeguarding reform implementation, Colombia's health councils were designed to feed information back into the system. None of the councils were granted formal policymaking authority, and in practice their responsibilities only covered a small portion of the health system. Private sector actors are main players in Colombia's health system, and given this market focus less is on the table, particularly when compared to the Brazilian health system. As we will see later in this chapter, the tangential role of the health councils meant the most powerful actors with a vested interest in the reform –

[161] This table excludes two spaces for participation in health in the national legal framework: health users associations and *veedurías* (citizen watchdog groups). I exclude these two instances of participation from my analysis because they do not match this study's definition of a participatory institution, which requires direct engagement with the government in designing and implementing health policy.

insurance providers and service providers – did not need to have strong health councils in order to see their reform needs met.

3. THE ABSENCE OF PRO-PARTICIPATION REFORM LEADERS

While the sweeping nature of Colombia's health reform might have created favorable conditions for the councils, this potential was undercut by the absence of elite reform leaders in support of participatory policymaking. In each of the other three sectoral cases, a group of elite professionals lobbied for government investment while mobilizing stakeholders behind the new councils. In the case of Colombia's health reform, however, no comparable leadership stepped forward in favor of the councils. Reform backers included economists and private sector actors who had little interest in establishing strong councils. Indeed, these reform leaders stood to gain more if the councils remained weak, or absent altogether.

Unlike in Brazil, Colombia's health reform was not driven by a group of pro-participation health professionals, such as physicians or nurses. Health professionals might have served as the defenders of participatory health councils, especially given that community participation in health management is one of the main precepts of the global right-to-health movement. However, Colombia's right to health movement is quite weak – certainly weaker than Brazil's. In contrast to Brazil, the movement did not have a seat at the table in discussing the structure of the new health system.[162] With health professionals sidelined, there would be no one supporting empowered and explicitly political health councils that would not only provide feedback on the quality of service delivery, but would shape the agenda of the health reform.

With health professionals sidelined, health economists developed the Colombian health reform. And while the design of the Brazilian health reform was a participatory process, Colombia's reform was elaborated behind closed doors in a highly technocratic process. In the quest for an ideal health system, the Colombian government brought in foreign economists to review extant models from throughout the world. These experts supported the creation of participatory councils in the health system as a means of providing more feedback into the system.[163] Providing insurance companies and service providers with input from patients would help them better target their services, and therefore participation would increase the efficiency of the new health system. However, these experts did *not* support the establishment of participatory councils that would give societal stakeholders considerable say in designing health policy. Indeed, excessive societal input was seen as worsening the old health system as different interest groups mobilized on behalf of their own personal interest at the expense of the public interest.[164] The economists behind Colombia's new health system supported the construction of health councils with very limited responsibilities and without policymaking or budgetary authority. These health councils were not designed to serve as a site to fight for the construction of the new

[162] Interviews with Jaime Ramirez, Professor, Programa de Pós-Grado en Administración de Salud, Universidad Javeriana, 16 October 2009; Mauricio Torres, Dirección de Participación Social y Servicio al Ciudadano, Secretaría Distrital de Salud de Bogotá, 19 April 2010; and Luz Dary Carmona, Director, Dirección de Participación Social y Servicio al Ciudadano, Secretaría Distrital de Salud de Bogotá, 21 April 2010.

[163] Interview with Jaime Ramirez, Professor, Programa de Pós-Grado en Administración de Salud, Universidad Javeriana, 16 October 2009.

[164] Interviews with Jaime Ramirez, Professor, Programa de Pós-Grado en Administración de Salud, Universidad Javeriana, 16 October 2009; José Fernando Cardona, Former Bogotá Secretary of Health (2000-03), 20 October 2009.

health system, in contrast to Brazil's health councils, which were conceived as a means of safeguarding reform implementation.

Private sector groups, including insurance companies, private hospitals and clinics, and pharmaceutical companies formed the core of the health reform coalition in Colombia. These actors had a considerable economic interest in the new health system. Using formal and informal channels, these groups applied pressure on the government to ensure that the components most to their benefit would be implemented. Thus, these groups were quite active in decisions related to what services and medicines would be covered in the national health plan, and the size of reimbursement rates from the government to insurance companies and from insurance companies to service providers.[165] The health reform coalition was less involved in developing information and monitoring systems, and the construction of participatory health councils. Indeed, these private sector groups had a clear disincentive to having strong state and societal oversight of the health system, since they were the ones facing oversight.[166]

Without pro-participation reform leaders, a reform coalition never formed to advocate for the participatory health councils. As we will see below, the absence of these leaders would hinder the creation of an empowered legal framework for Colombia's participatory health councils. The lack of a reform coalition also impeded the implementation of that legal framework, leading to the failed institutionalization of the health councils.

4. CREATION OF THE LEGAL FRAMEWORK: NARROW RESPONSIBILITIES (1990-1993)

Unlike the other sectoral cases, Colombia's health councils were created in the absence of any pro-participation reform coalition. Experts, primarily economists, designed the health reform behind closed doors. These experts included health councils in the reform because they believed that popular input would enhance the efficiency of the new health system. They were not created an organized social movement demanded new participatory spaces in health. The purpose of the new councils was to incorporate local knowledge into and enhance oversight of healthcare, with the aim of making the new market-based health system operate more efficiently. Implicit in this design was that the system itself would not be up for debate and that popular participation would aid policy implementation more than policymaking. Consequently, the health councils were not given formal policymaking authority and had a narrow scope of responsibility. This weak institutional design reflects the absence of a reform coalition looking to shape health policy via the councils.

4.1 Early Health Reforms

Initial steps towards health reforms were taken in 1990 and 1991. Law 10 from 1990 restructured the National Health System, the health system preceding the SGSSS. This law took

[165] Interview with Enrique Peñaloza, Director del Grupo de Política y Economía de la Salud, Centro de Proyectos para el Desarrollo – CENDEX/Universidad Javeriana, 15 September 2009; Arleth Mercado, Coordinator of Development and Research, GestarSalud, 28 June 2010; Elisa Carolina Torrenegro, Executive Director, GestarSalud, 28 June 2010.

[166] Interviews with Dagoberto Gómez, Delegada para la Protección al Usuario y la Participación Ciudadana, SupserSalud, 2 August 2010; Mónica Valdes, Fundación Colombia Multicolor, 9 July 2010; Jaime Ramirez, Professor, Programa de Pós-Grado en Administración de Salud, Universidad Javeriana, 16 October 2009.

major steps in decentralizing the health system, expanding its coverage, and introducing participatory mechanisms. Article 3 of Law 10 states that "the community has the right to participate in the diagnosis, formulation, and elaboration of [health] plans, programs, and projects; decisionmaking; and the administration and management of healthcare." The main participatory institution in health, the copacos, was created with Law 10. The participatory nature of Colombia's health system was reinforced the following year with the passage of the 1991 constitution, which declares in Article 49: "Healthcare will be organized in a decentralized form by levels of attention and with community participation." Despite the attention paid to participation in these legal documents, no popular movement had formed to press for participatory policymaking in health.

4.2 Creating a Weak Legal Framework: The 1993 Health Statute

The bulk of the health reform came with the passage of Law 100 in 1993. Law 100 was developed in a highly technocratic fashion. The government contracted economists, particularly those from Harvard University, to develop a new healthcare system for Colombia that would incorporate best practices from other countries' healthcare models. Experts were needed to safeguard efficiency and effectiveness in the new health system; stakeholders had little say in the process.

One Colombian economist involved in the process explained that they sought to exclude societal groups from the reform process because these groups would just seek out particularistic benefits for their own category of people at the expense of the general public.[167] Insulation from civil society groups did not mean that the health reform process would be designed in isolation from *all* societal groups, however. Stakeholder groups that had valuable input included doctors' associations, service providers, and other private sector groups. Groups with less legitimacy that were seen as corrupting to the system included health workers' unions, which might seek higher wages and benefits at the expense of the health system, and patients' groups that might demand special benefits for their members that would undermine the goal of equity.

After the experts had developed the proposal for Colombia's news structured pluralism health system, the government then took this proposal to the "legitimate" stakeholder groups to hammer out details. The resulting agreement was known as the Pacto Quirama, which established a structured pluralist model that would cover all Colombians.[168] Participating groups included economic associations (such as the Colombian Coffee Federation), government bureaucracies active in the old health schema, hospitals, and subnational governments. Behind closed doors, technocrats set the agenda and developed the proposals debated at the Pacto Quirama meetings. The closed nature of Colombia's health reform contrasts sharply with that of Brazil, in which a broad array of stakeholder groups – including grassroots actors – developed proposals and drove the reform process.

The Pacto Quirama reform project was translated into legislation with Law 100 of 1993, the Health Statute. Law 100 was followed by Decree 1757 of 1994, which outlined the specific structure and responsibilities of the various health councils. Once again, this decree was

[167] Interview with Jaime Ramirez, Professor, Programa de Pós-Grado en Administración de Salud, Universidad Javeriana, 16 October 2009.
[168] Interview with Jaime Ramirez, Professor, Programa de Pós-Grado en Administración de Salud, Universidad Javeriana, 16 October 2009.

developed in a technocratic fashion, in isolation from major stakeholder groups.[169] Thus, at the end of the creation period, the health councils had gained a weak institutional design that granted the councils minimal responsibilities and policymaking prerogatives.

5. IMPLEMENTATION (1994-2002)

Colombia's health councils made only minor advancements during the implementation stage. The health councils entered this stage already in a difficult position, given the weakness of their institutional design and the lack of a reform coalition. The national government made some initial investments of material and human resources into the councils, but ultimately failed to take the next steps involved in constructing and enforcing a regulatory framework behind the councils. At the end of the implementation stage, both state and societal actors began to grow pessimistic about the capacity of these councils to play a meaningful role in health policy, which would lead to their further decline in the institutionalization stage.

As implementation began, no clear reform coalition existed in support of empowered health councils, and no reform coalition would coalesce during the implementation stage. As mentioned earlier, the main reform advocates – technocrats and private sector actors – did not support strong health councils. In fact, the private sector actors had clear economic incentives to *oppose* the construction of strong health councils. And unlike in the case of Colombia's planning councils, NGOs did not mobilize support behind the construction of the health councils. Some NGOs, such as the Corona Foundation and Foro por Colombia, did provide some technical support of the councils. However, these groups chose to focus their energies on the planning councils rather than the health councils. Consequently, there was no pro-participation leadership mobilizing grassroots actors into the councils and applying pressure on governments. While community health movements formed in some locations, Colombia failed to develop a strong right-to-health movement – a movement that had proven crucial for institutionalization in the Brazilian case.

Despite the lack of civil society mobilization, the national government did make some early investments in the health councils. As mentioned in Chapter 5, the Samper administration (1995-98) emphasized participation as one of its priorities and developed an inter-sectoral strategy to support participatory institutions. Health was included in this strategy. The Ministry of Health placed support for the participatory health councils high within its organizational structure with the creation of the Sub-Department for Social Participation. Creating a sub-department signaled a degree of investment in the health councils, given that only departments were higher on the Ministry's organizational chart. The Ministry of Health assigned approximately 30 staff members to work in the Sub-Department for Social Participation, which was charged with providing technical assistance to subnational governments looking to create health councils and producing training materials for governments and new councilors. The office produced documents such as "The Municipality, Health, and You" and "A Manual for Concertation in Local Health Plans," which explained how participatory health councils should operate and reviewed the process of policymaking in the new health system (Ministerio de Salud - Colombia 1997d, 1997c, 1997b, 1997a).

[169] Interview with Jaime Ramirez, Professor, Programa de Pós-Grado en Administración de Salud, Universidad Javeriana, 16 October 2009.

These efforts notwithstanding, the national government failed to make the more costly investments needed to construct a national system of health councils. For example, the government did not expand upon the regulatory framework established with Decree 1757 of 1994, which only outlined the councils' basic functions and left the different types of health councils with overlapping jurisdictions and responsibilities.[170] The central government provided assistance for those subnational governments that actively pursued participatory health councils. However, it did not monitor compliance, nor did it establish enforcement mechanisms. Truly constructing an empowered regulatory framework for the health councils – one that challenged municipal governments to shift interest representation in their communities – would have involved real political costs. The government was not eager to face these costs, particularly without a reform coalition pressuring it to do so.[171]

Government investments meant that the number of health councils *did* expand throughout the 1990s, yet these councils never even reached 50% of municipalities. As of 1998, there were only 12 municipal health councils (CTSSS - *Consejos Territoriales de Seguridad Social en Salud*) in the whole country (Echeverry López 2000: 18). In a 2002 survey, there were hospital ethics committees established in 31.4% of municipalities, CTSSS in 35% of municipalities, and copacos in 36.8% of municipalities (Velásquez and González 2003: 434). Colombia's various health councils stagnated because the national mandate was really not mandatory at all, but rather left to the governments that were interested in the councils.

In sum, at the end of the implementation stage we see some construction of Colombia's various health councils, yet on net the institutional infrastructure behind these councils remained weak. Funding was limited, the regulatory framework remained unclear, enforcement mechanisms were non-existent, and compliance was mixed. Moreover, the lack of a reform coalition left the health councils in an unstable political position, since their implementation depended almost entirely on government interest in participatory health policymaking. As we will see in the next section, this weak political position would result in a failure to become institutionalized.

6. INSTITUTIONALIZATION (2003-2010)

In the institutionalization stage, negative feedback effects set in as both state and societal actors grew increasingly pessimistic about the value of the health councils. In the implementation stage, support had been tepid but at least sufficient to garner some investments in the councils. This support would collapse in the mid-2000s. The health councils failed to become institutionalized, in terms of both routinization and infusion with value. Routinization was negligible, given the lack of a clear regulatory framework, the paucity of funding for the councils, and an almost complete lack of compliance with the participatory mandate. The health councils also had low infusion with value, since the few councils that existed could not credibly claim to represent the public interest, and were excluded from policymaking processes.

[170] The regulatory framework *did* advance with the passage of Law 715 of 2001, which differentiated some of the responsibilities of the three levels of government in promoting participation. Nevertheless, much of the provisions established in Law 715 never went into effect. For example, earmarks for participation were never set up in the intra-government transfer system.

[171] Interview with Janette Bonilla, Dirección de la Gestión de la Demanda en Salud, Ministerio de Protección Social, 21 October 2009.

6.1 Negligible Routinization

The health councils became *less* routinized, rather than more routinized, during the institutionalization stage, using the three criteria of routinization used in this study: the elaboration of a regulatory framework, government funding, and compliance with the regulatory framework.

First, the regulatory framework remains vague on the rights and responsibilities of the different participatory health councils vis-à-vis the government. One person who has spent 30 years working to strengthen social movements and popular participation in politics explained that "there isn't a clear focus in what participation even means, what it looks like."[172] There is considerable overlap in the responsibilities and authorities of the various local participatory institutions, which has led to confusion about the roles of different participatory institutions and how each should be linked to the state. Enforcement mechanisms behind the mandate for participatory health councils are non-existent. And unlike in planning, the judiciary has not ruled that the health councils must be implemented.

Second, government funding to support the health councils declined during the institutionalization stage. Whereas in the late 1990s, the Ministry of Health had an entire sub-direction dedicated to supporting participatory processes in health, this sub-direction was downgraded on the organizational hierarchy to an office, and then was eliminated altogether.[173] Currently, responsibility for participatory health councils is left to the Ministry of Social Protection's beleaguered Subnational Government Support Group (*Grupo de Apoyo Territorial*) – far down the institutional hierarchy.[174] With a staff of four, this group is charged with providing technical assistance to Colombia's subnational governments in *all* aspects of managing the health system. This group is responsible for complex tasks such as contracting with local insurance companies and service providers, monitoring the quality of service delivery, registering poor families into the subsidized insurance system, leaving the group's staffers with little time to provide technical assistance to support participatory policymaking in health, and their help is restricted to sending basic information about the (vague) regulatory framework for councils to governments that ask for such information.[175] They do not actively monitor implementation of the participatory mandate, nor do they provide training for subnational governments or civil society groups seeking to participate in the health system.

Third, compliance with the participatory mandates in health fell from their already mediocre levels during the institutionalization stage. The lack of government investment in the health councils means that reliable (or even unreliable) statistics on council implementation are not available, since the government does not monitor council implementation. In an informal survey of Colombian municipalities, Ministry officials found that the copacos only exist and operate in any meaningful way in 14 municipalities – in Bogotá and in the small department of

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[172] Interview with Marta Tamayo, program officer with GTZ, former staff of international NGO, former advisor to the Human Rights Ombudsman and Ministry of Culture, 26 October 2009.

[173] Interviews with Janette Bonilla, Dirección de la Gestión de la Demanda en Salud, Ministerio de Protección Social, 21 October 2009 and Leonardo Cubillos, Director, Dirección de Gestión de la Demanda en Salud, Ministerio de Protección Social, 16 October 2009.

[174] Interview with Mauricio Torres, Dirección de Participación Social y Servicio al Ciudadano, Secretaría Distrital de Salud de Bogotá, 19 April 2010.

[175] Interviews with Pilar García, ex-Director of the Grupo de Apoyo Territorial, Ministerio de Protección Social, 19 May 2010; Osvaldo Sierra, technical advisor, Grupo de Apoyo Territorial, Ministerio de Protección Social, 22 June 2010; and Rosedelia Usme Sabogal, technical advisor, Grupo de Apoyo Territorial, Ministerio de Protección Social, 22 June 2010.

Risaralda in the coffee region.[176] In fact, the director of the Subnational Support Group stated that the participatory framework should be thrown out and redrawn because compliance was non-existent.[177] Clearly, Colombia's health councils have failed to become routinized.

6.2 Low Infusion with Value

The Colombian health councils have also failed to become institutionalized in the sense of value infusion, meaning the health councils are not respected and valued inherently. I focus on two aspects of infusion with value: the legitimacy of the councils, and the extent to which they are included in the policymaking process. A participatory institution with high legitimacy would be accepted by all major stakeholders in the policymaking process as a space that advances the public interest and makes policymaking more democratic and representative of citizens. A participatory institution that is included in policymaking will go beyond the formal requirements outlined in the legal framework to actually have a seat at the table in policymaking discussions and decisionmaking. Colombia's health councils fare poorly on both counts.

The health councils have low levels of legitimacy and are seen as ineffective at best, and corrupt at worst. This perception of corruption represents the greatest challenge to the councils' legitimacy. The most respected civil society groups do not participate in the health councils, since the councils have so little power.[178] Those participating on the few councils that do exist are perceived to be seeking their own private interest, at the expense of the public interest. Countless respondents from diverse backgrounds raised this critique, alleging that people would participate on the copacos or hospital ethics boards were bought off by service providers or insurance companies. Respondents explained that councilors would offer to vote in favor of a proposal supported by the insurance company/service provider, in exchange for some material gain. For example, the hospital might offer a job at the hospital to the councilor (or a family member of the councilor) in exchange for the councilor's support for a cut in public outreach funds.[179] The problem of corruption is worsened given the lack of term limits for councilors which deepens the clientelist relationship over time and leaves few openings for new perspectives. Copaco councilors themselves admit that co-optation is a common problem.[180]

Even when not corrupt, many view the councils as incapable of advancing the public interest. According to this perspective, councils will not be as capable of developing proposals and analyzing implementation as experts from the government or more elite organizations.[181] A former secretary of health for Bogotá explained that while participatory policymaking in health

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[176] Interviews with Pilar García, ex-Director of the Grupo de Apoyo Territorial, Ministerio de Protección Social, 19 May 2010; Osvaldo Sierra, technical advisor, Grupo de Apoyo Territorial, Ministerio de Protección Social, 22 June 2010.

[177] Interview with Pilar García, ex-Director of the Grupo de Apoyo Territorial, Ministerio de Protección Social, 19 May 2010.

[178] Interview with Jaime Ramirez, Professor, Programa de Pós-Grado en Administración de Salud, Universidad Javeriana, 16 October 2009.

[179] In interviews, many respondents from diverse backgrounds described this pattern; some respondents include Osvaldo Sierra, Grupo de Apoyo Territorial, Dirección de Planeación, Ministerio de Protección Social, 22 June 2010; José Fernando Cardona, Former Bogotá Secretary of Health (2000-03), 20 October 2009; Elsa Victoria Henao, Chief, Área de Salud, Fundación Corona, 8 September 2009; José Villamil, Veedor Nacional de Saúde, 22 October 2009.

[180] Interview with José Vicente Pachón, councilor, Comité de Participación Comunitaria – Bogotá, 22 July 2010

[181] Interviews with Elisa Torrenegro, Executive Director, Gestarsalud, 28 June 2010 and Leonardo Cubillos, Director, Dirección de Gestión de la Demanda en Salud, Ministerio de Protección Social, 16 October 2009, among others.

sounds nice in theory, in practice it is difficult to carry out due to the weak capacity of councilors. Councilors continually demand more and more clinics, even when creating more clinics would weaken the overall performance of the health system.[182] Thus, giving the councils a greater role in policymaking would mean distorting the health system's capacity to respond to the public's needs and priorities.

The weak legitimacy of the health councils can be seen in the lack of support from pro-democracy NGOs. The Corona Foundation is a reputable philanthropic organization that is known for its support of participatory processes and community development – yet the foundation does not invest in or work with health councils. The head of the Corona Foundation's health program explained that the organization believed that investing in the health councils would be a poor use of funds since the councils are so weak and so many are corrupt. The foundation ultimately decided that it would be wiser to invest in the elite-led Así Vamos en Salud, a replica of Bogotá Cómo Vamos for the health sector. Así Vamos en Salud collects and analyzes data on the country's health system and disseminates this information to the media and the public at large. Así Vamos en Salud is elite-led and has no participatory component, yet the Corona Foundation believes that this approach can promote participation better than the health councils because at least Así Vamos en Salud can produce useful information and analysis.[183]

The health councils also perform poorly on the other measure of infusion with value: inclusion in the policymaking process. Stating a common perception, the former director of the Office of Participation in Bogota's Health Secretariat asserted: "in health, I think that honestly there is no real participation of the community in the formulation of public policy."[184] A top health official in the Ministry of Social Protection agreed, arguing that Colombia's health system seems fairly participatory on paper, but in practice the participatory councils have no power. [185]

Some argue that the low inclusion of the health councils in policymaking is inevitable, given the market-based logic of the system. The health system user does not participate as a citizen, as in Brazil, but rather as a client of service providers and insurance companies. One activist explains:

> [The copacos] monitor a tiny part, service delivery in the public sector, but the rest of the system is not there – it's in the private insurance companies and private service providers, and participation doesn't fit there. They were replaced with a different framework based on beneficiary groups in which participants are clients, not citizens.[186]

Even those less critical of the market-based model of health agreed that the health councils could not gain a major policymaking role due to their paucity of prerogatives. The person currently in charge of participation for the Bogotá municipal secretary of health explained: "the government

[182] Interview with José Fernando Cardona, Former Bogotá Secretary of Health (2000-03), 20 October 2009.
[183] Interview with Elsa Victoria Henao, Chief, Área de Salud, Fundación Corona, 8 September 2009.
[184] Interview with Helena González, Chief of Participation (1995-2006), Secretaría de Salud de Bogotá, 22 October 2009.
[185] Interview with Leonardo Cubillos, Director, Dirección de Gestión de la Demanda en Salud, Ministerio de Protección Social, 16 October 2009.
[186] Interview with Diego Álvarez, Contraloría Delegada para la Participación Ciudadana, Contraloría General de la República, 6 April 2010.

[of Bogotá] supported the coapcos and invested in them. But the responsibilities of the copacos are still at a very micro level, so they did not have much capacity for real influence."[187]

Governments fail to grant the health councils a major policymaking role because doing so yields no clear benefits. The perceived lack of representativeness means that gaining health council approval of an initiative yields little legitimation for the government. Moreover, this low representativeness suggests that the health councils cannot even provide useful information to the government about the needs and interests of the community.[188] One former Ministry of Health employee explained that it usually is not worth it for governments to invest in participatory health councils and provide them with access. Doing so requires considerable investments of time, staff, and money – yet will only yield more problems for the government, which has only limited discretion and resources under the health system and cannot meet people's seemingly infinite demands.[189] According to this logic, why would a government open itself up to criticism when it doesn't have the capacity to change anything?

7. CONCLUSION

This chapter has shown without elite leadership backing empowered participatory councils, sweeping reform alone will not result in institutionalization. Like the Brazilian councils, Colombia's health councils were established as part of a sweeping policy sector reform that not only created health councils but also changed the objectives and content of health policy. Unlike the Brazilian cases, however, this sweeping reform did not result in the formation of a reform coalition that advocated for strong health councils. Instead, the reform's designers and supporters preferred to have weak councils (or no councils at all). Missing were the elite professionals that mobilized support behind the councils – leaders that were so influential in the other three sectoral cases. Without this leadership, a reform coalition backing the health councils failed to develop, and thus could not apply pressure on the government to invest material, human, and political resources in the councils. As a result, negative feedback effects kicked in that further discouraged both state and societal actors from investing in the health councils. Colombia's participatory health councils failed to become institutionalized either in terms of routinization or infusion with value.

While the health councils have failed to become institutionalized, there has been more success with other participatory mechanisms that rely more on the legal system rather than concertation with the government (Echeverry López 2000). The growth of these mechanisms for participation suggests that the failure of the health councils was not inevitable and that Colombians do act politically to shape health policy. In one mechanism, individuals can file *tutelas*, or legal suits against the government, when the government, insurance companies, or service providers failed to meet their rights as users of the health system. In 2005, 224,270 *tutelas* were filed in the area of health – 36.12% of all *tutelas* filed that year (Procuradoría General de la Nación and Dejusticia 2008: 151). With *veedurías*, citizens and civil society groups formed watchdog groups to monitor implementation of the health system and trigger legal proceedings in case of malfeasance. The *veedurías* began to spread precisely because of

[187] Interview with Helena González, Chief of Participation (1995-2006), Secretaría de Salud de Bogotá, 22 October 2009.
[188] Interview with Helena González, Chief of Participation (1995-2006), Secretaría de Salud de Bogotá, 22 October 2009.
[189] Interview with Mónica Valdes, Fundación Colombia Multicolor, 9 July 2010.

the lack of government investment in the copacos and other health councils.[190] The *veedurías* are more linked into the legal system and do not presume government collaboration, making it easier to demand data, documents, and other information needed to monitor health policy. The spread of the *tutela* and the *veedurías* show that Colombians do have an active interest in seeing changes in the health system, and are willing to participate politically to push for these changes – even if they do not use the health councils to do so.[191]

The case of the Colombian health councils provides a crucial test of this study's causal mechanism. While other chapters point to the importance of sweeping sectoral reforms that can mobilize stakeholders behind the health councils, this chapter examines how exactly sweeping reforms can give rise to pro-participation reform coalitions – and why they sometimes fail to do so. If the councils are not given a key role in securing implementation of the sweeping reform and protecting it from potential reform opponents, the councils will not become a site for the broader reform coalition to coalesce. The Colombian health councils highlight the vital role that pro-participation leaders can have in setting the reform agenda and positioning participatory councils at the center of reform battles.

[190] Interview with Pilar García, former Director, Grupo de Apoyo Territorial, Ministerio de Protección Social, 19 May 2010.
[191] Interview with José Vicente Pachón, councilor, Comité de Participación Comunitaria – Bogotá, 22 July 2010.

CHAPTER 8: PARTICIPATORY INSTITUTIONS AND INTEREST REPRESENTATION

1. INTRODUCTION

This project explores the ways in which interest representation, and the nature of democratic governance, is changing in Latin America. The issue of which interests gain a voice and representation in democratic politics is a central one in political science. Questions about the equality of interest representation and shifts in representative structures are particularly poignant in Latin America. Historically, the region has struggled to incorporate the masses in democratic politics. Indeed, in the 1960s and 1970s many Latin American countries experienced coups and prolonged military rule under the strain of these incorporation attempts. While popular incorporation has proven challenging, it is also essential for the region, given its high levels of poverty and inequality.

Participatory institutions can provide an opportunity for voice and access both to marginalized groups that previously enjoyed neither, as well as to groups that *have* enjoyed state access. Participatory institutions change the location, stakes, and rules of the game in interest representation. Thus, the shift towards participatory policymaking marks a significant development in interest representation in Latin America *even if* these participatory institutions fail to enhance the equality of representation. Participatory institutions may not always succeed in enhancing the equality of representation, but this does not mean that they do not succeed in representing interests.

This project moves beyond investigations of how to engineer successful participatory institutions to look at the larger question of how participatory institutions are constructed and how they gain a seat at the table. How can participatory institutions go from being a utopian idea to being concrete and operational state institutions? When do reform coalitions of stakeholders form that are capable of successfully pressuring the government to invest in these councils? How can this reform coalition be sustained over time, leading positive feedback effects that can entrench the institutional role of these participatory councils? In sum, when, how, and why do participatory institutions take root and transform patterns of interest representation?

To address these questions, I incorporate themes from the policy reform and institutional change literature that highlight how public policy itself can shift political dynamics in a policy sector. This dissertation has argued that the larger reform project matters: participatory institutions embedded in sweeping reforms that shift the substantive objectives and content of public policy can attract the diverse reform coalition needed for institutionalization, as we saw in Brazil. In contrast, participatory institutions are doomed when they are created in a procedural reform focused primarily on deepening democracy. This was the case in Colombia, where only those supporters that supported participation for the sake of participation mobilized in defense of the councils, and this narrow reform coalition was limited in pressuring the government to support the participatory framework.

This chapter will review this study's argument, highlighting the importance of substantive sectoral reforms and elite leaders in mobilizing the reform coalitions needed for institutionalization. I also discuss the implications of this study for larger questions of interest representation and democratic quality.

2. EXPLAINING DIVERGENCE IN INSTITUTIONALIZATION

This project utilizes an approach from the policy reform and institutional change literatures, summed up as "policy creates politics." I have demonstrated that nationally-mandated participatory institutions will only take root when they can be tied to larger substantive policy reforms. While the *creation* of participatory institutions may reflect a shift in the democratic regime, the *institutionalization* of these experiments is more a question of interest group politics than regime change. Below, I review this study's argument that the combination of sweeping policy reforms and reform leaders with a vested interest in having strong councils can spark the broad reform coalitions needed for institutionalization.

2.1 Reviewing the National Cases: Brazil and Colombia

While Brazil and Colombia both adopted expansive participatory policymaking frameworks in the early 1990s, the two countries followed very distinct paths. Each rewrote its constitution to emphasize the centrality of popular participation in democratic governance, and each followed up by establishing dozens of different participatory institutions across a range of policy sectors. After creation, Brazil's participatory institutions gained a major role in the policymaking process and spread into new areas, while those in Colombia stayed more on paper than in reality. The national level comparison between Brazil and Colombia highlights how proposals for participatory policymaking enter into the political agenda, and how these institutions spread across different policy areas.

In Chapters 2 and 5, I demonstrated that the different trajectories of participatory policymaking in the two countries stemmed from the legitimacy crisis that inspired the councils. In Brazil, participatory policymaking was adopted in response to the dual legitimacy crises of a lack of political inclusion and a lack of social inclusion. To redress these crises, social rights reforms would extend the reach of the state to include all Brazilians, and would inject popular participation into the state in the form of participatory councils. The marriage between participatory institutions and other substantive public policy changes would later prove crucial in garnering the stakeholder support needed for institutionalization. In contrast, Colombia's participatory institutions arose due to a crisis of political exclusion but without the crisis of social exclusion. Participatory institutions were established to open up the policymaking process to new voices, but were not tied to major substantive policy reforms. Consequently, only those groups with a direct stake in the success of these councils mobilized behind them; missing were the diverse stakeholders that were brought together by Brazil's sweeping reforms.

As time went on, participatory policymaking gained increased legitimacy as a model of public administration in Brazil, while it became more discredited in Colombia. Today in Brazil, a failure to invest in participatory institutions would be seen as authoritarian behavior. Governments create new councils to underscore their commitment to good governance. As a result, participatory policymaking spread to new policy areas in Brazil. In contrast, Colombia's participatory institutions failed to spread and even contracted as both government and civil society groups grew increasingly pessimistic about the capacity of the councils to contribute to the policymaking process in any meaningful way. Governments faced little incentive to invest scarce resources in the councils, and certainly would not gain by creating new ones.

2.2 Reviewing the Sectoral Cases: Health, Social Assistance, and Planning Councils

While the national comparison enabled us to discern macro trends in construction of participatory policymaking, a more micro level approach is needed to understand the mechanisms behind institutionalization. To this end, this study examined closely the trajectory of participatory institutions in different policy sectors. For each country, I selected two sectoral cases that varied in the degree of institutionalization. On net, participatory policymaking had great success in Brazil, yet the health councils are more institutionalized than their counterparts in social assistance. And while Colombia has struggled to implement its participatory institutions, the planning councils managed to become at least partially institutionalized, while the Colombian health councils failed to institutionalize altogether.

To account for these divergent outcomes, the sectoral comparison highlighted the importance of broad reform coalitions composed of diverse stakeholders in the sector. On their own, governments will be reticent to sustain investment in the participatory councils, yet will do so if pressured by a reform coalition that can mobilize a range of resources. To explain why broad reform coalitions coalesce behind participatory councils in some situations but not others, this study has highlighted two explanatory factors: the introduction of a sweeping policy sector reform that mobilizes stakeholders behind both participatory and substantive reform elements, and the involvement of elite reform leaders in mobilizing these reform coalitions behind the councils. Moreover, the contrast between Brazil's health and social assistance councils reveals that greater coherence among the reform coalition leads to greater legitimacy for the councils in their claim to represent the public interest, and consequently results in higher value infusion.

As outlined in Chapter 3, Brazil's health councils arose as part of a sweeping reform that was backed by pro-participation health professionals. These leaders helped mobilize a reform coalition of beneficiaries, health workers, and subnational governments in support of both the substantive changes to health policy and the creation of the health councils, which would serve as the site for battles about reform implementation. This broad and coherent reform coalition was able to advocate for a strong institutional design for the councils, and successfully pressured governments to invest material, human, and political resources into the health councils, ultimately resulting in their institutionalization.

Chapter 4 reviewed the case of Brazil's social assistance councils, which emerged as part of a sweeping reform that was supported by pro-participation social workers and professors. These reform leaders helped mobilize a reform coalition of beneficiaries, social workers and other professionals in the sector, service providers, and subnational governments behind the implementation of the social assistance councils. While the reform coalition was broad, it lacked the coherence seen in the case of Brazil's health councils due to ideological divides between the original reform leaders and service providers. Though divided, the broad reform coalition successfully pressured Brazil's governments to invest in the councils. As a result, the social assistance councils became highly routinized but only moderately infused with value, since divisions in the reform coalition challenged the councils' legitimacy as the voice of the public interest.

Chapter 6 profiles Colombia's planning councils. The planning councils were established through a procedural reform that created new spaces for participation, but did not alter the substance of planning itself. A group of pro-democracy NGOs allied together to push for the creation and construction of the planning councils, mobilizing community organizations in the process. However, other stakeholder groups, such as unions, planners, economic associations, and subnational governments did not mobilize behind the planning councils. Thus, the reform

coalition was narrow and limited in its capacity to pressure the government to invest in the councils. On the other hand,the reform coalition did have some success in advocating for the councils and constructing the councils themselves, leading to partial routinization and infusion with value, rather than a failure to institutionalize altogether.

Finally, in Chapter 7 we examined Colombia's health councils. The Colombian health councils were created in conjunction with a sweeping reform that established a universal, market-based health system. In contrast to the other three cases, there were no pro-participation reform leaders to advocate for the construction of the health councils; the reform was designed by technocrats contracted by the government. These technocrats included councils in the reform as a means of enhancing efficiencym but not as a site of contestation about the design and implementation of health policy. Private sector service providers, the stakeholders advocating for the reform, did not push for strong health councils. After all, they were the ones that would be overseen by the councils. Without a reform coalition mobilized in support of the health councils, the government failed to invest, giving rise to negative feedback effects that ultimately resulted in low routinization and low infusion with value.

3. PARTICIPATORY POLICYMAKING AND THE CHALLENGES OF INTEREST REPRESENTATION

This study makes important contributions to the study of interest representation and democratic governance. Scholars and policy practitioners have asserted that participatory institutions can deepen democracy by amplifying the voice of new groups. Critics, in turn, warn that participatory councils actually worsen democratic quality by replicating previously existing power dynamics. According to this pessimistic view, participatory institutions can legitimize undemocratic practices and confirm citizens' beliefs that the political system does not – and cannot – represent their interests, thereby reinforcing apathy and atomization. Based on the findings of this study, I contend that participatory institutions can both enhance *and* weaken the equality of interest representation – often at the same time. Below, I outline the implications of this study in understanding the potential of participatory policymaking to deepen democracy and improve equality in interest representation, and the sustainability of this model over time.

3.1 Do Participatory Institutions Deepen Democracy?

Participatory institutions do not uniformly enhance or weaken equality of interest representation. Both Brazil and Colombia provide examples in which participatory councils have provided access to new groups, as well as examples in which councils have reinforced anti-democratic practices. Like many existing studies, I show that the answer to the question of whether participatory policymaking serves to deepen democracy is: "It depends." Nevertheless, this study makes important contributions to the study of *how* it depends.

It is undeniable that participatory councils have provided avenues for interest representation to groups that lacked access in the past. In Brazil, the participation of these new actors is particularly noticeable at the national level. On the National Health Council, these groups include the new patients organizations such as the Brazilian Celiacs Association and the Federation of Brazilian Renal and Transplant Organizations, and groups that had not previously been involved in health policy, such as the LGBT movement, urban popular associations, and environmental groups. Likewise, the National Social Assistance Council includes

representatives from the nascent homeless movement, professional organizations previously uninvolved in social assistance (such as psychologists and lawyers), and new groups representing the disabled. These groups had not previously been involved in health and social assistance policy, and now deliberate on top issues in the sector, including the budget and policy initiatives.

Council participation helps these groups in both direct and indirect ways. Directly, they gain the opportunity to shape public policy and advocate for their policy priorities on the council. For example, the president of Brazil's celiacs association has used her position on the National Health Council to push successfully for the establishment of a national protocol for diagnosing and treating celiac patients. Indirectly, these groups gain a greater voice because participating on the council enhances their overall capacity to engage in advocacy. Councilors gain recognition through their participation on the council, enhancing their symbolic resources because they have been declared to be an important stakeholder. Enhanced recognition can lead to advocacy opportunities outside of the council. For example, a representative from the Brazilian Lesbian League was invited by the government to participate on an informal LGBT health policy working group as a result of her participation on the National Health Council. Council participation can also strengthen the position of councilors by facilitating the creation of networks among different stakeholder groups. Linkages among various organizations within the broader disability movement have strengthened due to their participation on councils. Even groups with little in common, such as the celiacs organization and the HIV/AIDS movement, have formed relationships that amplify the strength of each.

Despite these benefits, participatory institutions can also reinforce existing imbalances in interest representation and can legitimate undemocratic practices. Across both countries and all four policy sectors, numerous interviewees noted that participatory councils are used sometimes to distribute political patronage. Likewise, councils in both countries have served to co-opt civil society organizations and legitimate corrupt governments. In these instances, the councils do not transform interest representation as much as disguise existing dynamics under a democratic veneer. The difference among cases was not in whether participatory councils reinforce undemocratic practices, but rather to what degree.

These challenges are real, and at times can mean that the adoption of participatory institutions would worsen democratic quality rather than help it. Ultimately, the same problems with interest representation that arise with pluralism also emerge with participatory policymaking. Participation is not necessarily empowering, nor is it necessarily effective. It is also not necessarily co-opting. Constructing a participatory institution is a long-term endeavors that require substantial investments, often with uncertain payoffs. International donors and other policy practitioners that advocate for participatory policymaking should take seriously these limitations rather than focusing primarily on the potential benefits which may emerge slowly, if they emerge at all.

3.2 Improving the Equality of Interest Representation by Mobilizing Elites

Participatory policymaking is often praised for its capacity to bring new groups into the democratic process, and criticized when old groups participate in the councils. Unlike other studies, I demonstrate that even if participatory councils incorporate the "wrong" kind of civil society group – elite groups that already enjoy access to the state – this does not necessarily mean that marginalized groups do not also enjoy greater state access as well. This study goes even further to suggest that councils *must* amplify the voice of elite groups in order to amplify the voice of marginalized groups in the councils.

The experiences of the Brazilian health and social assistance councils demonstrate how participatory institutions that serve the needs of elite stakeholder groups can also bring new voices into the policy process. In both cases, broad reform coalitions composed of both elite and grassroots actors mobilized in support of substantive and procedural policy changes. Once created, the councils served as a site of incorporation for these diverse interests. Elite actors, such as health and social assistance professionals and service providers, were able to mobilize resources that were not available to grassroots groups but were needed to ensure government implementation of the participatory councils. For example, professional associations contributed unique expertise in the policy sector that enabled the councils could make useful proposals that would advance the government's policy project. Having a united front of such diverse stakeholders also amplified the symbolic resources of the councils: the reform coalition could assert that the councils represented the Brazilian population as a whole and acted in defense of the public interest.

In contrast, the Colombian cases proved less effective in providing access to grassroots organizations that previously had been excluded, precisely *because* they did not also create new opportunities for elite groups. The procedural nature of the planning reform meant that already powerful stakeholder groups such as economic associations had little interest in pressing for strong planning councils. The only groups that mobilized were NGOs and grassroots organizations, which lacked the resources and influence that the more elite groups possessed. The planning councils do grant voice to grassroots groups – but policymakers often fail to listen to this voice. The Colombian health councils failed to provide even this limited voice to grassroots groups. In health, elite actors in the sector, such as service providers or even health workers, failed to take an interest in the new councils. This lack of support stemmed from the lack of influential health professionals that sought to transform the health sector through the councils. While the causes were distinct for the planning and health councils, the result of weak elite support was the same. In the end, the absence of elite support limited the potential of the health and planning councils to provide voice and access to new groups of stakeholders.

3.3 Sustainability of Participatory Institutions

An important implication of this study is that while participatory councils can provide real policymaking access to new groups, this access will diminish to some extent over time. Councils become institutionalized when created as part of a broader policy sector reform, which provides them with opportunities to restructure the policy sector and secure a policymaking role for councils in the future. Thus, in their early years these councils will be involved in major policy decisions that have a huge impact on the policy sector as a whole. As time goes on, however, their importance will decline as key reform questions are decided and implementation becomes more secure. Whereas Brazil's National Health Council was involved in crucial decisions on how to fund the health system and how to structure inter-governmental transfers, by the late 2000s their decisions focused more on the more minor questions of how to improve healthcare for different population groups and the curricula for nurses and physicians assistants. This shift to more mundane policy questions is natural as the reform takes root, and even desired: if the National Health Council was still battling over the structure of decentralization 20 years after the health statute was passed, the health reform would be on shaky ground.

This shift towards the mundane may be natural, but it can also introduce new challenges for the councils. The narrower policymaking scope of mature councils will focus more on distributive questions, which can create new opportunities for the councils to lead to co-optation

or clientelist relationships. If this happens, the legitimacy of the councils may suffer, thereby resulting in a lower infusion with value and less access in the future. Indeed, a number of interview respondents in Brazil cautioned about this threat to the health and social assistance councils.

Despite these challenges, we need not be alarmed if the councils have less policymaking influence in some moments. The degree of dynamism in a policy sector will ebb and flow over time. If the councils have become institutionalized, the institutional infrastructure and value infusion will remain. When a period of greater conflict arises, the institutionalized councils will be in a strong position to have a voice in the policy reform process.

4. AVENUES FOR FUTURE RESEARCH

This project raises interesting questions for the study of participatory institutions, interest representation, and policy reform. Future work will build on the findings of this project to explore two questions: Why do national participatory institutions arise in some contexts but not others? And can weak institutions actually facilitate the adoption of broader social reforms?

4.1 Negative Cases: The Origins of Participatory Policymaking

This study has analyzed the trajectory of participatory institutions in countries that established extensive national frameworks for participatory policymaking. While most democracies in Latin American have established nationally-mandated participatory institutions, five countries have not. Several of these countries, including Mexico, underwent transitions to democracy during the 1980s, 1990s, and 2000s – moments in which participatory institutions *might* have been established. Whereas both Brazil and Colombia established expansive legal frameworks for participatory policymaking as part of political liberalization in the early 1990s, national participatory institutions were never implemented or even proposed in Mexico as part of the democratization process. Why did democratization and political liberalization lead to the establishment of national laws mandating citizen engagement in policymaking in Brazil and Colombia, but not in Mexico? More broadly, when does participatory policymaking enter the regime change and policy reform agenda?

4.2 The Benefits of Institutional Weakness for Social Rights Reforms

This project has highlighted the importance of sweeping policy reform in constructing participatory institutions. The question remains of why sweeping social rights reforms arise in the first place. Much of the current political science literature on Latin America highlights the persistence of clientelism in contemporary democracies (See, for example, Auyero 2001; Brusco et al. 2004; Magaloni 2006, among others). Yet by focusing on how clientelist relationships have evolved in recent years, these studies fail to question how important clientelism still is in the overall distribution of state resources. Indeed, the spread of social rights reforms suggests that clientelist relationships may be in retreat in some areas.

This project has suggested that weak institutions can facilitate the adoption and implementation of social rights reforms. Often weak institutions are blamed for reducing government efficacy and hampering accountability. However, while in Brazil I observed that it sometimes can be easier to get sweeping reforms on the books in a context of weak institutions. Clientelist politicians were willing to accept legislation that overhauled the health system since

they believed that the reforms would not be fully implemented. Weak institutions can sometimes help with reform implementation. Institutional weakness in the judiciary, public prosecutor, and bureaucracy created flexibility for these actors to redefine their role in Brazil's health policy, and to reinterpret how the reform should be implemented. This flexibility was used to sideline vested interests that initially opposed reform, such as private sector hospitals and insurance groups, and strengthened enforcement mechanisms. In sum, it seems that weak institutions *can* undermine democratic quality and efficiency – but can also block those factors that undermine democratic quality and efficiency. Future studies should examine how weak institutions can help construct participatory policymaking, and social rights reforms more broadly.

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APPENDIX: NATIONALLY MANDATED PARTICIPATORY INSTITUTIONS

Nationally Mandated Participatory Institutions by Policy Area – Brazil

BRAZIL				
POLICY AREA	PARTICIPATORY POLICYMAKING INSTITUTION	LEVEL OF GOVERNMENT		
		National	State	Muni.
Agrarian Development	Sustainable development councils	X	X	X
Agriculture, Livestock, and Food Supply	National Agricultural Policy Council	X		
Cities	National Cities Council	X		
Comptroller General	National Public Transparency and Anti-Corruption Council	X		
Culture	National Commission for Incentives for Culture	X		
	Guardian Council for the Fundação Cultural Palmares	X	X	X
	National Cultural Policy Council	X		
Development, Industry, and Foreign Commerce	National Industrial Development Council	X		
Education	Education councils	X	X	X
	Deliberative councils of the National Educational Development Fund - FNDE	X	X	X
	Councils of the Basic Education Fund – FUNDEB	X	X	X
Environment	National Environmental Council	X		
	Water resources councils	X	X	
	Water management committees	N/A - by river basin		
	National Commission for the Sustainable Plains Program	X		
	National Biodiversity Commission	X		
	Management Commission for Public Forests	X		
	National Forestry Commission	X		
Fishing and Aquaculture	National Fishing and Aquaculture Council	X		
Foreign Relations	Foreign Policy Council	X		
	Brazil Social and Participatory Council on Mercosul	X		
Health	Health councils	X	X	X

Nationally Mandated Participatory Institutions by Policy Area – Brazil (cont.)

BRAZIL				
POLICY AREA	PARTICIPATORY POLICYMAKING INSTITUTION	LEVEL OF GOVERNMENT		
		National	State	Muni
Human Rights	Rights of children and adolescents councils	X	X	X
	Guardianship councils for the rights of children and adolescents			X
	National Women's Rights Council	X		
	Council for the Defense of Human Rights	X		
	National Rights of the Disabled Council	X		
	National Rights of the Elderly Council	X		
	National Council for the Promotion of LGBT Rights	X		
	National Commission for the Eradication of Slave Labor	X		
Justice	National Drug Policy Council	X		
	National Justice Council	X		
	Federal Council for the Diffuse Rights Defense Fund	X		
	National Council to Fight Piracy and Crimes against Intellectual Property	X		
	National Council on Crime and the Penal System	X		
	National Public Security Council	X		
Mining and Energy	National Energy Policy Council	X		
Nutrition	National Food Security and Nutrition Council	X		
Pensions	National Pensions Council	X		
	Pension Financing Council	X		
	Complementary Pension Management Council	X		
Promotion of Racial Equality	National Council for the Promotion of Racial Equality	X		
Science, Technology, and Innovation	National Science and Technology Council	X		
	Administrative Council of the Center for Management and Strategic Studies	X		
Social Development	Social assistance councils	X	X	X
	Bolsa Família management councils	X		X
	National Commission for the Development of Traditional Peoples and Communities	X		

Nationally Mandated Participatory Institutions by Policy Area – Brazil (cont.)

BRAZIL				
POLICY AREA	PARTICIPATORY POLICYMAKING INSTITUTION	LEVEL OF GOVERNMENT		
		National	State	Muni
Sports	National Sports Council	X		
Treasury	Contributor councils	X		
Tourism	National Tourism Council	X		
Work and Labor	Deliberative councils of the Labor Assistance Fund	X	X	X
	Council of the FGTS social insurance fund	X		
	National Labor Council	X		
	National Economic Solidarity Council	X		
Youth	National Youth Council			
Intersectoral	National Economic and Social Development Council	X		
	National Committee for Indigenous Policy	X		

Nationally Mandated Participatory Institutions by Policy Area – Colombia

COLOMBIA				
POLICY AREA	PARTICIPATORY POLICYMAKING INSTITUTION	LEVEL OF GOVERNMENT		
		National	Dept.	Muni.
Agriculture and Rural Development	Municipal rural development councils			X
Culture	Culture councils			X
	Executive boards of houses of culture			X
Education	Municipal education boards			X
	Municipal education forums			X
Environment	Municipal environment councils			X
Health	*National Health in Social Security Council (eliminated)*	X		
	Community participation in health committees			X
	Hospital ethics committees			X
	Health users associations/leagues			X
	Municipal social security in health councils			X
Planning	Planning councils	X	X	X
	Consultative land use councils			X
Public Security/Peace	Municipal committees for the rights of the displaced			X
	Municipal participatory police commissions			X
	Community watchdog committee			X
	Municipal peace councils			X
Public Utilities	Committees for the development and oversight of public utilities			X
Sports	Municipal sports councils			X
Youth	Municipal social policy councils			X
Intersectoral	Community councils of Afro-Colombian communities	By designated Afro-Colombian territory		
	Consultative councils for planning of indigenous territories	By designated indigenous territory		
	Committees for the integration and development of the community			X
	Local disaster prevention committees			X