The most important aspect of modern medicine is unquestionably that of Public Health, embracing as it does the four fundamental historical functions of the physician: to heal, to know, to predict, to organize. Félix Martí-Ibáñez, "Foreword," cited in Rosen (1957, 13–14)

Medicine is a social science … Politics is nothing but medicine on a large scale. Rudolph Wirchow, cited in Rosen (1957, 13)

1 Introduction

Since the last quarter of the twentieth century and against the backdrop of democratization and market-oriented reforms, countries around the world have devolved fiscal resources, administrative responsibilities, and political authority to local governments (Grindle, 2000; Montero and Samuels, 2004; Willis et al., 1999). Even if the degree of power devolved to subnational authorities has varied widely across countries (Falleti, 2005, 2010a), subnational governments have acquired more political and policy salience. The sweeping wave of decentralization of governance resulted in the increasing importance of regional and local governments over the management, funding, and delivery of social services and local public goods. Throughout the world, local governments are not only responsible for water distribution, sewerage (where available), and garbage collection – the traditional responsibilities of local governments – but also for administering poverty alleviation and welfare programs, managing public primary education, and providing at least some primary health care services (Arretche, 1999; Souza, 2004; Weitz-Shapiro, 2008).

Decentralization has also facilitated civic participation at the local level (Goldfrank, 2007b). Around the world, local civic engagement has been advocated by both the political left and the political right, whether by design or by default (Baiocchi and Ganuza, 2017). By design, local, regional, and national governments (largely) on the left of the political spectrum have promoted participatory institutional innovations to increase citizen participation in public decision making and strengthen political incorporation (Goldfrank, 2011; Heller, 2001; Pogrebinschi and Samuels, 2014). By default, recurring financial and economic crises have turned local governments into the first trenches of heightened societal needs and demands (Wolford, 2010). After the adoption of neoliberal reforms, civic society participation to address problems with public goods management and social services provision has been functional to the withdrawal of the nation-state from many of its social welfare functions (Collier and Handlin, 2009; Ewig, 2010). Former Conservative British Prime Minister David Cameron dubbed this

increased role of civil society in governance the "big society."[1] Interestingly, in the same way that decentralization reforms had been advocated by societal and political actors on both the left and the right of the political spectrum (the former pursuing democratization through political and fiscal decentralization, the latter seeking to shrink the state through administrative decentralization),[2] societal participation, too, has been advocated by social and political actors at opposite ends of the ideological spectrum in the pursuit of varying goals.

In political science, a growing literature exists on community participation, by which we mean the type of civic engagement activities that are outside what is generally understood as political participation, that is, voting, contacting a public official, contributing to a political campaign (Verba et al., 1995) and also outside what is conceptualized as social contestation (e.g., McAdam et al., 2001, Tarrow, 2008 [1998]). This type of civic participation is part of what scholars have alternatively called civic engagement (Putnam, 1993), social activism (Seligson and Booth, 1976, 97), volunteering (Schmitt, 2010, 1443), or programmatic associational participation (Dunning, 2009). Most of the recent literature on community participation, particularly as it pertains to the local level, has focused on the institution of participatory budgeting, an institutional innovation designed to include civil society in local investment decisions (Abers, 2000; Baiocchi et al., 2011; Goldfrank, 2007a; Sintomer et al., 2010; Souza, 2001; Tranjan, 2016; Wampler, 2007). Among international donors, community participation and monitoring have also been at the center of attention of researchers and program evaluators (Björkman and Svensson, 2009; Humphreys et al., 2012). Civic participation in educational councils (Altschuler and Corrales, 2012), security councils (Gonzalez, 2016), and water basin councils (Abers and Keck, 2013), among other local, regional, and national (Pogrebinschi and Samuels, 2014) participatory institutions has also been studied. Relatively less attention, however, has been paid to civic participation in public health, on which we will focus our empirical analysis.[3]

In fact, little attention has been paid to health politics within political science, despite the fact that health is a defining feature of life (Carpenter, 2012) and that minimal health conditions are necessary for human functioning

[1] On British Prime Minister David Cameron's project of "big society," see the series of articles featured in *The Economist*: "Big society: Radical ideas from a fusty old island," March 17, 2011; "What's wrong with David Cameron's 'Big Society,'" Feb. 10, 2011; "The Big Society. Platoons under siege," Feb. 10, 2011.

[2] For a conceptual and operational definition of decentralization that distinguishes among its administrative, fiscal, and political components, see Falleti (2010a, 33–39).

[3] The main exception is the case of Brazil, where an abundant literature exists on civic engagement in local health councils (see, among others, Avritzer, 2009; Cornwall, 2008; Labra, 2005). The field experiment by Björkman and Svensson (2009) also analyzes the effects of a community participation and monitoring intervention in health in rural Uganda.

in other realms such as citizenship, labor, education, consumption, reproduction, leisure, and spirituality (Sen, 1999). Moreover, civic participation in health systems is puzzling. Unlike the case of educational councils, for instance, where parents with children of school age interact with their children's schoolteachers and administrators on a regular (sometimes daily) basis, the average individual interacts far more sporadically with the health care system. Also, in many societies doctors have high social status prestige, knowledge, and power over quality-of-life decisions, even over life or death decisions, affecting their patients. Legitimated healers enjoy a particular legal authority and cultural power (Carpenter, 2012, 298) that intimidates a large portion of their patients, particularly those who are users of public health systems. Thus, on the account of both regularity of interaction and social hierarchy among doctors and patients, civic participation in health is unexpected or surprising, and its politics awaits further study.

In this Element, we comparatively study the origins and the initial legal regulation and implementation of participatory institutions in public health. The Element is organized in five sections. The next section advances our conceptualization of programmatic participation and our main argument: the origins of participatory institutions in health (i.e., whether they are born out of administrative or political reform processes) are strong predictors of the type of programmatic participation that results. In this section, we also engage with alternative arguments and describe our research design. The third section empirically applies our main argument, as it compares the institutional origins of participatory institutions in public health in eleven countries across Western Europe and Latin America. In the fourth section, we delve into an in-depth analysis of a participatory experience in Argentina, which allows us to tease out some of the characteristics of the process of institutional creation and evolution of programmatic participation in health. In the final section, we conclude by summarizing our main findings and the contributions of our study to the literature on public health and participation.

2 Programmatic Participation and Institutional Origins

Theoretically, we are interested in a specific type of civic participation*: programmatic participation*. To define programmatic participation, we draw from Booth and Seligson's definition of political participation as behavior oriented toward the distribution of public goods (Booth, 1979, 30–31; Booth and Seligson, 1978, 5–9) and from Davies and Falleti's definition of local programmatic participation as organized behavior that aims to influence the distribution or management of social services (Davies and Falleti, 2017, 1704). We define

programmatic participation as "institutionally organized and state-sanctioned individual or collective behavior that influences or attempts to influence the management or distribution of public goods or social services," such as public budgets, schools, health clinics, or environmental protection. The fact that this participation (whether individual or collective) seeks to influence public goods or social services is central to our labeling it "programmatic." This is to say, this is not participation that seeks to gain individual access to services or goods, such as in the case of clientelistic exchanges where political support is provided to gain individual access to either public or quasi-market social services. Hence, it is worth reviewing the types of goods and services to which programmatic participation applies.

As defined by Olson (1968, 14), a *public good* is "any good whose consumption by any person in a group does not entail withholding of the good from others in that group." Or, as Cammett (2014, 268 n. 5) explains, "public goods are nonexcludable (i.e., those who have not paid for them can use them) and nonrivalrous (i.e., one users' consumption does not impede another's use of the good, at least not until consumption reaches a point of saturation)." Clean air, potable water, garbage collection and processing, road infrastructure, electricity infrastructure, telecommunication networks, public parks and recreation are all examples of public goods.

With regard to social services, as Cammett (2014, 12) explains:

> Welfare and social services encompass a wide array of policies designed to redistribute income and mitigate risk. These programs can operate through insurance schemes designed to cushion life-cycle and market-based vulnerabilities, such as ill health or unemployment, or through expenditures of basic services such as health care, schooling, or direct income assistance.

Unless there is perfect universal access to social services, they are excludable: they target certain sectors of the population under certain criteria, such as level of income, place of residence, citizenship status, employment status, and so on. Social services may also be rivalrous in that one person's or community's consumption of the good takes resources away from another person's or community's ability to enjoy it. Take, for instance, the decision over the construction of a local health clinic or the definition of its catchment: only those in the chosen community or catchment area will enjoy (whether de jure or de facto) the health services provided by that clinic. Finally, whereas either state or non-state actors can provide social services, for the purposes of this Element, we are primarily concerned with programmatic participation oriented toward social services provided by the state, and toward public health services in particular.[4]

[4] For excellent analyses of non-state provision of public services around the world, see Cammett and MacLean (2014).

Programmatic participation is voluntary behavior; but unlike broader definitions of civic engagement or volunteering, we are interested in programmatic participation that is *sanctioned, promoted, or at least institutionally recognized by the state, in any of its territorial levels (central, intermediate, or local).* In this volume, we focus our empirical analysis on programmatic participation that seeks to affect the design, management, and delivery of health care services in the public sector, particularly at the local level and in the context of health councils or committees that include civil society members. These health councils are examples of participatory institutions.

We follow the definition of *institution* proposed by Brinks, Levistky, and Murillo (2018, 7): "a set of formal rules structuring human behavior around a particular goal by (a) specifying actors' roles, (b) requiring, permitting, or prohibiting certain behaviors, and (c) defining the consequences of complying or not complying with the remaining rules." Participatory institutions, in turn, belong to what Graham Smith (2009, 1) has called *democratic innovations* – institutions "specifically designed to increase and deepen citizen participation in the political decision-making process." Or, as previously defined in collaborative research (Davies and Falleti, 2017; Falleti and Riofrancos, 2018), participatory institutions are formal, state-sanctioned institutions explicitly created to augment citizen involvement in decision making over public goods or social services. These institutions provide citizens with a normal politics means of interacting with the state and are potentially more substantive than sporadic electoral participation at the ballot box, while being less disruptive than social protest (Cameron et al., 2012; Fung and Wright, 2003). Examples of participatory institutions include, among others, participatory budgeting, water committees, local oversight committees, prior consultations, and health councils, on which we focus our analysis.

Building upon and combining insights from previous typologies of civic participation (in particular, Sáez González, 2013, 50; Anigstein, 2007), we distinguish between civil society's activities of consultation, planning, monitoring, and execution that can take place within participatory institutions in the public health sector.[5] C*onsultation* refers to cases where the state disseminates

[5] Sáez González (2013, 50) distinguishes among advising, resolutive, and executive participation. Advising participation refers to those instances in which citizens can give their opinion on a specific issue (but this opinion is not binding for policy makers). Resolutive participation implies that citizens participate in the design of a public program and their opinions are binding. Finally, executive participation supposes taking part in the performance of an activity and/or in the provision of a service. Similarly, Anigstein (2007) proposes distinguishing among informative, advising, monitoring, and agenda-setting participation. Informative participation refers to those cases in which citizens are only informed about what the state is doing. Advising participation (as in the case of Sáez González's typology) entails those cases in which citizens can give their opinion on a specific issue. Monitoring participation is related to those cases in

information on a specific issue and/or invites the community to express an opinion on it. However, it is not mandatory for the state to implement the community's opinion. By *planning*, we refer to cases of community participation where the community's resulting decisions or outcomes of discussion or deliberation become a mandate for the state, which must translate those decisions into policies or practices. Planning activities often presuppose the act of prioritizing among possible outcomes or courses of state action in policy making. *Monitoring* is the third type of community participation and entails the community having the authority to evaluate the delivery of the public services or the execution of a certain policy. It is related to surveillance and accountability practices. In public social services, telephone lines or complaints books are sometimes designed to promote this type of participation (which can be exercised both individually and collectively). Finally, the fourth type of community participation, which we label *execution,* consists of community participation experiences in which citizens have the authority to execute or carry out a certain policy or program.

While exhaustive of the different functions that community participation may have vis-à-vis social policies and practices, these participation activities (consultation, planning, monitoring, and execution) are not exclusionary. In fact, as we show in the comparative empirical analysis in the next section, institutional designs for programmatic participation most often combine two or more of these functions. Consultation – as the act of the state providing information to civil society – is present in all institutional designs of participation in public health, but variation exists regarding the presence or absence of the other three types of activities.

We distinguish between two ideal types of programmatic participation. We label the first ideal type of participation *programmatic participation for monitoring*. In this type of participation, the main roles of civil society are to observe public officials and employees and to denounce them whenever they deviate from the prescribed or desired behavior. If authorities or employees at the local level, for instance, divert public money or resources, civil society is engaged through this type of participation to bring accusations to higher-level government officials. In this modality of participation, civil society is informed of projects, programs, and policies, but it does not provide feedback that is conducive to policy action. Participants receive and process information (consultation). They

which citizens evaluate and control public programs. Lastly, participation related to agenda setting refers to those instances in which citizens can put certain topics into the public agenda.

also monitor, becoming watchdogs or advocates and enforcers of accountability.[6]

The second ideal type is *programmatic participation for policy making*. This modality of participation entails collective or collaborative behavior, many times requiring face-to-face interactions and gatherings among participants. Participants collectively set communal priorities, plan social policies, or design programs (planning). All these activities presuppose the existence of at least a modicum level of deliberation and moderating mechanisms within participatory institutions. In this modality of participation, where civil society is highly engaged in policy making, civil society participants may consequently be invited or have the initiative to execute (at least in part) the designed policies and programs, often with the financial and technical backing of the state bureaucracy (execution).

These two ideal types of programmatic participation are directly related to what Carol Pateman (2012) identifies as the two modes in which democracies can engage the public in participatory innovations. According to Pateman,

> In a privatized social and political context in the twenty-first century, consumer-citizens need to be extra vigilant and to monitor providers; they require information, to be consulted, and occasionally to debate with their fellow consumer-citizens about the services they are offered. In contrast, the conception of citizenship embodied in participatory democratic theory is that citizens are not at all like consumers. Citizens have the right to public provision, the right to participate in decision-making about their collective life and to live within the authority structures that make such participation possible. (Pateman, 2012, 15)

As we survey the public health care systems around the world, and in particular in Latin America and Western Europe, that have instituted civic participation, our main contention is that *the type of programmatic participation observed in the health sectors' institutional innovations for civic participation* (whether those institutions are primarily oriented toward programmatic participation for monitoring or for policy making) *is the result of the administrative or political process behind their creation.* To put it succinctly, administrative reforms lead to participatory institutions for monitoring, while political reforms lead to participatory institutions for policy making.

By *political reform process*, we refer to the collection of political events taking place in the larger political system when the institutional innovations for participation in health are created. Political reform processes can entail events

[6] In fact, such accountability may be based in informal mechanisms and thus even operate in authoritarian regimes (Tsai, 2007).

as radical as those present in a social revolution (which as defined by Skocpol (1979) implies a complete transformation of the state and the economy) or those present in a political regime change (such as a transition from authoritarianism to democracy, or vice versa). Such changes can also entail more moderate events that are still significant from a public policy orientation perspective, such as a transformation in the balance of power among political parties and their social bases, which may imply a transition from governments based on right-leaning electoral bases and rightist policies to governments based on left-leaning electoral bases and policies (such as occurred during the period of the left turn in Latin America).

By *administrative reform process*, we refer to the collection of events that affect a particular policy sector (such as education, health, housing, pensions, etc.). Administrative reform processes are closely linked to ideas of *governance* reforms or transformations of the state's bureaucracy. This is to say, in the context of administrative reform processes, there are no radical changes in the state or the economy, in the type of political regime, or in the overall balance of power among political parties and societal actors.

We argue that where civic participation in public health is the result of administrative reforms of the health care system, institutions that promote programmatic participation for monitoring are most likely to be implemented. In cases where civic engagement in public health is the result of a broader political reform process that transcends the health sector (such as in the context of social revolutions, democratic transitions, or a "left turn" in politics), the resulting participatory institutions in health will promote programmatic participation for policy making.

These two types of programmatic participation are ideal types of different forms of civic engagement in public health. However, as we show in the next section, the institutions that promote civic engagement in public health operate in a continuum that goes from a minimum of only implementing consultation and monitoring activities (close to the ideal type of programmatic participation for monitoring), through an intermediate area in which planning is also included, to a maximum level of activities including consultation, monitoring, planning, and execution. This is to say, in practice, the participatory institutions that promote programmatic participation for policy making through the activities of planning and execution also include the less demanding (from a civil society's engagement point of view) activities of consultation and monitoring. It is also worth noting that our argument applies to the features of institutional design and its initial implementation through regulatory legislation. We do not attempt to account for institutional evolution through time, institutional strengthening, or institutional performance, which would require a different research design.

2.1 Alternative Explanations of Types of Participatory Institutions

Our comparative cross-national analysis of institutional designs for programmatic participation in public health systems (Section 3), as well our in-depth comparative analysis of local participatory projects in health carried out in Argentina during its left turn (Section 4) aim to dialogue and probe some of the political science and sociology explanations regarding two main questions: (1) What accounts for different types of participatory institutions? and (2) Who participates?

2.1.1 What Accounts for Different Types of Participatory Institutions?

The literature on participatory democracy has identified two causal pathways to the adoption of participatory institutions. First, participatory institutions may result from bottom-up mobilization and demands. In Porto Alegre, Brazil, for instance, participatory budgeting was initially a social movement proposal. It was adopted by the municipal government through a process of contentious interactions between neighborhood associations and the local administration as part of a broader set of institutional reforms centered on the democratization of the state, social justice, and economic redistribution (Baiocchi and Ganuza, 2015). Second, participatory institutions can be imposed from above, absent a demand from civil society, as was largely the case in Peru, Mexico, or in many instances of diffusion of participatory budgeting as "best practice." In these cases, studies have shown that participatory institutions do not fundamentally alter state-society relations and remain weakly institutionalized (see, among others, Hevia de la Jara and Isunza Vera, 2012, 80; McNulty, 2011; Zaremberg et al., 2017). Lindsay Mayka (2019) probes the question of institutional strength of participatory institutions more deeply: a participatory institution is strong when it has a proper and explicit institutional design, combined with high routinization and high infusion with value. For Mayka, sweeping sectoral reforms that change the status quo and thus allow for the formation of a broad reform coalition that in turn activates pro-participation policy entrepreneurs are the necessary conditions that combine to produce strong participatory institutions in health.

We believe similar causal dynamics apply to the type of programmatic participation taking place in the health sector. Our analysis of the secondary literature on participation in health reveals that when the social actors pushing for participation in health are closely linked to civil society (or have a history of working collaboratively, even if they are members of sectoral or bureaucratic

elites), programmatic participation for policy making is more likely. Instead, when participatory institutions are imposed by administrative reforms and particularly by international donors, programmatic participation for monitoring is more likely. However, our argument does not perfectly map the idea of the reforms being implemented from above or below or with broad reform coalitions. It is important to emphasize that our dependent variable or outcome of interest is not institutional strength, but type of participatory institution. Thus, even if programmatic participation takes the form of participation for policy making, this does not necessarily imply institutional strengthening. The case of local participatory projects in health in Argentina, which were adopted extensively as an initiative from above, led by social scientists, doctors, and health practitioners with a progressive agenda and a history of participation with civil society, shows that they did not endure after political change. The program was institutionally weak, as it did not survive after its creators and first implementers left the national public administration. Yet, it was a case of programmatic participation for policy making.

The analysis of local participatory projects in health in Argentina (Section 4) also shows that, as in the case of other health reforms such as universalization of coverage, elites were instrumental. Similar to Harris's (2017, 4) findings regarding the processes of universalization of coverage in Brazil, South Africa, and Thailand, we also find that "'professional movements' of progressive doctors ... and other medical professionals with access to state resources" were key actors for the design and enactment of the participatory reforms. As Harris (2017, 4) writes, these are "elites from esteemed professions who, rationally speaking, aren't in need of health care or medicine themselves and who would otherwise seem to have little to gain from such policies," including participation. Their work with the poor, nonetheless, informed their advocacy for health reforms that would include community participation as a means to empower poor individuals, women in particular, and poor neighborhoods and communities. Similarly, Natasha Borges Sugiyama (2008) shows that Brazilian municipalities with authorities linked to a public health professionals association (*Centro Brasileiro de Estudos de Saúde*, CEBES) were more likely to adopt a primary care family health program (*Programa Saúde da Família*). And Mayka (2019) has also stressed the importance of pro-participation policy entrepreneurs to activate participatory institutional designs. Our empirical analysis is consistent with these findings.

However, two alternative explanations do not find support in our study. In her analysis of different participatory experiences around the world, Pateman (2012, 15) suggests that whereas engagement of participants as policy makers is present in the experiences of developing countries, engagement of