DEMOCRATIZING PUBLIC SERVICES

Lessons from Other Jurisdictions and Implications for Health Care Reform in BC

By Marcy Cohen

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CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
BC Office

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Summary

Over the last 15 years there have been repeated calls to reform and modernize how services are delivered within the Canadian public health care system. Yet, despite broad and continuing support among academics, unions, government and the public alike, there remain systemic barriers that limit the effectiveness and scope of new approaches for delivering public health care services.

This paper argues that health care reform cannot be achieved by relying exclusively on the traditional mechanisms of governance available within liberal democracy: that is, representative government backed up by a hierarchically organized administrative structure. To effectively reform health care (and other public services) and to mobilize sufficient support for reforms in the face of opposition from entrenched interests, the forms of governance must, themselves, be democratized. This will require greater involvement of non-elite individuals and groups in governmental decision-making, as well as new ways of working within and between the public sector and the broader community.

The paper draws on four case studies where the evidence clearly shows that the skillful introduction of more participatory forms of governance increased the effectiveness and capacity for governments to introduce a more egalitarian distribution of societal resources. The four case studies are:

- The Greater London Council, 1981 to 1986
- Kerala, India, 1996 to present
- Porto Alegre, Brazil, 1989 to present
- Ceara, Brazil, 1989 to 1994

In all four examples, more participatory forms of governance increased the effectiveness, creativity, and competence of public sector systems by increasing the capacity of governments to do one or more of the following:

- Provide citizens with new opportunities to monitor and direct government activities;
- Extend the reach, competence and commitment of front-line staff within the public service;
- Bring more experiential and practical forms of knowledge and expertise to the process of policy formation and implementation;
- Increase the openness, transparency and accountability of decision-making within the administrative structures of government;
- Address bottlenecks within the administrative agencies of government that could not be resolved internally; and
- Ensure the durability of reforms beyond the mandate of the sitting government.

Lessons from the Case Studies

Democratization is not as simple as decentralization. In each of the four cases, the stage for democratization was set by combining centralized and decentralized authority. It is the "creative tension" between these seemingly oppositional tendencies that produces more effective government.

Getting the right combination of centralized and decentralized authority is not a straightforward task. It depends on a sophisticated and robust senior level government with the capacity to establish a strategic direction, and to determine how to distribute power in ways that support decentralization and self-organization, while leaving room for co-ordination, monitoring and reworking of the policy framework over time.

Successful models increase the capacity for citizen participation in government decision-making processes. While the emphasis and form of civil participation and engagement differed in each of the four cases, the intent was similar: to increase the capacity for non-elite groups and individuals to build cross-sectoral alliances, become actively involved in political processes, and effect change in public policies.

Resources and opportunities for participation did not simply flow to already well-established, left-leaning organizations (i.e. unions and social movement organizations) with ties to the party in power. Rather, they were used to mobilize new constituencies and new sources of power based on criteria that were seen as fair and equitable by a broad cross-section of the citizenry. What distinguishes these four examples is the direct outreach of government to the population on issues of concrete and practical concern, and the creation of ongoing and multi-level connections among citizens and between citizens and government.

In each of the four cases, the stage for democratization was set by combining centralized and decentralized authority. It is the "creative tension" between these seemingly oppositional tendencies that produces more effective government.

Deliberative (i.e. reason-based) decision-making processes in key policy areas are a vital component. It is important to acknowledge that public perceptions of government bureaucracies as too remote and insular are widespread. Lessons point to improving government performance through the creation of new institutional channels that directly link the public service with diverse individuals and non-elite groups outside government who have additional information sources, differing perspectives and direct hands-on experience.

With more participatory forms of governance, policy formation and implementation are understood as part of a dynamic, iterative process built on sustained forms of deliberation between state officials and diverse groups and individuals outside the state. Deliberative decision-making processes provide participants with a unique opportunity to apply their practical experience and direct knowledge of a situation in considering options and the merits of supporting one outcome over another. Front-line staff in government play a key role in providing the resources to support deliberative decision-making, such as training, facilitation and ongoing technical advice.

Linking Democratic Forms of Governance to Progressive Health Care Reform in BC

The analysis of health reform in BC is a specific application of the central thesis of this paper: that is, to move forward a progressive reform agenda and counter the influences of more established interests, provincial leadership is required to provide citizens opportunities to become directly involved in advocating health care reform at the local, regional and provincial level.

The provincial NDP government in the 1990s did maintain health care spending in the face of federal cuts. However, its achievements in the area of health care reform were much more limited specifically because of the lack of innovations in democratic governance. For example, in response to recommendations of the Seaton Commission, the government invested considerable time, energy and resources in devolving health care governance to regionally appointed boards/community health councils. It paid little attention, however, to the substantive issues in the Seaton Report or to the key role the Ministry of Health must play in a regionalized system.

The Seaton Commission outlined the need for provincial leadership – in developing accountability processes to ensure equity of access, in targeting funding to support specific community reform initiatives (i.e. community health centres) and in providing infrastructure and research and policy development support. NDP politicians seemed to be either unaware of the need or uncertain about how and where to assert leadership within a regionalized health system.

Nor did they create many opportunities for citizens to become involved in these regional structures. While they did agree to provide health care unions with a seat on each regional board and community health council, there was no additional provision to ensure representation from other non-elite constituencies and user groups, and no mechanism for ensuring that health regions took into account the views of its citizenry.

It is interesting to note that in Nova Scotia the *Health Authorities Act* includes a specific requirement that District Health Authorities (DHAs) take into account priorities developed by Community Health Boards in preparing their business plans. The Community Health Boards, in turn, are expected to organize public consultations in local communities to develop these priorities. It is also noteworthy that the regulations under this legislation include a very clear set of criteria for appointing Board members to ensure that the process is open, transparent and representative of the population.

For progressive policies to have a chance of succeeding, there is a clear need not only to involve non-elite groups and individuals in health system decision-making and monitoring, but also to introduce changes in the organization and forms of accountability within the public service itself. This requires the establishment of more open oversight committees in key policy areas, and increased training and support for front-line staff in community development, negotiations and deliberative decision-making skills.

The paper concludes with a proposal to give one-half of one per cent of the health care budget – or $60 million – directly to communities (divided between geographic communities and population-based groups), for early intervention, health promotion and prevention initiatives.

Activities at the community level would depend on support of front-line staff from community agencies (e.g. medical health officers, nurses, community mental health and home support workers, occupational therapists) with training and experience in community development processes and expertise in the areas of health promotion, prevention and/or early intervention, as well as funding to ensure community participation. Communities would be responsible for organizing deliberative forums in each of the priority areas, open to all citizens at the community level.

Introduction

Over the last 15 years there have been repeated calls to reform and modernize how services are delivered within the Canadian public health system. In BC the key document was the 1991 Royal Commission on Health Care and Costs, which continues to be widely referenced today.[1] And yet, despite broad and continuing support for the report among academics, unions, government and the public alike, its main recommendation – to move away from crisis-oriented acute care interventions to focus more on community-based early interventions and preventive strategies – has not taken hold.[2]

This paper analyzes many of the systemic barriers that limited the effectiveness and scope of new approaches for delivering public not-for-profit health services in the decade following the publication of the Royal Commission Report. These limitations created an opening for for-profit alternatives – "solutions" that have come to prominence in recent years. To re-establish the viability of public health care reform in BC, it is important to understand the systemic changes that would have made a difference in the past, and will, in the future, ensure that progressive approaches to public, not-for-profit health delivery are effective and long-lasting.

The main thesis of this paper is that, in the current social-political context, strategies for strengthening and expanding public services, and health services in particular, cannot be achieved by relying exclusively on the traditional mechanisms of governance available within liberal democracy: that is, representative government backed up by a hierarchically-organized administrative structure.

To effectively reform health and other public services and mobilize sufficient support for these reforms in the face of opposition from entrenched interests, the forms of governance must, themselves, be democratized. This will require greater involvement of non-elite individuals and groups in governmental decision-making, as well as new ways of working within and between the public sector and the broader community.

In making this argument the paper relies on four international case studies where the evidence clearly shows that the skillful introduction of more participatory forms of governance increased the effectiveness and capacity for governments to introduce a more egalitarian distribution of societal resources. The lessons garnered from these case studies are described in some detail and then applied to health care reform in BC in the 1990s. The aim of the exercise is to illustrate how and why increased democratization is an effective strategy for ensuring the sustainability of public health reform. And although the specific focus is on health care reform in BC in the 1990s, the lessons from the case studies have broad applicability across the public and not-for-profit sectors.

More democratic forms of governance require higher standards of transparency and accountability and create new opportunities for reason-based, as opposed to power-based, decision-making. The intent of democratic reform is, in my view, to entrench a more egalitarian distribution of societal resources by providing progressive political actors and ordinary citizens with more opportunities to counter the influence of powerful and entrenched interests. However, not all forms of democratization are equally effective, and democratization is not equivalent to devolution. The determination of how and what decisions should be democratized is a strategic question that requires more, and not less, capacity and leadership from political actors at the senior (e.g. provincial) level of government.

The goal of this paper, then, is to open up a discussion of how governance might be organized differently at a provincial level in BC and to show how innovations in governance could increase the capacity of the provincial government to implement an agenda of progressive policy reform, despite the substantial external constraints on provincial government action.

To this end, the paper draws primarily on two sources: the literature describing the experience in four cases where progressive state and municipal governments in other jurisdictions succeeded in democratizing the mechanism of governance; and the literature on health care reform in BC in the 1990s, together with my own direct experience as the senior health policy researcher with BC's largest health care union.

To effectively reform health and other public services and mobilize sufficient support for these reforms in the face of opposition from entrenched interests, the forms of governance must, themselves, be democratized.

Increasing the Effectiveness of Public Systems Through Democratic Governance

While there is a fairly generalized consensus, at least in progressive circles, on the importance of developing more participatory forms of governance, particularly in response to the loss of government programs, these discussions have not been translated into concrete proposals for how the process of governance might be organized differently (other than broad sweeping statements about the need to democratize the public service). There are a number of critical questions that require further analysis. For example:

- How can progressive political actors mobilize the support and expertise of non-elite groups and individuals outside of government in ways that are perceived by the majority of citizens as fair and equitable?
- What forms of democratic governance will be most effective in increasing the overall creativity and competence of the public sector system?
- What needs to change in the relationship between elected officials and the public service

and in the structure and organization of the public service itself to support these more democratic forms of governance?

In developing some initial responses to these questions, the paper draws on four case studies in which efforts to democratize the mechanisms of governance have been relatively long-lasting and successful. Taken together, the evidence from these jurisdictions suggests that more entrenched forms of civic participation and engagement increase the effectiveness of public sector systems and therefore lend legitimacy to, and reaffirm the role of, "the activist state."[3]

In each case, the idea for developing more participatory forms of governance originated with progressive left-leaning political actors, with close ties to social movement organizations, interested in addressing the failures within the existing administrative infrastructure and strengthening the effectiveness and the durability of their reform initiatives. In some of the examples cited, public sector officials took a lead role in fostering active citizen involvement as a strategy to increase the effectiveness of government agencies, while in others they were reluctant partners of more forward-looking politicians and social movement organizations.

In all four examples, more participatory forms of governance increased the effectiveness, creativity, and competence of public sector systems not only by ensuring greater responsiveness to the demands of citizens (i.e. for a more egalitarian distribution of societal resources), but also by increasing the capacity of governments to do one or more of the following:

- Provide citizens with new opportunities to monitor and direct government activities;
- Extend the reach, competence and commitment of front-line staff within the public service;
- Bring more experiential and practical forms of knowledge and expertise to the process of policy formation and implementation;
- Increase the openness, transparency and accountability of decision-making within administrative structures of government itself;
- Address bottlenecks within the administrative agencies of government that could not be resolved internally; and
- Ensure the durability of reforms beyond the mandate of sitting government.

The four case studies described below illustrate the ways in which effective government action fosters more active forms of civic participation and engagement (including but not limited to participatory governance), and civic participation and engagement in turn nurtures good government. The question then becomes how to apply this type of positive dynamic or "virtuous circle" in the context of British Columbia in 2005 and beyond.

Four Case Studies of Democratic Reform

The following case studies were selected based on their success in developing innovative and participatory forms of decision-making that were relatively long-lasting and effective.[4] In each case social movement activists played a key role prior to the election in developing the political platform and defining how they would govern once elected. This planning was key to setting a new course for government action and building support for these initiatives over time. This first section summarizes the history, key reforms and significant achievements in each of the case studies.

The Greater London Council, 1981 to 1986

Until it was disbanded in 1986, the Greater London Council was responsible for running London-wide services, such as transportation, waste disposal, certain forms of housing, social services and land use planning, for the 33 boroughs that made up Greater London. In the late 1970s the left within the Labour Party of Greater London organized large-scale, and multi-layered discussions involving both party members and the broader community. These discussions resulted in the development of innovative policies in areas such as housing, the environment, transportation, social services and the economy.[5] These policies were then incorporated into a Labour manifesto that formed the basis of the Labour Party's political platform and electoral victory in 1981.

Many of the newly-elected GLC politicians were themselves grassroots activists with considerable community and social movement experience (e.g. in opposing the corporate development of London's land base). Some had been instrumental in raising concerns about the lack of accountability of national Labour politicians to party policy. Once elected to the GLC, they demonstrated a strong strategic sense of how to move forward on a progressive agenda, and shared both a commitment to transparency and an understanding of the value of sharing power with community organizations, labour and citizen groups outside of government. To this end, they put a number of "popular planning processes" in place to ensure that key administrative decisions on issues such as transportation, urban land use and housing could not proceed without the support of groups outside of government. In terms of urban land use, the GLC went so far as to purchase land threatened by property developers and then put the development under the direct control of community groups.[6]

To ensure that traditionally disenfranchised groups (e.g. low-income and working-class neighbourhood associations, women's and visible minority organizations, youth groups, etc.) could participate in these political processes, the GLC provided funding for these groups to establish independent advocacy services to address issues of bureaucratic abuse, organize campaigns to pressure for changes in municipal policies and planning processes, and undertake community economic and training development projects. In addition, the GLC devolved the delivery of some direct housing, welfare and social services to multi-use neighbourhood offices in London's boroughs. The intent of this devolution was to provide local residents with increased access to and influence over front-line staff and to ensure that front-line staff, in turn, had greater autonomy to address local needs. Not surprisingly, some of these experiments in local control were more successful and long-lasting than others.[7]

In the late 1970s the left within the Labour Party of Greater London organized large-scale, and multi-layered discussions involving both party members and the broader community. These discussions resulted in the development of innovative policies in areas such as housing, the environment, transportation, social services and the economy.

While the attempt to "run a vast city government in new ways was incomplete, as any social experiment inevitably is," it did succeed in demonstrating the value of power-sharing with non-elite groups both inside and outside the traditional public service in building more innovative and effective policy solutions.[8] One spectacular success was the GLC transport policy initiative to increase access to public transportation for low-income Londoners (e.g. the working poor and pensioners). Between 1982 and 1986 the GLC's policies led to an increase in passenger kilometres of 70 per cent, fare reductions in real terms of 35 per cent, and revenue increases of 11 per cent.[9]

Unlike many left-leaning governments in the 1980s, the GLC retained its popularity with the electorate until the Thatcher government abolished it in 1986. The head of the GLC from 1981 to 1986, Ken Livingston, was recently re-elected as Mayor of Greater London. While his powers are much reduced, he has brought back a number of the policy initiatives from the Labour manifesto related to reducing fares and increasing access to public transportation for low-income riders.

Kerala, India, 1996 to present

In 1996, Kerala, a state in southern India with a population of 29 million, elected a left-leaning government (the Communist Party of India – Marxist) that took the unprecedented step of giving local citizen groups control of 37 per cent of the state budget for new investment and planning. This initiative was introduced through a centrally-organized but locally-delivered popular campaign and training process. The goal was to ensure that local citizens had the tools and resources needed to develop projects in areas such as agricultural production, infrastructure development, social services, gender inequality, and resource depletion and environmental clean-up.

This local development initiative was conceived as a response to slowed economic growth in the 1980s and 1990s, together with concerns that the re-distributive strategies of the past could not be sustained without more activist and innovative forms of sustainable development at the local level. Leadership for the initiative came largely from the People's Science Movement of Kerala (KSSP), a very large social movement organization with a history of environmental and social activism, and close ties to the left leaders in the state government, labour unions and peasant movements.[10] In 1996 the KSSP won the Right Livelihood Award (dubbed the "Alternate Nobel Prize") for its work in the areas of environmentalism and alternative development.

The KSSP-led political experiment in mass mobilization for local development builds on Kerala's exceptional history of social and re-distributive development over the last 50 years. This history includes mass mobilizations and government action in support of the most successful and radical land reform on the Indian sub-continent, an extensive system for public food distribution (price shops), large investments in public education, and a government-run network of primary health centres.

The results have been impressive: adult literacy, infant mortality, and life expectancy rates in Kerala are decades ahead of the rest of India and close to First World standards. These achievements have occurred against the backdrop of a state with the highest population density in India and per capita GNP in 1997 of US$324, below the Indian average.[11]

Throughout this 50-year history, Kerala's state government has shifted back and forth between the Congress Party and the Communist Party of India (CPM) with the loyalties of the population fairly evenly divided between the two parties.[12] And so, while the primarily leadership and support for mass mobilization and progressive policy reform came from the CPM, the Congress Party in Kerala has developed a more participatory approach to politics than is typical of the Congress Party in other states.[13]

In 2001, the CPM in Kerala was defeated once again by the Congress Party. Prior to the election, the Congress Party was seen as very critical of the decentralization campaign and even attempting to disrupt it. However, once Congress Party members were elected they decided not to reduce funding for locally-initiated investment and planning projects although "they have not supported the campaign with the same commitment and movement-like logic of the CPM."[14]

And so, while the 1996 initiative has suffered recent setbacks, there have been some significant achievements as well. These include: an unprecedented and systematic mapping of resources organized in comprehensive reports for each of the 990 communities; an increase over the past in resource allocations for housing schemes, sanitation and drinking water; an increase in the number of initiatives that foster greater equality for women, including political participation projects; employment training initiatives and child care programs; and a proliferation of innovative experiments such as "social auditing," a suicide prevention project, a biological mosquito-control project, a medicinal plants garden and a "fair price" pharmacy.[15] In addition to funding innovative projects, the very public campaign mode of organizing brought about what was seen as "major reductions in corruption and a more effective delivery of public services."[16]

Porto Alegre, Brazil, 1989 to present

In 1988, after contributing to the defeat of the dictatorship in Brazil, Workers' Party (PT) members elected to local government in a number of municipalities introduced democratic reforms to counter the "backroom dealing" that was characteristic of local government under the dictatorship. One of the most successful initiatives is in Porto Alegre, a city of 1.3 million people in south-eastern Brazil.

When Porto Alegre first elected a PT mayor in 1988, the party won just 34 per cent of the vote and controlled only a minority of the municipal council seats.[17] The PT's strategy for consolidating support followed very closely the agenda laid out by the neighbourhood associations and other social movement organizations that had been very active in organizing at the community level over the previous 15 years. In fact, the determination of the PT leadership to address the problem of corruption in local government, redistribute municipal resources in favour of poorer neighbourhoods and provide new avenues for citizen participation originated from their experience as activists in neighbourhood associations.[18] Their primary strategy for achieving these aims was participatory budgeting.

Beginning in 1989, citizens and community groups in Porto Alegre were given the authority to determine spending priorities at the district level for the municipal capital budget and then elect two representatives to the city-wide Municipal Council of the Budget (MCB). These representatives worked with the city administration to reconcile the demands of the 16 districts and propose a municipal capital investment budget to council. Within each district other delegates were elected to monitor the MCB, pressure their representative to vote according to the priorities set up by the district assemblies, and inform them of any new problems at the neighbourhood level.[19]

The participatory budget process has greatly enhanced the legitimacy of government decisions and extended the capacity of Porto Alegre's municipal government. Funds previously used for patronage payoffs have been diverted into investments for neighbourhood improvement projects – from 2 per cent in 1989 to 20 per cent of the capital budget in 1994.

The relative success of the process is reflected by the fact that, even though the majority of city councillors were not PT members and many were initially opposed to the development of a parallel, participatory budgetary process, they approved the first budget put to them without alterations. The popular pressure on the municipal council from the community, the support from the mayor's office, and the visibility of the participatory budgeting process effectively safeguarded its autonomy.[20]

Over time, the participatory budget process has greatly enhanced the legitimacy of government decisions and extended the capacity of Porto Alegre's municipal government. Municipal funds, previously used for patronage payoffs, have been diverted into investments for neighbourhood improvement projects – from 2 per cent in 1989 to 20 per cent of the capital budget in 1994.[21] Revenues were further increased on the basis of increased public support for a more progressive approach to property taxation and other improvements in the municipal financial administration.[22]

The positive outcomes speak for themselves: there has been an increase in investment in municipal services in poorer areas of the city, bringing them up to the level of wealthier districts. For example, 98 per cent of residents have running water and sewage connections, up from 75 per cent and 46 per cent respectively in 1988.[23] There has also been a dramatic increase in the funds available for housing assistance for families, and an increase in the number of public municipal schools. As a further testimony to the success of the budget strategy, the Workers' Party has been elected to three uninterrupted terms of municipal government in Porto Alegre, and one term at the state level.

At the same time, however, the participatory budget process in Porto Alegre has been criticized of late. Because the process in Porto Alegre is focused primarily on the capital budget at the district level, there have been limitations in its capacity to influence city-wide issues and long-term municipal planning.[24] And while there have been some improvements to the process, including the initiation of citizens assemblies (held every four to five years) and thematic city-wide councils, these shortcomings remain an ongoing concern.

Ceara, Brazil, 1989 to 1994

In 1988, Ceara's newly-elected, reform-minded state government in Brazil's poor north-eastern region launched a new preventative health program, the Health Agent Program (HAP), with an unusual and extended communication and outreach strategy. Families were promised a dramatic improvement in the health of their babies if they actively lobbied their local mayor and council and convinced them to sign on to the program and agree to the terms and conditions outlined by the state government.[25]

The hiring of community workers was organized through a large-scale, very public and rigorous process. Local citizens were recruited to work with the municipality under the direction of a nurse and to do outreach to families in their homes. The public attention and visibility of the program, and the fact that the health agents came from the local community, contributed to the overall success of the program and the high level of trust that developed between the health agents and the families they visited.

In just five years virtually every municipality in the state had signed on to the program and health agents were visiting 850,000 families in their homes every month – roughly 65 per cent of the state's population – providing advice and assistance on a full range of preventative health services.[26] During this period there was a dramatic reduction in infant mortality, and a tripling of vaccination coverage for measles and polio. The success of the program has been recognized internationally: in 1993 Ceara won the UNICEF prize for child-support programs, the only Latin American government to do so since in the prize's 27-year history.[27]

Lessons from the Four Case Studies

This section identifies four key strategies common to all of the case studies. Despite the differences in cultural context and socio-economic conditions in the four jurisdictions, these strategies were critical in each case. As a result, they represent a useful framework for explaining how and why each jurisdiction was relatively successful in entrenching more democratic forms of governance. Because of this broad applicability, these strategies can be extended to other jurisdictions, including BC.

Combining Centralized and Decentralized Authority

In discussions on how to increase the responsiveness of governments, decentralization is often posed as the positive alternative to centralized, command-and-control forms of bureaucratic decision-making. Decentralized and disbursed forms of governance are often viewed as preferable because they increase the capacity of government agencies to respond quickly and flexibly to the needs of local communities and citizen groups. However, issues of co-ordination, fairness in resource allocation, and the benefits that derive from economies of scale are often lost when decentralization is posed as the only option.

What is clear from the four case studies is that the ideas of centralization and decentralization are not posed as "either/or" alternatives, but instead combine elements of each. It is the "creative tension" between these seemingly oppositional tendencies that produces more effective government.[28]

Getting the right combination of centralized and decentralized authority is not a straightforward task. It depends on a sophisticated and robust senior government with the capacity to establish a strategic direction, and to determine how to distribute power in ways that support decentralization and self-organization, while still leaving room for coordination, monitoring and reworking of the policy framework over time. As Peter Evans puts it, "Uniformity is the simplest rule; constructing the kind of intricate interplay of hierarchy and latitude…requires much more capacity and sophistication."[29]

More, Not Less, Strategic Leadership from Political Actors

The decision by the GLC to devolve power to community groups and government offices in local neighbourhoods required greater strategic leadership and direction from political actors, not less, including increased capacity within at least some of the central agencies of government. Quite early on in GLC's mandate, the political leadership realized that in order to accomplish the strategic policy objectives of the Labour manifesto (i.e. to generate quality, local employment opportunities, increase access to affordable housing and transportation, and improve training and work opportunities for women and minority groups), they would need better reporting from the different departments within the GLC on their activities and assets, and more flexibility to redirect these activities and assets towards the overall strategic objectives of the GLC.[30]

This required two important changes in the organization of the civil service itself: first, improved co-ordination – and hence to some extent centralization – of decisions and resources that were previously allocated at the departmental level, but were reallocated to cross-departmental teams/units where there would be greater opportunities for input both from political leaders and the community; and second, an expansion of the objectives within departments and public corporations to include council-wide strategic concerns.[31] Senior civil servants within some of the departments and agencies resisted the transfer of authority from their departments to cross-departmental teams/units because it challenged their traditional hold on power and increased "the scope for initiative and networking among junior staff," and between junior staff, community groups and GLC politicians.[32]

> What is clear from the four case studies is that the ideas of centralization and decentralization are not posed as "either/or" alternatives, but instead combine elements of each. It is the "creative tension" between these seemingly oppositional tendencies that produces more effective government.

Mackintosh and Wainwright agree that it was the "creative tension" between the elected GLC politicians with a clear progressive vision on the one hand – "choosing political priorities, winning democratic support for them and sticking to them" – and the decentralization of resources on the other hand – passing them over to front-line staff and people in local communities – that made the positive difference.[33] The GLC politicians provided the overall strategic direction and had a strong sense of how one policy related to another, but on the ground it was the front-line staff, union activists, consumers and communities that provided the ideas and information for most of the creative and innovative policies and programs that were implemented by the GLC.

Similarly, in Porto Alegre the decentralization of the budgeting process to 16 district-level assemblies created unique challenges because at some point the decisions process had to be centralized (to the municipal level) and limited resources allocated to some projects and not others. Success of the participatory budget process depended on the development of a clear system of rules for negotiating competing interests and determining which neighbourhood would get its priorities funded in a way that was seen as fair by all concerned. At the end of the yearly budget cycle the Municipal Budget Councillors – two from each of 16 districts – reviewed the process with their constituents and proposed modifications to be introduced in the following year.

In the early years, two problems arose related to representation and the allocation of resources in Porto Alegre. There was more demand for public services from better organized, often wealthier neighbourhoods, and second, the representatives on the Municipal Budget Council tended to focus on district-level services and projects rather than on concerns affecting the city as a whole.[34] To remedy the first situation, civil servants employed by the municipal government worked with the Municipal Budget Council to develop a rating system that included priority investment categories and criteria for determining the relative need of each district in each investment category (e.g. the proportion of the population from each district without water, storm drains, paved roads). Thereafter, participatory budget discussions about "the relative needs of different parts of the city and how investments could be justly distributed among them" were guided by objective measures/criteria that led over time to increasing the level of public works in poorer neighbourhoods and support for these investments by the entire Council.[35]

On the second point – the need to encourage participants to think more about city-wide issues and longer term planning – a City Constituent Assembly was formed with several working groups and with representation from local activists, union leaders and interested professionals. Their efforts resulted in the expansion of the participatory budget process to include city-wide thematic areas (i.e. transportation, education, culture and recreation, health and social services, economic development and tax policy, and urban development and city organization) to work alongside the 16 district councils, each with two representatives on the Municipal Budget Council.[36]

State Governments Establish the Framework for Local Democratization

Turning from the municipal to the state level, in Ceara and Kerala the idea for reforms again originated with members of social movement organizations with strong ties with the leadership in progressive state government. In each case, even though the goal was to strengthen the capacity of local government and communities through the devolution of significant resources to local level agencies, the process for achieving this goal required increased capacity and direction from state-level agencies.

In Ceara, for example, the Health Agent Program was designed by a small number of progressive public health professionals, working within the reform-minded state government. These health professionals had a long history of involvement in the movement for democracy in Brazil and in discussions about how to deliver public health in ways that promote democratic citizenship. And while the goal was to increase capacity at the local/municipal level, the strategy was largely funded and led by the state. It was the state government's "constructive mistrust" of local government's tendency to patronage that gave rise to the interventionist role played by the state administrators.[37] Funding was not automatically given to the municipality. To participate, local mayors had to submit a request to the state and agree to accept the hiring protocols and the limitations on political interference (i.e. no electioneering could accompany the provision of services) imposed by the state. They also had to agree to recruit and hire a registered nurse to oversee the program in their municipality. In return, 85 per cent of the funding for this municipally-delivered service was provided by the state.

In Kerala, prior to the 1996 election, the members of the People's Science Movement (the KSSP) organized within the Communist Party of India to secure a commitment that, if elected, they would implement the National Directive – mandating the devolution of power to the local level – in ways that would support an expansion of democratic governance and the development of community-based strategies for environmental protection and sustainable development.[38] After the election, members of the KSSP were hired to work in the central agencies of the State Planning Board. The State Planning Board set the broad parameters for how the devolved funds could to be spent: 45 to 50 per cent for productive projects in agriculture (animal husbandry), fisheries, and small scale industries; 30 to 40 per cent in social services

(education, health, sanitation, drinking water supply, housing); and no more than 10 to 25 percent on infrastructure (i.e. roads). In addition, there were specific reporting criteria to ensure that 10 per cent of the total funds were allocated to special projects for women and low-caste populations, and a process was put in place for "monitoring the implementation to avoid corruption and ensure the effective use of funds for the intended ends."[39]

The outreach, training and technical support for the program was coordinated centrally by KSSP staff recruited to work in the State Planning Board and then delivered locally. In the beginning 600 people were trained centrally. Their task was then to train 15,000 people regionally and approximately 100,000 locally. In addition, because many of the community participants ran into problems in developing the technical aspects of these development proposals, more than 4,000 volunteer experts – retired teachers, engineers and scientists living in local communities – were recruited through the central State Planning Board. These volunteer expert committees provided technical advice to the task groups responsible for developing specific project proposals in each village. They "were expressly forbidden to alter the priorities set by the local bodies," although they were encouraged to make suggestions on to how to make projects more feasible.[40]

Not surprisingly, the more successful village projects followed a pattern quite similar to that described in the other jurisdictions above: that is, they included the presence of enthusiastic local politicians on the one hand and genuine popular organizations "focused on political development work, which was not narrowly party-political and which did not just demand state and local government measures but also facilitated citizens' own actions" on the other.[41]

Not surprisingly, the more successful village projects included the presence of enthusiastic local politicians on the one hand and genuine popular organizations on the other.

By way of summary, it is useful to note some of the areas where the process for decentralizing and democratizing the mechanisms of governance required more, not less, from central agencies with the senior government:

- The provision of facilitation, co-ordination, training and standards related to the government's strategic objectives;
- The formulation of a framework for distributing resources and decentralizing power based on government strategic objectives, including strategies to foster self-organization among non-elite groups and individuals;
- The development of processes that guarantee basic transparency, accountability and fair representation;
- The organization of mechanisms for addressing problems when local groups run into roadblocks, including providing opportunities for representatives of local groups to come together in larger formations and with technical experts; and
- The development of processes for re-evaluating and modifying these processes over time.

Increasing the Capacity for Citizen Participation

While the emphasis and form of civil participation and engagement differed in each of the four cases, the intent was similar: to increase the capacity for non-elite groups and individuals to build cross-sectoral alliances, become actively involved in political processes, and effect change in public policies.

The GLC, for example, supported the goals of industrial democracy and as a consequence created opportunities to involve front-line public sector workers in policy discussions. It also provided financial resources to support self-organization, political activism and campaign organization among a broad range of traditionally disenfranchised constituencies (e.g. people on welfare, women's organizations). These groups brought forward new ideas, resisted attempts by more established groups to highjack the policy agenda, and mobilized support in favour of a more egalitarian distribution of urban resources in areas such as transportation, land use planning, and economic development. When the GLC politicians and senior staff "shielded themselves from outside pressure they tended to become captive" to more established ideas and approaches from within the bureaucracy and business establishment, and innovative ideas "tended to wilt for lack of staff time and resources."[42] As Mackintosh points out, although "improving and incorporating the policy capacity of citizen groups may seem like funding the opposition…the development of the constituencies that will pressure the elected authority is essential to its continuing creativity, even if it causes trouble."[43]

Broad Outreach to Support Self-organization Among Constituencies Not Previously Represented in the Power Structure of the Left

In all four case studies, resources were provided to support the self-organization and mobilization of non-elite groups of citizens who previously lacked influence within the power structure of the left. In other words, resources and opportunities for participation did not simply flow to well-established, left-leaning organizations (i.e. unions and social movement organizations) with ties to the party in power. Rather, they were used to mobilize new constituencies and new sources of power based on criteria that were seen as fair and equitable by a broad cross-section of the citizenry.

In Kerala, for example, the decision to devolve 37 per cent of the state investment and planning budget to the local level came out of concerns that the re-distributive strategies of the past had favoured constituencies loyal to the leading left party (the Communist Party of India – Marxist, CPM) and, consequently, were not seen as legitimate by broad segments of the population. Social movement activists, primarily from the People's Science Movement (KSSP)[44] were critical of practices of "left patronage" and recognized the need for reform:

> *Most of the popular movements – the political and trade union movement especially – had hitherto mainly demanded state and local measures and furthermore had done their utmost to ensure that such measures would favour their own members and sympathizers. This, the reformers claimed, had helped to cause conflict between different special interests, and to create the expectations that the state would do everything. Thus the participation of the citizens themselves had been set aside and development efforts to the benefit of all had been neglected. The goal now was to promote cooperation and complementary volunteer efforts on the basis of the broadest possible discussions within each district and locality of what needed to be done…This was not, of course, a kind of apolitical developmentalism. On the contrary it was a conscious political project on the part of reformist left-centre forces to ensure that all local governments and citizens would enjoy equal opportunities to participate in the new efforts to be undertaken.*[45]

The goal of the KSSP was to compensate for the waning support for the trade union and political movements by appealing to new environmental and alternate development constituencies committed to "democratic decentralization and its attendant principles of non-partisanship, de-bureaucratized government and sustainable development."[46]

The 1996 plan included a very broad outreach strategy to local communities to mobilize new constituencies and citizens who stood to gain from locally-based environmental and sustainable economic development strategies. This was accomplished by launching an extensive "campaign mode" process for building village capacity to conduct rural assessments, formulate development plans and design appropriate local interventions. Open assemblies were organized in 990 communities with about 10 per cent of the population in attendance. Invitations to participate in these village assemblies were delivered to each household, and across Kerala thousands of artists and performers organized street theatre and "power to the people" processions.[47] From local assemblies, citizens volunteered to participate in educational forums, work with professional planners in mapping resources in their communities, and then in smaller working groups to develop specific development priorities and proposals for funding.[48]

This approach was based on the previous experience, both successes and failures, of the KSSP working on large-scale campaigns in community development, literacy, group farming and resource mapping in local communities across Kerala. One of the lessons from these earlier campaigns was that the long-term success of projects depends on the inclusion and support not only of activists in community organizations, but also individuals who are not part of any formal organization (e.g. interested young people and people with specific expertise) as well as local political leaders.[49]

In all four case studies, resources and opportunities for participation did not simply flow to well-established, left-leaning organizations with ties to the party in power. Rather, they were used to mobilize new constituencies and new sources of power based on criteria that were seen as fair and equitable by a broad cross-section of the citizenry.

Although organized quite differently, the Health Agent Program in Ceara, Brazil was also initiated through an outreach strategy directly to the public and was designed for similar purposes: that is, to mobilize local citizens who had had little direct involvement in politics – and who, based on past experience, were suspicious of local government – in support of policies that had the potential to enhance the well-being of themselves and their families. In the case of the HAP, broad public awareness and interest in the program was achieved:

> *…with an unusual and unending flurry of publicity – directly through the media, particularly radio, and through the visits of the state coordinating team to communities during the hiring process…. These messages regaled citizens with promises of dramatic improvements in the health of their babies. At the same time, they instructed the public as to what they would have to do in order to bring those improvements about: they would have to urge their mayors to hire a competent nurse, pay her salary, and run the program cleanly. "Simply don't vote for your mayor," some of the program's managers advised or implied on their trips to the interior, "if he doesn't provide you access to our health program."*[50]

The direct outreach to citizens, encouraging them to pressure their local politicians to buy into the program, proved very effective both in gaining support from politicians on the terms outlined by the state (strict limitations on political interference) and in positioning the local citizenry to monitor adherence to these terms once the HAP was underway.

According to Judith Tendler, the researcher who studied the HAP, the publicity that accompanied the program's hiring process and the fact that the preventative health workers came from the community where they worked had very positive implications for the morale of the workforce, their dedication to their jobs and their desire to be respected by their clients (even more so than their supervisors). At the

beginning many families were reluctant to even open their door to someone from the government. To build trust between themselves and their clients, the preventative health workers decided on their own to help with mundane tasks with no direct relationship to the preventative health program itself (i.e. cooking and bathing a baby). They were willing to go this extra step because they saw the community as their reference group and "their clients not only as subjects whose behavior they wanted to change, but as people from whom they want respect and trust."[51]

Creating Multi-layered Connections Between Citizens and Their Government

In Porto Alegre, *every* citizen has the opportunity to participate in district assemblies and debate budget priorities related to the capital side of the municipal budget (i.e. for roads, schools, and other municipal services). This has proved to be a very effective strategy for mobilizing interest in civic activities and inspiring self-organization among citizen groups in both working and middle class neighbourhoods. From 1989, when the participatory budget was first introduced, to 1998, the number of neighbourhood associations tripled.[52] In addition, an entirely new form of civil association, Popular Councils, emerged into prominence. Popular Councils are autonomous district institutions, with no official status within the Participatory Budget Process and no direct power over neighbourhood associations. Rather, they are coordinating mechanisms established by neighbourhood associations to increase their capacity to participate in municipal and state planning processes, monitor municipal government institutions and settle internal disputes.[53]

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In addition to increased participation, the participatory budget process had a positive influence in terms of the government's overall performance. There was a dramatic decline in corrupt administrative practices and an increase in the proportion of municipal revenues spent on service provision as compared to administration.[54] This resulted, in large measure, because citizens involved in developing municipal budget proposals at the district level demanded more and more information about how city spending was structured. As one administrator in the finance department noted,

> *Before the participatory budget the budget typically involved little more than allocating the same percentage of revenues to each department that it had received the year before. But with the Council, we had to explain how the money was spent. We really had to plan for the first time.*[55]

In other words, the involvement of citizens in the budgeting process not only shifted budget priorities (i.e. more spending on water and sewage coverage particularly in low income districts), it also fostered new competencies related to planning and accountability within the administrative units themselves. This, in turn, increased the legitimacy of government and enhanced its capacity to raise revenues. As one researcher, Baiocchi, noted, both increased compliance with taxation and "public support for the raising of land-use taxes" can be attributed to the participatory budget process.[56]

The "magic" in each of the four cases – what made them effective public sector systems – was the willingness of a state and municipal government to turn over considerable authority and resources to non-elite groups outside of government in order to build the momentum and capacity for progressive changes on the ground.

In the academic literature there is some question about whether pre-existing associational ties and bonds of trust (i.e. social capital) are a precondition to the development of responsive (democratic) government institutions.[57] The examples cited above suggest that government action can support self-organization among civil associations and that there is a symbiotic relationship between state-initiated policies and social mobilization, with one building on the other.

Peter Evans argues that limits on civic activism are not set by the lack of trust or community ties at a local level, but by the difficulties in "scaling-up" micro-forms of inter-connectedness to generate solidaristic ties and social action on a scale that is politically and economically sustainable and effective.[58]

Opportunities for local groups to meet on a regional or cross-sectoral basis are often limited by traditional forms of decision-making that rely on the expertise of civil servants within a specific government department organized along hierarchical and functional lines. What distinguishes these four examples is the direct outreach of government to the population on issues of concrete and practical concern, and the creation of ongoing and multi-level connections among citizens and between citizens and government.

Introducing Deliberative Decision-Making

In BC, as elsewhere in the Western world, the erosion of public belief in the capacity of governments to play an active and creative role in resolving complex social and economic challenges is a consequence of, among other things, more than 20 years of "bureaucracy bashing." Right-wing politicians, economists, corporate leaders and the media have attributed the lack of responsiveness, limitations on flexibility, and failures to innovate on the inertia, waste and over-regulation within public sector bureaucracies.

These claims are quite clearly ideological driven. And yet at the same time, it is important to acknowledge that public perceptions of government bureaucracies as too remote and insular – and therefore lacking the information sources and capacity to respond to change and effectively manage public services – are widespread. In particular, the increased technical complexity of issues, diversity of the social cultural environment, the rapid pace of change with globalization, and the expectation for involvement by a more educated citizenry, pose new challenges for state bureaucracies. These challenges cannot be easily met through the existing structures of state bureaucracies. They point, instead, to the importance of improving government performance through the creation of new institutional channels that directly link the public service with diverse individuals and non-elite groups outside government who have additional information sources, differing perspectives and direct hands-on experience.[59]

Not All Forms of Knowledge Can Be Centralized in the State Bureaucracy

Traditional forms of liberal democracy assume that the political process of policy formulation can and must be sharply distinguished from policy implementation, which is seen as the technocratic process carried out by a "neutral" and "value free" civil service working within hierarchically-organized, functional units. With more participatory forms of governance, the assumptions change; policy formation and implementation are understood as part of a dynamic, iterative process built on sustained forms of deliberation between state officials and diverse groups and individuals outside the state. These new institutional channels open up the potential to improve government decisions by creating closer connections between policy formation and implementation including new and shorter feedback loops, faster response times, and the increased potential to modify and improve policy initiatives over time.[60]

Another assumption in traditional liberal democracy is that all the knowledge necessary for implementing policies can be codified and therefore centralized into a single institution, the civil service. As Hilary Wainwright and others in the GLC noted, the inclusion of non-elite individuals and groups in policy deliberations increased the effectiveness and creativity of government action because these groups brought new and diverse forms of practical knowledge and hands-on experience that was essential for effective policy formation and implementation.[61]

An example of this can be found in the GLC efforts to develop transportation polices for improving access and affordability, and supporting re-development and employment in London's decayed inner

town centre.[62] Ideas for how to improve the transportation system did not come primarily from the engineers and administrators working within the council administrative structure, but rather from trade unions. Union officials and grassroots activists from the shop floor had more direct experience with how the transportation system worked in practice. And they, like the leadership in the GLC, were more committed to developing transportation policies that would increase access for low-income riders and support local economic development initiatives. Maureen Mackintosh, reflecting on her experience at the GLC notes:

> *It would have been impossible to develop alternate transportation policies without the involvement of the unions. Their enthusiasm, ideas and information* was essential to the policy proposals put forward by the GLC *with regard to such issues as service patterns, safety, and engineering and vehicle design.*[63]

James Scott, in his book *Seeing Like a State*, constructs a convincing argument that practical, experiential knowledge is essential to the formulation and implementation of effective public policy. He argues that in the 20th century many state-imposed, so-called "socially progressive" reform schemes ended in disaster precisely because they ignored and even suppressed the practical knowledge that underwrites any complex activity.[64] Scott documents case after case where large-scale state reform measures failed because of their exclusive reliance on the expertise and knowledge of senior state officials who either failed to consider and/or consciously rejected the practical hands-on knowledge of people with direct experience in these activities.

It is the combination of different forms of knowledge within what might be termed deliberative decision-making structures where new opportunities are created for extending the reach, effectiveness and legitimacy of government action.

The analyses by Scott, Mackintosh and Wainwright point to some very specific reasons why democratizing the mechanisms of governance can increase the effectiveness of government action. These relate to the fact that not all forms of knowledge can be codified or reduced to abstract rules and principles directly accessible to those working within hierarchically-organized state bureaucracies. Some forms of knowledge are context-specific and experientially-based. These forms of knowledge are also important to the processes of policy formation and implementation.

It is the combination of different forms of knowledge – both experiential/practical and generalized/abstract knowledge – within what might be termed deliberative (reason-based) decision-making structures where new opportunities are created for extending the reach, effectiveness and legitimacy of government action.

The Benefit of Deliberative (Reason-Based) Decision-Making Processes

The term *deliberative decision-making* "comes from political theory, and refers to the act of considering different points of view and arriving at a reasoned decision."[65] As a strategy for extending democratic control, it depends on modifying the mechanisms of governance so that decisions on certain key policies depend on deliberative discussions among "an active citizenry" that must "forge alliances through dialogue" to arrive at a decision that is seen to have the best possible justification by a majority of participants.[66]

This is quite different than current practices of liberal and/or social democratic governance in which large-scale government funding allocations and priorities are approved by the legislature, and then specific policies and programs are designed and implemented by the minister and civil service with few opportunities for input for non-elite groups and individuals outside of government.

Deliberative decision-making is fostered when individuals and groups within a geographic (or other) community, from different sectors and with relatively equal power, are required to meet together over time and come to a common understanding of their priorities if they are to receive public resources and/or

to take action on issues that are of practical importance to their community. Under these conditions participants cannot simply press their preformed ideological agendas without thinking through the reasons why all others involved in and affected by the decisions would support their approach over other options.[67]

This form of decision-making provides participants with a unique opportunity to apply their practical experience and direct knowledge of a situation in considering the reasonableness, fairness and acceptability of each option and the merits of the arguments for supporting one outcome over another. In such circumstances there is always the "potential for participants to transform preferences upon reflection," and it is this potential for transforming and redefining what is the "common good" that is central to deliberative decision-making.[68]

In both Kerala and Porto Alegre, and to a lesser extent in the Greater London Council, decisions about how to allocate financial resources and set priorities on issues of direct concern to communities (i.e. on issues such as local area improvements, infrastructure projects, and sustainable economic development) were organized through deliberative decision-making structures. In meetings open and accessible to the entire community (within a set geographic or population base), priorities were debated and representatives elected to organize further community discussions, develop project plans, and represent the priorities to higher levels of government. This created not only new opportunities for participants to bring their hands-on knowledge and experience into the process of political decision-making, but also to learn new skills and develop new competencies.

Resources Needed to Support Citizens' Engagement in Deliberative Decision-Making

While deliberative decision-making clearly recognized the experience and knowledge of community participants, these groups were not left on their own. Training, facilitation and ongoing technical advice was provided to local community groups. As already noted in the case of Kerala, for example, 100,000 local people were trained through a train-the-trainer format to develop local planning, community governance and community development skills:

> *Training included sessions on what the campaign was about, how to lead an effective discussion, how existing government regulations would affect local planning, and how to draft project proposals. Each training session included a handbook, and an appeal for continuing self-study after the session. Lectures were supplemented by group discussions and, in some stages, "project clinics".*[69]

One of the greatest achievements of the early stages of the campaign in Kerala was resource mapping conducted in each of the 990 villages and 63 municipalities. The framework for the development of these resource maps was organized through a process where "some able and committed geographers, sketched out a program whereby they themselves would attend to the advanced aspects of the mapping, while volunteer groups would gather a large portion of the information."[70] Based on these activities, very thorough and impressive development reports were prepared in each village and municipality.[71] These reports were then available to community participants and working groups responsible for developing specific project proposals.

Similarly, in Porto Alegre the application of popular education methodology to the organization and facilitation of the district assembly meetings was viewed as critical to increasing the capacity for participation among community members who traditionally had been excluded from political processes (e.g. women, people with limited formal and education). As Baiocchi noted, it was evident from the early training materials produced by the administration, that "the ideas of popular educators and urban social movements were an important source of inspiration in how to run meetings and how to develop norms of dialogue that were respectful of different types of speech."[72]

The facilitators from the city administration, who were schooled in this methodology, saw it as their role to ensure that the values of "cooperation and solidarity" and not "competition and taking advantage"

were at the centre of the negotiation process within the district assemblies.[73] In addition, participants were provided with the opportunity to learn how to effectively engage in a debate and mobilize support for collective goals. Baiocchi notes that at the beginning of the participatory budget process women and less educated community members were less likely to speak up at meetings or be represented on the Municipal Budget Committee. However, over time these differences declined as they became more experienced with, and confident in, the negotiating process.

In addition to the application of popular education methodology to district assemblies, considerable meeting time was "devoted to learning procedures and rules as well as more specific technical criteria for municipal projects."[74] Abers, a researcher who interviewed government officials directly involved in the Porto Alegre participatory budgetary process, notes that these officials were surprised to discover that "the capacity of the participants to understand the subtleties of budgeting was much greater than they had initially expected."[75] Training sessions on budget process emphasized not only how city funds were distributed but also how the city acquired its revenue. Abers also points out that "this educational effort resulted in a widespread popular campaign that successfully pressured the city council to institute progressive property taxes, substantially increasing municipal revenues."[76]

On the other hand, it is important to note that in contrast to the district councils, the participants delegated to deal with city-wide issues on the six city-wide thematic councils were much less likely to propose policies that they themselves designed, but instead were more likely to debate and discuss proposals put forward by city officials.[77] This occurred because most participants did not have direct experience with these more abstract policy questions,[78] and as a consequence were much more dependent on the leadership of civil servants and professional policy experts.

This example points to the ongoing key role played by civil servants, as well as some of the limitations of participatory processes in situations where citizens lack the requisite expertise and resources available to government administrators. The next section attempts to take on this problem and concern more directly.

Developing New Competencies and Roles for the Public Service

Many of the examples described in the previous sections of this paper point to ways in which public servants have played a key role in developing and organizing more participatory forms of governance. There are, as well, other counter-examples where civil servants resisted changes that challenged their traditional control. This was particularly the case with the GLC where the authority of senior bureaucrats was challenged, sometimes unsuccessfully, by GLC political reforms. The GLC is particularly relevant to BC since of the four examples the GLC most closely resembles our own in terms of the level of development, complexity of issues, and political and institutional context.

At the same time, it is important to note that in comments from researchers on all four examples, and especially in the GLC, there was a recognition that "much of the initiative and creativity in providing services" in more democratic ways must of necessity come from state workers. Therefore the democratization of the civil service itself is essential "if such initiatives are to flourish."[79]

Why Bureaucratic Forms Continue Over Time

In this context it is important to understand not only what it is about civil service bureaucracies that make them problematic, but also how and why they continue as the dominant organizational form within public sector systems around the world. It is useful to refer back to classic sociological explanations of why bureaucratic forms of state organization in Western Europe developed in tandem with capitalist

forms of economic activity. Max Weber and others argue that the establishment of state bureaucracies with internally-defined reward structures (i.e. long-term career ladders, and merit-based recruitment strategies) effectively insulated civil servants from the influence of individual entrepreneurs, and positioned them instead as "unbiased" functionaries able to establish "rules of the game" common to all. This, in turn, created a sense (or illusion) of fairness and neutrality in government decision-making among the populace, thereby ensuring continuity of social and economic relations over time.

Peter Evans, Theda Skocpol and many others have argued that the classic notions of bureaucracy need to be updated to take into account the ways in which bureaucratic state activities can influence and transform societal relations and not simply serve as a passive "adjunct to private capital."[80] In his research, Evans tries to identify the characteristics of public administration that increase the capacity of a state to act as a transformation agent in society through what he defines as "embedded autonomy." He argues that the existence of a cohesive and coherent bureaucracy (i.e. one that attracts highly-skilled people and has a long and independent tradition) creates the conditions for engagement (i.e. connectedness) with society/industry without being captured by it. Evans contrasts this with governments where the coherence of government institutions is compromised and responsiveness to society reverts to pre-bureaucratic forms of patronage and favouritism.[81]

Evans employs the concept of "embedded autonomy" primarily in explaining how and why some governments have been more effective than others in linking with elites in society to transform social relations in ways that promote capitalist development (his prime examples are Korea, Taiwan and Japan) in what he refers to as "developmental states." But he also uses this idea of "embedded autonomy" to describe the characteristics of public administration in what he refers to as "redistributive states" (of which Kerala, India is his prime example). These are states that have been very effective in using their expertise and resources in support of mass mobilizations and transformations to entrench a more equitable distribution of societal resources.

These are states that have been very effective in using their expertise and resources in support of mass mobilizations and transformations to entrench a more equitable distribution of societal resources.

This discussion then focuses attention in two directions simultaneously: first, on the continuing importance of a coherent and independent civil service capable of resisting back-room pressure from powerful organizations and individuals seeking special favours and concessions;[82] and second, on the fact that redistributive strategies are dependent on increasing the capacity and inclination of the civil service to foster ongoing forms of public engagement in ways that are viewed by the majority of the citizenry as transparent and fair.[83]

Strategies for Increasing the Capacity of the Civil Service to Support Deliberative Decision-Making

In the four case examples described above, involving citizens in an ongoing way in decision-making set a new, higher standard for accountability and transparency for governments. Not only did it reduce opportunities for corrupt practices and favouritism in the allocation of public resources, it also raised the performance expectation of the administrators who now had to explain publicly how they had arrived at a particular decision.

Traditionally, civil servants are relatively insulated from popular participation. In the context of more democratic forms of governance, however, they are expected to engage citizens directly in decision-making and so no longer hold exclusive power to make important decisions. As Fung and Wright put it, "Their task… is to facilitate popular deliberative decision-making and to leverage synergies between professional and citizen insights rather to preempt citizen input."[84]

To achieve these types of synergies and at the same time not to be seen as showing favouritism to one group over another, the roles, competencies and training for the civil service must shift in two directions simultaneously. In the first instance there must be an increase in the capacity and inclination among front-line government staff to facilitate community development processes that build on the expertise of individuals and groups within communities, support them in building alliances, and assist them with deliberative decision-making. These processes require a greater tolerance for conflict and increased skills and capacity on the part of the public service to negotiate between the interests of the newly empowered non-elite groups in the community and more established interests in government and business.[85]

In the four case studies described above, community participation and negotiating processes were organized through a central agency of government with staff recruited largely from social movement organizations with experience in community development processes. To further support training in these areas, respected experts from the community and/or academia could be recruited or seconded into key leadership positions to work with line managers, front-line staff and unions in developing participatory process guidelines, conflict-resolution processes and training materials.

Somewhat different strategies, however, are required to equip civil servants with the research, communication and analytical skills required to ensure that clear, up-to-date and accurate information is readily available related to both internal government processes (e.g. how funding is allocated to different populations and regions over time), and substantive public policy issues (i.e. the evidence from the literature and other jurisdictions on the effectiveness of different policy options). In the first instance there is an obvious need to provide policy-oriented individuals working in the public service with new education and training opportunities. There are, as well, potential benefits to increasing their linkage with independent publicly funded research and policy institutes.

At present, most governments in Canada – whether they are liberal, conservative or social democratic – rely heavily on private consulting firms to assist with large-scale analytic and policy development work, such as PriceWaterhouseCoopers and KPMG. Not only are these consultants oriented to generic business solutions, they often have only a superficial understanding of substantive and operational issues that must be addressed in a public sector environment.[86] Building the capacity of publicly-funded research institutes could significantly increase the quality of the information available to decision-makers both inside and outside of government.

Further support for democratic transformations could be provided by establishing oversight committees in key policy areas with representation from senior civil servants in the relevant government departments, community agencies, front-line staff and service users. These committees would have considerable resources and authority to assess the success of key policy initiatives and to propose modifications over time. They would be required to base their deliberations on input from individuals and groups outside government and to be directly linked to the research institutes referred to in the previous paragraph.

As Robin Murray from the GLC points out, developing more democratic forms of governance requires a flatter organizational structure, with more linkages across functional units and between front-line staff and community organizations on the one hand, and senior political leaders on the other.[87] In the GLC the development of cross-departmental task groups at the community level was one of the strategies that met with considerable success.

Similarly in Porto Alegre, the participatory budget initiatives led to administrative reforms that increased the integration and co-ordination among bureaucratic units and forced the politicians to take direct control of the bureaucracy to ensure that participatory budget initiatives were fully addressed within the agreed upon time frame.[88] As one researcher points out, "this intensive, hands-on process was not anticipated by the participatory budget founders, but has helped to revitalize and reform existing bureaucratic structures."[89]

Linking Democratic Forms of Governance to Progressive Health Care Reform in BC

The final section of this paper focuses on health reform initiatives of the provincial New Democratic Party government in the 1990s following the publication of the Royal Commission's *Report on Health Care and Costs*, commonly known as the Seaton Commission. While the NDP government did maintain health care spending in the face of federal cuts, its achievements in the areas of health care reform were much more limited.

In this section I argue that there are two principal factors that explain these limitations. The first is the very effective behind-the-scenes lobbying by the more established groups within health care (i.e. physicians' organizations, pharmaceutical companies, senior administrators) who opposed health reform initiatives that they saw as a threat to their interests. The second was the failure of provincial politicians to consider more democratic forms of governance as a strategy for implementing health reform initiatives.

This analysis, then, is a specific application of the central thesis of this paper: that is, that providing citizens with more opportunities to become directly involved at different levels of the health system – from developing services in local communities to providing direction on priorities for health care spending and accountability at the provincial and national level – is the best way to move forward a progressive reform agenda and counter the influences of more established interests.

The section is organized around the four successful strategies identified in the case studies. Evidence is presented to show that these strategies were not adequately considered and that greater attention to them in the future could be effective in ensuring the sustainability of public health reform over the long-term.

An Ongoing Role for the Provincial Government Ignored in Regionalization Framework

When the New Democratic government came to power in 1991, it had at hand a very credible document from which to construct its health reform agenda: that is, the report of the Seaton Commission. The Commission's recommendations were based on findings from a large number of technical research reports and input from public hearings held around the province. The research highlighted the benefits of moving from a crisis-oriented acute care system to a system that relied more on community-based primary care, early intervention, and prevention strategies.

The Commission authors argued that implementing these strategies would be the most effective way to improve the health status of BC's citizens, reduce emergency hospital admissions, and ensure a more appropriate and cost effective utilization of physician specialists and drug therapies.[90] In particular, they recommended shifting health care resources from acute to community care, creating multi-disciplinary community health centre alternatives to traditional fee-for-service, physician-led primary care practices, and regionalizing health services to enhance responsiveness and promote continuity of services provided "closer to home."

In response to these recommendations, the NDP government invested considerable time, energy and resources in decentralizing health care governance to regionally-appointed boards/community health councils. However, its approach to regionalization relied almost exclusively on structural reforms required to devolve authority to the regions: that is, the composition of the boards and the boundaries between regions/community health councils. There was little attention focused on the substantive issues outlined by the Seaton Commission and/or on the key co-ordinating role for the provincial Ministry of Health.

Provincial politicians seemed to be either unaware of the need or uncertain about how and where to assert leadership within a regionalized health system. As a result, little progress was made in developing and entrenching innovative approaches to community health care delivery.

The authors of the Seaton Commission Report clearly outlined the role that the Ministry of Health must play in setting standards, co-ordination, planning, evaluation, and monitoring in a regionalized system.[91] However, in reality the need for provincial leadership – in developing accountability processes to ensure equity of access, in targeting funding to support specific reform initiatives, and in providing infrastructure and research and policy development support – was never addressed or resolved at a political or bureaucratic level.

Provincial politicians seemed to be either unaware of the need or uncertain about how and where to assert leadership within a regionalized health system. As a result, little progress was made in developing and entrenching innovative approaches to community health care delivery. For example, in 1999 a provincial Review of Continuing Care faltered largely as a result of the lack of clarity about the respective roles of the provincial Ministry of Health and regional boards/community health councils in promoting continuing-care reform.[92]

As further illustration of this point, when the decision to regionalize health services was first announced, there was provincial funding made available to local communities to develop "closer to home" pilot initiatives.[93] Some of these pilots were very effective and quite innovative. However, there was no provincial infrastructure established to evaluate the initiatives and ensure that the most successful projects were publicized and replicated across the province. Because these projects had no provincial profile or targeted funding, continued support depended on a local champion, and in many cases these initiatives were trumped by more traditional calls for health care dollars from more established interests.

Similarly, the Seaton Commission recommendations related to the development of alternatives to fee-for-service physician practices were largely ignored. There was, for example, no mention of this priority in the mandate for the regional boards and community health councils. The Ministry of Health steered away from the already existing Community Health Centre alternatives largely because of the opposition of the BC Medical Association (BCMA).[94]

The BCMA's opposition was not at all surprising given that the factors that contributed to the success of these alternatives – multi-disciplinary practice, community governance, and a focus on community development, education and outreach – challenged physicians' position as the sole "gatekeeper" to the primary health system. In fact, the authors of the Seaton Commission note that many physicians see Alternate Delivery Organizations as simply adding "a layer of unnecessary bureaucracy to the health care system, and that fee-for-service is efficient and fair, rewarding the physicians who work hardest and who satisfy their patients."[95] They go on to note that because the BCMA represents the economic interests of physicians, it is "understandably concerned that Alternatives might lead to reduced income for its members."[96]

Quite clearly, developing a strategy to counter the undue influence of physician organizations both within the bureaucracy and beyond is necessary to support a progressive agenda of health care reform. As I argue in the sections to follow, the NDP government did not give serious consideration to the option of providing citizen groups with significantly more information and decision-making authority as a strategy for countering the influence of more established interests.

Regionalization Processes Provided Citizens with Few Avenues for Participation

During the 10 years that the NDP was in government in BC, strategies for the inclusion of non-elite groups and individuals followed the standard format for "consultation" and "representation" of centre to left-leaning federal and provincial governments in Canada over the last 20 years: consultation processes were episodic and time-limited with government retaining control of the "agenda, the invitees and the decisions about how the information obtained would be used in decision-making."[97]

For example, while the government did conduct public hearings across the province prior to regionalization in 1997, these hearings provided only minimal opportunities for public input on the role and mandate for regional boards and community health councils. A number of unions and community groups argued that the regional health boards and community health councils should be elected and not appointed.[98] This proposal was rejected, but the government did agree to provide health care unions with a seat on each regional board and community health council. There was no additional provision, however, to ensure representation from other non-elite constituencies and user groups.

The Vancouver Health Board was the only one of the 11 regional boards to establish local area (i.e. geographic) and population health advisory committees (e.g. for women, people with disabilities and seniors) with majority representation by non-elite citizens. However, while these committees continued over time, they had limited resources and no direct access to decision-making authority within the Board.

If, instead, some of the seats on the Vancouver Health Board had been reserved for representatives from the population groups and these representatives were accountable to their respective population groups, the population health committees would have had a much higher profile and greater influence both on the Board and within their own constituencies. Similarly, if health authorities were required to demonstrate how they had taken into account the views of the population health and local area advisory committees in setting funding priorities, these committees would have garnered significantly more attention and support.

It is interesting to note that in Nova Scotia the *Health Authorities Act* includes a specific requirement that in preparing their business plans District Health Authorities (DHAs) must take into account the priorities developed by Community Health Boards.[99] The Community Health Boards, in turn, are expected to organize public consultations in local communities to develop these priorities. It is also noteworthy that the regulations under this legislation include a very clear set of criteria for appointing DHA Board Directors to ensure that the process is open, transparent and representative of the population. In the regulations there are: first, specific criteria for the selecting Board members to ensure that the appointees are knowledgeable of the health system and representative of the demographics of the population; second, a requirement that when the nomination process includes public input on the relative suitability of various applicants this process must be open to all members of the public and advertised publicly; and third, a requirement that appointees are representatives of the different geographic communities within the DHA.[100]

BC's Review of Continuing Care in 1999 provides another interesting example of a missed opportunity. One of the key points to emerge from community consultations for the Review was the importance of providing seniors and people with disabilities with greater say in how continuing care services were delivered.[101] And yet while client-centred care was articulated as the key principle throughout the final report, there was no specific mechanism put forward that would ensure the involvement of seniors in decision-making related to continuing-care reform at either the provincial or regional level.[102] As a consequence, following the publication of the report no concrete steps were taken to engage citizens in the ongoing reform of the continuing-care system.

In fact, the re-organization of health services that followed on the heels of regionalization actually reduced the avenues available for input from community organizations and citizen groups. Based on the rationale that administrative savings could be achieved through amalgamation of organizations into provincial or regional structures, a number of agencies and boards were disbanded.

For example, the BC Association for Continuing Care (BCACC), the organization representing not-for-profit continuing care services across the province, was amalgamated into the BC Healthcare Association (BCHA). The agenda for BCHA was heavily influenced by large acute care hospitals and regional structures. Once the BCACC was incorporated into this much larger organization, it lost its capacity to organize and lobby at the provincial level, on behalf of long-term, community and home care.

Similarly, to reduce administrative overhead, not-for-profit long-term care societies were amalgamated under the regions. As a result, community boards ceased to exist. Many of these boards had played a very active role in raising funds, providing volunteers and ensuring that their facilities provided good quality care. Developing an alternative shared-governance model that would provide administrative cost savings, and yet still maintain the active involvement of citizens, was not considered.

Overall, then, the process of regionalization in BC provided limited opportunities for citizens to become directly engaged in health care decision-making. As a consequence, it is not surprising that there was little public outcry when these regional boards and community health councils were disbanded in 2001 shortly after the Liberals were elected.

Deliberative Forms of Decision-Making Not Explored

In 2002, the Romanow Commission on the Future of Health Care in Canada organized a Citizens' Dialogue based on deliberative principles.[103] The Citizens' Dialogue provides a very limited but interesting illustration of what might be achieved if deliberative forms of decision-making were an entrenched feature of our health system. It included 12 groups, each with 40 citizens representative of a cross-section of the Canadian population meeting for one day.

In the morning each of the 12 groups were given a number of scenarios from which to create their own vision of the health care system they would like to see in 10 years. Then, for the remainder of the day, they had to work through the trade-offs and choices to realize that vision. In the end both the vision and the choices and trade-offs to realize that vision were remarkably similar across the 12 groups.

Initially the groups hoped that the system could "be 'fixed' simply by eliminating waste and improving the efficiency of management and service delivery."[104] When it was clear that this would not be sufficient, they then turned their attention to strategies for reforming primary care. However, even with these changes, participants realized that additional funding would be necessary to sustain public health services over the next 10 years. And yet all of the groups rejected the alternative of injecting additional money through either greater investment from a parallel private system or user fees for basic services, although they did not rule out the idea of paying user fees for a limited number of extra (i.e. discretionary, non-medically necessary) services.

In the end, participants turned to public funding and tax increases rather than cuts to current services and programs. However, as Judith Maxwell et al. explain in one of the Romanow Commission's reports:

> *At the same time citizens place very stringent conditions on their support for any tax increase. They insist on stronger accountability from providers and government as well as from users. The message is "we are spending $100 billion already; we have to get our act together." Citizens demand greater transparency about where the money goes and what actions add value. Distrust of the way the health care system is currently managed was palpable in every dialogue. Concerns about accountability, transparency and value for money echoed throughout each session.*[105]

Initially the Romanow Citizens' Dialogue working groups hoped that the system could "be 'fixed' simply by eliminating waste and improving the efficiency of management and service delivery." When it was clear that this would not be sufficient, they then turned their attention to strategies for reforming primary care.

Further to this point, the participants were much more open to fundamental changes in how primary health care is delivered than the medical establishment. They saw the benefits of having a more coordinated, cost-effective, interdisciplinary team approach to primary care, were willing to sign up with a primary care team for at least one year, see a nurse for routine care, and take more responsibility for managing their own care.

What comes across very clearly from this Citizens' Dialogue is the depth of commitment of the Canadian population to progressive health care reform and the potential positive benefits of more directly engaging citizens in health care decision-making. Ordinary citizens are far ahead of their leaders in understanding the changes needed in primary health care, and in the management of health services more generally, to sustain the health care system they value over the long-term.

While the NDP government did not initiate any new forms of deliberative decision-making during its 10 years in office, near the beginning of its mandate it did lay the groundwork for engaging the health care workforce in the broad range of discussions about the content and direction of health care reform. In 1993 the provincial government signed a Health Care Accord with the three major health care unions providing the workforce with employment security (i.e. job placement, training, and early retirement) when health reform or restructuring initiatives were introduced. This opened up the possibility for front-

line workers to become involved in setting the agenda on health care reform without the fear that they would doing themselves out of a job.

However, when the provincial government regionalized health services it did not introduce specific measures to ensure that regions did, in fact, involve front-line staff and the community on an ongoing basis in discussions related to the content and substance of health care reform. And while there was some provision in the collective agreement for employers to consult with unions prior to the introduction of major restructuring initiatives, this language was very weak and the commitment from management minimal.

Consequently, there were limited opportunities for health care unions to move away from their traditional role as defensive organizations and to participate in deliberative processes of decision-making on specific health reform initiatives. These more deliberative processes would have opened up the potential for front-line staff from different sectors and at different levels in the organization to fully utilize hands-on experience in defining what actually works on the ground.[106]

At a more macro level, if the deliberative processes outlined in the Citizens' Dialogue were extended and became an entrenched feature of the health care system, the likelihood that progressive reforms would see the light of day could be significantly increased. For this transformation to occur, the provincial government would have to mandate deliberative decision-making processes on key issues and then agree to implement the recommendations from these processes.

Deliberative processes would be most effective in areas of direct concern to a broad constituency (i.e. both within and beyond the health care system) and where there is considerable evidence to suggest that new approaches would significantly improve outcomes and constrain costs. Some examples of topics that could usefully be addressed through deliberative decision-making are: end-of-life care; hospital waiting lists; strategies for managing drug, lab and technology costs; multi-disciplinary/shared practice issues; and emergency room utilization.

The current government's Citizens' Assembly for Electoral Reform is an example of one type of a deliberative decision-making process. There are many other examples from various jurisdictions where citizens' juries, consensus conferences, and scenario workshops were used to address controversial health policy issues.[107] In most cases, groups of randomly-selected citizens, representative of the demographics of the population, were asked to consider the scientific evidence on a specific topic from a number of perspectives and then reach a conclusion on the appropriate course of action.

While most of these processes are limited, in that they focus on time-limited and discreet issues, they do provide a useful starting point. By combining these methodologies with the deliberative strategies employed in the case studies, it is possible to begin to see how more deliberative processes could become an entrenched feature of health care decision-making in BC. In the addendum at the end of this paper, I outline just such a proposal for community control of early intervention, health promotion and prevention initiatives.

Support from Senior Levels of the Civil Service Not Forthcoming

Throughout its ten years in office, attempts by the NDP government to introduce progressive health care reforms were hampered by an unwilling bureaucracy. There are numerous examples of progressive health policy initiatives proposed by NDP politicians and/or the central agencies of government that were either entirely ignored or significantly modified by senior administrators within the civil service. There are other examples where progressive policies, developed by Ministry staff, were reversed by senior bureaucrats and politicians in response to behind-the-scenes lobbying by powerful interests within the health care establishment.

Consider this example: in the 1998 contract settlement with health care unions, an accord was negotiated between the unions and government on a process for expanding the public role in laboratory and other services (i.e. claims through the Workers' Compensation Board and the Insurance Corporation of BC). The provisions in the accord required that the Ministry of Health establish a committee to oversee its implementation. The committee never met. The Deputy Minister of Health ignored the accord at least in part because of pressure from the medical establishment.[108] The unions, in turn, did not organize a concerted public lobbying effort to force the issue.

A similar example was the agreement obtained by the Hospital Employees' Union from the central agencies of government regarding the introduction of innovative pilot funding for five non-profit long-term care facilities based on a social housing financing model.[109] This model had the advantage of keeping the debt off-book, but still increasing the availability of not-for-profit long-term care spaces.[110] The entire project was short-circuited when the Deputy Minister of Health (and presumably the Treasury Board) turned over the management of long-term care infrastructure to the BC Buildings Corporation. This handover did not include a requirement to implement the five not-for-profit long-term care pilot projects. Once again, the union dropped the issue and the long-term pilots became private sector initiatives.

Other examples exist where progressive initiatives were short-circuited as a result of backroom lobbying of politicians and staff in the central agencies of government. In the mid-1990s, staff in the Ministry of Health developed a program to control the rising cost of Pharmacare – reference-based pricing. It proved very successful in achieving the desired cost savings.[111] Under reference-based pricing policies, Pharmacare is not required to cover the costs of newer, more expensive drugs if there is no proven therapeutic benefit. However, reference-based pricing applied only to three of the most widely-used drug therapies. It has not moved beyond this point despite the potential for considerable additional savings with the addition of new drug therapies. This is because of intensive behind-the-scenes lobbying by the pharmaceutical industry.

For progressive policies to have a chance of succeeding, there is a clear need not only to involve non-elite groups and individuals in health system decision-making and monitoring, but also to introduce changes in the organization and forms of accountability within the public service itself.

These examples point to the importance of mobilizing public support to counter the influence of more established interest groups who operate most effectively behind closed doors. For progressive policies to have a chance of succeeding, there is a clear need not only to involve non-elite groups and individuals in health system decision-making and monitoring, but also to introduce changes in the organization and forms of accountability within the public service itself. This requires the implementation of a number of the suggestions described earlier in this paper related to the establishment of more open oversight committees in key policy areas, and increased training and support for front-line staff in community development, negotiations and deliberative decision-making skills.

It also points to the importance of building the capacity of the public service to provide clear and accurate information on the costs of different health care reform options and the "best" evidence on the health outcomes of these options. BC has a distinct advantage over most jurisdictions in that there is a linked database with information on health service utilization and health status for the entire population.[112] This linked data system could be used much more extensively in providing the information and analysis required to support more deliberative forms of decision-making and planning on key health policy issues.

Conclusion

This paper provides some concrete ideas of how more democratic forms of governance could contribute to advancing and maintaining progressive policy reforms. While the focus was on health care, the ideas presented can be applied to other areas of government activity as well. To this end, it is helpful to keep a few general points in mind.

First, the overall aim of introducing more democratic forms of governance is to entrench a more egalitarian distribution of resources in ways that are seen by the majority of the citizenry as fair and equitable. This requires more, not less, leadership from senior politicians and the civil service. Second, not all aspects of government decision-making can or should be transformed. The decision as to where to begin is a political and strategic one that requires a careful analysis of the social-political context, other government priorities, and an assessment of the areas where the potential gains are the greatest.

Whatever area or approach is selected, it must include a public outreach and engagement strategy in order to ensure that the initiative cannot be easily reversed through behind-the-scenes maneuvering by more established interests. Finally, it must entrench forms of deliberative decision-making that build the capacity of non-elite groups and individuals to form cross-sectoral alliances and to modify and extend these initiatives over time.

ADDENDUM

A Proposal for Community Control of Early Intervention, Health Promotion and Prevention Initiatives

This proposal builds on research showing that there are numerous health promotion, prevention and early intervention strategies that have proven effective in improving health outcomes and reducing health expenditures in different populations.[113] The evidence consistently indicates that to be successful these interventions require the active involvement of patients, communities and the non-physician health care workforce. Hence the proposal: to give one-half of one per cent of the health care budget – $60 million – directly to communities (divided between geographic communities and population-based groups), for early intervention, health promotion and prevention initiatives.

The goal of this proposal is to inform and mobilize ordinary citizens so that they too are able to take an active role in proposing health promotion, prevention and early intervention strategies, and in monitoring health expenditures and practices more generally.

To undertake this initiative, leadership would be required at the provincial level. This leadership could come from an interdisciplinary team of professionals committed to the goals of the project who would work with user groups and the provincial government to:

- Establish a number of concrete priorities and determine the proportion of funding that would be allocated to each priority area. These priorities would likely include programs for managing care for people with chronic ailments (e.g. depression, hypertension, diabetes, asthma), prevention strategies for children and youth at risk, and activation programs for frail seniors, but could potentially be expanded to include such issues as food and housing security for single parents and other low-income populations;
- Provide the infrastructure support to assist each geographic and population-based community to map their needs (e.g. demographic characteristics, health status, acute and emergency care utilization) and community health resources;
- Create a provincial resource centre to provide training and information to communities on the costs and benefits of different types of prevention and early intervention strategies, examples of successful models, and processes to support community participation and involvement. This centre would also do outreach to the general populace both through the media and through the development of educational materials for community groups, schools, colleges and universities;
- Develop criteria to ensure that community processes across the province reflect the key principles of the program related to factors such as openness and transparency, fair representation, and accountability for funding; and
- Provide funding to ensure that community representatives (both geographic and population based) are able to meet at regular intervals, both regionally and provincially, to coordinate their activities, share their successes and failures, and recommend new provincial initiatives and changes in how resources are allocated to specific priorities and across regions.

Activities at the community level would depend on the support of front-line staff from community agencies (e.g. medical health officers, nurses, community mental health and home support workers, occupational therapists) with training and experience in community development processes and expertise in the areas of health promotion, prevention and/or early intervention, as well as funding to ensure community participation (i.e. both geographic and community-based). Communities would be responsible for organizing deliberative forums in each of the priority areas open to all citizens at the community level to:

- Introduce the initiative and recruit people to participate in the community mapping process to document the strengths and gaps in existing community programs and infrastructure;
- Discuss the outcome of the mapping process and begin developing a multi-year community plan that addresses provincial priorities and local needs, including priority interventions and strategies for improving co-ordination and collaboration within and between community health agencies, other community services, and local citizen groups;
- Develop a process for getting community feedback on and revising multi-year community plans based on input from the broader community;
- Recruit local experts – nurses, physicians, mental health workers, etc., both working and retired – willing to work with local agencies and community groups to develop specific interventions and proposals for funding; and
- Develop a process for selecting/electing a committee to review specific project proposals from community partners and represent the community at regional and provincial meetings.

The public awareness and media attention that would result from an initiative of this size and magnitude would provide citizens and community groups with no previous political experience in community health new opportunities to become directly involved in developing innovative, community-based interventions. In addition, the process could open up health care decision-making more generally by increasing the capacity and inclination of citizen groups to monitor activities and expenditures in other parts of the health system and to analyze the relationship between these expenditures and health outcomes.

Notes

[1] Peter Seaton et al. *Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs, Volume 2,* (Victoria: Crown Publications, 1991).

[2] Donna Vogal, "Unfulfilled Promises: How Health Care Reform of the 1990s is Failing Community and Continuing Care in B.C.," *Without Foundation*, (Vancouver: Canadian Centre for Policy Alternatives – BC Office, 2000).

[3] Archon Fung and Erik Olin Wright, "Deepening Democracy: Innovation in Empowered Participatory Governance," *Politics and Society*, Vol. 29 No. 1, March 2001, p. 5.

[4] While three of the four examples focus on a broad range of social and economic policy areas, the fourth example, in Ceara, Brazil, focuses specifically on one program, a preventative Health Agent Program.

[5] Marion Chester, Borough Councillor in Camden 1979–82, telephone interview, October 20, 2003.

[6] Hilary Wainwright, "The State and Society: Reflections from a Western Experience," in Mary Kaldor, Gerard Holden and Richard Falk (eds), *The New Détente: Rethinking East-West Relations*, (London and New York: Verso, 1989), p. 280.

[7] Robin Murray, "Transforming the 'Fordist' State," in Gregory Albo, David Langille and Leo Panitch (eds), *A Different Kind of State? Popular Power and Democratic Administration,* (Ontario: Oxford University Press, 1993), p. 62-3.

[8] Hilary Wainwright, "The State and Society: Reflections from a Western Experience," p. 274.

[9] GLC – *The Facts*, November 2003.

[10] Olle Tornquist, "The New Popular Politics of Development: Kerala's Experience," in Govindan Parayil (ed), *Kerala: The Development Experience, Reflections on Sustainability and Replicability*, (London and New York: Zed Books, 2000), pp. 120-121.

[11] Ibid, p. 1055.

[12] Patrick Heller, "Degrees of Democracy: Some Comparative Lessons from India," *World Politics*, Volume 52, July 2000, p. 511.

[13] Ibid.

[14] T. M. Isaac, "For a Democratic Alternative," *India's National Magazine*, Volume 20, Issue 03, February 2003, p. 3; Patrick Heller email, January 26, 2004.

[15] Patrick Heller, "Moving the State: The Politics of Democratic Decentralization in Kerala, South Africa and Porto Alegre, *Politics and Society*, Volume 29, No. 1, March 2001, p. 142-143; Richard W. Frank, "Democratic Decentralization: The Kerala Experience in International Perspective," Presented at seminar at the A.D.G. Centre for Research and Studies, Thiruvananthapuram, Kerala, May 18-19, 2002, pp. 4-5.

[16] Richard W. Franke and Barbara Chasin, "Is the Kerala Model Sustainable? Lessons from the Past, Prospects for the Future," in Govindan Parayil (ed), *Kerala: The Development Experience, Reflections on Sustainability and Replicability*, (London and New York: Zed Books, 2000), p. 5.

[17] While the administration was a minority in the city council, it greatly benefited from a majority centre-left coalition that comprised 21 of the 33 seats. And while the PT's electoral support was initially low, its appeal went beyond the organized sectors of the lower class population and included significant middle-class and progressive professional support.

[18] Brian Wampler, "A Guide to Participatory Budgeting," paper presented at conference on participatory budgeting, October 2000, pp. 3 and 8, accessed at www.internationalbudgets.org/cdrom/papers/systems/ParticipatoryBudgets/Wampler.pdf.

[19] Rebecca Abers, "From Ideas to Practice: The Partido Dos Trabalhadores and Participatory Governance in Brazil," *Latin American Perspectives*, Issue 91, Vol. 23, No. 4, Fall 1996, p. 45.

[20] Gianpaolo Baiocchi, "Participation, Activism and Politics: The Porto Alegre Experiment and Deliberative Theory," *Politics and Society*, Vol. 29, No. 1, March 2001, p. 62.

[21] Ibid, p. 48.

[22] Abers, p. 44.

[23] Baiocchi, p. 48.

[24] Wampler, pp. 22-24.

[25] Judith Tendler, *Good Government in the Tropics*, (Baltimore MD: John Hopkins University Press, 1997), pp. 21-44.

[26] Ibid, p. 22.

[27] Ibid.

[28] Maureen Mackintosh and Hilary Wainwright, *A Taste of Power: the Politics of Local Economics* (London: Verso, 1987).

[29] Peter Evans, "Government Action, Social Capital and Development: Reviewing the Evidence on Synergy," *World Development*, Vol. 24, No. 6, 1996, p.1126.

[30] Maureen Mackintosh, "Creating a Developmental State: Reflections on the Policy as Process," in Greg Albo, David Langille and Leo Panitch, *A Different Kind of State? Popular Power and Democratic Administration* (Toronto: Oxford University Press, 1993), p. 39.

[31] Ibid.

[32] Ibid., p. 40.

[33] Hilary Wainwright and Maureen Mackintosh, *A Taste of Power*, p. 402.

[34] Rebecca Abers, "From Ideas to Practice: The Partido Dos Trabalhadores and Participatory Governance in Brazil," p. 47.

[35] Ibid., p. 48.

[36] Ibid.

[37] Judith Tendler, *Good Government in the Tropics*, pp. 146-147.

[38] M.P. Parameswaran, "What Does the Kerala Model Signify? Towards a Possible Fourth World," in Govindan Parayil (ed), *Kerala: The Development Experience, Reflections on Sustainability and Replicability*, (London and New York: Zed Books, 2000), pp. 240-241.

[39] Franke, "Democratic Decentralization: The Kerala Experience in International Perspective," p. 35. Rene Vernon, "Sustainability and the New Kerala Model, in Govindan Parayil (ed), *Kerala: The Development Experience, Reflections on Sustainability and Replicability*, (London and New York: Zed Books, 2000), p. 222.

[40] Franke and Chasin, p. 36.

[41] Ibid., p. 133.

[42] Hilary Wainwright and Maureen Mackintosh, *A Taste of Power*, p. 402; Mackintosh, p. 44.

[43] Ibid.

[44] The KSSP began its work as a narrow apolitical educational organization aimed at spreading rational thinking and scientific methods to "the people." It was transformed into a much broader social movement organization with ties to environmental, alternate development, peasant and labour movements in the 1970s when it opposed a large power plan development in Northern Kerala. Since that time the KSSP has initiated large-scale local literacy campaigns, group farming and local resource mapping projects and worked in co-operation with state agencies, local government and elected politicians. In the process it has amassed considerable practical experience related to local participatory planning processes.

[45] Tornquist, pp. 127-128.

[46] Heller, *Politics and Society*, p. 14.

[47] Franke, p. 34.

[48] Resource mapping was a process used to develop a profile of a community's assets and vulnerabilities. It included information on the employment situation, economic activities, social and educational services, and population characteristics of a community. The more complex aspects of the mapping was done by professional planners who worked with local citizen groups in collecting and collating the information that went into the resource mapping reports.

[49] Tornquist, p. 128.

[50] Tendler, p. 26.

[51] Ibid., p. 42.

[52] Baiocchi, p. 55.

[53] Ibid.

[54] Ibid., p. 48.

[55] Abers, p. 48.

[56] Baiocchi, p. 62.

[57] Jonathan Fox "How Does Civil Society Thicken? The Political Construction of Social Capital in Rural Mexico," *World Development*, Vol. 24, No 6, 1996, pp. 1089-1090.

[58] Evans, pp. 1124-5.

[59] In Western countries over the last 20 years there has been considerable emphasis on the importance of opening up government to the influence of individuals and groups outside the civil service. However, these have focused almost exclusively on developing new institutional channels that bridge the gap between the civil service and leaders in industry and commerce (for further discussion of this point see pp. 23-24, footnote vi).

[60] Fung and Wright, p. 26.

[61] Hilary Wainwright, "A New Kind of Knowledge for a New Kind of State," in Greg Albo, David Langille and Leo Panitch, *A Different Kind of State? Popular Power and Democratic Administration*, (Toronto: Oxford University Press, 1993), pp. 114-115.

[62] Mackintosh, p. 41.

[63] Ibid., p. 46.

[64] James Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Fail*, (New Haven and London: Yale University Press, 1998), p. 311.

[65] Julia Abelson and Francois-Pierre Gauvin, "Engaging Citizens: One Route to Health Care Accountability," Health Care Accountability Paper Number 2 (Ottawa: Canadian Policy Research Networks), April 2004, p. 8.

[66] Fung and Wright, pp. 21-23; Mauve Cooke, "Five Arguments for Deliberative Democracy," *Political Studies*, Volume 48, 2000, p. 956.

[67] Ibid, p. 950.

[68] Fung and Wright, pp. 21-23; John Dryzck, *Deliberative Democracy and Beyond: Liberals, Critics, Contestations*, (Oxford University Press, 2000), p. 8.

[69] Franke and Chasin, p. 36.

[70] Tornquist, pp. 124-125.

[71] Franke and Chasin, p. 34.

[72] Baiocchi, p. 53.

[73] Ibid.

[74] Ibid.

[75] Abers, p. 45.

[76] Ibid., p. 44.

[77] Wampler, pp. 16-17.

[78] Ibid., p. 23.

[79] Murray, p. 61.

[80] Peter Evans, *Embedded Autonomy: States and Industrial Transformation*, (Princeton: Princeton University Press, 1995), pp. 21-43, 227-250.

[81] Over the last 20 years there has been a trend among right wing governments in the industrialized world, most noticeable in Britain in the 1980s and 1990s, to regard more market-oriented entrepreneurial forms of government modelled on and/or run by private enterprise as preferable to more traditional forms of bureaucratic governance. Underlying this approach is the belief that all government relationship can be reduced to a contractual arrangement in which governments contract services to arms-length agencies/enterprises and monitor their performance through outcome measures and performance standards. However the evidence suggests that these forms of government greatly increase the potential for favouritism to businesses with close ties to the ruling party and reduce the independence and clout needed by government to effectively monitor the corporate sector. Changes in Britain in the 1980s coincided with many well-publicized failures in administrative and financial controls, huge cost overruns and a reduction in service quality and standards.

[82] While this example assumes the possibility of both left and right patronage, it is clear that organizations such as unions are much less powerful than most corporation and professional associations and rely far more extensively on public processes for exerting influence. At the same time, union leaders do sometimes make backroom deals in order to secure benefits or concessions from a sympathetic government and this cannot be ignored.

[83] As already noted, in Kerala the state government lost credibility in the 1980s because government programs seemed to favour only those sectors and regions that were sympathetic with the party in power (see p. 15).

[84] Fung and Wright, p. 18.

[85] Mackintosh, p. 48.

[86] John Langford, "Ethical Challenges of New Approaches to Service Delivery," in *Public Sector Ethics*, (Paris: OECD, 2000).

[87] Murray, p. 61.

[88] Wampler, p. 22.

[89] Ibid.

[90] Peter Seaton et al. *Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs*, *Volume 2*, p. B52.

[91] Ibid, p. B36-B39; Hospital Employees' Union, British Columbia Nurses' Union, and Health Sciences Association, *Blended Care: Combining the best of institutional and community care*, a discussion paper (Vancouver), October, 1999.

[92] In 1999, the Minister of Health established a Continuing Care Review to develop a plan for reforming the continuing care system in the province (i.e. long-term, community and home care). There were 12 members of the steering committee and I was one of two union representatives. Within the steering committee there were differences of opinion as to the appropriate role for the provincial Ministry of Health within a regionalized system and no political process to resolve these differences. The regional authority representatives felt that most, if not all, policy decisions related to continuing care should be turned over to them, while others on the committee, including myself, felt there was an ongoing role for the Ministry of Health to provide policy, research and infrastructure to support innovation

and set policies to ensure quality standards and equity of access across the province. These differences represented a significant roadblock for the committee in developing concrete proposals for how to support a process of continuing care reform at a provincial level. As a consequence, the report produced by the committee was quite inclusive and provided little concrete direction to the Minister.

[93] Ministry of Health, Transition Issues Management Branch, *Closer to Home Fund; Information for B.C. Stakeholders*, Appendix F, pp. 1-2.

[94] As an outcome of an extensive lobbying effort by the health care unions, the Registered Nurses' Association of B.C. and the Health Association of B.C., the provincial government did in 1997 provide minimum financial support for a two-year period to a provincial committee (the Provincial Health Centre Working Group) to promote a Community Health Centre (CHC) alternative model. The Working Group developed educational materials and workshops for communities around the province interested in starting their own CHC. The B.C. Medical Association decided not to participate on the working group. And in 1998-99 when the Ministry of Health received its fist allocation of funding from the federal government's Transition Fund for primary care reform, the Working Group and CHC model were not included in the provincial plan for primary care pilots.

[95] Seaton et al., p. B54.

[96] Ibid., p. 55.

[97] Susan Phillips, et al., *Mapping the Links: Citizen Involvement in Policy Processes*, (Ottawa: Canadian Policy Research Network, 2002), p. 3.

[98] Hospital Employees' Union, *Submission to the Regionalization Assessment Team,* Aug. 1996, p. 10.

[99] District Health Authorities are required to demonstrate how they have taken the Community Health Plan into account in developing their business plan. If the business plan does not provide for implementation of elements of the Community Plan, they must set out the reasons why those elements are not recommended for implementation.

[100] In N.S. each DHA has a number of regional based Community Health Boards responsible for appointing a certain proportion of the members of the Board of Directors for the DHA.

[101] Review of Continuing Care Services, British Columbia Ministry of Health, *Consultation Document,* Oct. 1998, p. 9.

[102] Barb Burke et al., *Community for Life: Review of Continuing Care Services in B.C.*, Report of the Steering Committee, October 1999.

[103] Judith Maxwell et al., *Report on Citizens' Dialogue on the Future of Health Care in Canada*, (Commission On the Future of Health Care in Canada, June 2002), pp. v-xii.

[104] Ibid., p. vii.

[105] Ibid., p. viii.

[106] The health care unions jointly published a report, *Blended Care*, with a number of specific examples for how to develop more innovative approaches to the delivery of public and not-for-profit health services. The ideas in this report were based on input from front-line staff and discussions with Michael Rachlis, a health policy consultant from Ontario.

[107] Abelson and Gauvin, p. 31.

[108] In a *Review of Diagnostic Services* for the Ministry of Health in 1993, Miles Kilshaw outlines the benefits of expanding public laboratory services as a strategy for reducing costs, eliminating unnecessary duplication, and improving overall coordination within the laboratory system. Based on this report there were a number of attempts to introduce reforms at a regional level (e.g. by the Vancouver/ Richmond Health Board), all of which failed. In the 1998 round of provincial bargaining health unions signed an accord with the government related to laboratory reform based largely on the findings of the Kilshaw report. One of the key barriers to laboratory reform is the control by the Medical Service Commission of the licensing processes for laboratory services. The expansion of public laboratory services depends on the issuing of new licenses to public hospitals. Physicians on the Medical Services

Commission with economic ties to private laboratory services were unwilling to issue licenses to public hospitals. In July 2003, another review for the Ministry of Health Planning and Health Services was completed, the *BC Laboratory Services Review* by Lillian Bayne. It pointed to the fact that lab costs in BC are the highest in the country and called for significant reforms of the lab system. Initially the Liberal government agreed to reforms that would allow both private and public labs to bid on out-patient lab services, but has since changed its position. According to a Health Sciences Association release on June 4, 2004, the government has agreed to a deal with the BCMA that guarantees "massive profits for private labs and divert[s] $60 million in savings back to a fund controlled by the BCMA."

[109] This alternate financing model was developed in response to concerns raised by HEU and some members of the public in Nanaimo who were told that, without funding from Victoria, the only way the community would get a much-needed new long-term care facility was if it was built and owned privately. The agreement to develop this alternate financing arrangement was negotiated in a closed meeting between HEU and a representative from the central agency of government.

[110] Marcy Cohen et al., *Not-Profit Continuing Care – New Projects and Partnerships*, (Victoria: City Spaces), March 2000.

[111] Steven Morgan et. al. "International Report: Outcomes Based Drug Coverage in British Columbia," *Health Affairs*, Volume 23, Number 3, May/June 2004, pp. 271- 273.

[112] The linked database, organized through the Centre for Health Services and Policy Research (CHSPR) at UBC, includes safeguards to protect individual privacy, and includes information on acute care utilization, physicians visits, prescription drug utilization, continuing care and work-related injuries. It is currently being expanded and upgraded.

[113] Michael Rachlis, *Prescription for Excellence*, (Toronto: Harper Collins Publishing, 2004), pp. 65 and 91-144.

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