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# Participatory mechanisms and inequality reduction: searching for plausible relations

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# Participatory mechanisms and inequality reduction: searching for plausible relations

## Abstract
Brazil is known for being one of the most unequal countries in the world. Since the 1990s many scholars, both in Brazil and those analyzing the country[1]s trajectories from abroad, have been describing a decrease in country[1]s inequalities. In this article we discuss the possible role of expanding citizen participation in policy making processes and overseeing their implementation in inequality reduction. To do so we explore the connections between the participatory mechanisms and the implementation of policies that are expected to reduce inequalities in two different participatory experiments that have taken place in Brazil: São Paulo municipal health councils and the country[1]s participation in the Open Government Partnership (OGP). We argue that, despite their thematic and historical differences, there are good reasons to believe that these two participatory experiences sustained the expectations concerning their role in contributing to reduced inequalities. However, these cases suggest that their contributions were less determined by the quality of the participatory process, as defined by the deliberative democracy literature, than by the nature of political alliances and mobilization processes that supported these spaces.

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## Keywords
social participation, inequality reduction, health councils, Open Government Partnership, political mobilization

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Brazil is well known for its carnival, beaches, democratic innovations, and many other good things.  Sadly, the country is also known for being one of the most unequal countries in the world. Many scholars, both in Brazil and those analyzing the country's trajectories from abroad, have been describing a possible decrease in country's inequalities rates since the 1990s[1]. The extent of this success, how to explain it and to what atribute it remains an unfinished debate. Even more so since the coming out of Thomas Piketty's new theory on how to conceive and account for wealth and income inequalities. Piketty's theory has sparked a new round of discussions as whether this new frame adapted to the country's trajectory would mean that the expected decrease in inequality was methodologically inaccurate. In the absence of a consensus around the topic, in the present article we will stick—albeit cautiously—to previous results that point out to the shrinking of inequalities in the country (Arretche, 2015; Coelho, 2015; Lima e Prates, 2015; UNDP, 2014;).

Many concurrent explanations have been mobilized by those recognizing a decrease in inequalities in Brazil. In addition to more traditional explanations for the closing of the inequality gap—such as the return, in the 1990s, of competitive elections for the main executive branch positions, economic stabilization and growth, and the adoption of a series of targeted social policies—there are also those that point to the importance of expanding citizen participation, in mechanisms such as participatory budget and policy councils.

The rationale behind these explanations goes as follows. Electoral competition drives politicians to try to meet their constituencies' expectations, while economic growth contributes to an increase in wealth circulating in society. Participatory institutions democratize access to decision-making processes in regards to public policies and can contribute to making them more responsive to people's needs, and in particular to the need of the poor. Yet it is less evident how to measure and isolate the real contribution made by each of these factors to the reduction of inequalities.

In Brazil, the economic growth of the 2000s has been accompanied by an increase in both the minimum wage and public spending on social policies, including the expansion of income transfer programs. However, it is difficult

[1] We have chose to discuss inequalities, rather than inequities, in Brazil, due to the fact that most of the national debate has been framed using the inequality concept and referring to the multiple and intersecting inequalities existing in the country. Nonetheless, discussions around 'equity/inequities' have been progressively incorporated in Brazilian policy debates in the last decades, notably in the Health sector, after the creation of the Brazilian Universal Health System (SUS), and often referring to the conceptual framework developed by Margareth Whitehead's (1992) at the Pan American Health Organization. We do acknowledge the differences between the two concepts and their implications, still we thought that adding the participatory discusson to the existing debates around inequalities in the country would speak to the broader literature around the topic, coming not only from the health sector, but also informing policy discussions in other sectors.

to identify what exactly can be attributed to policy decisions or to economic acceleration. It is also difficult to discern when the effectiveness of social programs should be associated with the high level of electoral competition and when it responds to increased public participation in managing and refining social programs.

How can we move forward on recognizing the specific contribution of the economy or the political process in reducing different types of social inequalities? And particularly, can we recognize the role of social participation in this process? Is it reasonable to keep social participation in the list of variables that have been used to explain inequality reduction in Brazil?

Due to methodological difficulties in conducting quantitative assessments to test expectations and hypotheses about the role of social participation in reducing inequalities, we chose to approach this subject tangentially. Based on a literature that has sought to establish causal relationships between the design of deliberative and/or participatory institutions, their operationalization, and their outcomes, we will discuss two participatory processes taking place in Brazil, seeking to identify possible mechanisms that have associated them with inequality reduction in the country. This exercise combines inductive and deductive efforts, seeking above all to establish plausible connections between the routines of participatory mechanisms and the implementation of policies that are expected to reduce inequalities.

The cases examined here refer to the experiences of São Paulo municipal health councils and the Brazilian participaton in the Open Government Partnership (OGP). Health councils grew in the 1990s, notably after the country's re-democratization process. They provide forums in which citizens join service providers and public officials in defining public policies and overseeing their implementation. In 2011, Brazil co-founded the OGP, a global initiative that aims to provide an international platform for domestic reformers committed to making their governments more open, accountable, and responsive to citizens. Those two experiences have very different features. Health councils were generated and improved nationally and work through face-to-face meetings that happen at the local, state, and federal levels. The OGP, alternatively, has a clear international genesis, is held mostly at the federal level, and works toward "securing concrete commitments from governments to promote transparency, empower citizens, fight corruption, and harness new technologies to strengthen governance" (Open Government Partnership, 2011).

The present analysis focuses on the participatory cycle - design, dynamic and outcomes - looking for elements that can connect it to the reduction of inequalities in Brazil, such as inequalities in access to public services or in health indicators for different social groups. Our aim here is not to establish a

direct connection between the two experiences, but to understand how the question of inequality appears and is dealt with in both participatory mechanisms and what are the possible consequences for inequality reduction.

In the next section we turn to literature that has dealt with assessing the impact of public participation. In the third section we examine selected aspects of the experience of health councils in the city of São Paulo and the Brazilian participation in the OGP looking for possible connections with a set of inequality reduction outcomes. The fourth section discusses these experiences, seeking to identify the conditions that favored processes of inequality reduction. Finally, we present our conclusions and suggestions for future research on the connection between dynamics and outcomes of public participation processes.

## Linking Public Participation and Inequalities Reduction

Worldwide, from the 1990s on, there was an increased call for public participation in areas such as health care, the environment, transportation, and local government (Rowe, Marsh, & Frewer, 2004). This participation varied widely in form and intent, but basically involved face-to-face interactions. From the 2000s on, the Internet provided conditions for public online involvement and open access to a wide range of information, increasing initiatives concerned with transparency and accountability (Halloran, 2015).

In Brazil, almost 400 of the 5,507 municipalities have adopted the participatory budget process since 1989; more then 28,000 policy councils have been established for health policy, education, the environment, and other matters; and biannual policy conferences have been held regularly at the national, state, and municipal levels. In all cases citizens are invited to participate, and among those who attend there is a process of nominating the councilors who have the right to vote on the final decisions (Coelho, 2014). By the end of the 1990s, in addition to these face-to-face processes, there was an expansion of electronic government (e-gov), which includes new forms of policy governance and monitoring, electronic democracy, and government accountability (Diniz, Barbosa, Junqueira, & Prado, 2009).

The concept of participation assumes that the public has useful knowledge and values in their own right and that the inclusion of a broad spectrum of citizens in the policy process through mechanisms that fulfill deliberative requirements may lead to an increased circulation of information, greater transparency in political processes, and better decisions. Kies (2010) attempted to operationalize the normative requirements of deliberative theory as follows: deliberative processes ought to be inclusive; to guarantee discursive equality, reciprocity, empathy, sincerity, and reflexivity; to provide justification; to guarantee plurality as well as the external impact of the discussion. In short,

there is an implicit understanding among scholars that the democratization of debate and decision-making together with the fulfillment of deliberative requirements are key elements in an intricate process of improving systems of governance, which should contribute to more viable and just policies, with positive impacts on a range of social dimensions, including inequality reduction.

Despite expectations and the important efforts made to produce rigorous research, we still know little about the impact of participatory initiatives in general, and on inequality in particular (Gaventa, 2016). According to Abelson (2006), while outcome-oriented empirical research has consistently documented the impacts of public participation processes (and public deliberation processes in particular) on both a range of citizen participant attributes and public opinion changes, there has been much less produced about the direct impacts of public participation on the policy process, and what has been produced offers mixed and ambiguous results. Gaventa and Barrett (2010) point out that the effects of civic participation on measurable democratic and developmental outcomes have proved difficult to assess. Friess and Eilders in their systematic review of online deliberation research note that the majority of empirical studies exclusively focus on the communication process, aiming at measuring the deliberative quality of the discussions and that empirical investigations concerning outcomes are rare. For them, "we have a sufficient understanding of the process of deliberative communication, while input and outcome are less understood …Future research will have to close the gaps on the causal relations between the components and clarify the conditions under which particular factors gain or lose influence" (2015, p. 334-5).

Abelson (2006) suggests that public involvement can produce outcomes that influence policy but the conditions under which this occurs are not easily identifiable. In fact, there is no reason to believe in a linear relationship between designs and processes that are more inclusive, egalitarian and deliberative, and better outcomes concerning inequality reduction. As suggested by Abelson (2006), "there are no assurances that a decision maker is going to accept the outcome (the recommendations) of a process simply because it is perceived to be legitimate. Indeed, decision makers might challenge the legitimacy of the process to suit their interests" (p. 18).

Identifying the conditions that favor decisions that may lead to inequality reduction is indeed a complex task, which involves tracing the connections between multiple dimensions related to both the participatory process itself as well as to the public policy cycle. In this scenario our proposal is to explore with caution the relation between public participation and inequality reduction. We look at the health councils and the OGP to understand how a set of input and process variables, such as empowerment, inclusiveness,

moderation, and constructiveness (Friess & Eilders, 2015), have facilitated or constrained certain outcomes (decisions and processes) that promoted or supported public policies related to inequality reduction. In the next section we discuss the cases studies.

## Tackling Inequalities through Participatory Mechanisms

### Health Councils

The SUS, the Brazilian public and universal health system, was enacted by the 1988 Constitution, which restored democracy in the country. The SUS offers access free of charge to all Brazilians for appointments, tests, hospitalization, and a wide range of medicines, in addition to vaccination campaigns, prevention, and health surveillance actions. At present, about 70 percent of Brazil's population depends exclusively on the SUS. The implementation of the health councils happened hand-in-hand with the organization of the SUS. More then 5,000 health councils were created between 1990 and 1995, almost one for every municipality, involving nearly 100,000 individuals and a vast number of associations.

Participatory councils and conferences were created not only to bring projects and actions to the population, but also to act as a channel carrying suggestions from the population to the various levels of government. The legal *empowerment* of the councils is related to the transfer of federal health sector resources to the municipalities and states. These transfers are conditioned on both the formal existence of councils and their approval of the municipal and state annual plans and health budgets. If the council rejects the plan and/or budget that the health secretariat is required to present annually, the Health Ministry, which is responsible for around 50 percent of the system's resources, does not transfer funds. Although the legal powers of conferences and councils reside mainly in the technical and administrative realms, the councils are especially significant for their role in policy debates.

To understand the policy process that made this participatory structure possible, we need to go back to the 1980s, when thousands of citizens and interest groups worked throughout the country gathering support to demand the creation of the SUS and its participatory spaces. The Brazilian Health movement—made up of health sector workers, university teachers, researchers, and intellectuals—played a crucial role, advocating for the effective universalization of the health system and institutionalization of citizens' participation in the formulation, management and monitoring of health policy (Neder, 2001). Equally noteworthy was the role played by civil society associations. These associations were engaged in a number of local initiatives, such as the creation of HIV/AIDS programs, and also helped to disseminate the notion of health as a citizen's right (Nunn, 2009).

This background is important to better understand the actual features of the municipal and local health councils analyzed in this article. They are all located in the city of São Paulo. The six local councils researched are located in peripheral areas, and in three of these areas the health movement has been present since the 1970s. (For a detailed presentation of the research methodology and results presented in this article see Coelho, Ferraz, Fanti, & Ribeiro, 2010.)

Concerning *inclusiveness*, the rules that organize the councils clearly privilege the idea of representing civil society associations rather then autonomous citizens. Each council can determine the exact number of councilors and their mandate length. The Muncipal Law recommends, however, that Local Health Councils should have twenty-four effective members and twenty-four substitutes with mandates of two years and the possibility of one reelection. When we looked at the socio-demographic profile of the councilors, we found a notable participation of non-whites and of councilors that had not completed even primary education. We also found little evidence of gender imbalance; men and women were represented roughly equally on the councils. With respect to the political profile we found a strong predominance of councilors affiliated or sympathetic to the Workers Party (PT).

The councils are all structured around face-to-face meetings. Concerning *moderation,* public officials that have no training in participatory techniques facilitate most meetings. While the agenda is decided collectively, it should be noted that the Health Secretariat suggests an important part of the themes that are included. During the discussions we found a mix of rational and relational modes[2] of deliberation as well as of *constructiveness* and confrontational modes of interaction.

The minutes analyzed show that the discussions were not simply the presentation of “shopping lists” of councilors’ complaints and demands. On the contrary, councilors debated various types of health issues, including discussions about health policies and programs, and problems with service delivery; participation issues, dealing with procedures for elections and meetings; and local problems, such as water supply, infrastructure or security.[3]

One of the principal health policy discussions that we observed in the council minutes during this period was around outsourcing. This comprised the

[2] According to Friess and Eilders (2015) some authors have argued for the importance of considering emotional talk, humor, gossip, narratives, and casual talk as forms of deliberation. Considering this tendency Ryfe (2002) proposed the difference between “rational and relational modes of deliberation”.

[3] A more complete presentation of the debates can be found in http://www.centrodametropole.org.br/v1/dados/saude/Anexos_Artigo_Saude_CDRCCEM.pdf

contracting of *Organizações Sociais* (OS) (Health Organizations) to manage public hospitals and outpatient medical care units. Seven hundred health councilors rejected the use of OSs at the Municipal Health Conference, held in December 2005 (Teixeira, Kayano, & Tatagiba, 2007), but this did not stop the municipal government of São Paulo from passing a law implementing the outsourcing of hospital management to OSs in January 2006. In order to support this strategy, public managers have argued in favor of the flexibility to hire and dismiss employees, linking labor flexibility to gains in access to and quality of service delivery within the SUS.

In terms of health issues, the councils discussed how to reduce patient absenteeism for specialist consultations and suggested a range of solutions. One council organized a process of monitoring a hospital construction.

This short summary makes clear that health councils have opened the doors for civil society and health workers to closely follow and make their voices heard on Brazilian health policies, contributing to a more inclusive and dialogic decision-making process. Nonetheless, greater participation could not guarantee more equal relations among managers and councilors. For instance, in the outsourcing case public managers had their own agenda and the necessary means to make it happen, even when it implied ignoring civil society opposition.

Also relevant are the councils' monitoring activities, especially in poor and remote areas of Brazilian cities, including Sao Paulo. Equally important has been the defense made within the councils of access to health, infrastructure, and security as constitutional rights. Defending those rights not only within the local and municipal councils, but also in state and federal councils and national health conferences, was key to the implementation of the SUS during the 1990s against the tendency of reducing social policies, as well as to secure the expansion in the last 20 years of financing and access to public health services.[4] This expansion happened in parallel with the reduction of health inequalities in Brazil, as noted by Holcman, Latorre, and Santos (2004), Garcia and Santana (2011), and Coelho (2015). Their studies reported that between 1980 and 2010 considerable improvements were recorded in both infant mortality rates and life expectancy at birth, and also in reducing the

[4] Between 1995 and 2010, antenatal care coverage increased from 49 percent to 61 percent and practically universal vaccine coverage was attained for the main diseases and epidemics (DATASUS, 2011). The system's being universal and free of charge has also contributed to the success of national programs, such as the program to combat HIV/AIDS (levels of incidence and mortality in Brazil are considered low), and the Family Health Program, which served 34 million families in 2010. Health funding has also improved: health spending rose from 6.7 percent to 8.9 percent of GDP, with the public-sector portion of that total rising from 43 percent to 47 percent.

inequalities in these indicators among and inside Brazil's regions, states and municipalities.

**The Open Government Partnership**

If participatory experiments have been taking place in health-related policies for almost 30 years now, the Open Government Partnership is recent. The Partnership was set up in 2011 and today includes 69 countries. Brazil is one of the 8 founding members. According to OGP principles, each member country has to "develop and implement ambitious open government reforms" through biannual action plans. Those plans are to be developed and agreed upon by government and civil society in each country. Periodically, member countries report on their progress going forward, through an independent reporting mechanism - the IRM. This framework allows for a sort of built-in accountability system that favors citizen oversight over policy decisions coming from the Partnership.

To regulate the OGP nationally, Brazilian President Dilma Rousseff issued a decree that instituted the inter-ministerial committee on Open Government – CIGA (Brazil, 2011a; 2011b). The Comptroller-General of the Union (CGU) was initially appointed to coordinate this process and to be responsible for the action plans and the OGP governance in the country[5]. OGP in Brazil has a major focus on reforming public bodies in the federal administration.

Brazil is currently entering its third OGP cycle. After two cycles it is possible to reflect, albeit cautiously, on the designs, dynamics and outcomes of this experience in Brazil, and how does it relates to the general discussion about inequality and participatory mechanisms. Taking into account the country's tradition of spaces for public participation, OGP was received with high expectations. From its brief existence, it has nonetheless been a challenging process. Difficulties also stem from a particular political context in Brazil, where mobilized civil society groups perceive a less favorable space for dialogue, after almost a decade of expanding formal and informal channels for participation, notably at the federal level (Avritzer, 2014).

In its *inclusiveness,* the OGP faces challenges in fostering domestic coalitions, because participation was originally an external demand. Governments were supposed to create the necessary conditions for social actors in the country to

[5] The CGU was created in 2003 and its close links to the President's Office made it responsible for federal government efforts on agendas such as anticorruption, transparency and open government. As a consequence of the severe political crisis the country is facing culminating in an impeachment process that has removed elected President Dilma Rousseff from the Presidency in August 2016, several ministerial reforms were conducted and the CGU was formally abolished. The new 'Oversight, Transparency and Control' Ministry is expected to take over CGU functions, including on the OGP agenda.

take part in the process. But having to join this specific policy space meant that existing organized groups—already mobilized to address issues on the open government agenda (such as open data, budgetary transparency, and accountability in public management)—had to be sensitized and brought together, and at the same time had to perceive this new space as strategic and legitimate.

Participation has experienced peaks and valleys since 2011. Social groups' engagement was initially low, and then expanded during the implementation of the first plan and drafting of the second (mid-2012 until mid-2013), due to governmental efforts, mostly from the then-Presidency of the General Secretariat (SG-PR). Since then it has decreased again (Coelho & Waisbich, 2013; Steibel, 2015). Interactions have been more sustained in virtual spaces[6] than in the less frequent face-to-face meetings. Participation, even virtually, has been greater around key moments of the official calendar (such as action plans' drafting and evaluation), losing impetus in between those moments. The adoption of the *Participa.Br* platform also marked another governmental effort to foster inclusion through existing online tools, in an attempt to create synergies between the OGP processes and other virtual dialogues happening at the federal level. During the drafting of the third plan (in 2016) and as a response to a visible disenchantment and disengagement of civil society groups during the implementation of the second plan, government has proposed boosted online consultations for choosing thematic priorities for the upcoming round and has hosted face-to-face workshops to co-construct a few commitments, based on the most voted topics. Reassessing the balance between face-to-face and virtual dialogues seems to be a political choice from the government to respond to the challenges of sustaining organized civil society participation in OGP and fostering synergies among mobilized groups (within the federal administration and between public bodies and civil society).

Hypotheses for these *dynamics* were stated in the 2015 IRM report, which pointed out strong disagreements between state actors and some groups in civil society over OGP governance in Brazil (Steibel, 2015). The frame allowing for public participation has actually been one of the most important contentious issues in the Brazilian OGP experiment, with civil society calling for a multi-stakeholder arrangement to define which commitments should be included in the national plans, and how to measure their implementation, while government has resisted implementing such a model, preferring to leave overall coordination to the existing inter-ministerial body, CIGA.

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[6] Through autonomous mail lists such as the *ogp-br@googlegroups.com* and in governmental-led online platforms such as *E-Democracia and Participa.br*, where official consultations have taken place.

For participating civil society groups, a mixed model is the most consistent with OGP values, and the only one to make the partnership truly horizontal. Alternatively, the government prefers to keep civil society active in specific key moments, such as short-lived broad public consultations for drafting new plans and evaluating progress of current ones. Steibel (2015) defines this current deadlock as a contention over consultative versus collaborative participatory models. Steibel argues that even if the OGP does not actually require the latter, unless there is a renegotiation of OGP governance in Brazil, which means a new agreement on the modes of engagement and participation, it would be difficult to see this initiative prosper. This is because the tensions over participatory arrangements are having a demobilizing effect over the already-limited range of civil society actors initially engaged.

Several policy *outcomes* with potential to contribute to reducing inequalities should be mentioned. Transparency-related commitments, such as implementing an Access to Information Law (Plan I), updating the Federal Government Transparency Portal (Plans I and II), or even creating a system to monitor the National Plan on Nutrition and Food Security (Plan II), can have an impact on improving public services' quality and reducing inequalities by providing good information to the public and making citizen oversight possible. Even if there is a need to foster multi-stakeholder coalitions to make use of these data and sustain reforms that improve public resource allocation, opening up the black box of the State can be considered a real gain from the participatory experiment of the OGP. Other commitments that focus on the quality and integrity of public services are also relevant to reducing inequalities, such as efforts to develop the Public Services Portal and the Registry of National Education Prices (Plan I) or the National Program for Strengthening School Councils, the Digital Inclusion of Health Councils, and the Public Unified Panel for Data of the Water for All Program (Plan II).

In sum, the OGP agenda has great potential to help foster social participation in public policies. Its progressive consolidation inside the federal government, with more commitments being made from the first to the second cycle (from 32 to 52) and new public bodies taking responsibility for implementing them (from six ministries in 2011 to 19 in 2013) is encouraging. However, the current impasse around designing and enabling public participation can compromise the overall OGP potential, as suggested by the fact that the rate of commitments completion has dropped from the first to the second plan, from 25 completed commitments out of 32 (78 percent), to 31 out of 52 (60 percent) in the second cycle. These results will need to be studied in the future to understand the OGP's real impact on public management and inequalities reduction in Brazil.

## Discussing the Links

The health councils first appeared in the 1970s and were incorporated into the national health policy in the 1990s. The health movement fomented a coalition that worked for the implementation of this project. Subsequently, the consolidation of public participation mechanisms contributed to making this coalition alive and active in the Brazilian political scene. Its participation in health councils is marked by the permanent defense of the right to health, the requirement for greater transparency in health policy-related processes, and the monitoring of the SUS. The coalition has played a central role in the defense of a universal health care system that has strong potential for reducing inequalities.

This positive assessment is less evident when one evaluates these councils using the normative criteria advanced by deliberative theory. In this case, despite the encouraging results for the inclusion of various socio-demographic profiles, partisan diversity remains almost nonexistent. There is almost no use of moderation and facilitation techniques aimed at reducing asymmetries and facilitating the inclusion of actors with less discursive resources. When the subject in question is controversial and highly politicized—for example, hiring OSSs—the debate becomes confrontational, abandoning more constructive postures that allow for rationally considering the pros and cons of the proposed alternatives. In short, the fact that councils are legally empowered to make important decisions on health policy has not helped to strengthen their position when they differ from the choices made by public officials. In this particular case improving public deliberation mechanisms within health councils and conferences could have generated better and more widely accepted outcomes in regards to outsourcing for health services, which could have led, in their turn, to less conflict in policy uptake and implementation, as it was witnessed in the years that followed this debate. Developing and improving outsourcing arrangements for service delivery are at the core of several current public management debates in Brazil, both for the health sector and beyond. Taking all the documented controversies surrounding this topic, there is definitely a need for investing and improving deliberation tools, that can contribute to find agreed solutions to highly politicized debates, such as this particular one.

These different pictures emerge as one makes use of different analytical lenses. The first draws on the perspective of political mobilization (Carter, 2009; Dowbor, 2009; Tatagiba & Teixeira, 2016). The second makes use of criteria that, according to the literature, should be fulfilled to ensure the quality of public participation processes (and public deliberation processes, in particular). The analysis of the experience with the OGP further reiterates the importance of paying attention to the differences that emerge when analyzing participatory experiences with different analytical lenses.

The OGP experiment sprang from the Brazilian government's efforts to internationalize its anti-corruption and state democratization agendas since 2011. Our account of this experience showed the difficulties of integrating civil society groups involved in the process. To overcome these difficulties new governmental bodies were called upon to take leading roles, especially the Presidency's General Secretariat, which had extensive experience in fomenting participation in face-to-face mechanisms. SG-PR reinforced the use of online mechanisms and sought to improve the moderation process, increasing both virtual and face-to-face spaces for dialogue and the use of professional facilitators. These initiatives significantly helped to expand participation in the discussions during the first Plan but were not enough to stop the setback in the mobilization of civil society during the second Plan. The loss of vitality of the initiative happened in parallel with the slowing down of the percentage of commitments implemented by the Ministries. More investiment in improving public deliberation mechanisms here as well—with a strong accent on the specific needs of those recently created virtual spaces and a clearer strategy of how to connected virtual and face-to-face encounters—could have helped to sustain mobilization and to build a constituency around OGP in Brazil.

These two cases pointed to plausible connections between the functioning of participatory mechanisms and the implementation of policies related to inequalities reduction. It is reasonable to bet that the councils' permanent defense of the health care rights agenda and their continuous monitoring of the SUS have been associated with its expansion and vitality. The history of OGP is more recent, yet the initiative has contributed, especially in the short period in which it gained support from governmental and state actors, to the implementation of a set of engagements related to improving transparency, access to public data, and the integrity and quality of public services.

These two cases have also highlighted the need to reflect on the analytical tools that have guided research on the relationship between participatory processes and their potential contribution to the definition and implementation of public policies. There are many studies suggesting that truly inclusive and deliberative processes should lead to good proposals, which will feed the public sphere or, even better, will be quickly incorporated into the State's agenda. However, the health councils' case does not involve genuinely deliberative processes. It is to a certain extent the capture of these spaces by groups advocating predefined agendas that guaranteed the councils' effectiveness in defending the SUS model, one of a universal health care system with great potential to reduce inequalities. In its turn, OGP has seen its ability to implement its commitments reduced between the first and the second plans, despite having invested in improving the participatory process when adopting moderation practices to reduce asymmetries among participants and also widen the possibilities for online participation.

## Conclusion

This paper analyzed the experiences of local health councils and the Brazilian participation in the OGP in order to assess the plausibility of associating participatory processes, which grew in Brazil since the 1990s, to the dynamics of reducing different types of social inequalities, that began in this same period. In both experiments it was possible to advance plausible hypotheses about the relationship between these two dynamics.

We saw, however, that these results were less determined by the quality of the participatory process as defined by the deliberative democracy literature than by the nature of political alliances and mobilization processes that supported these spaces, both when they refer to face-to-face encounters and to virtual ones. Given this panorama, it seems important to invest in an analytical framework that, while dialoguing with the concepts that have guided the evaluation of deliberative mechanisms, allows us to analyze the participatory experiences as political mechanisms that can, even when operating outside the standards deemed appropriate by deliberative theory, enjoy the necessary vitality to foster policies capable of reducing inequalities.

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