Stewardship and governance: structuring dimensions for Implementation Primary Health Care Policies in Paraguay, 2008–2017

Abstract This study analyzes the conduction patterns of implementing Primary Health Care (PHC) in Paraguay in three government periods (2008–2012, 2012–2013 and 2013–2017) and three management levels (national, regional and local). This is a qualitative study based on grounded theory. A priori categories on PHC stewardship and governance in Paraguay were analyzed. An open-ended questionnaire was applied to a sample of social, political and technical stakeholders: ministers, coordinators, managers, consultants, and international organizations’ experts. Data were processed combining the use of Atlas Ti software and sorting findings in a structured Excel matrix. Gaps in leadership, regulatory mechanisms, technical capacities for health planning and management and financial implementation methods have affected PHC continuous expansion and strengthening process. The findings show limitations and possibilities for the implementation of this health policy in Paraguay, evidencing the need for greater qualification of management and political stability in its conduction.

Key words Stewardship, Governance, Health, Primary Health Care, Paraguay

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Introduction

Expanded freedom in democratic contexts and access to information through new technologies has increased the participation and expectations of society vis-à-vis its health authorities, including the internal health public (professionals and health staff). This setting exposes and makes visible the conduction methods and stewardship competences of managers responsible for the management and implementation of public health policies. This study proposes the analysis of PHC stewardship and governance.

Paraguay is a unitary and decentralized republic with a political and administrative distribution organized into 17 departments and 18 health regions, including capital Asunción and 249 municipalities. The estimated population was 7,112,594 inhabitants in 2017, of which 59% speak the original alternative language “Guarani” at home, and the illiteracy rate is 5.2%. The average life expectancy of women and men is 75.12 years and 70.83 years, respectively. The out-of-pocket expense per capita is one of the lowest in the region, with US$ 461 in relation to the Gross Domestic Product (GDP), considering the Latin American mean of US$ 718 per capita. Institutional deliveries have risen to 97%. The Human Development Index (HDI) holds the 110th spot (0.693) and the Gini index places the country at 48.3, although Paraguay stopped being among the most inequitable countries in Latin America.

The Paraguayan health system is inserted in a macroeconomic market model characterized by high segmentation and fragmentation, weak articulation and coordination among subsectors, with organizational adjustments to the system that have been incorporated through regulations of Law 1032/96 in the last 22 years. Social security covers around 17% of citizens, which is the lowest in the region, and the private subsystem does not exceed 7%.

The Ministry of Public Health and Social Welfare (MSPBS), simultaneously develops functions of stewardship, supply and financing and assumes the responsibility of ensuring health to 100% of the population, with real coverage close to 65%, through an integrated network of services, organized by levels of care and complexity, with asymmetric decentralization processes and current trend towards centralization.

In 2008, a model of care based on family health facilities and teams (USF) (ESF) was incorporated, which are integrated at the local level to provide immediate response and resolution of health problems and needs to individuals, households and communities in defined social territories, promoting a shared responsibility and management of intersectoral actions aimed at ensuring continuity of care, promoting functionality, integrality and integration of existing service networks, improving enabling conditions and environments, organization and integration of horizontal programs with a high health impact.

This study mainly aims to analyze the influence exerted by conduction methods in the process of implementing the renewed Primary Health Care model within the framework of government changes in the last nine years, through a systemic approach to the different issues that emerge in settings of political instability that influence and affect health outcomes.

Conceptual framework

The complexity and interdependence of political, economic and social variables underpin and influence the conduction methods and condition the course of implementation of public health policies and the ability to solve problems and needs related to the social determinants of health. In the case of PHC, governance proposes the reconfiguration of the health authority’s conduct profile, readjusting the means to achieve the agreed political objectives and results and incorporating features such as professionalism, conjugation of technical and political leadership, balance between efficiency and equity and its consequences in terms of decisions, respect for the principles and regulatory, administrative and legal frameworks inherent to the public sphere, which will allow the exercise of the governing role on behalf of the government, as part of a new social pact at the service of public interest, proposing a new scheme of relationships between government and society, understood as good governance.

In a democratic context, governance is a systemic function that facilitates adaptation and linkages between State and civil society, public administration and organizations, institutions and citizenship through exercises and dynamics of integration that progressively increase cohesion between higher and lower levels, in balance with cultural practices, openness to the application of new methods, tools, planning devices and information systems, with the purpose of influencing beyond the health field, projecting the
modification of the social environment for the
effective protection of an established right.

It is possible to revive, in the health field, an
effective model aimed at resolving conflicts, in
settings of large power asymmetries, where gov-
ernance can affect the equity and sustainability
of egalitarian distributive policies. This concep-
tion gives rise to the idea of reflective govern-
ance, which repositions the figure of the State, re-
sponsible for the equality of economic and social
conditions, to balance forces and power in deci-
sion-making.

Substantive competences for PHC manage-
ment are projected in the health and intersec-
toral realm, considering new coordination mech-
nisms, new strategies, different performance
criteria, based on values, socio-affective attitudes,
political intuition, suitability, negotiating capac-
ity to cope with level of resistance and conflict
nodes.

The effects of governability rely on the dy-
amic balance between styles of government and
social intelligence and capacity to achieve gov-
ernment responses at different levels. Govern-
ability occurs when spaces are institutionalized
so that organizations enable citizens to interact
with governmental levels, exercise their civil and
political rights and perceive democratic incen-
tives that protect population groups in settings
of inequality or political errors.

In countries with clear socioeconomic in-
equalities, digital gaps and access to information
affect the public function’s transparency and ef-
fectiveness. E-governance is an essential link to
strengthen the capacities and citizen participa-
tion in the decision-making processes.

In the context of PHC, the sustainable con-
duction method must overcome the traditional
hierarchical scheme, incorporating social cap-
tal, participatory spaces, cooperation modes
and flexible work styles, peer evaluations and
self-evaluations, as well as considering expecta-
tions of stakeholders and shared responsibility
between civil society and public authorities. It
must adapt changes in structures, management
procedures and power behavior for the adequate
management of emerging conflicts, endorsed by
the leadership of the public and political func-
tion.

Interdependence between politics, govern-
ability and health outcomes has great relevance
because of its effects in strengthening institu-
tionality, when government levels, management
and civil society stakeholders manage to oper-
ate together. Therefore, good governance corre-
sponds to the dynamics of policy networks with-
in a framework of responsibility in the exercise of
public action, where predominance of the social
and economic commitment that generates bal-
ance and the management of a code of values is
recognized.

The revised theoretical perspectives support
the understanding of health management mod-
alities, linking to research questions and con-
tributing with ideas originated in the findings for
the construction of this public policy.

Methods

This is a qualitative study based on the grounded
theory by Glasser & Strauss. This methodology
uses the interpretation of texts and statements to
approximate knowledge of the implementation
of the PHC policy in Paraguay in three govern-
mental periods (2008-2012, 2012-2013 and 2013-
2017). Sampling included 24 key stakeholders
who exercised leadership, management and tech-
nical advice roles in PHC. Academics, experts and
consultants from international organizations, se-
lected by convenience according to professional
profile, experience and knowledge in the imple-
mentation of this public policy, from national, re-
 gional and local levels were also included. A ma-
trix of identification of key players was drawn up,
with complete information, stratifying the select-
ed sample by institution (public and NGO), levels
of care and period of government. We collected,
analyzed and conceptualized contributions of re-

The categories of analysis explored included
knowledge and scope of the function of health
stewardship, interpretation of governance meth-
ods, mechanisms for the selection of government
managers and availability of evaluation tools, as
 well as technical capacities and skills, regulatory
and financial management aspects, factors, mech-
nisms and interactions that facilitate or hinder
governance, social cohesion, consolidation of in-
tersectoral achievements, effective coordination
of networks of people and institutions in order
to achieve results within the framework of this
policy. Chart 1 shows the systematization of these
categories, specifying realms and sub-realms.
Data processing started with the elaboration of
a list of those categories, adding other emerging
ones, selecting significant discursive fragments,
organizing them by realms, sub-realms, concepts
and constructs, generating hierarchies and spec-
ifications. It was necessary to proceed to an in-
### Chart 1. Categories of analysis: realms and sub-realms of PHC Stewardship and Governance – Paraguay.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Analysis categories</th>
<th>Realms</th>
<th>Sub-realms</th>
<th>Operational Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Policy planning and formulation</td>
<td>Health policy agenda and strategic plans in place.</td>
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<td></td>
<td></td>
<td>Sectoral regulatory and legislative capacity</td>
<td>Capacity to formulate new laws, regulations and standards that can be implemented on a national, regional and municipal basis.</td>
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<td></td>
<td></td>
<td>Financial management capacity in PHC</td>
<td>Financial sources and flows, transfer circuits, distribution of resources (installed capacity, staffing and human resource gaps, sustainable supply of medicines and supplies).</td>
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<tr>
<td></td>
<td></td>
<td>Stewardship functions</td>
<td>Empowerment of the Health Stewardship functions. Opening to Governance as a new social pact.</td>
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<tr>
<td></td>
<td></td>
<td>Health system</td>
<td>Knowledge about the Paraguayan Health System and its recent reforms.</td>
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<tr>
<td></td>
<td></td>
<td>PHC strategy</td>
<td>Knowledge about the PHC strategy: current definition and interpretation.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>RIISS</td>
<td>Compliance with the organization and structuring processes of the RIISS, through the coordination lines.</td>
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<td></td>
<td></td>
<td>USFs</td>
<td>Effective insertion and organization of USFs in local networks through a control panel.</td>
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<tr>
<td></td>
<td></td>
<td>HR-PHC</td>
<td>Balance, staffing according to gaps, identification of financial protection mechanisms, expanded recruitment of community workers and priority disciplines and their training.</td>
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<tr>
<td></td>
<td></td>
<td>Training and leadership</td>
<td>Training of managers in health administration and governance, type of selection of management personnel, labor and salary regimen of managers.</td>
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<td></td>
<td></td>
<td>Empowerment and Responsibility</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Principles and Values</td>
<td>Rights approach</td>
<td>Existence of mechanisms, spaces and indicators of transparent management with facilitated accessibility to all strata of society and public opinion - Transparency in the handling of information.</td>
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<td></td>
<td></td>
<td>Voice and accountability</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Fight against corruption</td>
<td></td>
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<td></td>
<td></td>
<td>Political Ethics</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Governance</td>
<td>Coordination mechanisms</td>
<td>Coordination mechanisms State, Private Sector, Third Sector, Community Organizations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Areas of influence</td>
<td>Influence in formulating policies, plans and administrative decisions.</td>
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<tr>
<td></td>
<td></td>
<td>Participation in decision-making, regulation and accountability processes</td>
<td>Influence in the production of services and financing.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Participation in ASIS and social management processes</td>
<td>Levels of participation and influence in health decision-making. Knowledge and management of legal changes and regulatory mechanisms. Knowledge and use of transparency and accountability mechanisms.</td>
<td>Contribution in dynamics of development and strengthening of social and environmental management processes, Decentralization and analysis of health situation.</td>
</tr>
</tbody>
</table>
interpretation of the referred conduction processes regarding PHC stewardship and governance, integrating findings, context, prior knowledge and experience in that field. Output was generated through Atlas ti software, and a complementary Excel matrix was used to sort and systematically analyze the categories. Results are organized from the key messages obtained from the interviews, in segments selected according to a priori codes and some of the emerging codes. Ethical considerations, informed consent, confidentiality, anonymity and voluntary participation were taken into account.

Results

Knowledge about Stewardship and Governance functions

The concept and functions of “health stewardship” have had several interpretations, with a predominance of a structured concept of conduct established by international organizations, linked to public policymaking and exercise of health administration, formulation of plans, programs and projects, provision of services, application of laws and regulations and implementation of standards. Some stakeholders affirmed that stewardship is put to the test through the ability to overcome bureaucratic hurdles, introduction of innovations, effective response to events or diseases of collective impact, power to call for the effective participation of the community in the social management of health, continuous and coherent application of health promotion strategies that allow for the joint installation of changes and transformations.

“Governance” has been linked to the integration of referents from different institutions in decision processes, in formal participation levels. Others related this concept to the public exercise of functions on behalf of the State and some showed lack of knowledge and difficulties to understand its meaning.

Selection of leadership positions in the public sector

There was consensus in affirming that some institutions carry out merit-based and aptitude-based competitions, although in most cases the designation for the exercise of management positions builds on trust, where competences are frequently not in accordance with the challenges and responsibilities. The selection based on skills and leadership originated in a solid academic education, or respect for a public administrative career that grants leadership skills is exceptional.

In the three periods of government, the competition has been incorporated for the operational levels, but not for the managerial levels (Regional level professional, 1st period).

Both the selection of ministers and selection of management cadres historically respond to the appointment by the Executive Power (Former Minister).

Ministers in office are surrounded by people who followed their vision not always based on suitability (Central level manager, 3rd period).

Availability of performance evaluation tools for managers

There are no known mechanisms to evaluate the skills and abilities of high public management or senior management that allow comparing, discerning and qualifying the management and conduction of processes with guidance and results.

... Directive cadres are evaluated indirectly through citizenship opinion surveys; in other cases, performance is measured through numerical weights, which do not reflect reality (Expert, 2nd period).

Regulatory devices

In the three periods of government, the application of regulatory tools at the first level of care was weak, both in the central and peripheral activities. The lack of specific technical evaluation and systemic analysis are confounded with control devices and the performance of specific audits, which prevent an overview of the limits of functionality of the local micro-networks where USFs are inserted. No sustained adjustments are achieved, despite available standards, manuals, protocols and guides and other operational tools, considered as a strength and indicators of stewardship.

... There is a perception that regulatory and corrective measures are installed once management problems are detected, and respond to complaints, which are followed by a passive wait for the response. (Consultant, International Organization, 3rd period).
Evaluation activities

In the first stage, external evaluations allowed an approximation to the macro diagnosis of ongoing processes, delaying the design of tools for the systematic evaluation of this new public policy. This was attributed to the short periods between governments, the use of usual indicators used in management controls of service networks and health programs, considered inadequate due to the need to identify new performance indicators that reflect the specific introduction and functionality of PHC.

... Social control is relevant when there are no other means to detect institutional shortcomings that prevent potential beneficiaries from organizing themselves properly and access their benefits. (Former Minister).

Financing model and sustainable sources of resources

The annual projection of funds conceived at the onset of the first stage of implementation of the renewed PHC raised the annual increase of 200 USFs per year. In the last two rotations of government, financial restrictions have shown the shift of PHC as a political priority, reflected in the discontinuity of installation and functionality of new family health facilities, reaching less than 40% of expected coverage in 9 years.

... There is a consensus that mechanisms for allocating resources are not carried out according to a correspondence analysis with Primary Health Care’s fields of action, including promotional, preventive, curative and rehabilitation activities ... (International Expert)

... There are no independent procurement processes; they are immersed in the general procurement processes of the Ministry of Health, in turn related to the complex organization and financial flow of the Ministry of Finance, which affects timely access to essential resources. The flow of PHC personnel and professionals remuneration follows its normal course, salaries credited to accounts. The financial flow for the acquisition of medicines and supplies is managed on a large scale...... It is difficult to clearly define the execution of assigned funds ... (Manager, 2nd period of government).

Quality of technical cadres

It has been affected by the successive rotation of governments, as well as the continuity of managerial training and their competences to exercise health stewardship, reflected in the performance, communication styles, peer relationship method, negotiation and conflict resolution and comprehensive knowledge of the realms subject of conduction.

Chart 2 summarizes the results, showing the realms and sub-realms of stewardship and governance in each period of government.

Discussion

The analysis of the capacities of conduction and construction of governance in the course of implementation of the renewed Primary Health Care shows the strong link between political processes and health outcomes. The successive changes of government in settings of political instability have put to the test the stewardship capacity and other multiple variables, and autonomy, leadership of political and civil society actors and financial sustainability were compromised.

The successive turnover of managers, technical cadres and operative personnel has influenced governance, affecting the continuity of intersectoral achievements, coordination processes of subnational teams, quality of planning and evaluation, effective coordination by levels for the implementation of strategic guidelines, commitment of technical working groups, change of priorities in the management agendas, and social cohesion has been weakened. Other effects generated have been the loss of clarity in the conduction and coordination of the guidelines established in the PHC’s initial Strategic Plan, losing the focus that effectively links health problems to their social, cultural and individual causes.

There is a need to concentrate State action on strategic functions for the development of human and social capital, for the strengthening of the rule of law and expanded and strengthened democracy.

Different conduction capacities have been seen in the three periods of government, although some realms have been more affected, such as weak information system, difficulties to develop systematic evaluation processes and the continuous training of the health workforce.

With regard to regulatory capacity, this realm is cross-cutting with all other sub-realms of stewardship, considering that it is linked to political variables of power and governability. Regarding the cyclical process of reorganization of public institutions and offices, after each change of government, and in particular those processes linked to the PHC strategy, the role of international
<table>
<thead>
<tr>
<th>REALMS</th>
<th>SUB-REALMS</th>
<th>1ST PERIOD 2008 - 2012</th>
<th>2ND PERIOD 2012-2013</th>
<th>3RD PERIOD 2013-2017</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Knowledge and scope of the term stewardship</td>
<td>Incorporation of the social perspective into the other functions and roles</td>
<td>Normative and traditional health services provision function</td>
<td>Compliance with Rules, Regulations and Laws</td>
<td>Strict conduction methods coexist, adherence to rigorous standards, decreases integration of new stakeholders, paralyzes work teams, alienates organizations and fragments the provision of services.</td>
</tr>
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<td></td>
<td>Reinterpretation of the stewardship concept</td>
<td>Adds social cohesion and aligns government and development policies</td>
<td>Overcomes bureaucratic barriers, facilitates structuring between upper and lower levels</td>
<td>Incorporates adjustments and adaptations into changes and organizational innovations</td>
<td>The governing role should broaden its scope, incorporate organizational innovations, adaptability, agility, leadership, specialization, it should promote governance, exercise the role of organizing and articulating of stakeholders, institutions and organizations.</td>
</tr>
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<td></td>
<td>Mechanisms for the selection of government officials</td>
<td>Trust positions, transfer of experts from other government secretaries</td>
<td>They do not respond to merits, some managers remain</td>
<td>Global rotation of HR, managers and technicians from all health authorities</td>
<td>Only in some cases, the HR profile is characterized by aptitude, suitability, leadership, training, skills and conduction abilities.</td>
</tr>
<tr>
<td></td>
<td>Existence of management assessment tools</td>
<td>They are evaluated by management results and the Executive evaluates the ministers.</td>
<td>There are no tools to assess skills and abilities of managers, but rather of middle managers</td>
<td>Popularity level is measured as a synonym of management acceptance</td>
<td>In general, they are evaluated by the results of management, through opinion surveys to the public (successful processes, cohesion of executives).</td>
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<td></td>
<td>Level of consensus achieved</td>
<td>High</td>
<td>Median</td>
<td>Low</td>
<td>Balance of authority, legitimacy of values and social norms.</td>
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<tr>
<td></td>
<td>Model (Political conduct)</td>
<td>Synergic model</td>
<td>Mixed</td>
<td>Hierarchical model</td>
<td>Trust-based cooperation is more effective than authority-based cooperation.</td>
</tr>
<tr>
<td></td>
<td>Participation of a diversity of stakeholders: Intersectoriality</td>
<td>Mixed decisional networks</td>
<td>Median</td>
<td>Weak</td>
<td>Multiple mechanisms and initiatives for the direct participation of society and communities in the management of public policies.</td>
</tr>
<tr>
<td></td>
<td>Perception of society and governability</td>
<td>Balance of authority, legitimacy of values and social norms</td>
<td>Transition, tendency to centralization</td>
<td>Centralized, bureaucratic management</td>
<td>Good governance: Mission to guide, within the framework of a comprehensive and sustainable development, the primary goals and objectives of health, quality of life and well-being.</td>
</tr>
<tr>
<td></td>
<td>Planning and Implementation of Policies</td>
<td>Strengthening strategic stakeholders vs Weak evaluative processes</td>
<td>Insufficient political and technical times.</td>
<td>Institutional Strategic Plan</td>
<td>Planning must incorporate the rights, values and practices approach, as a support for the regulatory framework designed to implement the policies.</td>
</tr>
<tr>
<td></td>
<td>Financial Management, quality of expenditure, efficiency, central government / subnational levels coordination</td>
<td>Free services</td>
<td>Management evaluation similar to the rest of the programs</td>
<td>Rotation of qualified stakeholders that affected the institutionality</td>
<td>Changes in care and organizational models are restricted due to lack of financial guarantees.</td>
</tr>
</tbody>
</table>
Conclusions

The findings suggest that the implementation of this public policy has been influenced by political instability. The successive rotation of governments in the last five years has diverted the implementation of PHC from its normal course, weakening comprehensive approaches and their potential as a State policy, reaching a coverage of 44% in nine years.

The guiding role has been tested beyond the usual performance criteria, given the challenges for overcoming various obstacles and bureaucratic hurdles to install changes and transformations around this public policy, including adaptability to complex settings, financial limitations and resolution of crises.

We identified the need to give strong impetus to training programs for managers and technical cadres that incorporate competences in a framework of demonstrated suitability according to position, area or performance organization to carry out the social development plan, and long-term projected social policies, incorporating competition for managerial positions.

Regarding governance, we note a shift between one government and another, moving from a flexible and inclusive mode to stricter hierarchy-oriented modalities.

Financial management has been affected by structural constraints, quality of spending, level of efficiency and coordination between the central government and subnational governments. The flows of resources have been insufficient to implement functions and norms, agreements and social and political dynamics, and to project sustainable changes.

Regulatory capacity was characterized in the beginning by the implementation of incentives and commitments, and in the following stages by the incorporation of oversight processes, while not of systematic evaluations to introduce improvement plans, gradually installing restrictive mechanisms that have affected social cohesion, reincorporating red tape practices. The reconstruction of governance will require considering the importance of mediation, social referents and interested parties from the public and private spheres, assuming dynamic and facilitating roles of interactions and relationships. This can exert influence to revive and maintain progress and achievements.
Collaborations

MS Cabral-Bejarano elaborated the design and the methodology, fieldwork, organization of the database, analysis, discussion of the results and drafting of the scientific paper. G Nigenda, A Arredondo and E Conill participated in the review of the design and methodology of the study and analysis and discussion of the results.

References