

Decentralization and Hospital Governance in Rural Paraguay

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Abstract

This study explores hospital board governance, particularly the dimensions of accountability, transparency and civic participation, within Local Health Councils (LHCs) in two locations in rural Paraguay. The democratization and decentralization efforts of the Paraguayan federal government in the last 20 years resulted in creation of the LHCs, but little research has been conducted on how these entities are now working in comparison to the expectations envisioned for them. This study examines LHC member understanding and practices by conducting semi-structured interviews with council members in two different locations. I reviewed relevant Paraguayan law and compared LHC member responses with the legal expectations of the role of the LHC and council member responsibilities. I also reviewed several health council organizational documents, such as rules and procedures, financial statements and by-laws, with the same intent. Using interpretive social science methods, I analyzed this data in conjunction with the information I gathered through participant-observation during my Peace Corps service in one of the communities examined here. This study finds that local health councils face numerous challenges to governance, including member role confusion, few implemented planning and oversight processes, weak systems of accountability and a lack of resources and support given to LHCs, creating a great challenge to meet expectations set out for them by federal law.

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List of Abbreviations

CG – Comptroller General
CIRD – Nonprofit *Centro de Informaciones y Recursos para el Desarrollo*
DAC – Development Assistance Committee
DHC – Departmental Health Council
DHP – Departmental Health Plan
GDP – Gross Domestic Product
IMF – International Monetary Fund
LHC – Local Health Council
LHP – Local Health Plan
MOH – Ministry of Health
NED – National Endowment for Democracy
OECD – Organisation for Economic Co-operation and Development
TI – Transparency International
UN – United Nations
UNDP – United Nations Development Program
US – United States
USAID – United States Agency for International Development
WB – World Bank

CHAPTER I INTRODUCTION

For the last two decades, the leaders of international institutions have argued democratization and decentralization represent key strategies for promoting socio-economic development, by contributing to equity and social justice (Regmi, 2010). An essential component of decentralization, as outlined in the Millennium Development Goals, is to attain universally accepted human values and rights, such as freedom from hunger, the right to basic education and the right to health. This achievement is viewed as critical to the overall process of decentralization because it ideally would diminish the problems found with over-centralization, such as undue levels of review, inflexibility, corruption and lack of community orientation (Regmi, 2010). The United Nations (UN) Millennium Declaration affirms decentralization as key to poverty reduction by allowing citizens to be active participants in policy decision-making, implementation and evaluation (Zanotti, 2005).

The UN established good governance standards as a means of implementing these democratization and decentralization initiatives at the institutional level (Zanotti, 2005). The metrics adopted by the UN represents an approach to improved governance that attempts to incorporate the dimensions cited above into practice within governmental entities: accountability, transparency and civic participation. Paraguay adopted the decentralization and governance initiatives proposed by the UN in 1994, a move many interested analysts attributed to pressures from within the State and internationally to do so (Mora, 1998; Rojas, 2000). However, the appropriateness and effectiveness of governance initiatives in achieving their stated goals, particularly in the ‘developing’ world, remains uncertain.

This study examines how closely aligned Paraguayan health council practices are with the stated objectives of these governance initiatives by the State by comparing current LHC member understanding and efforts with the expectations established by the Paraguayan federal laws that created them. This study reviews the concepts of decentralization and governance, while providing a review of Paraguayan history, specifically as it relates to decentralization and governance within the health sector.

I had the privilege to serve as a Peace Corps volunteer in a small town in rural Paraguay (referred to in this study as Town A). During my two-year tenure there, I assisted the district hospital with several small projects, mostly health campaigns via public forums and radio broadcasts and, as matters evolved, I personally experienced the medical services provided by the hospital on several occasions, most notably when I broke my foot and received medical attention. I also attended several LHC meetings and obtained a sense for how the council was implementing the decentralization and governance initiatives set out for them by federal law. I wanted to gain more knowledge of the perceptions of LHC members of their roles and the resources available to them to implement the responsibilities associated with them. From my vantage point as a community member, there seemed to be a disconnect between the Ministry of Health’s (MOH) policies and the ability of the LHC’s to implement them and I sought to explore this notion further.

I begin my analysis by examining the various classes of decentralization that have been identified by a variety of scholars (Oates, 1972; Sato, 2002; Tiebout, 1956). I then investigate

various explanations concerning why international institutions increasingly have embraced decentralization as a tool to increase democracy and efficiency, decrease corruption and alleviate poverty (Dincer, Ellis, & Waddell, 2010; Dowbor, 1998; Sato, 2002). After exploring the positive rationales for decentralization, I assess the potential undesirable consequences associated with such an approach as well as the difficulties that accompany its implementation.

Chapter III provides a brief overview of Paraguayan history and discusses decentralization within that context. I examine how democratization initiatives within the country are connected to decentralization. I also provide a description of relevant legislation that specifically references the health sector and assess a few known implications of decentralization for hospital governance at the local level.

Chapter IV explores governance and how it relates to decentralization in the Paraguayan context and more broadly. Following the Cold War, the UN and other international institutions began to promote good governance as a means of increasing democratic processes across the globe (Zanotti, 2005). Good governance initiatives, therefore, undoubtedly reached the Paraguayan health sector during the period following the creation of the nation's new democratic constitution in 1992. I describe how the Paraguayan government has defined good governance and how such initiatives were incorporated into health sector reform. I explore three aspects of good governance that I found to be most prominent in the governance literature: accountability, transparency and civic participation. I conclude chapter four by addressing the question of whether decentralization lends itself to improved governance particularly in developing countries.

Chapter V provides further historic context on Paraguay, focusing on the various institutions involved in district hospital governance, most notably, the Local Health Councils. I pay special attention to the LHC and its history and organizational structure. I also attempt to define the councils based on their organizational structure by applying the conceptualization provided by various governance theories and models (Conforth, 2003; Gaete, Sanchez, & Villalba, 2002). I end with a brief introduction to the two LHCs I chose for further study in an effort to give greater context to my research.

Chapter VI defines my research objectives and my expected outcomes. My inquiry sought to develop a better understanding of hospital governance within Paraguay by addressing the following questions:

- How do LHC members perceive their roles?
- How do those perceptions affect LHC board governance efforts in the dimensions of accountability, transparency and civic participation?
- How closely aligned are LHC practices in the hospitals studied to the expectations set out for them by federal law?

This chapter also details my research methods. I adopted a mixed methods approach to address the research questions identified above. Here I outline the approach and the strategies I used to guide my investigation. This chapter also presents detailed information on my approach to

gathering primary source data through document analysis and semi-structured interviews with LHC representatives of two councils located in rural Paraguay.

Chapter VII presents my findings from member interviews, addressing each question separately and providing a detailed explanation of the federal law to which I compared interview responses. I included findings from participant-observation and written materials analysis when doing so lent additional context or insight into interviewee responses. Lastly, I present my findings based on two comparisons, one of member responses to officer answers and another of responses of members of one LHC to those of another.

Chapter VIII provides an analysis of my findings, particularly with regard to the identified dimensions of governance. I strove to suggest the relationship of my research to the theoretical concepts elaborated by decentralization and governance scholars. I also sought to identify several other relevant themes that appeared in my analysis.

Chapter IX summarizes my study and poses several questions for further investigation concerning the relative efficacy and appropriateness of governance initiatives pursued in the Paraguayan context. My research contributes to the limited literature currently available on organizational governance in Paraguay. I also hope this study will help LHC members gain a greater understanding of the implementation dynamics of federal health policy decentralization efforts.

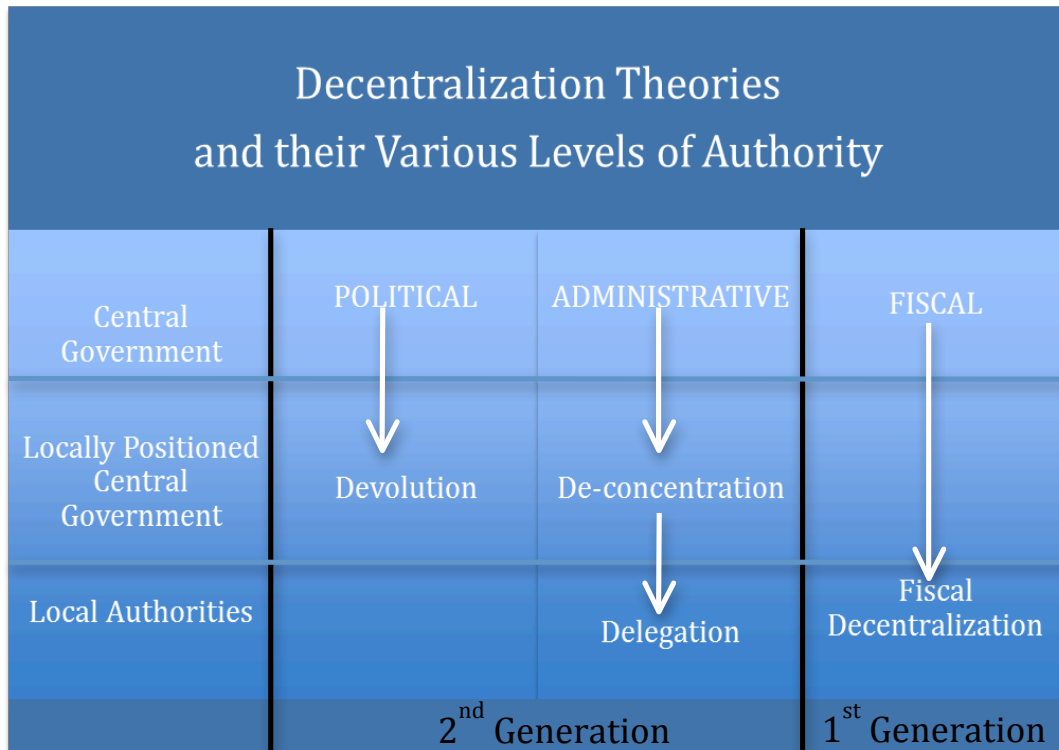
*Section 1**Literature Review & Paraguayan Context***CHAPTER II****DECENTRALIZATION**

The concept of decentralization is fundamental to the initiatives to improve governance that the Paraguayan federal government began to implement in 1995. This chapter provides a description of decentralization and its conceptualization in order to understand how it relates to governance reform. I define decentralization generally and then specifically, by identifying the various types that are most commonly implemented by governments. For purposes of clarity and to avoid undue repetition, I do sometimes employ certain of those terms as stand-ins for the more general term of decentralization. Those instances should be clear in context. I also seek to explain why the UN and other international institutions have identified decentralization as an important element in the struggle to decrease corruption and increase efficiency within governance (Dincer et al., 2010; Dowbor, 1998; Sato, 2002). I then provide an overview of the negative implications of decentralization identified by some scholars as well as common difficulties encountered in its implementation.

2-1 Decentralization Defined

Regmi (2010) has defined decentralization as the "... transfer of authority and responsibility in planning, management and decision-making from national to sub-national levels" (p. 365). The term does not refer to a single specific process, as it can take many forms, including territorial or institutional. Institutional (or functional) decentralization includes three major types: political, administrative and fiscal (Regmi, 2010). Political decentralization, sometimes called democratic decentralization or devolution, refers to the transfer of responsibilities to local populations, with the aim of increasing public participation in decision-making (Regmi, 2010). Devolution refers to the process of transferring authority from a central government to local government entities in an effort to increase transparency, accountability and civic participation (Regmi, 2010). Administrative decentralization does not transfer responsibilities to the local level, but instead relies on appointment of local officials as representatives of the central state. These individuals are primarily responsible for carrying out the functions outlined by the national government, but are also accountable to the local population in a process sometimes referred to as "downward accountability" (Regmi, 2010). Delegation implies the transfer of authority to organizations outside of government (at whatever scale), but still under its supervision (Regmi, 2010). Some of these forms are weaker than others, in terms of the relative extent of decentralization they create. For example, de-concentration redistributes administrative responsibilities to central government offices located locally, but without permitting any independent decision-making authority for local leaders. De-concentration does not include downward accountability. Thus, compared to democratic decentralization, de-concentration is much weaker (Regmi, 2010). Fiscal decentralization is the transfer of funds and/or the ability to fundraise from the central government to sub-national political jurisdictions (Regmi, 2010).

First generation decentralization theorists, including Tiebout (1956), Musgrave (1959) and Oates (1972) in the mid-20th century, viewed such efforts as transfer of fiscal power and responsibilities from the national to sub-national governments. Such initiatives are usually a response to a call for greater public sector responsiveness and economic efficiency through more effective resource allocation (Vo, 2010). Near the end of the 20th century, a second generation of decentralization theorists emerged that drew on ideas beyond public finance. These scholars examined the balance between fiscal centralization and devolution and argued that too much decentralization can be inefficient, as economies of scale disappear and negative fiscal externalities accrue (Vo, 2010). These analysts are best distinguished from first generation theorists by their differing motivations. While early decentralization thinkers focused on public sector responsiveness and economic efficiency through resource allocation, second generation devolutionists emphasized economic efficiency and knowledge of local preferences to avoid outward migration of people and firms when providing public goods and services (Vo, 2010). The various decentralization theories described here are illustrated in Figure 1.



Source: Modified from Regmi (2010), Litvac et al. (1998) & Ribot (2002)

FIGURE 1: THEORIES OF DECENTRALIZATION

2-2 Motivations for Decentralization

Dincer, et al. (2010) recently drew on several empirical studies to argue that corruption and decentralization are negatively correlated. In other words, they suggested greater decentralization leads to decreases in official corruption (Dincer et al., 2010). They contended a distributed economy creates more opportunities for citizens to act as a regulating force because it

facilitates cross-jurisdictional comparisons of policies and politicians (Dincer et al., 2010). Their model suggests that comparative observations made by a population across jurisdictions leads to decreased levels of corruption (Dincer et al., 2010). In other words, the greater the ability of the public to evaluate local authorities' performance against the behavior of officials in neighboring jurisdictions, the larger the impact of decentralization on curbing corruption. The authors argued this to be an effective measure of curtailing venality because it does not require detailed knowledge on the part of the public. In this view, the ability to compare authorities across jurisdictions increases downward accountability, which, in turn, hinders dishonesty (Dincer et al., 2010).

Many analysts see decentralization as a way to ensure democracy, by decreasing inefficiencies and improving accountability in the public sector (Balaguer-Coll, Prior, & Tortosa-Ausina, 2009; Sato, 2002; Zanotti, 2005). Fiscal decentralization allows local governments more freedom in allocating funds, yet the responsibility for providing support rests almost entirely with the central government, making local jurisdictions heavily dependent on the national (or other sub-national entity in federal systems) government (Sato, 2002). This can create tensions among the coordinating central and local institutions, as localities are not always capable of, or willing to seek, funds elsewhere.

2-3 Costs of Decentralization

Decentralized decision-making can lead to costs arising from a failure to account for external implications (Sato, 2002). With fiscal decentralization, it is common to find inequity when fiscal disparity, or the capacity of each locality to generate funds, is significant (Sato, 2002). Fiscal decentralization may not enhance accountability at the local level, especially when decentralization involves new local taxes, because this can lead to greater benefits for inefficient localities compared to more efficient ones (Sato, 2002).

Dowbor (1998) argues that inefficiencies are everywhere, not just in the public sector. Therefore, efficiency is not a sufficient reason to decentralize, as such might be even more inefficient than existing conditions. Dowbor gives the example of decentralization creating a situation in which local governments wait for central government transfers rather than pursue their own political interests. Decentralization may also increase inefficiency due to varying local levels of capacity and political will to implement initiatives and assemble the necessary resources to do so. He argues the overall logic of the political and administrative culture of a state is more important in addressing questions of efficiency and effectiveness than the simple alteration of organizational charts (Dowbor, 1998). Dowbor also contends that if developed societies are able to modernize and create more democratic institutional solutions by strengthening the central or national state, such a course should be regarded as acceptable (Dowbor, 1998).

In countries such as Sweden that enjoy high levels of citizen participation, decentralization of public resources can lead to improved state functioning (Dowbor, 1998). In Sweden, for example, 72 percent of national government funds are allocated to local jurisdictions and constituents participate in political meetings that directly affect decisions made about new buildings, expanding infrastructure and use of public lands, etc. (Dowbor, 1998). Although, this

high level of decentralization is not necessarily the most effective and efficient option for most countries, it is successful in the Swedish context, which has a small, well-educated and relatively homogeneous population.

There is little disagreement, Dowbor argues, that within the Latin American context, additional public resources must be made accessible at the local level, but that national governments receiving international aid or loans should be allowed to administer the resources themselves with more flexibility than is permitted by the decentralization guidelines outlined by the World Bank (WB) and other international institutions (1998). Dowbor agrees with the WB and other international governmental organizations that local governing entities do indeed need to be able to exercise more direct control over resource allocation. He nevertheless contends that the implementation of decentralization should be tailored to and driven by each country. He asserts that local governments need to concern themselves not only with infrastructure and social issues, but also with becoming a driving force for economic and social improvement. Lastly, he emphasizes the importance of horizontal networks of coordination among local governments, particularly in the case of critical sector-wide programs, such as health and education (Dowbor, 1998).

2-4 Challenges to Decentralization

Developing countries face far greater and more numerous challenges when implementing decentralization initiatives than do the nations of the developed world (Bardhan, 2002). Decentralization's supporters argue that population mobility (and "voting with your feet") will prove sufficient to determine a population's preference for public goods. But this assumption may not hold in the developing world context, nor for large segments of the population in developed nations, in which mobility is not always a feasible option due to economic constraints (Bardhan, 2002). Secondly, fiscal decentralization in practice assumes that funds allocated by local governments are indeed reaching their intended constituents. Often, however, this is not the case in developing countries, due to weaker information and accounting systems and monitoring practices (Bardhan, 2002). Third, political accountability is often lacking in developing countries where democracy is relatively new. Fourth, a major goal of decentralization (in the context of developing countries) is accessibility of services in remote areas, which is arguably more important than the efficient use of government resources (Bardhan, 2002). Despite these realities, the delivery of health services, for example, to remote areas is not necessarily undertaken to the detriment of efficiency, as it may actually increase efficiency in other areas, such as human productivity (Bardhan, 2002). Fifth, advocates of fiscal decentralization assume that low taxes result in a commensurately low level of public services while high taxes are correlated with a greater level of services. This relationship is more complicated than this claim allows, however, as its outcomes may be deeply inequitable due to the geographic concentration of local economies. That is, certain areas in a nation may have less trouble raising substantial tax revenues than others. Finally, the decentralization literature assumes that similar skills and capacities exist among the different levels of government, which is doubtful in most countries, especially in those in the developing world (Bardhan, 2002). This results in a problem of asymmetry, as described by Bird (1995), in which the central government does not know what to do and the local government does not know how to do it. This problem is more apparent in

services that require more technical skills, such as health, than those that do not, as, for example, street cleaning (Bardhan, 2002).

CHAPTER III DECENTRALIZATION IN THE PARAGUAYAN CONTEXT

Although there are many commonalities among decentralization initiatives within developing countries, there are also a number of differences in their implementation. This chapter provides a sketch of the context in which Paraguayan decentralization is occurring. It offers an overview of Paraguay's process of democratization that began in the 1990s and relates it to the nation's decentralization efforts. I also outline the decentralization legislation that relates to the health sector and summarize its process of implementation. This chapter aims to aid the reader in understanding key elements of Paraguayan history and their relationship to the nation's current health legislation.

3-1 Paraguayan Context

Paraguay is a landlocked country, bordering Brazil, Argentina and Bolivia in the heart of South America. The climate is subtropical and the land flat, but rich in water resources, timber and limestone. The nation has a total area of 402,752 square kilometers, which is slightly smaller than California. The Paraguayan people are 95 percent *Mestizo* (mixed Spanish and Native American) and speak two official languages, Spanish and Guarani. Gross domestic product per capita (GDP) in 2010 was \$ 5,200, ranking Paraguay 143rd in the world for GDP (CIA, 2011). The statistics reflecting access to healthcare in Paraguay are quite startling, with physician density for 2002 at 1.11 physicians and hospital bed density at 1.3 beds, per 1,000 population for 2009. For comparison, the United States has a physician density of 2.67 and hospital bed density of 3.1 (CIA, 2011). Many health problems are a direct result of poor sanitary conditions, a very significant concern, in light of the fact that only 40 percent of the nation's rural population had access to sanitation facilities in 2008, compared to 99 percent in the United States (CIA, 2011). These statistics are troublesome considering the high risk of infectious diseases, including bacterial diarrhea, hepatitis A, dengue fever and malaria in the country (CIA, 2011).

Spain colonized Paraguay in the 1500s, when Guarani Indians were then the country's primary inhabitants. Spanish settlers developed Jesuit missions to "Christianize" the Indians, but most missionaries allowed the Guarani to maintain a good portion of their culture and language. Unlike in many bilingual countries, where certain groups speak one language and others speak another, in Paraguay almost everyone can speak both Spanish and Guarani. Paraguay gained independence from Spain in 1811. In 1870, Paraguay engaged in the disastrous Triple Alliance war against Argentina, Brazil and Uruguay. The nation lost two-thirds of its adult males and much of its territory in that conflict. However, in 1935 in the Chaco war against Bolivia, Paraguay regained a large part of its territory, with the help of the United States (US) (CIA, 2011). The future Paraguayan dictator, General Alfredo Stroessner, fought as a general in that conflict and eventually led a coup against Paraguay's leader, Federico Chaves, and became the nation's president in 1954 (Mora, 1998). However, it became clear very quickly that Stroessner would not support democracy. During his 35-year tenure in office, the Paraguayan government became increasingly corrupt, periodically holding fraudulent 'democratic' elections, strongly restricting civil society and routinely violating the human rights of many of its citizens.

During Stroessner's tenure in office, Paraguay was considered a dependable ally of the US, until the Kennedy administration began to call for democracy. During that administration, the United States withheld 'Alliance for Progress' funds, equivalent to roughly 40 percent of the state's budget, from Paraguay to pressure the nation to adopt more democratic policies. The US also took steps to delegitimize Stroessner's regime in the decades following and effectively isolated the dictator during the second Reagan term in the late 1980s (Mora, 1998). In that decade Paraguay simultaneously experienced internal turmoil that contributed to the regime's destabilization. The lack of a successor for the aging and ill Stroessner caused a good share of that conflict. Two competing factions, traditionalists and militants arose from fractures concerning succession-related issues within Stroessner's Colorado party. The traditionalists sought a non-personalist change of power to follow Stroessner to guarantee the continued rule of the Colorado party, while militants supported the succession of his son, Gustavo Stroessner to the presidency (Mora, 1998). The economic recession of the mid-1980s intensified the struggle between the two factions as monies, long used to buy party support, dried up causing militants to stop backing Stroessner (Mora, 1998). The fierce differences between the two Colorado Party blocs is one of many factors that led to destabilization of the Stroessner regime, allowing for increased influence by organizations and institutions supporting democratization.

Yet, the most influential force for democratization, perhaps, was the internal insistence of the Paraguayan elite, including *Colorado* party members, military elites and businessmen, to reduce the size of the central government, cut fiscal deficits and boost markets (Mora, 1998). Outside the nation, the US, in particular, had a large influence in pressing for economic and democratic reforms. It used "soft power," including supporting democratic movements within Paraguay, to destabilize Stroessner's regime. From 1985 to 1988, organizations such as the 'Center for Democracy' and 'Women for Democracy,' sprang up in the country, most of which were funded by the National Endowment for Democracy (NED), which relies heavily on US government funding (Mora, 1998). These organizations, with vigorous NED support, increased pressure on Stroessner's regime to democratize and restore Paraguay's domestic and international legitimacy. Political pressure from the newly democratic neighboring states of Argentina and Brazil as well as pressure from international financial institutions, including the World Bank, also contributed to Paraguay's push for democratization (Mora, 1998).

A military coup ended General Stroessner's dictatorship in 1989 and installed General Andres Rodriguez as President. General Rodriguez, along with many other Paraguayan elites, became convinced that democratization was necessary if the nation was to regain its place as an actor on the South American and international stages (Mora, 1998). Nevertheless, Stroessner's overthrow created a vacuum as the aged leader had long served as a mediator between the military and the nation's political parties. This lacunae created an opening for social movements, business elites and the Church to press their demands for democracy more effectively (Abente, 1989). These simultaneous trends persuaded Rodriguez that it would require more resources to sustain an authoritarian regime than would be necessary to liberalize the government, at least to a certain degree (Abente, 1989).

As a result, the primary foreign policy goal of the Rodriguez' presidency (1989 to 1993), was to gain international support. The general hoped that through democratization, Paraguay would gain US aid, leading to increased foreign investment, trade concessions and credit

desperately needed to improve the nation’s economy (Mora, 1998). The President’s plan was relatively successful and relations with the United States improved dramatically. Rodriguez stepped down after four years, as he had pledged at the start of his tenure, and Paraguay conducted its first true democratic election in decades in 1993 (Mora, 1998), an important first step toward a functioning democracy. Figure 2 depicts key events in Paraguay’s history.

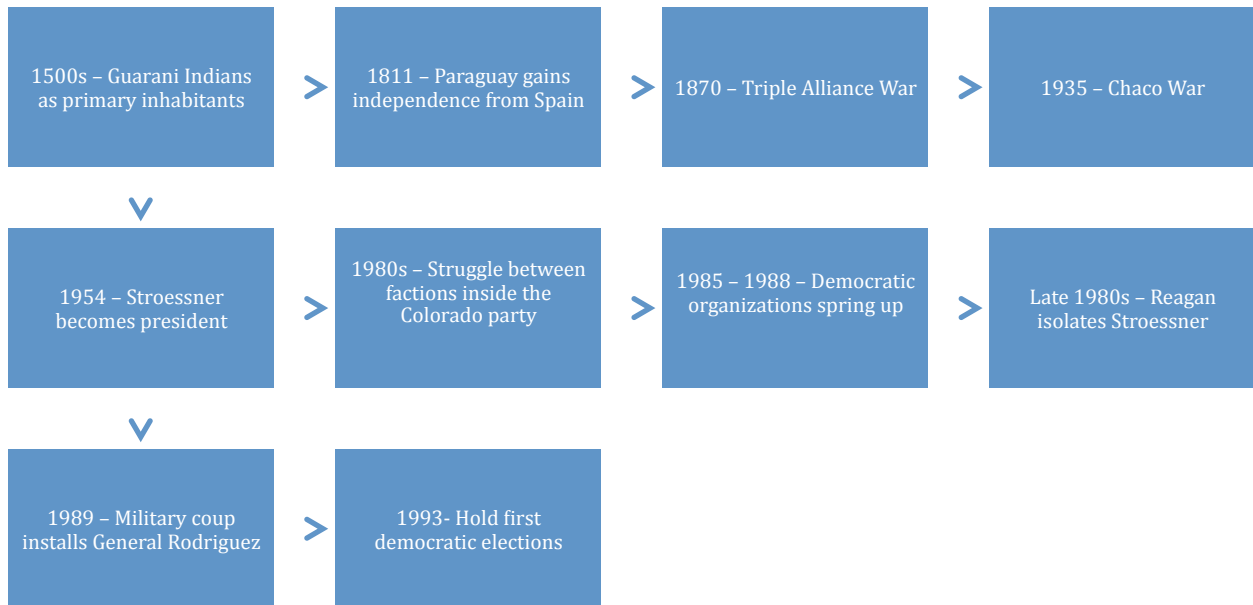


FIGURE 2: HISTORY OF PARAGUAY

3-2 Democratization and Decentralization in Paraguay

As already noted in passing, Paraguay was not alone in South America as it undertook governance change efforts. During this period, reform advocates routinely argued that democracy and decentralization were linked and should be implemented in concert. Proponents argued that decentralization of programs, in theory, allows for more civic participation, greater efficiency and effectiveness of service delivery as well as overall promotion of democratic processes (Pilar Garcia-Guadilla & Perez, 2002). The new Paraguayan constitution, ratified in 1992, incorporated this perspective by declaring the nation a unified and decentralized country (Angeles, 1999). In 1995, in accordance with ongoing efforts to de-concentrate federal power, the country’s health sector began a process of decentralization. Law 1032/96 (article 12) mandated the initiative by requiring health institutions to develop and implement a process of civic participation and local decentralization, through contracts, agreements, covenants and other forms of institutional coordination (1996).

In line with first generation decentralization theorists claims, Paraguayan law 1032/96 (article 12) established a national health system and encouraged civic participation and local decentralization through voluntary formation of LHCs. However, only ten municipalities in the nation initially created health councils because there were few incentives to do so, given that the

MOH continued to control the lion's share of funds for their operation (Carrizosa & Gaete, 2010).

Ordinance 22385/98 (law 1032/96), also passed in 1996, detailed the specific responsibilities of the LHCs, which included:

- co-management and administration of the hospital or health post within its jurisdiction (in cooperation with the National Ministry of Health);
- delivery of high quality health services, as defined by the Local Health Plan (LHP)
- development and implementation of a budget;
- presentation of weekly financial statements;
- establishment of administrative processes to guarantee the accurate and transparent allocation of resources;
- encouragement of methods and information systems for the better utilization of resources; and
- increased levels of efficacy and efficiency of health services delivery (1996).

Ordinance 19966/98 also detailed requirements for LHC board membership and community representation (Paraguayan law 22385/98, 1998). These two otherwise watershed statutes nonetheless ensured that LHCs would play strictly advisory roles in hospital administration as part of the first phase of decentralization initiatives.

A decade later, in 2006, law 3007/06 modified and expanded the first health sector decentralization legislation to provide LHCs authority to administer funds and pay for hospital functions (Duarte, Frutos & Martinez Dolan, 2006). This law ambitiously sought to redefine the relationship between the public sector and civil society through adoption of a more democratic and participatory process in order to encourage greater equity, efficiency, effectiveness and quality of health services (Duarte, Frutos & Martinez Dolan, 2006). Forty additional municipalities created LHCs to assume these new responsibilities for their communities after law 3007's amendments were adopted (Seall, Sasiain & Martinez, 2005). Lawmakers charged these new organizations with promoting equity and improving health care efficiency and quality for citizens in their jurisdictions (Ocampos Araujo, 2010).

This wave of health-related legislation resulted from an overarching series of good governance initiatives launched as a part of ongoing national efforts to democratize in Paraguay. As noted above, those reforms, in turn, were occasioned by World Bank and International Monetary Fund (IMF) requirements that aid-recipient nations meet certain operating standards to be eligible for loans on the view that good governance is necessary to ensure assistance is used effectively (Gonzalez, 2008).

Decentralization, in the health sector is generally concerned with reconfiguring the management and delivery of health services. This usually involves a change in power relations between the national and sub-national governments (Regmi, 2010). The central government's goals for health sector decentralization in Paraguay include creating a space in which local constituents are able to participate in health care planning, decision-making, monitoring and evaluation of service delivery (Regmi, 2010). This approach assumes that encouraging

community involvement through service delivery reform will make the government (at all levels) more responsive to local needs (Regmi, 2010).

CHAPTER IV: GOVERNANCE AND HOW IT IS AFFECTED BY DECENTRALIZATION

As was evident in chapter three, decentralization involves a significant change in how governance is organized. This chapter explores how such efforts shape governance generally and have played out in the Paraguayan context more particularly. The UN and other international institutions have repeatedly coupled good governance and decentralization as an approach to promote democracy (Zanotti, 2005). In this chapter, I explore the application of this approach to the Paraguayan health sector. I also expand on the three dimensions of good governance on which I chose to focus in this study: accountability, transparency and civic participation. I examine the realities of such reform initiatives within the Paraguayan context and the appropriateness of assumptions that decentralization necessarily would result in improved governance.

4-1 Interweaving Decentralization and Governance

According to the United Nations Development Program (UNDP), “Governance needs to be decentralized to allow greater access to decision-making. And the community organizations need to be allowed to exert growing influence on national and international issues” (UNDP, 1994, p. 4). The UNDP, among other international institutions, has argued that there are three domains of governance — the state, civil society and the market — and the relationship among them is important for achieving improved outcomes from development initiatives (UNDP, 1997). The Development Program has suggested that governance is improved by decentralization in the following ways:

- by addressing local needs and interests and thus increasing efficiency in resource allocation;
- improving efficiency through increased accountability of local governments;
- having fewer bureaucratic layers; and
- ensuring social, political and economic inclusion for all citizens (UNDP, 1997).

However, the argument that decentralization promotes efficiency assumes effective mechanisms by which to secure local accountability as well as continued central support (Abor & Abekah-Nkrumah, 2008). While there is surely some measure of truth to the idea that local governments will respond more subtly to the needs and priorities of their citizens than the national government is likely to be able to do, that assumption depends on the institutional arrangements that govern policy implementation and also on how well local authorities understand the national government’s decentralization objectives (Regmi, 2010). There is also a risk that a lack in professional capacities or political will to implement decentralization policies properly may obtain, despite the presence of a formal structure in place aimed at doing so (Regmi, 2010).

International institutions often recommend decentralization as a way to reduce the state role by means of increased intergovernmental competition and checks and balances; that is, by fragmenting the authority of the state (Bardhan, 2002). Advocates contend that such steps create a more responsive and efficient government, while also diffusing social and political tensions through the encouragement of local autonomy (Bardhan, 2002). Yet, this assumes an informed

and politically active civil society. Governments transitioning to democracy may suffer from particularly weak third sectors, which would then greatly affect governance and the nation's capacity actually to realize the posited benefits of decentralization.

During the post-Cold War period, the UN began to receive a substantial number of requests to intercede in democratization initiatives, with a large component of those requests taking the character of assistance with institution building (Zanotti, 2005). This turn of events sparked a debate within the world body about its role in democratization. In 1997, then Secretary-General Kofi Annan issued his first report on democracy in which 'governance' was selected as the central concept for organizing those activities related to democratization (Zanotti, 2005). This was partially a result of earlier reports by the UNDP that had begun to identify good governance as critical to the promotion of development (Zanotti, 2005). UN officials now saw underdevelopment as a consequence of poor institutional performance, which could be remedied by good governance practices (Zanotti, 2005). Good governance was "understood as 'the rule of law,' predictable administrations, legitimate power and responsive regulation" (Zanotti, 2005, p. 470). The UN began to insist that central state governments move away from their traditional role as service-providers toward a regulatory stance in order to allow the market and civil society to flourish (Zanotti, 2005).

Good governance is meant to address, although not exclusively, state institutions. As Laura Zanotti has observed, "it also promotes programs of diffused institutionalization of social processes" in order to foster a stronger civil society (2005, p. 471). The then UN secretary-general, Kofi Annan, highlighted the comprehensive nature of calls for good governance in 1998,

Good governance is effective, participatory, transparent, accountable and equitable and promotes the rule of law. Governance is led by the State, but transcends it by collaborating with the private sector and civil society. All three domains are critical for sustaining human development. The state creates a conducive political, economic and legal environment. The private sector generates jobs and income, and civil society facilitates political and social interaction and mobilizes groups to participate in economic, social and political activities (Zanotti, 2005, p. 471).

The UN views good governance as universally applicable and argues that the concept offers a standard set of techniques that can be useful in all countries to address a diverse array of problems (Zanotti, 2005). One facet of good governance aims to improve institutional functioning, with efficiency as a central aim. The secretary-general noted that using financial resources efficiently is particularly important in countries where funds are scarce (Zanotti, 2005). Ensuring competent use of financial resources is particularly important to the World Bank and the International Monetary Fund when issuing loans. These organizations go so far as to disqualify alternative models adopted by states that do not adhere to the stated principles of governance and do not 'obey the market,' such as those approaches adopted by Bolivia and Venezuela in the late 1990's (Joseph, 2010). Jonathan Joseph has argued this is a form of governmentality or power applied by institutions to control collective behavior, and describes the WB and the IMF as 'arrogant' by "... trying to apply techniques based on advanced liberal society to completely different social conditions. This cannot be anything other than a new type of imperialism based on ideological arrogance" (Joseph, 2010, p. 237). This power of

international institutions to impose their views is referred to as ‘transnational governmentality,’ because it acts in place of a local governmentality, which is either weak or nonexistent. Yet, the implementation of these governance policies is often ineffective in transitional governments that do not already possess advanced liberal economies (Joseph, 2010). Despite critiques of the implementation of these models, many major international organizations have continued to embrace them as a key approach to improving governance across the world.

4-2 Governance in Paraguay

As noted previously, good governance initiatives outlined by the UN sparked a new wave of health-related legislation in Paraguay. Those reforms, in turn, were occasioned by WB and IMF requirements that aid-recipient nations meet certain operating standards in order to be eligible for loans on the view that good governance is necessary to ensure assistance is used effectively (Gonzalez, 2008).

Roughly a decade ago, the United States Agency for International Development (USAID) created a synthesis of definitions for the term ‘governance’ drawn from those developed by the World Bank, the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) and the United Nations Development Program (UNDP): “Governance is a complex system of interactions among structures, traditions, functions (responsibilities) and processes (practices) characterized by three key values of accountability, transparency and participation” (Punyaratabandhu, 2004, p. 1). However, it is more difficult to find a concrete definition of the term ‘good governance.’ Although no single definition has been widely adopted, the following definition of good governance is now in use by several different international institutions: “[The striving for] rule of law, transparency, responsiveness, participation, equity, effectiveness and efficiency, accountability and strategic vision in the exercise of political, economic and administrative authority” (Punyaratabandhu, 2004, p. 1). The values of transparency, accountability and participation are treated as integral dimensions of good governance consistently in the governance literature. Many international government organizations argue that improved governance is essential for an effective democratic state (Bank, 2011; IMF, 1997; Punyaratabandhu, 2004).

However, good governance is not only essential for the federal (or central) government, but must also be embraced by all public institutions because governance and its functions go beyond ‘government’ to include a state’s “system of politics and how this functions in relation to public administration and law” (Nanda, 2006, p. 273). Thus, the Paraguayan federal government has sought to incorporate good governance initiatives in various public institutions, including public hospitals, through legislatively mandated reforms. In Paraguay, LHC’s have assumed responsibility for hospital governance defined as, “the process of steering the overall functioning and effective performance of a hospital, by defining the hospital’s mission, setting its objectives, and supporting and monitoring their realization at the operational level” (Abor & Abekah-Nkrumah, 2008, p. 48).

Eeckloo et al. (2003) suggest that hospital boards are challenged today more than ever to consider governance within their institutions. This is due to the increasing number of challenges facing health care institutions, which are complicated by the international and domestic pressures

placed on them to implement good governance practices. The realization of improved governance depends strongly on the context of particular organizations (Abor & Abekah-Nkrumah, 2008). Institutional goals and federal, departmental (the regional political entity in Paraguay), municipal and other regulations also play roles in determining the efficacy of reform efforts in practice. Paraguayan health institution governance initiatives have reflected the focus areas emphasized by various international institutions: accountability, transparency and civic participation.

4-3 Accountability

Accountability is essential within institutions to attain good governance objectives. The UN defines accountability as,

... The obligation of the organization and its staff members to be answerable for delivering specific results that have been determined through a clear and transparent assignment of responsibility, subject to the availability of resources and the constraints posed by external factors. Accountability includes achieving objectives and results in response to mandates, fair and accurate reporting on performance results, stewardship of funds, and all aspects of performance in accordance with regulations (Ki-moon, 2010, p. 1).

Dunleavy includes the promotion of ethical behavior, democracy and performance improvement through increased employee capacity when defining accountability (Dunleavy and Hood 1994). Ebrahim identifies external and internal processes of oversight and control as a key aspect of accountability, but rightly points out that accountability characteristics vary, depending on individual institutions and contexts (Ebrahim, 2003).

Accountability can be developed in an institution through the establishment of control and oversight policies, or 'self-binding' mechanisms (Santiso, 2001). When these processes are weak or nonexistent, the quality of democratic processes within an institution is greatly diminished (Santiso, 2001). While vertical accountability can be achieved through elections, horizontal answerability requires that those within the institution hold each other responsible for the realization of established policies and are willing to go so far as taking legal actions against those in violation (Santiso, 2001).

Financial management is one way accountability is operationalized. Fiscal management includes financial reporting, internal controls and audits, among other characteristics or functions. Periodic and professionally prepared financial reports safeguard against the possible misuse of organizational resources. Internal controls can increase the likelihood that organizations follow required financial and administrative procedures regarding the use of resources (McKinney, 2004). Internal audits evaluate such policies and procedures, while external audits ensure financial reports are prepared in accordance with best accounting practices (Mersel, Mor-Yosef, & Shapira, 2005). These three aspects of financial management act as checks and balances and help to ensure proper use of organizational resources, although by themselves they do not guarantee appropriate action.

Accountability within public institutions is often not clear-cut, due to multiple accountability streams and stakeholders (Robinson & Shaw, 2003). Greer has highlighted two forms of accountability specific to governing boards, political and managerial. Political accountability refers, “to how the governing body is called to account for its actions (linking to citizens, stakeholders including central government and users). The second dimension —‘managerial accountability’— focuses on how the governing body can hold its officials/executive to account [f]or internal governance” (Greer et al., 2003, p. 47). The authors separate these kinds of accountabilities from representativeness. The core of accountability lies in the ability to hold one (or an organization) to account for actions taken or neglected (Greer et al., 2003). The ability to hold a public institution accountable to its constituents requires a certain level of transparency to know what actions are indeed being undertaken or foresworn.

To determine the accountability of a governing board implies an analysis of the group’s dynamics, or how it is composed and functions, in practice. These depend, in turn, not only on legally assigned responsibilities, but also on board member understanding of roles and functions (Mette Kjaer, 2004). According to Naurin, transparency measures can assist in meeting accountability standards, but they are not the same as answerability because they do not include sanctioning mechanisms, a key component of accountability (Naurin, 2004). Public critique, which is often a result of transparency, also can be useful in achieving a certain level of accountability, but it is unlikely to result in job removal if one is determined not to be carrying out his/her responsibilities, particularly in a community with little civic participation (Naurin, 2004).

4-4 Transparency

The UN has defined transparency as the “unfettered access by the public to timely and reliable information on decisions and performance in the public sector” (Armstrong, 2005, p. 1). Transparency is completely dependent on securing accountability because without responsibility the concept becomes meaningless. These governance dimensions are mutually reinforcing and ensure that institutions will put the interests of the public first. Transparency allows the community to have access to important information (financial and administrative) and to monitor meetings and other decision-making processes as they occur. Gosseries (2006) has gone so far as to contend public participation in institutional governance efforts increases the quality of deliberation in democratic processes. From a social psychological perspective, he argues publicity forces a shift from what he calls a System 1 mode of reasoning to a System 2 method, “The former involves associative, holistic and automatic cognitive processes whereas the latter is characterized by rule-based, analytic and controlled modes of reasoning” (Gosseries, 2006, p. 86). System 2 processes are more likely to be based in reason and to be transparent in character, thus allowing for higher quality deliberation.

Transparency began to be commonly identified as an organizational value substantially unique from accountability in the early 1990s when Peter Eigen, a manager at the World Bank, decided to create the NGO, Transparency International (TI), in response to his view that the Bank was not sufficiently addressing this issue, particularly the high levels of corruption in the use of loans given to developing countries (Ball, 2009). One of TI’s first objectives was to curb corruption in Latin America through the advocacy of transparent practices (Ball, 2009).

Transparency within democratic institutions generally assumes that those entities are operating under public scrutiny (Gosseries, 2006). Intelligibility can increase accountability by raising public awareness and knowledge of organizational operations and performance (Greer, Hoggett, & Maile, 2003). Transparency might also be positively linked to effectiveness, due to its impact on ‘legitimacy for action’ (Greer et al., 2003, p. 53).

In practical terms, this generally means that users have access to the legal and financial documents of the organization and/or entrée to board meetings, although this second option is not a common practice among unelected boards (Greer et al., 2003). Scholars, such as Naurin (2004), have distinguished between transparency and publicity. Transparency, he claims, is merely a citizen’s ability to access information, while publicity is whether that information is actually being accessed (Gosseries, 2006). Education, or civic capacity, obviously influences a citizen’s ability to understand, and thus, properly access financial and legal information about an institution (Gosseries, 2006). In Naurin’s view, transparency only increases the possibility of access to information, but it by no means guarantees the public will seek out the available records (Naurin, 2004). Naurin rightly points out that transparency is only meaningful if it entails the possibility of accountability. If no one is reviewing these public documents, there is no benefit to their relative accessibility (Naurin, 2004). There are several reasons why information might not reach citizens, including lack of an effective mediator (i.e., news media), lack of demand and insufficient capacity among citizens to process the information (i.e., uneducated public). Thus, transparency measures are only effective when they are coupled with other governance reforms that allow citizens to hold their authorities accountable and encourage civic education and participation (Naurin, 2004).

4-5 Civic Participation

The UN has broadly labeled the third dimension of governance examined here “participation.” A 1993 UNDP Human Development report described civic participation, “as a process, not an event, that closely involves people in the economic, social, cultural and political processes that affect their lives” (Malik & Wagle, 2002, p. 3). Many popular theories of democratization stress the importance of good governance and emphasize that civic participation can be pivotal to the development and strengthening of a democracy (Mette Kjaer, 2004). Democratization scholars argue civic participation plays a disciplinary role in the governance process, ensuring that states follow the policies they have in place and are held accountable to them (Mette Kjaer, 2004). For these reasons, Paraguayan law in the late 1990s began to require high levels of diverse community representation on LHC hospital boards (Paraguayan Decree 19966/98, 1998).

Findings among scholars of multilevel governance suggest that flexibility in the production and distribution of public goods is stronger when public responsibilities are divided across multiple jurisdictions, rather than confined to a single centralized governance structure (Kauneckis & Andersson, 2008). Scholars such as Oates (1972) and Scott (1998) cite several advantages to decentralization, improved ability to adjust to diverse local needs and circumstances, enhanced facility to incorporate local knowledge and citizens that are more likely to take part in deliberative democracy, due to their increased authority to establish their own institutions. These analysts also contend that constituent authority to influence governance

processes allows for the creation of policies designed to support variations in local conditions and inclinations (Kauneckis & Andersson, 2008). Yet this argument holds true only when local authorities are both motivated to involve the community in decision-making and are held accountable to them.

As noted above, international institutions have widely adopted the view that decentralization facilitates participation by bringing the government closer to the people (Kauneckis & Andersson, 2008). One problem with this assumption is that it ignores the various contextual factors that influence the implementation of decentralization policies, such as reform strategies and local capacities and resources. In many Latin American countries, local political authorities come from an elite class that cannot be expected to change its leadership style spontaneously. Many studies of local democracy claim that a possible remedy to overcome traditional clientelistic politics is augmentation of communication between the state and civil-society representatives (Kauneckis & Andersson, 2008). These scholars also contend that inclusive decision-making can lead to improved quality of public services and greater accountability of local authorities (Kauneckis & Andersson, 2008). Yet these remedies are not themselves sufficient without strong popular engagement and sustained public leadership.

Civic participation is necessary to ensure democratic processes are effective. Without democratic control, it is very tough for a public to influence a hospital board in decision-making (Robinson & Shaw, 2003). It can also be extremely difficult to remove ineffective board members when they are not elected (Robinson & Shaw, 2003). However, if there is not a strong and active democracy and civil society, the real difference made by board member elections can be minute.

4-6 Does Decentralization Really Lend Itself to Improved Governance?

Much of the academic literature concerning decentralization claims that such policies, when implemented, will almost certainly improve governance because they provide more information to both the authorities and community members, strengthen the links between local representatives and the provision of local services, thus improving accountability, increasing efficiency and decreasing corruption and heightening democratic participation (Kauneckis & Andersson, 2008). However, several scholars have documented evidence that suggests that the opposite, in fact, might be true (Crook & Manor, 1998; Manor, 1999; Prud'homme, 1995). Some scholars have identified negative implications of decentralization, including increased conflict over political resources among municipalities and higher risks of elite rule and/or exclusion of marginal populations (Kauneckis & Andersson, 2008).

Decentralization scholars have posited various reasons to explain why many such efforts have not proven effective means of improving governance. Purcell and Brown assert that challenges in governance are just as likely to occur at the local level as the central one. Dillinger (1995) and Seabright (1996) attribute the failures of decentralization policies to the rarely complete nature of such initiatives, which leaves local governments responsible for implementation, but nonetheless lacking authority to raise revenues or budgetary decision-making. Others have cited the lack of capacity at the local level as often the greatest factor influencing decentralization success (Deininger & Mpuga, 2005; Larson, 2002). Some political

ecology researchers claim that local service delivery is not inherently more effective, as local governance structures are subject to the same challenges as their centralized counterparts. What is more important, they claim, than localization is the accountability of political institutions to their communities through the creation of institutional measures and incentive structures that ensure accountability (Kauneckis & Andersson, 2008).

Other scholars have found that local institutions experience difficulty in allocating services because their level of decentralization is incomplete (Deininger & Mpuga, 2005). Often, certain responsibilities are given to local institutions, while others continue to be centralized. Some scholars have argued there must be a complex system of financial management shared by the local and central governments, including financing, spending and resource provision in order for decentralization initiatives to be effective (Kauneckis & Andersson, 2008).

Another group of analysts maintain that the capacity of local institutions to respond to community-level needs should be emphasized, rather than allocated authorities (Crook & Manor, 1998; Kauneckis & Andersson, 2008; Ribot, 2002; Teune, 1996). Capacity, in this context, refers not only to the knowledge and skills of staff members and the education and training they receive, but also to basic administrative infrastructure and resources (Kauneckis & Andersson, 2008). These scholars claim that local governments must function democratically, with proper institutional controls and capacities in place to secure public accountability, if decentralization is to be effective (Kauneckis & Andersson, 2008; Ribot, 2002; Teune, 1996). These basic requirements are often not met in practice, which can create a situation in which the local government risks capture by community elites. This situation can also lead to an increase in local rent seeking (Bardhan, 2002; Kauneckis & Andersson, 2008; Seabright, 1996). Although it is evident that effective decentralization depends on effective democratic political institutions, the exact character of that relationship is not clear (Kauneckis & Andersson, 2008). Some scholars maintain that decentralization reforms without necessary changes to ensure democratic processes at the local level will lead to increased power among political elites and not improve local service delivery substantially, if at all (Crook & Manor, 1998; Manor, 1999).

Putnam famously asserted in his analysis of Italy's regional local governments that the probability that devolution will lead to increased community-level effectiveness depends strongly on how well civil society is organized and the sector's ability to monitor and hold local authorities accountable (Putnam et al 1993). This is particularly applicable in the case of many Latin American countries that have struggled against corporatist traditions and oppressive leadership and local accountability structures dominated almost exclusively by political party elites, rather than citizens (Rodriguez 1997 and Ward 2000, Peterson 1997).

Another challenge implicit in securing effective and equitable governance lies in the necessity of establishing a balance of power between central and local governments. For example, when control is given to municipalities to address local health needs and those communities fail to provide necessary services, they are nevertheless not often willing to give authority or resources back to the national government, despite the likely benefits of doing so (Regmi, 2010). Furthermore, when localities gain power and influence, there is no guarantee that such a step alone will ensure resources are allocated in a way that best serves the interests of the community (Regmi, 2010). It is even possible that community participation may worsen

inequalities, as urban areas might attract more resources than their rural counterparts, for example. Decentralization can also lead to higher costs, as it requires investment in coordination. Local communities often lack the capacities necessary to manage finances professionally thus leading to misuse of funds (Mills, 1994). In summary, potential risks associated with increased decentralization include the possibility of elite capture, increased conflict over newly accessible political resources at the local level and the exclusion of local minority groups (Kauneckis & Andersson, 2008; Prud'homme, 1995; Ribot, 2002). Another practical problem for developing countries in implementing decentralization is that it often amounts to little more than a formal exercise on paper while in practice, the central government actually devolves very little power over funds and decision-making (Regmi, 2010). Thus, the assumption held by several international organizations that decentralization would probably lead to enhanced governance seems unlikely to hold true as the generalization it is conceived to be. Indeed, I wish here to advance the notion that the opposite is true and improved governance is a necessary pre-condition for effective decentralization. I will do this by demonstrating the numerous challenges to governance facing LHCs when attempting to implement decentralization initiatives.

CHAPTER V THE STRUCTURE OF HEALTH GOVERNANCE IN PARAGUAY

Decentralization legislation created a new structure of governance within the Paraguayan health sector. This chapter describes that schema, including the roles of the Ministry of Health (MOH), the Departmental Health Council (DHC), the regional and local governments and the Local Health Councils. This part offers historical information on the various institutions and focuses heavily thereafter on the structure of the LHCs, which are my target of study. I also tie in theoretical conceptualizations of government institutions in an attempt to identify how the LHC relates to various governance models and theories (Conforth, 2003; Gaete et al., 2002; Saldivar et al., 2008). I conclude with a brief description of the two LHCs I chose for this study.

To begin the explanation of the structure of governance within the Paraguayan health sector, Figure 3 illustrates this hierarchy. Below, I will detail the role of each entity in the role of hospital governance.

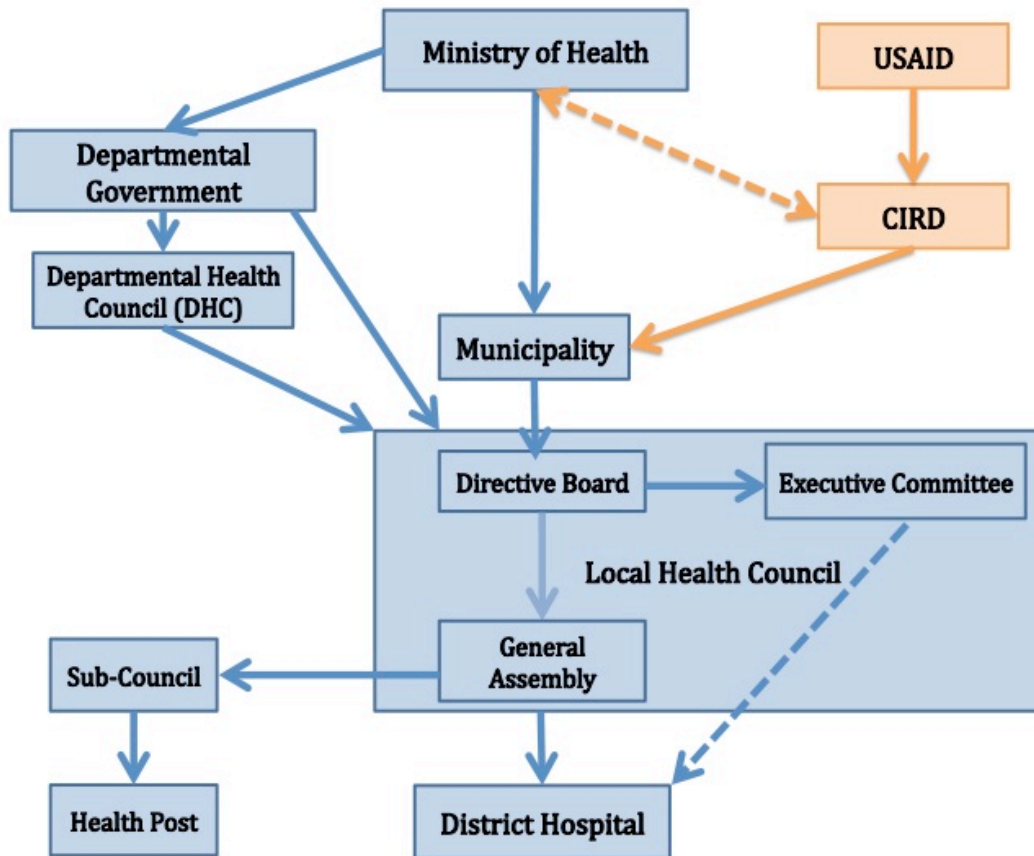


FIGURE 3: ORGANIZATION OF HEALTH SECTOR GOVERNANCE

5-1 The Ministry of Health

The Paraguayan federal government created the MOH in 1936 under the government of Colonel Rafael Franco by law 2001/36 (2012). Before this time, the Ministry of the Interior

provided all health services. In 1998, 2001/36 was repealed and replaced with 21376/98, which created a new organizational structure for the Ministry. The new legislation placed greater emphasis on public and environmental health and their critical role in societal well-being. Article 68 of the National Constitution defines health as a “fundamental right of persons and in the interest of the community” (Saldivar et al., 2008, p. 1). This legislation began a series of reforms and a process of modernization within the MOH to achieve the stated goals. The role of the Ministry within this governance structure was defined as follows:

- co-manage the district hospital with the LHC, to ensure that the council is guaranteeing health service provision, particularly the assistance included in the LHC’s local health plan and the national health plan;
- authorize the LHC to receive and allocate funds to further the goals established by the MOH;
- assist the LHC with budget creation, allocation and implementation, facilitated by the Departmental Health Council;
- create an organizational structure that responds to the needs of the country;
- communicate to the DHC and the LHC investments scheduled to be made in the district hospital, including increases or decreases in human resources;
- ensure basic means for the implementation of national health programs;
- supervise the allocation of resources (financial, human or other) through appropriate administration of the DHC and the LHC;
- perform audits on the DHC and the LHC; and
- independently supervise the revenues, expenditures, fiscal resources, human resources, exemptions and health services rendered (Saldivar et al., 2008).

5-2 Nonprofit *Centro de Informaciones y Recursos para el Desarrollo (CIRD)*

CIRD is a nongovernmental organization whose mission is to promote the creation of social capital in an effort to increase the impact and sustainability of development programs, through the promotion of capacity, skills and civil society organizations, whether those be private or public (CIRD, 2012). CIRD receives a large portion of its funding from USAID to further its efforts to support Paraguayan public institutions, including the MOH, as well as local governments. CIRD has also dedicated considerable time and resources to the promotion of civil society participation in the design, implementation and evaluation of public policies in an effort to promote positive and sustainable change within the country (CIRD, 2012).

5-3 Departmental Government

Paraguay is divided into 17 political regions, called departments, and each enjoys some measure of political autonomy and is responsible for management of a share of its interests. Each department has authority to collect taxes and allocate resources as needed and has a governor and a regional council, similar to a town board at the municipal level. Governors are elected by popular vote and serve a five-year term. The Health Sector Decentralization Agreement requires that departments carry out the following:

- support the LHC with a percentage of the departmental health budget proportional to the population served by that council and in accordance with budget constraints;
- support the LHC with the resources necessary to fulfill its monitoring function and to carry out decentralization; and
- monitor and supervise the application of proper policies and the execution of health programs (Saldivar et al., 2008, p. 3).

5-4 The Departmental Health Council (DHC)

The Departmental Health Council is responsible for its corresponding political region and is charged with designing and implementing monitoring and evaluation programs for the Departmental Health Plan (DHP) and the LHP. The DHC is also responsible for a semi-annual public presentation of financial reports on behalf of all the LHCs within its jurisdiction (Saldivar et al., 2008).

5-5 The Municipality

The municipality is the local government entity that assists in the creation of the LHC, according to the guidelines established by article 24 of national law 1031/96 (1996). The town is responsible for the following:

- annual contribution of a minimum of five percent of gross tax revenues to supplement the finances necessary to provide services and improve infrastructure;
- establish a criterion of socio-economic classification of the municipal population to identify areas in need of public health investment;
- participate in the creation and implementation of the LHP including the priority health programs identified by the MOH; and
- provide capacity-building and orientation to LHC board and staff so that they may properly realize the expectations set out for them (Saldivar et al., 2008, p. 3).

5-6 The Local Health Council (LHC)

As of 2008, 51 municipalities managed their health resources through an interagency commitment and cooperation contract with the MOH. The Ministry has encouraged decentralization of health services as a way of improving program implementation (Carrizosa & Gaete, 2010). That is, the MOH has devolved resources and authority to local governments in the hope that doing so will result in more effective representation of local needs. Beyond improving services, the government argued decentralization would strengthen democracy through community participation and capacity development, increased local expertise, transparency and accountability, supported by collective decision-making. This process, which took nearly 15 years to develop in Paraguay, operated under a strong cooperation policy facilitated by the transfer of resources from the federal government to the LHCs (Carrizosa & Gaete, 2010). Between late 2008 and early 2009, the MOH transferred a total of 1.94 billion Guaranis (approx. 432,000 dollars) to 43 regional and Local Health Councils to support services and program improvements through local administration of resources (Carrizosa & Gaete, 2010).

The LHC, including all participating members from a particular locality, is referred to as the ‘general assembly.’ The general assembly is chaired by the Mayor and is comprised of representatives of interested community organizations. According to Law 1032/96, the assembly should meet a minimum of once every two months for regular session and can meet more often if needed (1996). The national government requires these tasks be carried out with the support of the major share of LHC members. Federal guidelines oblige councils to share decisions with service users and other hospital stakeholders by increasing civic participation in decision-making, as individual citizens are most directly affected by those choices (Law 1032/96, 1996). One form of participation outlined in LHC rules and procedures is a yearly assembly meeting to elect council authorities and present an annual financial statement to the public. By law, the general citizenry is able to provide its views and input on the creation and implementation of the LHP at this constituent assembly (Saldivar & Velasquez de Arenas, 2007).

The general assembly is directed and managed by the directive board. The LHC directive board is responsible for proposing to the general assembly policies, activities and necessary resources to ensure timely and effective implementation of the local health plan. The board also makes decisions on and coordinates administrative matters related to the council. The LHC governing body is composed of a chair, a vice chair, a secretary and three additional members (Carrizosa & Gaete, 2010). The town Mayor chairs the group (or, if applicable, the director of health and hygiene of the municipality does so). The vice chair, secretary and three members are elected from members of the council during its first general assembly meeting (Carrizosa & Gaete, 2010).

The executive committee of the LHC board links hospital program implementation efforts to the council’s governance structure. The executive committee presents budget and program proposals to the LHC and supervises and evaluates their implementation. I will detail further the roles of the executive committee in my findings. This group is chaired by the director of the hospital and includes three representatives, one from the municipality’s department of health, one from the community’s urban development commission and one from its local medical association (Paraguayan Law 1032/96, 1996). Both the directive board and the executive committee can create sub-committees to contribute to improved implementation of the local health plan, if they choose. An LHC member heads up each sub-committee whose other participants are not required to be members of the council. Some commonly created sub-committees have included financing, education, communication, environment, LHC oversight and health and professional training and development (Carrizosa & Gaete, 2010).

Finally, each LHC has a trustee and a supplemental trustee responsible for overseeing and monitoring its activities (Carrizosa & Gaete, 2010). The duties of these roles include:

- attend board meetings;
- examine books documents and assets of the LHC;
- submit a written report concerning the financial statement and inventory to present to the general assembly;
- call for meetings when the board has not followed procedures as established in its bylaws; and
- generally perform all other expected duties as trustee (Carrizosa & Gaete, 2010, p. 20).

The governance tools used for the organization and proper functioning of the LHC include the following documents; bylaws, legal status, long-term strategic health plan, management and financial reports, rules and procedures, Health Sector Decentralization Agreement and governance manuals prepared by the MOH (Carrizosa & Gaete, 2010). Many of these official papers are co-signed by the various governmental institutions mentioned above.

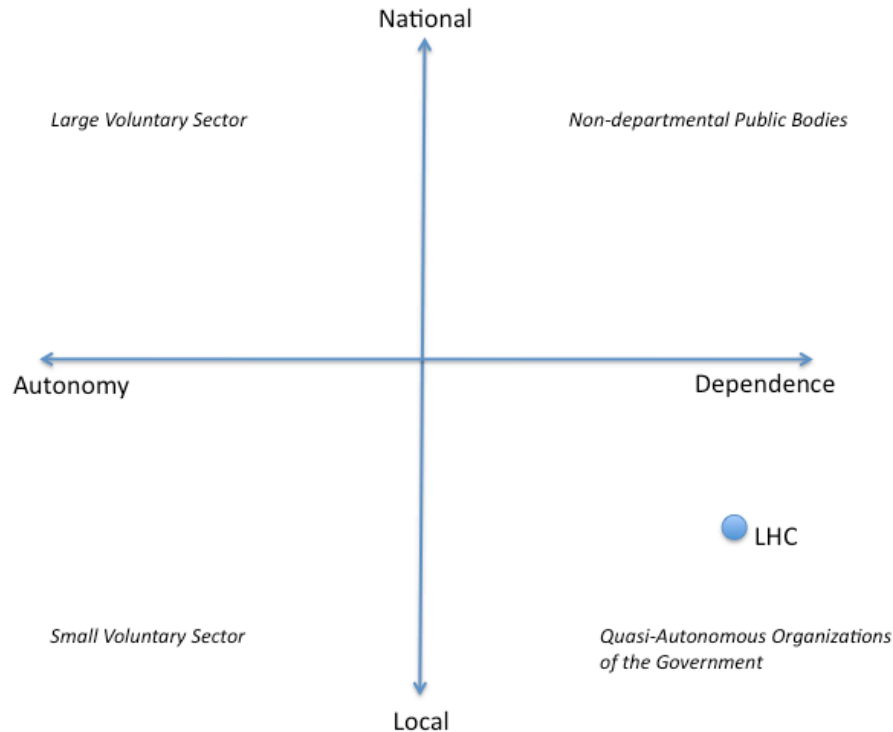
5-7 Situating the LHC within the Public Sector

Nonprofit and public governance theories and models are numerous and too often depict governance in very superficial terms. Therefore, these theories are often more useful when looked at in conjunction (Conforth, 2003). Popular approaches include agency theory, stewardship theory, resource dependence theory, a democratic perspective, stakeholder theory, managerial hegemony theory and a paradox perspective (Conforth, 2003). The behaviors of many governing boards do not fit neatly within one of these conceptualizations. It is more likely that a single board will possess characteristics of several of the models offered by these various constructs, rather than of one single model. This notion resonates closely with the paradox perspective, which I will outline below. LHC governance practices include aspects of almost all of these theories, with the only exceptions being the managerial hegemony and resource dependence approaches.

The LHC, as created by Paraguayan law, is charged with ensuring managerial compliance by monitoring staff behavior, as described by agency theory. The stewardship theory views the primary role of the board as a strategic one, which can be argued to be true for the formal aims assigned the LHCs, focusing efforts on creating policies and clearly defining the mission and vision of the organization (Conforth, 2003). The importance of community representativeness, emphasized in the democratic perspective, parallels the requirements of board composition for the LHC. Paraguayan law requires councils to include community representatives from various local institutions and stakeholders (Gaete et al., 2002). Along those same lines, stakeholder theory is based on the premise that a board should be representative of an organization's various constituencies so that the board is responsive to the broader social interests of the population that is interested and/or involved in the organization or institution (Conforth, 2003). Morgan, in the paradox perspective, addresses the complexity of organizational realities and argues that various approaches to governance are necessary and should be employed variably as an institution's context dictates (Conforth, 2003). This is essentially the case for the LHCs I explored as they have incorporated aspects of various governance theories in their organization and practices.

The LHC is perhaps best considered a 'para-government organization' as defined by Greer et al. (2003) as the councils were created to deliver public services, but were charged with doing so outside of the core government bureaucracies. Para-governmental organizations can range from highly dependent to strongly autonomous and from highly nationalized to extremely local. The authors present a typology that displays dependence to autonomy on a horizontal axis, and national to local orientation on a vertical one. This typology and the placement of the LHCs within it are illustrated in Figure 4. This is a useful way to understand the various relationships between public organizations and the federal government. The LHCs would fall at the very end of the dependence side and almost the very end of the local side. The councils receive almost the

entirety of their yearly budget from the federal government and the MOH, with the only notable exception being the five percent of local gross tax revenue allocated for hospital use (Gaete et al., 2002). In addition, some organizations donate gifts-in-kind, such as medical supplies and equipment, to LHC affiliated hospitals that are not reflected in their annual budgets. The councils fall closest to the local end of the vertical continuum, presented by Greer et al., due to the characteristics that make up the governing board. LHC members are exclusively citizens of the town in which they serve, as opposed to central government employees working in a local office.



Source: Modified from Greer et. Al., 2003

FIGURE 4: GREER TYPOLOGY

5-8 Health Sub-Councils

Health sub-councils are smaller citizen groups formed within the district of an LHC. Much like the councils, they are made up of community organization representatives making efforts to include citizens from various segments of the community they serve. The objective of sub-councils is to increase civic participation through the direct involvement of beneficiaries in the planning, managing and implementation of public health services (Carrizosa & Gaete, 2010). In 2001, in an effort to regulate health sub-councils more effectively, the federal government passed statute 05/01. This law defined health sub-councils as neighborhood organizations that act as a coordinating body in concert with the LHC (Carrizosa & Gaete, 2010). A minimum of 12 members is required per sub-council and their functions include:

- take actions that develop and implement the promotion of a healthy lifestyle for its community;
- develop community health projects in line with the LHP;
- make relevant decisions that benefit the community (i.e. public health campaigns, proposals for the LHC);
- produce evaluation reports on the impacts of health projects on the community;
- encourage the formation of volunteer health promoters to assist in community health activities; and
- work directly with local health officials (if present) in a coordinated fashion that respects each other's areas of competence (Carrizosa & Gaete, 2010, pp. 30-31).

5-9 The Local Health Council of Town A

Town A has approximately 13,000 residents and is located in the department of Cordillera, east of the capital city of Asunción. Most inhabitants of the community commute either to Asunción or a large town nearby, as there are no industries or large companies in Town A. The biggest private employer in the town is a bus transportation firm that employs approximately 50 people. Most residents of the community are self-employed or are government employees, i.e., teachers, municipal civil servants, etc. The LHC, created in 2005 as part of the country's broader health sector decentralization effort, oversees the local district hospital. This facility serves the community and three other surrounding communities in its district. The LHC's annual budget for 2009 was approximately \$ 30,000 (Saldivar & Escobar Aguero, 2009). Although this is a very small budget by US standards, considering minimum wage is less than \$ 200 a month in Paraguay, this small amount of funding can go a long way.

5-10 The Local Health Council of Town B

Town B is located south of Asunción in the department of Central. The city's population is approximately 38,000, including those inhabiting surrounding rural areas (Alfonso, 2009). Town B is the site of a large port that continues to have a major economic impact on the community. A considerable number of factories are located in the area, producing such materials as cement and iron rods for export. These industries, however, also have a measurable negative impact on the community's environment—in particular on water and air quality, and thus on public health. The LHC of Town B, formed in 2005, oversees a district hospital and social pharmacy. The Ministry allocates approximately \$ 39,000 annually to Town B's health council (Alvarenga, 2010).

5-11 Comparing LHCs

Town B is quite different from Town A in that its population is about three times larger and its economy is primarily industrial while that of Town A is largely commuter oriented. The two locales differ geographically as well. Town A is in the hills and Town B is located near a river. They are also located in different political regions, or departments. Town A and Town B share a similar health sector history, however, as both of their LHCs were founded in 2005 and both have since been awarded similar annual budgets by the Ministry of Health (Alfonso, 2009; Saldivar & Escobar Aguero, 2009). Both of these communities are very typical Paraguayan

towns in so far as urban design, character, development and wealth. Therefore, these were attractive locations for study.

Section II *Research Methods*

CHAPTER VI RESEARCH OBJECTIVES AND METHODS

This chapter explains the methods I employed to create the study, collect data and analyze the data once gathered. I detail the three strategies I used for data collection: document analysis, semi-structured interviews and participant-observation. I also address the limitations of my analysis in this chapter.

6-1 Purpose of Study

This study explores governance within two LHCs that oversee two public hospitals in Paraguay. I sought to gain an understanding of how council boards in rural Paraguay are functioning against the expectations detailed for them by federal law. Put differently, this analysis seeks to examine how closely aligned LHC governing board practices are with the nation's stated decentralization objectives for them. I assessed council board governance practices in two rural towns that I have labeled A and B against the expectations established by the Paraguayan federal laws that created them. Overall, as also outlined above, this study sought to address the following questions:

1. How do LHC members perceive their roles?
2. How do those perceptions affect council board governance efforts in the dimensions of accountability, transparency and civic participation?
3. How closely aligned are LHC practices regarding the hospitals studied to the expectations set out for them by federal law?

I explored how board members perceive their roles and the role of the LHC in hospital governance and how those perspectives and perceptions shape broader hospital accountability, transparency and civic participation. My research methods section outlines the particular requirements of federal law I used as benchmarks against which to compare the three identified dimensions of governance—accountability, transparency, civic participation—within the LHCs to make sense of health council board practices.

6-2 Research Expectations

Before beginning this study, I expected to find evidence indicating that decentralization has had both positive and negative impacts on hospital governance. I also expected that health care decentralization might not be meeting the stated objectives of Paraguayan federal law. Administrative and planning powers may be delegated to local organizations, but this step does not necessarily lead to significant improvements in health services (in this case) for communities (Madon, Krishna, & Michael, 2010). As outlined in Chapter III, failures of decentralization can occur for many reasons, including a lack of political will at higher levels of government to provide adequate resources, or a dearth of capacity at the local level to perform necessary tasks (Madon et al., 2010). In order to assess board management and oversight efforts, I asked

members how they define their roles and those of the LHC, more generally. I also queried board members concerning their consciousness of the relationships, if any, between the nation's overall decentralization aspirations and hospital governance efforts. I compared and contrasted board member perspectives in the two exemplar LHCs in the three major dimensions of board responsibility outlined in federal law. By comparing the two cases, I aimed to understand better the dynamics of accountability, transparency and civic participation in governance of two quite distinct LHC hospitals.

Due to the recent creation of LHCs in Paraguay and in rural areas particularly, I expect this research will contribute to the organizational governance literature, as there have been few studies conducted on this topic in the Paraguayan context. I hope my findings will be employed by the LHCs to deepen their awareness of the implementation dynamics of federal health policy decentralization efforts. I hope this study's findings will also inform policy and help to shape expectations of the roles of LHC governing boards by the local, departmental and federal Paraguayan governments.

6-3 Research Methods

I used a mixed methods approach for this study. Document analysis and semi-structured interviews provided qualitative data for this interpretive study. The three identified dimensions of governance: accountability, transparency and civic participation, are among the most important objectives of decentralization initiatives in Paraguay, according to the nation's government as well as international institution proponents, such as the WB, the UN and the IMF (Bank, 2011; IMF, 1997; Punyaratabandhu, 2004). Accountability is reflected in the federal laws that give LHCs the responsibility for co-managing hospitals with the MOH, encouraging oversight methods and information systems for improved utilization of resources. The municipality is charged with building LHC capacity to implement decentralization policies, which can also be considered an accountability dimension of governance. Transparency is reflected in the federal laws that require weekly presentation of financial statements and proper allocation of funds. National law addresses civic participation with the requirement to create an LHC hospital governing body that represents various community institutions, enacts a local health plan with citizen involvement and creates and implements a budget. These federal laws and their corresponding dimension of governance and method of analysis are outlined in Table 1.

TABLE 1: PARAGUAYAN LAW AND METHODS OF ANALYSIS

	Law	Expectation	Dimension(s) of Governance	Method of Analysis
1	19966/98	Co-management and administration of hospital with the ministry of health	Accountability	LHC member interviews
2	19966/98	Creation of local health plan with community involvement	Civic Participation	Collection and analysis of written materials and LHC member interviews
3	19966/98	Creation and implementation of budget	Civic Participation and Accountability	Collection and analysis of written materials / LHC member interviews
4	19966/98	Annual presentation of financial statements	Transparency	Collection and analysis of written materials / LHC member interviews
5	19966/98 and 3966/10	LHC constituted by representatives of the institutions related to the health sector, specifying specific required roles	Civic Participation	Collection and analysis of written materials / LHC member interviews
6	2051/03	Orientation and capacity-building provided to LHCs by municipality to implement decentralization policies	Accountability	LHC member interviews
7	3007/06	Administration of funds	Accountability and Transparency	Collection and analysis of written materials / LHC member interviews

6-4 Documents Analysis

As a first step in creating this study, I conducted a documents analysis concerning Paraguayan federal law, various international institutions and LHC policies in an effort to frame the research questions for my analysis. That effort provided a foundation for this investigation by allowing for a basic understanding of Paraguayan public institution processes and how these have been shaped by policies of various international governmental organizations. For the second phase of documents analysis I examined relevant LHC documents for each community, including, but not limited to, council rules and procedures, bylaws, financial statements, local health plans (LHPs) and annual budgets. Taken together, these records allowed me to identify the expectations of the federal government and the steps LHC hospital governing boards took to address those aims.

Table 1 identifies seven core federal concerns as outlined by law, the corresponding dimension(s) of governance and how I explored the concern in my analysis. First, I addressed the issue of whether the LHCs had created a local health plan with community involvement, as, under national law, this strategy should be written and the process by which it was prepared documented. Second, I ascertained to what extent the LHCs are in line with the federal requirement of a planned and implemented budget by reviewing financial documents and determining if a financial plan was indeed adopted. Third, I attempted to gauge to what extent each LHC had adopted and executed an annual budget. I did so by analyzing written materials as well as council member interviews. Fourth, federal law requires annual presentation of financial statements, so that these should appear in health council records. Fifth, the national statute

requires that LHC members be drawn from various community organizations. I explored this concern by reviewing relevant organizational reports to identify the local organizations represented in the LHC in practice. Sixth, I addressed the requirement of the municipality to provide various kinds of support to the councils by asking participating members about this issue directly. Last, federal law requires that the LHC funds administration role be transparent, which I explored through an analysis of written materials and council member interviews.

I collected and analyzed the policies, rules and procedures and by-laws of the two LHC's I studied to determine the extent to which accountability, transparency and civic participation concerns and measures have been incorporated in their governance efforts. I developed documentation for each factor. Findings and observations that arose from documents analysis that were also found in LHC member interviews increased the validity of my findings through data triangulation (Neuman, 2009). More broadly, documents analysis provided a necessary historical context for current LHC governance and allowed me to assess more effectively certain technical and financial information that is better understood in written form.

6-5 Semi-Structured Interviews

I also employed semi-structured telephone interviews with a sample of five board members from each of the two LHCs in December 2011 and January 2012. I sought to gain knowledge of how board members perceive their roles and how those perceptions are shaping organizational governance efforts, with particular attention given to accountability, transparency and civic participation. I undertook the interviews in accord with IRB requirements and recorded and transcribed each session. I then coded the transcriptions and analyzed them for salient themes. I spoke with five LHC board members from each community, including the President, the Director of the hospital, one other LHC officer (i.e., secretary, treasurer, etc.) and two board members that did not hold an officer position. The two non-officer members were self-selected in that I included those who volunteered in the study. I chose this population due to its members' unique and personal perspective on hospital governance during the decentralization process. The semi-structured interviews included questions similar to those outlined in Table 3 (see appendix A).

I contacted the President of each LHC in the two participating communities. The President then communicated the basics of the study and shared the consent form and study questions (in Spanish) with the entire LHC board and selected officers and two others from each board were asked if they were willing to participate. If LHC members decided to participate, I contacted each individually to explain the purpose and process of the analysis and set up a time for a formal interview. I telephoned the participant at the scheduled time on their personal phone to ensure interviewees did not incur any charges. The interviews were semi-structured in character and ranged from approximately thirty minutes to two hours. Follow-up questions were employed for clarification purposes with certain participants. These interviews did not exceed 15 minutes. All interviews were recorded using digital audio recording software to ensure proper comprehension and accuracy. This step was particularly important in my view, given the language difference. Table 2 shows the breakdown of participants in this study.

TABLE 2: OVERVIEW OF INTERVIEWEES

LHC Members Interviewed	Town A	Town B
President of the LHC (mayor)	1	1
President of the Executive Committee (hospital director)	1	1
Secretary	1	0
Treasurer	0	1
General Members	2	2
Total Members Interviewed	5	5

6-6 Participant-observation

I served as a Peace Corps Volunteer in Town A from May 2008 to February 2011. During that period, my activities included participating in LHC meetings as well as collaborating on small health promotion projects with several nurses and the director of the hospital. In the case of Town A, I personally know all of the members of the council. This knowledge allowed me to have a better understanding of how the LHC and its district hospital function. The second town I selected for study was Town B. I had visited the community on several occasions and chose the community for analysis because of its rough comparability to Town A, specifically within the health sector. Nonetheless, it is different enough in other characteristics, including population and economic infrastructure, to provide an alternate perspective on LHC governance efforts. While my findings are not generalizable to other LHCs across Paraguay, they are nonetheless analytically generalizable when compared to the theoretical conceptions against which I have investigated each. I suspect therefore they may well be useful to public decision-makers in Paraguay at all scales of governance.

6-7 Limitations of Study

This study might be limited by the willingness of interviewees to give honest judgments due to various reasons, some known and some unknown. Possible motives for less than open answers from interviewees include an unfounded fear of consequences if they admit a lack of knowledge, with regard to their position on the LHC, or speak poorly about certain governance processes. The vantage point for analysis employed here also limits this study, as it only examines governance from the perspective of those governing at the level of the LHC, municipality (the Mayor) and district hospital (Hospital Director). I did not interview the national, departmental or third sector health governance actors.

The records available for review limited the scope and character of my documents analysis. After various requests to LHC administrators, I became convinced the councils I sought to examine had not updated many documents, particularly in the case of Town A. In those cases, the administrators informed me they were still working in accordance with the outdated materials and had simply not yet gone through the process of updating them. Appendix B provides a full list of the most recent documents available for review.

6-8 Analysis of Data Gathered

Semi-structured interviews with LHC members focused on the effects of decentralization initiatives on hospital board governance, with particular attention paid to accountability, transparency and civic participation. Questions employed were similar to those listed in Table 3.

TABLE 3: INTERVIEW SCHEDULE FOR COUNCIL MEMBERS

	Question	Expectation of Federal Law	Dimension(s) of Governance
1	What do you see to be your role as a member of the Local Health Council hospital governing board?	How well do LHC members understand their roles? Is their understanding of their role similar to their intended role outlined in laws 19966/98 and 3007/06?	Accountability
2	What do you view as the three main functions of the Local Health Council governing board?	Do these functions align with the functions outlined by laws 19966/98 and 3007/06?	Accountability
3	What kinds of policies and oversight processes are in place to ensure that those functions are being addressed?	Are these policies in line with those required by law 19966/98?	Accountability
4	What are the three greatest challenges facing the Local Health Council in governing the hospital? How might those challenges be addressed by the LHC or other entities?	Are current federal laws addressing the challenges identified by LHC members? If so, there may be a lack of implementation on the part of the LHC or a need for an alternate policy design at the federal level. There may also be a lack of support provided by the government.	Accountability
5	In what ways does the Local Health Council involve the community?	Does the LHC involve the community in the ways required by law 19966/98?	Civic Participation and Accountability
6	What are the three most important tasks of the Local Health Council as you see matters?	Are these tasks in line with the functions outlined for LHCs by law 19966/98 and 3007/06?	Accountability
7	What do you view as the main goals of decentralization?	Is there a clear understanding of the objectives of these laws and the reasons why they were created and how their aims relate to the roles of the governing board?	Accountability
8	How have those large goals for the nation shaped or structured what your board does now?	Have decentralization laws meaningfully affected LHC board governance?	Accountability
9	What kind(s) of support, if any, is provided to the Local Health Councils by the government or other entities?	Have LHC board members been provided with training regarding their roles as required by law 2051/03?	Civic Participation and Accountability
10	What efforts are made by the LHC to ensure public accessibility to financial documents? Are any other measures taken to facilitate public understanding of LHC processes? *	Does the LHC provide presentation of financial statements as required by law 19966/98?	Civic Participation and Transparency

*I did not ask many questions about transparency because the majority of my concerns linked to this criterion could be addressed by reviewing board rules and procedures and hospital financial statements. However, the last question on the interview schedule did seek to clarify the relationship between what the LHC actually does versus what each has stipulated it will do in its rules and procedures regarding transparency.

I compared question responses to the expectations outlined in federal law to determine how closely board practices align with decentralization objectives and also how role perceptions, on the part of council members, shape hospital governance (specifically in the three focus areas). After transcribing the interviews, I separated responses by question and analyzed them for salient shared themes relevant to board functions in each of the three domains of interest. I then performed open coding to allow for the initial identification of topics throughout the interviews at a basic level of abstraction. During the next step, axial coding, I reviewed the data again, focusing particularly on examining initial codes and determining links among them. This step was also useful for identifying key analytical categories. Finally, selective coding allowed me to identify particular cases that illustrated themes and supported the conceptual coding categories I had developed (Neuman, 2009). Responses were analyzed once collectively, then again, separating by LHC officers and non-officers, and a third time, separating responses from the two distinctive councils. Data analysis was nonlinear, as I created a unique analytical framework for this study (Neuman, 2009).

*Section III**Findings and Discussion***CHAPTER VII****FINDINGS**

This chapter presents my findings from data collection, using the methods outlined in Chapter VI. I begin by describing LHC member responses to each question, including data and examples from document analysis and participant-observation, when relevant.

The following questions addressed various aspects of the identified dimensions of governance and, when analyzed collectively, began to give a sense of how LHCs are currently carrying out their hospital governance roles and which areas require improvement, in light of federal expectations. Appendix A provides the complete interview question schedule and the governance dimensions addressed by each question.

7-1 LHC Member Responses*Question 1: What do you view as your role as a member of the LHC?*

I analyzed the LHC member responses against their corresponding role description, as outlined in Paraguayan law or, in some cases, as outlined in an ‘Internal Rules and Procedures’ document created with the assistance of the nonprofit CIRD, in collaboration with the MOH. The results of my analysis appear below.

Presidents of the LHC (and Directive Board) / Mayor

According to Law 1032/96, decree 19966/98, the President of the LHC is required to:

- legally represent the LHC within and outside of the community;
- convene general and special meetings;
- open and preside over the meetings of the directive board, guide debates, maintain order and take disciplinary measures when necessary;
- sign correspondence, contracts, notes, communications, reports and meeting minutes with the Secretary;
- sign checks, bonds and balances with the Treasurer;
- direct health services suggestions promptly to the board;
- monitor interactions with corresponding institutions;
- propose the appointment of LHC members and suggest disciplinary measures of the same when necessary;
- monitor and intervene in the work of the LHC’s sub-committees; and
- Make decisions in emergency situations in the name of the council (1998).

The Presidents interviewed, responded:

- create a link between the hospital, ministry and the municipality (Town A) and

- coordinate everything related to public health and the needs of the hospital and the various health posts (Town B).

Both Presidents of the LHC that I interviewed spoke very generally about their role and did not include in their description any of their daily responsibilities or any duties related to monitoring and evaluation. Council members rarely mentioned sub-committees throughout the interviews. Sub-committees did not seem to be an active part of these LHC organizations. In any case, neither board president mentioned them.

President of the Executive Committee / Director of the Hospital

The President of the Executive Committee's role is not explicitly defined in law, but law 1032/96, decree 19966/98 does outline the functions and duties of the executive committee as a whole:

- facilitate and develop the programs, services and activities outlined in the local health plan based on the resources given to the LHC;
- control, operationalize, supervise and evaluate the programs, services and activities requested by the council;
- coordinate with the hospital director the participation of diverse health establishments and social organizations in activities aimed at implementing the local health plan;
- create programs to acquire staff, equipment and food to present to the LHC;
- create a reference and cross-reference system for patients in coordination with the local hospital, regional and specialized doctors;
- inform the LHC routinely concerning the functioning of the hospital, the execution of the local health plan and its use of financial and technological resources;
- establish rules and procedures for the best quality attention through services and programs;
- create a handbook of medicines needed locally for health services of medium complexity;
- evaluate staff performance periodically ;
- present recommendations for staff to the LHC;
- exercise oversight and control of services and programs, according to the expectations outlined by the MOH;
- propose the implementation of basic health plans and plan for medical assistance; depending on the socio-economic situation of the population of the district; and
- establish sub-committees at the services level to increase the efficiency and efficacy of medical services (ethics commission, medical audit, teaching commission) (1998).

The Presidents of the Executive Committee interviewed, responded:

- plan for the short-and long-term needs of the hospital (Town A); and
- control the implementation of the local health plan and report on its progress to the board (Town B).

Once again, member role descriptions were very general, which is not to say that the presidents of the executive committee do not perform the other duties. But if they do, they did

not mention them and those responsibilities did not appear to receive much emphasis. Neither executive committee president mentioned their responsibility for staff performance evaluation, creation of necessary rules and procedures and the establishment of sub-committees. This might imply a larger trend of general disregard for monitoring and evaluation, policy creation and establishment of sub-committees, which are continuously left out of discussions. In any case, this silence merits further study.

Technical Secretary

Decree 19966 allows LHCs to define the functions of board members in the 'Rules and Procedures' document for each individual council. In this case, both LHCs defined the duties of technical secretary as listed below:

- write and organize meeting minutes;
- establish meeting agendas;
- sign notes and resolutions issued by the LHC;
- prepare notes, invitations, resolutions and other documents by the directive board; and
- in the absence of the President, s/he can sign invitations for general meetings with the authorization of the President or the Vice President (1998).

I interviewed the Technical Secretary from Town A and he defined his role as:

- write and organize meeting minutes.

The technical secretary has few responsibilities, although they are important for LHC functioning and accountability. The development of meeting agendas and the preparation and signing of official documents were not mentioned by this secretary and it did appear that this might be attributed to the small amount of activity that the LHC carries out on a regular basis. Writing and signing invitations, resolutions and other documents appears to be a relatively infrequent occurrence for this council.

Treasurer

The Rules and Procedures of both LHCs define the role of Treasurer as to:

- control the revenues and/or the funds administered by the LHC, whether for the hospital, social pharmacy, community projects or other activities that require financial support;
- prepare a monthly report that reflects the most recent financial transactions to present to the directive board; and
- propose activities to generate funds (Saldivar & Velasquez de Arenas, 2007).

I interviewed the Treasurer from Town B and he defined his role as:

- share views during board meetings;
- bring health concerns from his organization to the attention of the LHC;
- bring responses and general knowledge back to his organization; and

- find ways to save the LHC money when acquiring resources.

The treasurer responded in a way that generally reflected his role as a member, but his response was only vaguely connected to his position as a board officer. He did not emphasize the preparation of financial reports, controlling fund administration or proposing fund-generating activities as key components of his delegated responsibilities. This could be attributed to various causes, such as a misunderstanding of the question or a lack of importance placed on his role as treasurer compared to his more general role as board member, but there did seem to be a disconnect between the expectations outlined in federal law and his understanding of his organizational responsibilities.

General Members

Rules and Procedures of both LHCs define general member duties as:

- attend meetings regularly and punctually; and
- collaborate with the other members to achieve LHC objectives.

Decree 19966/98 includes the following as part of general member duties:

- represent the users and beneficiaries of the health system (1998).

General Members interviewed responded:

TABLE 4: GENERAL MEMBER ROLES

Responses	# Of Respondents from Town A (n=2)	# Of Respondents from Town B (n=2)	Total # Of Respondents (n=4)
Share their views on behalf of the organization they represent	2	1	3
Create a plan for addressing health challenges	1	1	2
Identify health challenges in the community	0	1	1
Administer funds	0	1	1

General member responsibilities are vaguely described in Paraguayan law and were well understood by the LHC members I interviewed. Nonetheless, the board members, like the officers, did not emphasize the need for sub-committees or collaborative groups or describe the activities of any such entities.

Question 1 aimed to gauge how well LHC members understood their individual roles and how their understanding compared to their intended role as outlined in Paraguayan law. It appears that members have a basic understanding of what is expected of them, but not a comprehensive one. All responses were generally in line with the expectations laid out for them in Paraguayan law and in LHC documents.

Question 2 and 6: What do you view as the three main functions and/or tasks of the LHC?

Due to the similarities and common characteristics of responses for questions 2 and 6, I decided it would be useful to analyze responses to these queries jointly. I found value in asking the question in two different forms (one specifically asking about the functions of the LHC and another inquiring into the daily tasks of the LHC), as the respondents were able to think of the role of the LHC incrementally as well as holistically. That said, most responded in generalizations.

Many LHC functions and tasks are listed in Paraguayan law (Decree 19966/98), including:

- co-management and administration of the hospital with the Ministry of Health;
- creation of a local health plan with community involvement;
- creation and implementation of the budget;
- weekly presentation of financial statements to the board; and
- encourage methods and information systems for better utilization of resources (1998).

Law 3007/06 adds the administration of funds as part of LHC responsibilities.

The most common explanation of the functions of the LHC (seen in 19996/98, rules and procedures and various manuals prepared by the Ministry of Health) is:

- plan, implement and control the administrative processes for the development of plans, programs, projects and services with guidance from the executive committee (Carrizosa & Gaete, 2010; Paraguayan Decree 19996/98, 1998; Saldivar & Velasquez de Arenas, 2007).

The most important functions of the LHC identified by interviewees is shown in Table 5.

TABLE 5: LHC FUNCTIONS

Responses	# Of Respondents from Town A(n=5)	# Of Respondents from Town B (n=5)	Total Number # Of Respondents (n=10)
Manage funds	3	3	6
Augment resources	2	3	5
Increase community participation	0	3	3
Create plan to address health issues	1	1	2
Control use of funds and implementation of local health plan	1	1	2
Support sub-councils	1	1	2
Coordinate work with sub-councils	0	2	2
Identify community health challenges	2	0	2
Increase access to health services	1	0	1
Maintain current levels of services	1	0	1
Coordinate the various institutions involved	0	1	1
Implement new projects	0	1	1
Oversee health services delivery	0	1	1
Increase quality of services	1	0	1
Evaluate LHC sub-councils	0	1	1

Once again, these individuals exhibited a general understanding of the LHC's primary functions. However, respondents placed much greater emphasis on managing funds than on planning and controlling administrative processes. Only two interviewees mentioned supervising administrative processes as a duty of the LHC and no respondents mentioned planning administrative processes, although two did indicate direct involvement with developing their community's health plan.

Interviewees mentioned the role of the 'administrator' repeatedly. Decree 19966/98 states briefly that the administrator will assist the LHC to program, administer and control financial resources from various sources. The administrator was a paid position in both LHCs I studied and each had a prominent role in the logistical operations of their respective councils. The role of the administrator, in theory, should be to assist the hospital in carrying out the wishes of the council, but there seems to be some overlap between the role of the administrator and that of the board offices of treasurer and secretary. The role of the administrator is a useful one, bridging the two organizations, although it appears that both LHCs rely very heavily on this single person to carry out the responsibilities that should be held by several individuals, which could create inefficiencies and/or opportunities for corruption. One member posited, "The most important people of the LHC are the treasurer and the administrator... These are the people addressing these issues on a daily basis. The other members only participate twice a month in meetings to make decisions on the most important issues but the daily work is carried out by the administrator and the treasurer, or the president" (Anonymous Treasurer of Town B, Personal Communication, January 4, 2012).

Question 3: What kinds of policies and oversight processes are in place to ensure that those functions are being addressed?

Law 1032/96 (Decree 19966/98) states:

- LHC participants are the civic participation that represents the users and beneficiaries of the health system;
- the council should be made up of representatives from all the various institutions related to the health sector in the community;
- the executive committee must include civic participation in the implementation of health programs and services;
- the Ministry of Health and the Departmental Health Council supervise these processes;
- the LHC administrator assists in the administration and supervision of financial resources from the various sources of funding;
- LHC evaluates local health plan implementation quarterly and monitor the execution of the budget and actions to be carried out during the following quarter in relation to the priorities of the plan and the local health situation;
- LHC controls hiring, transferring and commissioning professional, technical and administrative staff in collaboration with the hospital director;
- LHC creates a system of incorporation and control of users and beneficiaries of the local health system, based on a socio-economic study to avoid inequities in implementation of the local health plan;

- LHC presents reports and evaluations on the process and impact of LHP implementation on the population;
- LHC communicates and publish reports detailing how resources are being administered
- directive board present reports and evaluations on LHC actions’ impacts on the population;
- executive committee informs the LHC about the functioning of the hospital and local health plan implementation and the use of financial and technological resources;
- executive committee establishes sub-committees at the services level to increase efficiency and efficacy of medical services (ethics commission, medical audit, teaching commission);
- LHC participates in the creation of guidelines and strategies for national, regional and local health, consistent with national health policies;
- executive committee reports back to the MOH every two months concerning progress in realizing the goals of the national health plan, the budget and the achievements and difficulties encountered in efforts to realize those aims;
- total transparency of the information system inside and outside the organization; and
- LHC integrates sub-committees for the study and development of concrete areas of the local health system (1998).

Interviewees identified the policies and oversight processes outlined in Table 6 as currently in place.

TABLE 6: POLICIES AND OVERSIGHT PROCESSES

Responses	# Of Respondents from Town A (n=5)	# Of Respondents from Town B (n=5)	Total # Of Respondents (n=10)
Yearly presentation of financial documents	3	1	4
Policy manual prepared by the Ministry of Health	1	2	3
Rules and Procedures document	1	2	3
Control of fund allocation	1	1	2
Budget	0	2	2
Administrator as overseer on behalf of LHC	1	0	1
Controlling implementation of local health plan	0	1	1
Evaluation sub-committee	0	1	1
Bylaws and other legal documents	0	1	1
Identification of challenges to community health	1	0	1

One interviewee mentioned LHC sub-committees and identified the evaluation committee as playing a part in program oversight. Councils do not appear to be making active use of sub-committees. The evaluation committee, in this case, is probably fulfilling a role similar to that of an audit committee, but not as formally. The interviewee did not mention any other oversight committees, such as a legal committee, health promotion committee, financial committee, environmental committee or ethics committee. The MOH recommends that LHCs establish all of these (Carrizosa & Gaete, 2010). Council members seemed to have a general knowledge about existing oversight documents, yet struggled to describe the policies and processes they contained. Responses from LHC members from Town A focused more heavily on activities carried out by members and the processes they undertake to ensure the LHC is carrying

out its functions. Responses from Town B were more varied and more members mentioned physical documents that detail policies as the key mechanisms by which to ensure proper LHC functions are carried out.

Question 4: What are the three greatest challenges facing the Local Health Council in governing the hospital?

Interviewees identified the challenges shown in Table 7.

TABLE 7: CHALLENGES FACING THE COUNCIL

Responses	# Of Respondents from Town A (n=5)	# Of Respondents from Town B (n=5)	Total # Of Respondents (n=10)
Lack of resources	4	2	6
Maintaining motivation among LHC members	1	2	3
Equal access to healthcare services	0	3	3
Management effectiveness	1	1	2
LHC capacity	1	0	1
Provision of comprehensive healthcare	0	1	1
Political tensions among LHC members	0	1	1
Dependence on MOH	0	1	1
Administration of funds	0	1	1

Town A LHC interviewees pointed to a lack of resources as the greatest challenge facing their organization, followed by council capacity and motivation. Town B member responses were more varied and included lack of resources, lack of access and MOH dependence, among others cited above. I reviewed Paraguayan law to determine which of the obstacles identified by the LHC members were addressed at the federal level. Decree 19966/98 addressed the lack of local resources (and subsequent dependence on the Ministry of Health) by requiring the LHC, in conjunction with the executive committee, to develop a system of acquiring equipment, materials and other necessary resources for health services and programs (1998). LHC rules and procedures documents in both towns place this responsibility to generate funds on the treasurer. Because these policies have not been the subject of implementation efforts in the LHCs, however, I perceived the councils were very dependent on the resources allocated by the Ministry, which is barely enough to maintain current functioning capacity and certainly not sufficient to improve health services delivery, a major goal of local health plans.

The effectiveness of management and board capacity (or lack thereof) was addressed by national decree 19966/98, which stated that each LHC should promote the conscious participation of municipal authorities and district organizations through capacity-building of local leaders and strengthening of civic and health education programs for the community (1998). The same decree called on LHCs to promote the development of informative and educational programs for members of the councils to strengthen their capacity for full participation in the administrative process (1998). Although the MOH and the nonprofit CIRD do offer annual workshops to assist LHCs with this task, they are targeted to the officer positions and the remainder of the LHC members are not given any formal management training to aid them in fulfilling their responsibilities.

Board members identified funds administration as a challenge stating that the LHC should write administrative rules and regulations for the normal functioning of the accounting units and administration of services. As previously noted, there are stated rules and regulations for accounting, but processes of ‘normal functioning’ are not detailed and I would posit that, because of this absence, administration of funds is not particularly clear or efficient.

Although comprehensive healthcare is listed as a ‘core value’ of the national health system, it is one that has yet to be implemented in Town A and B. Decree 19996/98 states the LHC should develop plans, programs, projects and services of local interest that are related to the priorities to ensure comprehensive healthcare for all the population with quality and equity of attention and without discrimination (1998). The LHPs of Town A and B outline a comprehensive healthcare system, but the lack of sufficient resources makes an inclusive approach to healthcare extremely challenging.

The national health system law also calls for equal access to healthcare services as part of the ‘core values’ of Decree 19966/98 (1998). One initiative aimed at addressing the issue of equal access is the formation of sub-councils located in the more rural and isolated regions. Sub-councils can develop health posts in their communities with the assistance of the LHCs. These groups help to increase rural populations access to healthcare services. Both Town A and B have a number of developed sub-councils, some more active than others, yet the services they provide are extremely limited due to budgetary constraints facing the LHCs as a whole. The Mayor of Town A described these constraints in the following comment:

There are several challenges today but we do not have any major challenges as before. Before, the biggest challenge was that there was no ambulance. Today we have an ambulance that was obtained by the LHC with a grant from the German [Association]... Before there was a problem of [no] gasoline, but today with a credit card the Ministry [of Health] that pays for all of it and we no longer have this problem and now we have the ambulance that is working the most in the region... We do not have any big problems currently but we always need more human resources... Specialists, for example, like an orthopedic doctor... we would like to have one for the following year... (Anonymous, Personal Communication, January 4, 2012).

The Mayor here expresses his perception of the health services that have been extended through the work of the LHC and those that are still needed. A member of Town B’s LHC expressed her concerns about budgetary constraints as follows:

...For example, a sum of money is given to the LHC [from the Ministry]... for a health campaign about preventative measures against dengue. The Ministry [of Health] signs an agreement with the LHC and gives us a sum of money... the amount of money is announced on the radio and TV. Well, this amount was given to the LHC but soon enough the district hospital is left without gauze. It is the small things that we have to plead for... (Anonymous, Personal Communication, January 14, 2012).

This member illustrates the tension between MOH guidance and local needs. In this scenario, the budget is designated for specific national health programs, yet the document did not factor in the health needs and priorities of the local community. LHCs' high level of dependence on the MOH is a key factor contributing to ongoing situationally specific institutional tensions.

Political tensions and difficulty maintaining motivation pose serious threats to the proper functioning of the LHC and those challenges are not specifically addressed in law, as they arise from board dynamics. Two council members from Town B and one from Town A perceived a lack of LHC motivation to be a real issue in fulfilling its role as governing board. As the Hospital Director of Town A explained:

The biggest challenge is the continuance and permanence of the LHC... Since the LHC is voluntary and members do not receive any economic incentive or any other type of incentive...the continued maintenance of the LHC is a challenge... and besides that, member understanding of the problems relating to the hospital is in much need of enlargement... (Anonymous, Personal Communication, January 4, 2012).

The Hospital Director touched on the difficulties encountered when working with a volunteer board. He also alluded to LHC members' general lack of understanding of hospital organization and management. This lack of comprehension persists despite laws that obligate several institutions to provide training and guidance, namely the municipality and the MOH (Paraguayan Decree 19966/98, 1998; Saldivar et al., 2008). Otherwise, all of the concrete challenges identified by LHC members are in fact treated in law, a fact that highlights a significant gap between what is outlined in national health care statutes and LHC implementation. At least some council inefficiencies are directly linked to this mismatch.

Table 8 details the LHC functions required by federal law and which tasks the LHCs were addressing in both towns at the time I conducted my research.

TABLE 8: CURRENT LHC FUNCTIONING ANALYSIS

Law	Description	Town A	Town B
Decree 19966/98	Sign the contractual agreement of commitment to decentralization with the Ministry of Health	X	X
Decree 19966/98	Create a financial and administrative system for health services and programs based on resources received from all sources to develop the local health plan.	X	X
Decree 19966/98	Adjust the administrative process to the norms of the Ministry of Health, the Department and the local Municipality	X	X
Decree 19966/98	Facilitate administrative audits and technical audits of programs and services		
Law 3007	Outline procedures for receiving, managing and allocating resources mentioned in the bylaws or rules and procedures of the LHC. Procedures should be outlined for accounting for revenues and expenditures for operations of the hospitals. Those that review these procedures are not part of the executive committee or employees of the regional health councils		
Decree 19966/98	Write administrative rules and regulations for the normal functioning of the accounting units and administration of services	X	X

The nonprofit organization CIRD assisted both LHCs during their creation. Thus, many of the founding documents are accurate and in accordance with Ministry requirements. Formally, many of these records exist but that step while necessary, does not ensure compliance. For example, the MOH requires both LHCs to conduct an annual internal audit to be performed by the ‘audit committee.’ In practice, however, neither LHC I studied possessed knowledge of how to perform an internal audit, nor who would be responsible for such a task. Although the Comptroller General (CG) of Paraguay does carry out audits on various governmental entities, that office has not yet audited the district hospitals I analyzed. This is so mostly because of the small size and limited resources of the CG office, which are not sufficient to meet the needs of the 830 governmental units for which the agency is responsible (Cohen et al., 2004). CG audits are usually performed in response to a scandal or specific public request. Nevertheless, it is useful to keep in mind that even these audits are not sufficient, as their focus is to ensure that funds are being appropriately allocated to achieve the stated mission and they do not include a review of program accountability (Cohen et al., 2004).

Law 3007 requires a document outlining accounting procedures for the hospital (2006). Nevertheless, my interviewees had little knowledge of such a requirement. Accounting for the LHCs was regularized, but my interviewees knew little about how that current process was adopted or what it entailed. The current local health plan for Town B identifies accounting as a weakness and has articulated a specific improvement objective, but the approach for addressing the issue was poorly developed (Carrizosa & Gaete, 2011).

The second half of question four asked, ‘How might those challenges [identified by respondents] be addressed by the LHC or other entities?’ I decided not to include these responses in my analysis, as they did not provide any further insight into the current functioning of the LHC or member perceptions of those operations. For example, if the respondent identified the challenge to be a lack of resources, when asked to address that challenge, their solution was to find more resources or request more from the MOH. Due to the redundancy of answers, by the fourth interview I no longer asked members the second half of this question so that I could spend more time on additional inquiries linked to other questions that I determined provided more insight into LHC governance processes.

Question 5: In what ways does the LHC involve the community?

The issue of community involvement is addressed in national law in the following ways:

- representatives of the various community health sector organizations must be invited to participate in planning efforts;
- the LHC must promote the participation of municipal and district authorities through capacity-building with local leaders and strengthening civic education and health programs;
- the LHC must represent the users and beneficiaries of the health system;
- the executive committee must ensure civic participation health programs and services implementation;
- the LHC must present yearly financial statements and elect LHC officers at the annual general assembly meeting; and

- national law cites civic participation in healthcare as a core value of the national health system (Saldivar & Velasquez de Arenas, 2007).

For their part, interviewees identified several ways of involving the community (see Table 9).

TABLE 9: CIVIC ENGAGEMENT IN LHC PROCESSES

Responses	# Of Respondents from Town A (n=5)	# Of Respondents from Town B (n=5)	Total # Of Respondents (n=10)
The annual constituent assembly meeting	2	4	6
Representation by LHC members	3	0	3
Representation and community involvement through Health Sub-Councils	0	3	3
Participation in the process of creating the local health plan	0	1	1
Direct interaction with the LHC office	0	1	1

Town A respondents suggested strongly that citizen participation was facilitated through presentations to the community and LHC member representation, while Town B interviewees most frequently identified the annual constituent assembly meeting and health sub-council participation as ways to involve the community in LHC processes.

Generally speaking, LHC members have a developed understanding of ways to involve the community in their deliberative processes, yet several of these professionals commented on the need to make still greater efforts to elicit citizen engagement. For example, the annual constituent assembly provides a strong opportunity for community involvement in electing LHC leadership, yet the gathering is not promoted well and community participation is therefore low. LHC members do indeed represent their respective community institutions, yet it is by no means clear that those efforts are adequately capturing and representing broader town needs. This concern was addressed further in the next question.

Follow-up: How accurately do you feel the LHC represents the community?

The interviewees responded to this question as outlined in Table 10.

TABLE 10: REPRESENTATIVENESS OF LHC

Responses	# Of Respondents from Town A (n=5)	# Of Respondents from Town B (n=5)	Total # Of Respondents (n=10)
The LHC is politically diverse	2	3	5
The LHC represents the community well	3	1	4
The LHC has few women	1	1	2
The LHC is not diverse	1	0	1
The settlements are not represented in the LHC	0	1	1
All the members are of a certain economic level	0	1	1

Although almost half saw the LHC members interviewed saw the council as representing the community well, the group did identify a few areas where improvements are possible, including gender ratios and socio-economic diversity. Town B reported more gaps in diversity among

members than Town A. Although low levels of participation by diverse social groups does not necessarily implicate low levels of representation, in the case of both LHCs this did indeed seem to be the case.

Question 7: What do you view as the main goals of decentralization?¹

Decentralization is depicted, in law, as incorporating community participation, health decentralization and local management to develop a strategy for healthier communities. This strategy must ensure equitable availability of healthcare services and must coordinate services among institutions with the goal of guaranteeing access for all. The LHC manual, created by the MOH (with assistance from CIRD), explained the aims of decentralization were to “improve public health services delivery and increase services offered through the implementation of innovative, timely, efficient and equitable solutions to address local needs and priorities defined by stakeholders... to improve services, increase democratic processes and increase capacity, transparency and accountability through collective decision-making” (Carrizosa & Gaete, 2010, p. 9). Table 11 summarizes the main goals of decentralization as respondents reported them.

TABLE 11: DECENTRALIZATION OBJECTIVES

Responses	# Of Respondents from Town A (n=5)	# Of Respondents from Town B (n=5)	Total # Of Respondents (n=10)
Increase local participation and influence	3	4	7
Local knowledge allows for better identification of challenges to local healthcare	3	2	5
Increase community contribution to health services	1	1	2
Increase access to health services	0	1	1

LHC members understand the general decentralization rhetoric, as demonstrated by the following representative's comment,

Decentralization, I believe, is what is going to provide the final solution for the country ... because a Ministry can barely address all the problems throughout the country. I believe that, little by little, we will give more control to the departmental and municipal governments. I believe that this will be much more effective in controlling the function of each [hospital] ... Not only in the health sector, but in every sector, education, agriculture...because it is us [the locals] that learn how to deal with the [health] problems that arise in our respective district (Anonymous Mayor of Town A, Personal Communication, January 4, 2012).

Other members also embraced greater decentralization:

I believe decentralization has been implemented because locals know their immediate needs better than outsiders. Local [health] needs vary from one place to another and are very diverse, as the reality of each community is different. Current decentralization does not meet my standards for satisfaction. I would like to see total decentralization, where

¹ Question 6 was combined previously with Question 2.

each community completely defines their own health needs and healthcare preferences independent [of the Ministry]. Yet, we currently have about a ten percent level of decentralization... The rest of the decisions are made centrally. The reality of each community is different and that community knows its own needs and should take an important role in decision-making with regard to their communities. ... There should be more like a fifty percent level of decentralization (Anonymous Hospital Director of Town A, Personal Communication, January 4, 2012).

Follow-up question: Has health services delivery improved, worsened or stayed the same since the implementation of these decentralization initiatives?

Nine of the ten interviewees responded to this question by suggesting health services had improved in some way since the beginning of the decentralization initiatives. Nevertheless, it is difficult to correlate decentralization policy changes directly with service improvement, as there have been numerous economic and political changes in the past 15 years, many of which are not related to decentralization per se. For example, since President Fernando Lugo took office in 2008, the MOH has gradually begun to eliminate fees for many health services. However, it is difficult to attribute this change to decentralization as those efforts began under the previous regime. The Mayor of Town A gave the following explanation for why he believes that health care services have improved:

One can see that before the LHCs existed, one had to pay for all [healthcare services]. Today, no one pays anymore, doctor's consultations are free, medicines are free... not a hundred percent but some have better luck than others and get all their medicines for free. Before, for example, in the case of dentists, one had to pay everything, but today it is completely free... The ambulance is free now too. Many things have come a long way. (Anonymous Mayor of Town A, Personal Communication, January 4, 2012).

The Mayor here views free services as creating greater access to services by all constituents. I am uncertain as to whether this change resulted from LHC management or simply from policy changes at the federal level, though I imagine this was most likely a result of the political party change at the national level rather than directly correlated to decentralization. One respondent thought that health services delivery had stayed the same and no one argued health care access had worsened.

Question 8: How have the large goals of decentralization shaped or structured what the LHC does today?

After reviewing responses to this question, it was evident that many of those provided on other topics, such as the functions of the LHC and their roles as members, were direct answers to this question as well. Thus, replies to this question have been integrated into corresponding areas of investigation.

Question 9: What kind(s) of support, if any, is provided to the LHCs by the government or other entities?

The MOH, departmental government, DHC and the municipality have all agreed to certain responsibilities to support the LHC in a variety of ways by signing the Health Sector Decentralization Agreement. As noted in Chapter V, the MOH is required to assist the LHC in understanding budget creation, allocation and implementation, facilitated by the DHC and to ensure basic resources for national health programs implementation. The departmental government is obliged to support the council with a percentage of the departmental health budget proportional to the population served by that LHC and in accordance with budget constraints and assist the council in gathering necessary resources to fulfill its monitoring function and to carry out the process of decentralization. The DHC is responsible for designing and implementing monitoring and evaluation programs for the DHP and the LHP. The municipality must assist the LHC by annually contributing five percent of current revenues to supplement the finances necessary to provide services and improve infrastructure, establishing a criterion of socio-economic classification of the municipal population to identify areas in need of public health investment and providing capacity-building and orientation to the LHC so that it may properly address its responsibilities. Respondents identified the sources of support shown in Table 12.

TABLE 12: AVAILABLE ASSISTANCE TO LHC

Assisting Institution	Type of Assistance	# Of Respondents from Town A (n=5)	# Of Respondents from Town B (n=5)	# Of Total Respondents (n=10)
MOH	Funds	3	5	8
	Workshops	1	1	2
	Professional salaries	1	1	2
	Gasoline	2	0	2
	Medical students	1	0	1
Department	Funds	0	2	2
	Funds and oversight for operations of several health posts	0	1	1
	Salaries for professionals	0	1	1
	Food	1	0	1
	Gasoline	1	0	1
Municipality	Funds	1	3	4
	Infrastructure	0	1	1
	Salaries for Professionals	0	1	1
Departmental Health Council	Medicines	0	2	2
CIRD	Workshops	1	3	4
	Logistical assistance	0	2	2
Pan-American Health Organization	Vaccinations	0	1	1

There are several inconsistencies when comparing support called for in the Health Sector Decentralization Agreement and interviewee responses. The Departmental government has committed itself to assist the LHCs in gathering resources, although this was not a service mentioned by respondents. The DHC is charged with designing and implementing a process for monitoring and evaluating the implementation of the LHP, but respondents did not address this provision either.

In the case of Town A, very few services and little support, in fact, were attributed to the Departmental government, whose only contribution consisted of gasoline for the ambulance and food for patients. However, respondents from Town B attributed some professional salaries, medicines and general funds to their Department. The DHC contributed very little, with gasoline for the ambulance and a few medicines for the hospital being the only contributions mentioned by respondents from either LHC. The municipality is charged with identifying areas of necessary social health investments, although respondents did not address this charge. LHC ‘orientation or capacity-building services’ were also not mentioned by any respondent, although these services are supposed to be provided by the municipality. However, respondents mentioned several institutions providing aid that were not treated in law, including vaccinations from the Pan-American Health Organization and salaries for professionals provided by the municipality. Although its host community does provide funds to each LHC, two respondents claimed that their municipality rarely gives the full five percent of revenues called for in Decree 19966/98 and the amount contributed by the municipality was often closer to two or three percent of revenues (1998).

Question 10: What efforts are made by the LHC to ensure public accessibility to financial documents? Are any other measures taken to facilitate public understanding of LHC processes?

The following steps should be taken according to law to ensure public access to LHC information:

- total transparency of the system of information inside and outside the organization (Paraguayan Law 1032/96, 1996);
- communicate and publish all relevant financial and administrative documents and be open to the public record (Paraguayan Decree 19966/98, 1998);
- weekly presentation of financial statements to the directive board (Paraguayan Decree 19966/98, 1998); and
- presentation of annual financial statement and elect authorities at the annual general assembly meeting (Saldivar & Velasquez de Arenas, 2007).

Respondents identified the following ways that public accessibility to financial and administrative LHC documents is currently being ensured (see Table 13).

TABLE 13: LHC FACILITATION OF PUBLIC UNDERSTANDING

Responses*	# Of Respondents from Town A (n=5)	# Of Respondents from Town B (n=5)	Total # Of Respondents (n=10)
Constituent assembly and presentation of financial report	2	4	6
Direct interaction with the LHC	1	0	1
Educational campaigns to increase understanding of the health system among citizens	0	1	1

*Note: Two members from Town A were unable to identify ways in which the LHC facilitates public understanding

Seven respondents expressed explicit concern about the level of understanding on the part of the community of how the LHC functions and, in some cases that it even existed. The

secretary from Town A asserted that “Many people do not know [about the LHC] because the public is indifferent if they have not had to deal with health problems themselves. So if one is just a member of the community, there is little interest to involve oneself” (Anonymous Secretary, Personal Communication, January 2, 2012). Another member of the LHC of Town A believes, “In reality, there are a few people that understand [the function of the LHC] and there are others who do not... They will say to you that you are there for some personal benefits or profits, these kinds of things...” (Anonymous LHC Member, Personal Communication, December 29, 2011). Therefore, community members rarely seek to obtain LHC financial information because there is little knowledge and/or interest in the organization and the role it plays in the community. In my personal experience it became apparent that, in the case of the LHC from Town A, there was no system in place to facilitate sharing financial documents with the public. It took a period of several months to get the materials I requested and the information finally provided was out of date. I am not certain if that is because they have yet to prepare the most current financial documents, or if they were simply unwilling to share them with me. Table 14 shows the legal documents I was able to review and the latest update of each document given to me.

TABLE 14: LHC DOCUMENT ACCESSIBILITY AND TRANSPARENCY

LHC Legal Documents		Most Recent Available	
Legal Document	Description	Town A	Town B
Bylaws	Rules made by the LHC to govern the regulation of the organization	2005	2006
Internal Rules and Procedures	The document that establishes how the LHC will function, the responsibilities of the various officers, members and procedures dealing with meetings, finances and oversight	2008	2006
Financial Statement	A document that indicates revenues and expenditures from a fiscal year	2009	2010
Decentralization Agreement	A contractual agreement between the LHC and the Ministry of Health that gives the LHC control to administer funds from municipality, the department and those generated through the provision of services	2005	2005
Local Health Plan	A local health plan is prepared with the participation of the community with a corresponding budget for implementation	2009	2011 - 2013
Quarterly Evaluation	The quarterly evaluation determines the success of implementation of the local health plan, budget and should be presented to the MOH, department, municipality and the community	none	none

As illustrated in the above table, most documents accessible to the public are extremely out of date. I contacted the LHCs of both towns in October of 2011 and the records cited above were the ones that were most recently available and quarterly evaluations were not available at all. Some documents, such as the decentralization agreement and the bylaws did not require yearly updates, but others, such as financial statements and quarterly evaluations do. LHPs are updated depending on the period of implementation established by their creators, in some cases a plan is created for one year, other times two or three. Town B had notably more updated documents than Town A, which might be attributed to that LHC’s overall higher level of activity and the relatively stronger support it received from collaborating institutions.

7-2 Comparison of Members and Officers

As might be expected, LHC officers (President, Hospital Director, Secretary and Treasurer) were considerably more knowledgeable about the functions of the council and these individuals were able to answer the questions that I asked more readily as compared to general members. Their responses also aligned more closely with the expectations set out in Paraguayan law when compared to general members. Some of the LHC members were not able to answer some of my questions because they were not familiar with some of the institutions or legal documents about which I inquired. For example, one member did not know about the existence of the LHP, which is the document the LHC must approve and also oversee its implementation. Another member had not heard of the nongovernmental organization CIRD, which has continuously supported both LHCs since their creation. This could be a result of the Ministry's LHC member training offered for officers and not for general members, or simply a greater level of involvement and interest on behalf of officers compared to general members.

7-3 Comparison of LHCs

Town A and B receive similar amounts of funding from the MOH, both are district hospitals, meaning they serve several surrounding towns as well as their own, and have received (in the past) similar amounts of logistical support and capacity-building from CIRD. Yet, Town B has enjoyed greater support from its corresponding departmental government than that of Town A. Town B respondents mentioned professional salaries, funds, medications and even health posts in the rural areas of their district fully supported by the department. Respondents from Town A suggested that their departmental government was contributing only food for patients on extended stay and, at times, gas for the ambulance.

A trend is apparent of greater comprehension of national requirements and expectations among LHC members from Town B than from Town A. This is particularly evident in responses to questions 2, 3 and 5 in which respondents were asked to discuss LHC functions, policies and participatory opportunities. Town B council members were able properly to identify more functions, policies and civic participation opportunities than Town A, whose members struggled with both and whose council overall appeared to provide few opportunities for civic participation in its processes. This difference could be attributed to several causes. One plausible explanation is that members of the LHC of Town B are more knowledgeable than those of Town A due to the greater Departmental support they receive. Through discussions with members of both LHCs, I learned that the LHC from Town B was much more active than its Town A counterpart. My belief was confirmed when I reviewed each council's financial and administrative documents and Town B had mostly updated governance documents while Town A had mostly outdated records.

7-4 Summary of Findings

Internal Challenges to Governance

- Little development of sub-committees
- General disregard for monitoring, evaluation and policy creation
- Very basic understanding of role on the part of many LHC members
- Disconnect between LHC member understanding and expectations outlined by law

- Greater emphasis on managing financial resources than on planning and controlling the administrative process
- Overlap between duties of administrator and secretary and treasurer
- Basic level of understanding of LHC functions by both LHCs
- High level of dependence on MOH, especially in a financial sense
- Few capacity-building opportunities for LHC members
- No documented normal functioning for accounting processes
- Fund administration seems lacking in efficiency and precision
- Lack of resources to carry out LHP and provide comprehensive healthcare
- Difficulty motivating LHC members to be active participants
- Several governance processes outlined on paper but not implemented
- No internal or external audits carried out
- Little diversity among LHC members
- Difficulty accessing council financial and administrative documents
- Low level of general activity, particularly in the case of the LHC in Town A

External Challenges to Governance

- Many budgetary constraints and other restrictions placed on the LHC by the MOH
- Little support from Department and the DHC
- Municipality should be providing five percent funding and also identifying areas of necessary social health investment and does not appear to fulfill this role fully
- Little community interest in LHC processes and functions
- Need for greater community participation in both towns
- Low turn out to constituent assemblies

Further Observations

- Health sector improvements are most likely not correlated with decentralization
- Decentralization rhetoric is well understood by most LHC members
- For Town A, participation is primarily carried out through the annual constituent assembly and representation
- For Town B, participation is primarily carried out through constituent assembly and sub-councils
- The LHC from Town B has a more comprehensive understanding of LHC functions than Town A
- Greater understanding of LHC roles and functions on the part of LHC officers than general members

CHAPTER VIII**DISCUSSION**

My findings explore further my first two research questions: how do LHC members perceive their roles? And how closely aligned are LHC board governance practices with the stated objectives of decentralization as outlined in federal law? My aim in this chapter is to synthesize the data presented in Chapter VII and to apply those findings to the three identified dimensions of governance in an attempt to address my third research question: how does board member perception of their roles affect LHC board governance, in the areas of accountability, transparency and civic participation? I also discuss briefly other dimensions of governance that were relevant to my findings.

8-1 Civic Participation

Civic participation is incorporated into LHC governance very minimally. Six respondents identified the annual constituent assembly meeting as the only form of direct citizen engagement with council operations. Neither LHC made great efforts to include the public in identifying community health needs or in decision-making concerning those requirements. As Kauneckis (2008) has pointed out, little civic participation can lead to weak democratic processes within an institution. One benefit of decentralization touted by some scholars is the incorporation of local knowledge, leading to greater efficiency, improved responsiveness and decreased corruption. Yet, when community members take little interest in participating in LHC processes and authorities are also not making vigorous efforts to encourage them, there is little added benefit from decentralization.

One question that is contested in the board governance literature concerns selection of individuals for membership. The answer is not simple or straightforward. The concept of board diversity provides an excellent example of divergent views because there are some scholars who see diversity as secondary to effectiveness and others who view it as an integral part of efficacy (Greer et al., 2003). Federal law requires that LHC boards include representatives from multiple community institutions and political parties (Gaete et al., 2002). Yet, these requirements do not go further to include a diversity of race, gender or socio-economic levels. The board members do indeed represent multiple community institutions, including the municipality, the school, the women's center, the football league and the German association (Saldivar & Escobar Aguero, 2009). Yet, they are mostly middle-aged men who are economically well off and live in the town center. There are no representatives within either LHC from rural areas or of modest income. Though the important fact that local delegates are now involved in decision-making allows for greater inclusion of stakeholders than was offered before when the MOH was completely centralized, there is a missed opportunity for representative efficiency when only a portion of the local population participates. This is because only a portion of local knowledge is included in decision-making and that understanding could be augmented through increased participation from a larger share of population segments. This is particularly true in the case of the LHCs I studied, as it seems these council members did not actively represent those who were not participating.

Representativeness, which is repeatedly emphasized in the nation's guiding health sector legislation, exists at relatively low levels within both LHCs. Although diversity is important,

there is always the risk of ‘tokenism’ in implementing such efforts, meaning one board member that belongs to a certain minority is asked to represent the entire relevant population of that group (Greer et al., 2003). The LHCs do not appear to be at high risk of tokenism, mostly because of the lack of diversity of members of the boards. Through my participation in board meetings in Town A in 2009-2010, I noticed that, despite the two female board participants’ presence, male board members spoke far more frequently and engaged more actively than their female counterparts, who were more likely to listen quietly. Thus, despite the presence of female board members, their representation might be seen as less than sufficient, as a result of their lack of participation. Locke et al. (2003) assert that board members often justify a lack of attention to diversity by arguing a more demographically diverse membership does not actually improve organizational effectiveness, but instead, only yields a measure of political correctness. However, the board members I interviewed did seem to accept that diverse representation on the board was intrinsically valuable, although members defined the concept quite differently. Most respondents defined diversity in terms of political parties or organizational representation, while relatively few conceptualized the idea in a way that included gender or socio-economic status.

Another challenge implicit in attaining diversity might lie in the character of LHC board service (Greer et al., 2003). A certain percentage of the population might not be able to participate because they cannot afford to forgo the hours of earned income required so to serve. This obstacle can be overcome through income replacement schemes (Greer et al., 2003). Nevertheless, it might be difficult for the LHC to justify compensating board members in any capacity, given the tight budgets and scarce resources that are arguably needed for services directly related to the LHC’s mission. Greer argues that a lack of diversity in board membership weakens board accountability (2003). The lack of diversity among LHCs becomes more problematic when civic participation is limited.

This diversity deficit could partially be a result of board appointments or selections rather than board elections (Robinson & Shaw, 2003). The LHC accepts applications for new board members and is solely responsible for deciding who joins the general assembly and who does not. As Robinson and Shaw have observed, “this produces boards that are self-perpetuating cliques” (2003, p. 36). I would posit that this is true in the case of the LHCs I studied because boards identify safe candidate choices on the basis of their apparent similarities to current members. Robinson and Shaw argue that most unelected bodies “... should be replaced by elected ones as a matter of principle to provide the basis for accountability” (2003, p. 37). LHC elections or other processes to increase diversity among members would strengthen downward accountability. Otherwise, boards will operate largely unquestioned by the public (Robinson & Shaw, 2003). This is very much the case for the LHCs I examined. With the exception of two elected directive board members and the Mayor, who serves as LHC director, the majority of the members of the LHCs I investigated were appointed. Constituent meetings are poorly attended and therefore members are elected from a small percentage of the population. Despite the high number of hospital users, the general public knows little about how the institution is governed. Seventy percent of interviewees expressed concern about public understanding about the LHC and its processes. With the public not fulfilling its disciplinary role, as should be the case in many democratic institutions, the LHC becomes accountable only to the MOH. This situation is exacerbated by the little interest in and investigation by the public into what the LHC is doing

and how it is doing it, as long as there is no scandal reported in the media (Cohen, Berthin, & Mizrahi, 2004).

Board composition can highly influence governance processes, as a lack of knowledge, proper skills and/or experience among board members as they carry out their roles can negatively influence board capabilities and choices (Conforth, 2003). This, coupled with a lack of training, can have serious consequences for a governing board and, thus, the entire organization. The LHC suffers from deficiencies in preparedness and development opportunities for its members. It is not surprising that relatively rural areas, in which both LHCs are located, often lack the skilled professionals necessary to be able to work effectively on governing boards. Council members would benefit from a greater understanding of their role and influence on governance processes, as it was clear to me in my conversations with several trustees that they did not have a fully developed understanding of their role. The lack of professional capacity in the region, coupled with a lack of resources for training, results in constraints on board effectiveness (Conforth, 2003). Due to a lack of LHC support in practice that the municipality and the Department are required formally to provide, both council's members demonstrated a lack of full understanding concerning how to operate effectively. As mentioned earlier, board composition, in terms of diversity, representativeness and the general capacity of members, can also affect the accountability of a governing board. Public accountability is obtained, to a large degree, through organizational representativeness of the community. Both LHCs displayed a low level of community representativeness, which leads to limited accountability.

8-2 Accountability

The LHC is, formally speaking, financially and politically accountable to the MOH and the federal government. Each council is charged with ensuring the implementation of Ministry mandated health initiatives. Moreover, the LHC determines what is important for its public hospital, within guidelines published by the MOH. Greer, et al., have suggested that other forms of accountability, apart from responsibility to the federal government, should also be in place. They emphasize the importance of downward and horizontal accountabilities, such as 'peer groups,' stakeholders and constituents (Greer et al., 2003). As noted earlier, the LHC is not held accountable, using the core definition of the word, to any of the listed groups because the mechanisms in place to do so are very weak. There is a level of required community representativeness, which would increase stakeholder accountability if implemented, but representativeness is low. There is also no ready way for constituents to hold the LHC accountable for its actions, given that the majority of its members are not democratically elected, as previously mentioned (Carrizosa & Gaete, 2010). The implication of the self-perpetuating nature of the LHC is that removal of ineffective members by constituents is difficult, if not impossible, which can create institutionalized challenges to increasing board effectiveness if many board participants are ineffective.

LHC board dynamics, which includes member functions and understanding of their role, is a key aspect of accountability (Mette Kjaer, 2004). Although my study respondents had a general understanding of member roles, their apparent dearth of understanding concerning the specific tasks for which they are responsible is concerning, particularly in the case of Town A. Interviewees consistently overlooked sub-committee creation and participation as a

responsibility of member roles. I posit that the generally low-level of activity generated within the LHCs has led to the dismissal of sub-committees entirely, as members have the tendency to perform the minimum of what is expected of them by law.

LHC members understand the general functions of the LHC, or, more accurately, they understand the rhetoric behind the decentralization initiatives and the creation of their institution. Generally speaking, council officers possessed a better understanding of their roles and the functions of the LHC than general members evidenced. Respondents (of all roles) placed little emphasis on planning and administrative processes, which could lead to poor accountability, if mechanisms are not in place to ensure their appropriate implementation (Naurin & Schuman, 2006). LHC member understanding of decentralization objectives was high. These individuals correlate decentralization and more democratic processes, which hypothetically leads to improved healthcare services with greater access to them. Nonetheless, based on my findings, I doubt this assumption holds true in the Paraguayan context.

I found that, despite a variety of forms of support provided by various governmental and nongovernmental institutions, the LHC member training that should be provided by the municipality, according to law 2051/03, was not provided to either council board studied. Another complaint, voiced by council members themselves, was that the municipalities were not providing funding to the LHC as required by law. Municipalities must also be accountable for the services they are required to provide to the LHC so councils can achieve their highest possible levels of effectiveness. Nonetheless, the federal government has not provided for sanctions when municipalities fail to uphold their fiscal responsibilities (Cohen et al., 2004). Lack of accountability of the municipalities presents a challenge for the LHC because their proper function as an organization relies on the support of these government institutions.

All of the concrete challenges to LHC governance shared by council members are in fact addressed in Paraguayan law. Many of these difficulties could potentially be mitigated if members were adhering to procedures and policies required of them. Unfortunately, because of existing gaps in understanding among members as well as ongoing fiscal constraints, the LHCs are not able to function nearly as effectively or efficiently as might be possible if national policies were followed.

The councils possess clearly established policies and procedures to ensure accountability, or self-binding mechanisms as described by Santiso (2001), although many required updating. The greater concern, in this regard, is whether the formal procedures are understood by LHC members and followed in practice. There was little reference to administrative documents used to inform council functions and procedures, particularly in the case of Town A. The weak state of self-binding mechanisms within the LHCs could be a cause of these institutions' overall low-quality of democratic process (Santiso, 2001).

The LHC's members, similar to those of many boards, are charged with making financial decisions, yet all too often governing groups rely on one or two financially literate members to guide these decisions (Harrow & Palmer, 2003). Moreover, the diverse array of financial responsibilities resting on the board would be challenging even if all members had a background in finance. In the case of the LHCs, respondents indicated they relied on the councils'

administrators to address financial responsibilities. The councils are charged with creating an annual budget, a long-term strategic plan and annual financial and management reports (Gaete et al., 2002). Harrow and Palmer cite research that suggests that financial concerns are found throughout almost all board activities, not just the obvious financial management tasks listed here (Harrow & Palmer, 2003). For example, if the LHC decides it is important to keep hospital staff on duty for longer hours, there are financial implications to that decision. Therefore, financial and administrative responsibilities should be undertaken by those indicated in Paraguayan law, primarily the secretary, treasurer and trustee, although the administrator can serve to facilitate such processes, particularly when aggregating hospital data (Paraguayan Decree 19966/98, 1998).

8-3 Implications for Accountability

The structure of the health sector is well defined, yet lacks the institutional support and internal mechanisms to secure its proper implementation. According to Huque, a weak system of accountability creates a great challenge for public management for governmental institutions. He also asserts that good governance is an impossibility if a strong accountability system is not present (Huque, 2011). Without such a system, effective LHC governance will be difficult to attain.

Effectiveness refers to the ability of a board to achieve its purposes (Greer et al., 2003) and is linked to clearly defined objectives, board composition and internal governance patterns, including key professional relationships (Greer et al., 2003). The national government has clearly defined its organizational objectives for LHCs in its social statute. Yet, in order to carry out these functions successfully, the councils must have access to appropriate knowledge and resources to do so. The LHC board members I interviewed expressed concern about their preparedness to serve effectively in their assigned governance roles as well as the resources available to them to do so properly. As Joseph (2010) has argued, this might be the result of applying advanced liberal society policies to a country with weak local governmentality.

Another consideration is board composition, which requires an overall balance among members to increase effectiveness (Greer et al., 2003). Greer argues that, “Board members have to ‘gel’ with each other, while allowing for the possibility of the ‘creative tension’ that can contribute to effectiveness” (Greer et al., 2003, p. 50). The LHC from Town A (during 2009-2010) did appear to work well together, with members sharing varied viewpoints, but in a respectful and useful manner. A plausible reason this board was able to find a good balance could be attributed to their familiarity with each other, as many board members are active community members who engage in multiple community organizations and events simultaneously. Also, both councils evidence a certain level of homogeneity, as noted above, in that all members are from a certain socio-economic level (mid-to-high) and almost all live in the center of town, where the wealthier citizens tend to reside.

Even with an ideal board composition, board effectiveness can be challenged by too many restrictions and guidelines by the federal government (Greer et al., 2003). This is indeed a problem for the LHCs. The legislature and MOH have issued countless requirements and stipulations resulting in less space available for input from the board members, at least with

regard to important decisions. The federal government offers a seemingly endless array of requirements and guidelines (many of which were created at the instance of USAID), and little room is left for any real input from LHC members in this process. This was evident in discussions with a Town B council member who described a situation in which funds were given to the LHC, but de facto were already allocated to meet national health requirements with no resources left for basic hospital necessities, such as gauze.

Scenarios such as the one just described might affect council members' attitudes as they begin to see their role as merely carrying out orders from the MOH as opposed to responding strategically to local health care needs. Various countries are experiencing this same phenomenon in their health sectors. As Greer has suggested in a commentary on the United Kingdom's health system, "Current government rhetoric speaks of the need to implement national priorities in a way that is responsive to local needs, but most services are now governed by such a comprehensive array of nationally prescribed indicators that the space for local responsiveness has all but disappeared" (Greer et al., 2003, p. 51). This is a fairly accurate description of what is happening in the two LHCs I examined as well. Nonetheless, the ability of the councils to achieve their missions, and effectiveness in doing so, is an area that requires further investigation.

8-4 Transparency

Greer et al. (2003) argued that transparency can increase accountability by increasing public knowledge of organizational operations and performance. Nonetheless, transparency has very little effect on accountability when documents are not published and made readily available for study by the public, which is the case for the LHCs I studied. In the case of Town A, there was a waiting period of about three months to gain access to documents, which were mostly outdated. The performance of Town B's LHC was slightly better, but neither board made an effort to ensure ready accessibility of LHC financial and administrative documents to the general public.

Public access to board meetings is one kind of transparency, though not a common practice among unelected boards (Greer et al., 2003). The LHCs I examined do allow members of the public to observe their meetings. However, aside from this opportunity, there are few occasions for public comprehension of LHC responsibilities and processes. Financial reports, local health plans and decentralization agreements were available upon request, but the LHCs do not make them easily accessible, often with long waiting periods and a lot of loopholes. Quarterly evaluations that are required by law were not available at all, and other documentation, such as bylaws and internal rules and procedures, were considerably outdated. This might be the case due to a general lack of importance placed on transparency by the LHC, which may see the perceived costs of dedicating time and resources to transparency as greater than the perceived benefits generated.

As noted earlier, the UN has defined transparency as "unfettered access by the public to timely and reliable information" (Armstrong, 2005, p. 1), yet what I found in my interactions with Town A could not be defined as transparency, using this definition. Town B, however, was able to provide me with the requested documents within a period of a month and a half. CIRD

also facilitates transparency, to a certain extent, by publicizing a select number of LHC financial and administrative documents on its website, although their publication selection is quite random and out of date. The most recent document that can be found on the NGO's website, for example, is from 2008 (www.cird.org.py).

8-5 Implications of Transparency

Transparency, as noted earlier, is often discussed in tandem with accountability. Transparency has become the buzzword solution to the governance problem described as a "democracy deficit" (Hale, 2008). Transparency responds to a dimension of accountability, which is answerability (Hale, 2008). Accountability involves being held responsible for one's actions, which is one of the primary functions of transparency. The LHCs are tied to several streams of accountability, which include the MOH, the DHC, the departmental government, the municipality and the public. Accountability to the public is facilitated through public access to LHC financial and administrative documents. However, public accountability is not effective when the public is disinterested and does not engage itself in monitoring the council's governance processes. Transparency assumes organizations are operating under public scrutiny, which is simply not the case for either of the examined LHCs.

One of the greatest obstacles to effective LHC governance is the discordance of current health governance policies with the greater Paraguayan cultural context. The legacy of the dictatorship, from 1954 to 1989, shaped civil society in the nation (Mora, 1998). After many years of restrictions on civil society, a certain fear and unwillingness to participate developed, especially among older citizens. This affects the transparency of LHC operations because it might lead the councils not to emphasize transparency of their operations and decision-making because of little public demand to do so, despite the UN's emphasis on securing this goal.

The highly centralized nature of the government during the dictatorship and the decentralization initiatives beginning in 1992, have also affected current LHC board actions. The councils are creatures of the nation's larger 'good governance' reforms and are currently involved in a slow process of decentralization. This process has been underway for nearly two decades now and decision-making in the health sector is still highly centralized, in many respects. Certainly, a lack of skilled professionals to plan the local response to healthcare needs presents a challenge to effective LHC governance. The predicament facing the LHCs thus can be stated as, can these governance policies laid out by the UN and other international institutions be applied to Paraguay in the same way they could be applied to a country in the European Union (Joseph, 2010)? The answer is a not an easy one, as there are numerous challenges facing public institutions in Paraguay when attempting to meet 'good governance' standards, as outlined by the various international institutions. Yet, there continues to be a push to implement these reforms across the globe, claiming them to be the most efficient and effective path to development. In the next section, I identify some relevant discussion themes that became evident in interviews with members of the exemplar LHCs.

8-6 Relevant Discussion Themes

8-6-1 *Legitimacy*

Board legitimacy draws on all of the areas of board composition, accountability, transparency and effectiveness. Greer et al. define board legitimacy as, “the extent to which the organization represents its stakeholders (including government) and is accountable to them from its performance” (2003, p. 54). A legitimate board must possess a clearly stated mission and objectives (that are specifically linked to organizational purpose). Stakeholder representation and outcomes must also be present and clear to ensure board legitimacy (Greer et al., 2003). The LHCs have clearly outlined their mission and objectives, but stakeholder representation could be improved to include more diverse representation requirements. Outcomes are slightly more challenging to measure. According to the President of the LHC of Town A, the council is functioning effectively, within its economic restraints (Anonymous, Personal Communication, January 4, 2012). One challenge in both LHCs is a disregard for formal policies and procedures. Governance outcomes and, thus, effectiveness may be negatively affected by this lack of regard for procedures, and in turn, decreasing legitimacy. LHCs could improve governance effectiveness by improving internal supervisory systems and practices and implementing formal policies already nominally available.

8-6-2 *Strategic Contribution*

One challenge facing many public and nonprofit organizations is the unclear distinction between strategic and operational management (Conforth, 2003). Strategic management refers to the role of the board in advancing effectiveness, developing a working partnership with management, ensuring democratic accountability, transparency and adherence to federal policies and performance requirements (Conforth, 2003). Operational management refers to the CEO or director charged with implementation of those strategies. This separation is particularly challenging to make because strategic and operational management can be defined differently for each organization, depending on the needs of that particular entity and such definitions often overlap (Conforth, 2003).

In the case of the LHCs, the areas of strategic and operational management are complicated further by the presence of management and staff on the boards. Although there is much literature supporting the usefulness of management participation on governing boards, it can also lead to role confusion. The LHC’s I studied were quite dependent on the reports and recommendations provided by the management staff on the board. They expressed particular reliance on the information and recommendations provided by the administrator, who is not even a member of the LHC, but an employee of the council whose job it is to gather hospital data on behalf of the councils. That fact appeared to pose difficulties in developing a strategic approach to governance.

Public institutions frequently confuse strategy with policy (Conforth, 2003). These cannot be substituted as policy reflects efforts to make substantive claims about collective values while strategy is based on how organizations position themselves to be competitive. Within the LHCs, member functions are clearly outlined as a formal proposition, yet in practice there is little

distinction between management and governance roles, particularly in the case of the administrator. This is a good example of the fuzzy boundary between strategic and operational management because policy change initiatives usually involve both kinds of management (Conforth, 2003).

8-6-3 *Context*

As noted earlier, cultural context plays a large role in the implementation of governance initiatives. Board inputs (i.e., board member knowledge, experiences) and processes (i.e., board organization) are shaped and influenced by the context within which an organization operates (Conforth, 2003). Therefore, the actions of an institution should be understood through its organizational history, i.e., previously defined roles, norms, actions, board members, etc. (Conforth, 2003). Board activities are highly situational. Therefore, it is important to understand context in order to understand board behavior (Conforth, 2003). Expectations of LHCs must also be qualified by the context in which they operate. As noted earlier, Paraguay is not an advanced liberal society with a high quality of democratic processes within its institutions. It is instead a nation only recently recovering from a lengthy dictatorship; the manifold impacts of which cannot be overlooked. Civil society is at a low level of functionality. Many of the governance mechanisms put in place during the decentralization of the health sector are largely unfamiliar to those expected to implement them. These realities set up the LHCs for various challenges in attaining effective governance. This challenge could be mitigated through increased training to council members.

Context also comes into play in shaping the institutional environment (Conforth, 2003). Institutional cultures are created over time by the continued acceptance of a certain way of thinking and carrying out tasks (Conforth, 2003). These ideas become routinized and ingrained in a unique organizational culture and can be difficult to change. Context can be used to understand board action and inaction. The institutional cultures of the LHCs I investigated were difficult to discern. From my participation in LHC meetings, I would posit the following as likely dimension of both boards' institutional culture. Council members tended to see their roles as implementing orders given by the MOH, rather than strategically planning for the direction of the hospital. I observed a top-down approach to governance because the President and the Director of the Hospital were almost the only participants speaking during meetings. There was very little dissent shown on any issue raised in any board meeting and I believe that might also be a consequence of the top-down approach, where other board members might not have felt sufficiently knowledgeable to oppose any suggestions or decisions on the part of the President or the Director. Members do not want to step outside of the line and question LHC authorities. These realities may be shaping council governance possibilities.

CHAPTER IX

CONCLUSIONS

9-1 Research Questions Revisited

As noted above, I sought to address the three identified research questions in an effort to understand better hospital governance and challenges to its implementation at the council level. I begin my conclusions by returning to the original intent of my analysis.

I addressed question one, “how do LHC members perceive their roles?” through interview questions aimed at identifying council member perceptions of their governance roles in overseeing the hospital, as well as their understanding of council policies and procedures. My findings suggested respondents possessed a general understanding of their individual board roles although they placed little emphasis on the development of sub-committees. Member perceptions of LHC functions were also very general, with a greater emphasis placed on managing funds than on planning and controlling administrative processes. Interviewees also noted the role of the administrator on several occasions as performing the duties of other trustees, such as the secretary or treasurer. Board participants possessed a general knowledge of LHC documents but struggled to identify the policies they contained. Overall, interviewees appeared to lack a comprehensive understanding of their roles as LHC members.

I addressed question two primarily through council member interviews as well; “How do those perceptions affect LHC board governance efforts in the dimensions of accountability, transparency and civic participation?” Member perceptions highly influenced hospital governance in both case studies because many challenges could have been mitigated if members had possessed a greater understanding of governance processes. Those concerns could also be diminished if councils were receiving the support guaranteed to them in federal law, which was not the case when I conducted this analysis. Accountability is shaped by member perceptions, as a limited understanding of council roles will lead to decreased ability to carry them out. As noted in Chapter VII, members seemed fairly unaware of any monitoring and evaluation policies in place and sub-committees were continually left out of discussions. The lack of emphasis members placed on these responsibilities has a direct impact on governance and its implementation. Similarly, a limited understanding of LHC functions, more generally, also creates difficulties for the council in meeting its commitments, due to confusion surrounding what exactly those might be. Interviewees did not emphasize “planning and controlling administrative processes” as part of their LHC’s responsibilities. Many interviewees even noted that the administrator fulfills several roles that council members should be implementing. Members’ limited understanding of policies and oversight processes has created a situation in which management is fulfilling board responsibilities and the board is not emphasizing its important roles of overall leadership and planning.

Interviewees possessed a clear understanding of why the federal government first sought to create the councils. They were also able to articulate how LHC objectives related to their role in hospital governance. By clearly understanding the aims of council creation, they are able theoretically to align the governance practices of the council with them, thereby increasing accountability. Though members identified increased civic participation and inclusion of local

knowledge as key reasons for decentralization, it is unclear what steps (if any) the boards I studied had taken to ensure their incorporation in hospital governance. Members had a fairly comprehensive understanding of which entities are currently contributing to the council and which should be. While they were able to identify units that were not meeting federal obligations, they seemed to accept this reality, rather than seek to find ways to hold them accountable for their failures. Most interviewees identified civic engagement as a key objective of decentralization. Members were also able to identify the ways in which the LHC involves the community in its processes and how the councils may serve to facilitate public understanding of those efforts. However, member knowledge of LHC transparency, specifically through public access to council documents, was particularly weak. Board members did not emphasize transparency, probably due to a perceived lack of interest on the part of the community. As is evident in the summary of findings in Chapter VII, some of the misinformed perceptions of LHC members can create many challenges for council governance.

I also asked each interviewee to compare council practices, as outlined in board documents, to national law; “How closely aligned are LHC practices in the hospitals studied to the expectations set out for them by federal law?” Members possessed a general understanding of their roles and that of the council, with several holes, which ultimately created challenges for governance. As noted above, federal law requires entities, such as the municipality and the departmental governments, to provide assistance in specific ways. In the case of Town A, the departmental administration contributed very little support, much less than required by law. Similarly, municipalities did not provide any training, despite a federal requirement to do so. Both LHCs addressed, at least on paper, many national requirements, such as the development of a financial and administrative system for health services and written rules for accounting units. However, both councils I examined lacked any entity designated to perform audits and each failed to outline formal procedures for receiving, managing and allocating resources. Many council documents that should be updated each year were either neglected or councils failed to provide them when requested to do so. In short, the LHCs I investigated did not meet the federal obligation to ensure full transparency. Most interviewees viewed the councils as effectively representing the community, which is an expectation explicitly stated in federal law. However, some members did identify groups whose views could be incorporated more effectively into council decision processes to improve representation. In summary, both councils neglected many steps necessary to align governance practices with the expectations set out for them.

9-2 The Challenges of Governance

Public board governance does not follow an easy set of guidelines that can be applied to every governing body. Governance is a complicated balancing act that involves many considerations, including (but not limited to) those factors that have been explored above. The quality of democratic governance is low in many Latin American countries, including Paraguay, which some have argued must be considered at best as semi-democratic (Mainwaring & Scully, 2008). Achieving effective democratic governance has turned out to be more challenging than it was perceived to be in the early 1990s.

After identifying numerous challenges to the implementation of the governance initiatives outlined by Paraguayan law, the question of the appropriateness of those policies

cannot be ignored. As Teune (1996) and Ribot (2002) have observed, local institutions must possess the necessary capacities essential for decentralization initiatives to have a positive impact on service delivery. The LHCs I investigated displayed low capacity, given their limited training, knowledge and administrative infrastructure and resources. Seabright (1996) has stressed the need for institutional restraints to allow for accountability. Although these constraints are present in law and formally in by-laws too, they are almost completely absent in practice, which creates a system not much more effective and quite possibly less effective, in some cases, than its centralized counterpart. Without the implementation of institutional restraints, new risks are created, such as elite capture and minority exclusion (Seabright, 1996). Finally, the low level of civic participation across both of these LHCs creates a system of high dependence on the MOH, weak democratic processes and low popular accountability, due to a disengaged public. These are problems that cannot be addressed easily or individually.

International institutions now see ‘good governance’ as the framework for democratization and a means for avoiding the risks posed by dysfunctional states, by supposedly making government processes more transparent and codified (Zanotti, 2005). Democratization, decentralization and governance are not inherently effective or ineffective policies, but they are highly dependent on cultural and political context. The implementation of decentralization in Sweden and in Paraguay will result in very different outcomes. It is arguable how well the governance policies outlined by the UN travel across borders. It is evident, however, that ‘good’ governance policies cannot be applied equally in every state (Joseph, 2010). Analysts must instead be aware of the nature of the differences among nations and not try to apply a general set of policies in the belief that these will have the same results irrespective of the context in which they are applied (Joseph, 2010). Joseph (2010, p. 243) is correct in advising that, “We must not dogmatically cling to the idea that governmentality does still apply. It could well be that in such cases where governmentality fails, we are left with a different type of power relation something more like disciplinary power or a different form of biopolitics”.

In the case of the transitional democracy of Paraguay, the implementation of decentralization and governance initiatives is particularly challenging, given the lack of available resources, local capacity and comprehension and cultural appropriateness of many of these initiatives. After almost two decades of effort, little progress has been made toward efficiently and effectively governing public hospitals in Paraguay. LHCs face more challenges than ever now, because of these initiatives, than they would have otherwise. I hope the challenges to LHC governance presented in this study provide a greater depth of understanding of the difficulties in implementing decentralization and instituting adopted governance structures that are not designed to be consonant with local conditions.

Appendix A: Interview Schedule for Council Members

TABLE 3: INTERVIEW SCHEDULE FOR COUNCIL MEMBERS

	Question	Expectation of Federal Law	Dimension(s) of Governance
1	What do you see to be your role as a member of the local health council hospital governing board?	How well do LHC members understand their roles? Is their understanding of their role similar to their intended role outlined in laws 19966/98 and 3007/06?	Accountability
2	What do you view as the three main functions of the Local Health Council governing board?	Do these functions align with the functions outlined by laws 19966/98 and 3007/06?	Accountability
3	What kinds of policies and oversight processes are in place to ensure that those functions are being addressed?	Are these policies in line with those required by law 19966/98?	Accountability
4	What are the three greatest challenges facing the Local Health Council in governing the hospital? How might those challenges be addressed by the LHC or other entities?	Are current federal laws addressing the challenges identified by LHC members? If so, there may be a lack of implementation on the part of the LHC or a need for an alternate policy design at the federal level. There may also be a lack of support provided by the government.	Accountability
5	In what ways does the Local Health Council involve the community?	Does the LHC involve the community in the ways required by law 19966/98?	Civic Participation and Accountability
6	What are the three most important tasks of the Local Health Council as you see matters?	Are these tasks in line with the functions outlined for LHCs by law 19966/98 and 3007/06?	Accountability
7	What do you view as the main goals of decentralization?	Is there a clear understanding of the objectives of these laws and the reasons why they were created and how their aims relate to the roles of the governing board?	Accountability
8	How have those large goals for the nation shaped or structured what your board does now?	Have decentralization laws meaningfully affected LHC board governance?	Accountability
9	What kind(s) of support, if any, is provided to the Local Health Councils by the government or other entities?	Have LHC board members been provided with training regarding their roles as required by law 2051/03?	Civic Participation and Accountability
10	What efforts are made by the LHC to ensure public accessibility to financial documents? Are any other measures taken to facilitate public understanding of LHC processes? *	Does the LHC provide presentation of financial statements as required by law 19966/98?	Civic Participation and Transparency

*I did not ask many questions about transparency because the majority of my concerns linked to this criterion could be addressed by reviewing board rules and procedures and hospital financial statements. However, the last question on the interview schedule did seek to clarify the relationship between what the LHC actually does versus what each has stipulated it will do in its rules and procedures regarding transparency.

Appendix B: LHC Document Accessibility and Transparency**TABLE 14: LHC DOCUMENT ACCESSIBILITY AND TRANSPARENCY**

LHC Legal Documents		Most Recent Available	
Legal Document	Description	Town A	Town B
Bylaws	Rules made by the LHC to govern the regulation of the organization	2005	2006
Internal Rules and Procedures	The document that establishes how the LHC will function, the responsibilities of the various officers, members and procedures dealing with meetings, finances and oversight.	2008	2006
Financial Statement	A document that indicates revenues and expenditures from a fiscal year	2009	2010
Decentralization Agreement	A contractual agreement between the LHC and the Ministry of Health that gives the LHC control to administer funds from municipality, the department and those generated through the provision of services.	2005	2005
Local Health Plan	A local health plan is prepared with the participation of the community with a corresponding budget for implementation	2009	2011 - 2013
Quarterly Evaluation	The quarterly evaluation determines the success of implementation of the local health plan, budget and should be presented to the MOH, department, municipality and the community	none	none

Appendix C: IRB Approval Documentation



VirginiaTech

Office of Research Compliance
 Institutional Review Board
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MEMORANDUM

DATE: December 19, 2011

TO: Max O. Stephenson, Julie Erickson

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires May 31, 2014)

PROTOCOL TITLE: Decentralization and Hospital Governance in Rural Puraguay

IRB NUMBER: 11-853

Effective December 16, 2011, the Virginia Tech IRB Chair, Dr. David M. Moore, approved the new protocol for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at <http://www.irb.vt.edu/pages/responsibilities.htm> (please review before the commencement of your research).

PROTOCOL INFORMATION:

Approved as: **Expedited, under 45 CFR 46.110 category(ies) 6, 7**

Protocol Approval Date: **12/16/2011**

Protocol Expiration Date: **12/15/2012**

Continuing Review Due Date*: **12/1/2012**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals / work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

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