Guidelines For Functional Integration

A Key Strategy Towards Full Implementation Of The District Health System

Department of Health

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1. Introduction

In October 2002 the national Cabinet made three important decisions related to the District Health System. These decisions are explained in a press release dated 9 November 2002 and were based on recommendations that had been endorsed by both the Health MinMEC and the Local Government MinMEC. These Cabinet decisions are:

- Municipal Health Services will be defined as environmental health services;
- Municipal Health services will be a function of metropolitan and district municipalities; and
- In order to provide for a smooth transition, these decisions will come into effect on 1 July 2004 and all municipalities must continue to provide, until then, the health services that they currently provide.

The only way to prepare to implement these decisions and to take the District Health System forward is through functional integration. This has been recognized for some time. The Minister of Health challenged all those attending the February 2002 DHS conference to commit themselves to developing one functionally integrated district per province within a year, and the Health MinMEC in July 2002 decided that functional integration must be implemented in all health districts.

Without a strategic approach, it is likely that the current fragmentation and duplication of PHC will continue for several years. Functional integration provides a process to improve quality of care through greater integration of the health system. It has been tried over the past few years and there are both successes and failures, and challenges to implementation. Crucial to the success of functional integration are a number of key requirements. This document builds on experiences around the country and provides guidelines for successful implementation of the MinMEC mandate for functional integration. A checklist to assess progress with functional integration is provided in the Appendix.

2. Purpose of the Guidelines

The purpose of this document is to assist provincial and local government managers to implement functional integration at district level. These guidelines clarify:

- What is meant by functional integration;
- What are the key requirements;
- What are the key challenges; and
- How to implement functional integration.

Case studies of successful functional integration further illustrate the benefits for service delivery. Where functional integration is already taking place, managers are encouraged to use these guidelines to assess the progress made in each district and to expand their plans for functional integration. The document can also be used by managers to leverage support for functional integration from other important stakeholders including politicians and community representatives.

3. What is Functional Integration?[1]

In these guidelines the term functional integration means integration of provincial and local government health services. Functional integration means structured co-operation and collaboration between provincial and local government *health* rendering authorities for the purpose of decreasing fragmentation and duplication, enhancing integrated service provision, and increasing efficiency and quality of primary health care. This takes place *in the absence of* legal, financial and administratively integrated governance and management structures.

4. Model for DHS Adopted by MinMEC in July 2002

In the final stage of the development of a fully functional DHS, all staff working at district level will be on the same conditions of service, with a single local government employer and a single management structure. In most health districts, how quickly this can occur will depend mostly on how quickly agreement can be reached between employers and organized labour on the creation of a "single public service". President Mbeki and his Cabinet have made it clear that this is one of their key political objectives for transformation, and the Health MinMEC has stressed how important this is for the full implementation of the DHS.

But even in this final stage of the DHS, funding for the services will come partly from the province and partly from local government. There will still therefore be a need for cooperative governance. The model for the DHS adopted by MinMEC therefore, both now and for the future, is the model of cooperative governance.

The Health MinMEC decided that ***functional integration*** is an important and useful step prior to the full implementation of the DHS, and even prior to the passage of the National Health Bill. Functional integration often starts as a process of informal cooperation and then progresses through verbal agreements and common practice before being captured in a formal, signed service level agreement. The better the quality of the preceding informal cooperation and

[1] The term functional integration has been used in a variety of ways. These include a) integration of PHC services within province or within LG b) integration of vertical programmes into primary health care e.g. comprehensive reproductive health services c) intersectoral integration e.g. between health, social services, education etc.

common practice, the more likely it is that the formal agreement will truly reflect the best interests of staff and community. However, formal agreements can also be improved over time and functional integration can also start with an initial service level agreement. A number of initial service level agreements between provinces and municipalities have already been signed, and by July 2004, more comprehensive service level agreements between each district or metropolitan municipality and its province(s) should have been signed.

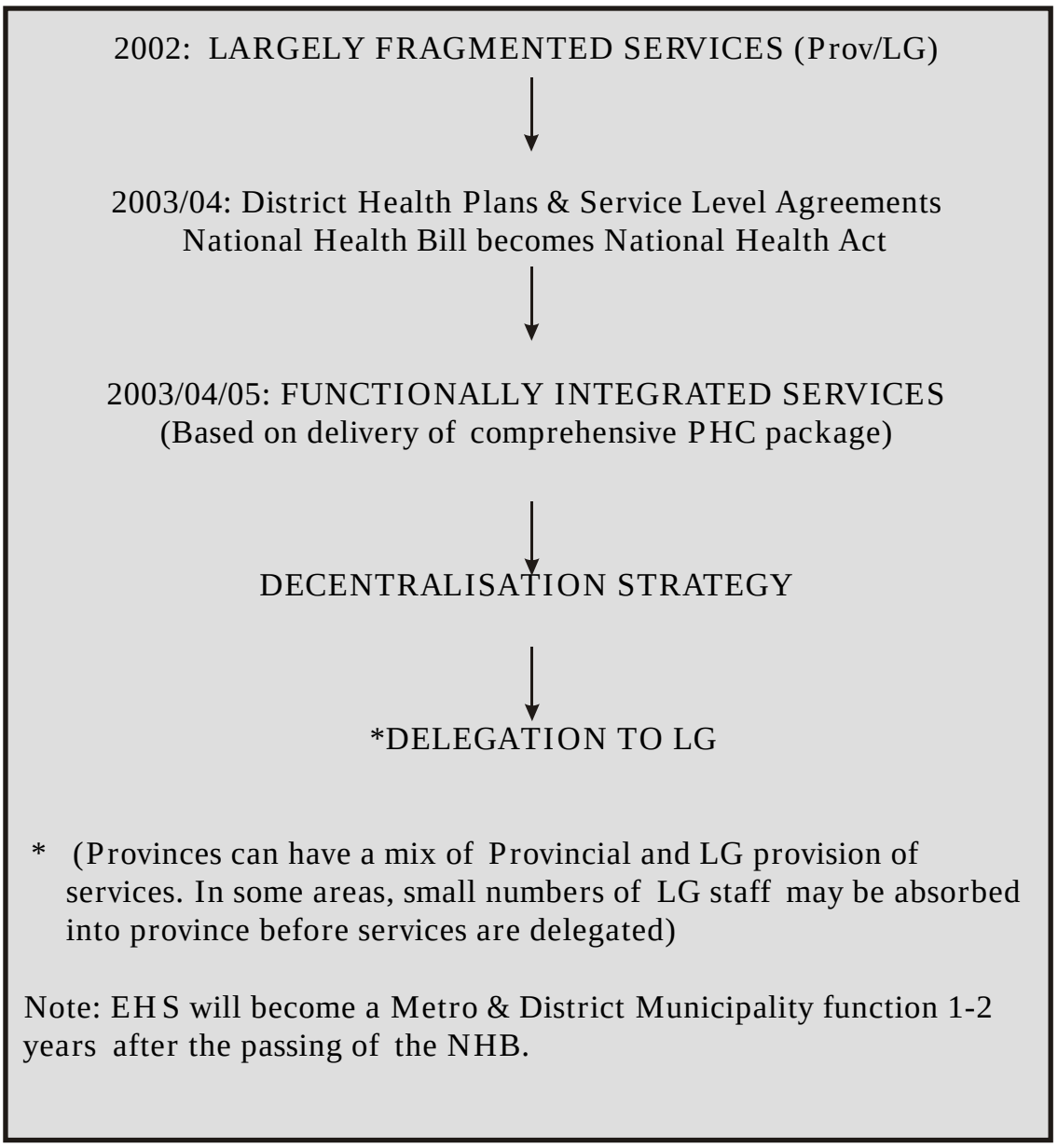
The July 2002 MinMEC also reaffirmed the decision that provinces should delegate to district and metropolitan municipalities the provision of PHC services at clinics and community health centres wherever capacity to manage these services on a day to day basis exists or can be created. District Municipalities may in turn delegate to a local municipality the provision of both environmental health and other PHC services.

The degree and speed of delegation will vary between and even within provinces. It is likely that delegations to metropolitan municipalities will proceed relatively rapidly, while delegations to some rural district municipalities will proceed more slowly, but that will all depend on negotiations between provinces and municipalities as they work towards service level agreements.

Once the National Health Bill becomes an Act, with whatever amendments are agreed in Parliament, there will be legal certainty about the definition of Municipal Health Services and any transitional arrangements. This is likely to come in the first half of 2003. However, functional integration will be necessary during the transition until the definition of Municipal Health Services comes into effect (currently scheduled for 1 July 2004), during the next period until all staff in a district move onto the same conditions of service, and even thereafter to ensure that environmental health services remain integrated with other PHC services.

The alternative to a well-planned functional integration strategy is the current ad hoc approach, which is inefficient, and also demoralizing to health personnel employed by local government and provincial departments. The likely future scenario for the implementation of a DHS is given in Figure 1 (see next page).

Figure 1: Schematic diagram of link between functional integration and a fully functional DHS



Where there is no delegation of PHC services, the province will fund and provide all PHC services except environmental health services. Where there is full delegation, the municipality will provide all PHC services, with funds coming partly from the province and partly from the municipality. In most districts the current position is somewhere between these two extremes, and this "mixed picture" is likely to continue with the degree of delegation generally increasing.

Regardless of which position a district is in, they all require staff employed by province and municipalities to work together. Functional integration is an important step in preparing for working together, and is a vital step to providing integrated comprehensive PHC services.

5. Key Requirements for Effective Functional Integration

There are four key requirements to implementing functional integration. The requirements follow the planning cycle, which include preparation (vision and leadership) planning, implementation and evaluation. A checklist, with these key requirements, is provided at the end of this document to assist managers to assess feasibility and progress made in the implementation of functional integration.

5.1 Political and top management vision and leadership

Senior politicians in provinces and municipalities must instruct their managers to proceed with functional integration, and the senior managers must have a clear vision of what they want to achieve and how they intend achieving it.

At the political level, functional integration needs to be debated and a way forward agreed at the Provincial Health Authority (currently referred to in the National Health Bill as the Provincial Health Council). In each province, this body should provide the vision and leadership and monitor progress made in the implementation of functional integration.

Once agreement has been reached there, the MEC for health and the municipal councils through the mayors must instruct their managers to implement whatever decision has been reached. This is best done through joint management structures at all levels. In each health district, the District Health Council as provided for in the National Health Bill is designed as a structure to facilitate cooperative governance, and is expected to play an important role in facilitating functional integration. It can also get insights into the health needs of communities from clinic committees, other community representatives and NGOs.

Functional integration plans should be a combination of a top down and bottom up approach in that there should be leadership and commitment from the top as well as buy-in to the concept of functional integration by all management and staff. In particular, the frontline staff expected to implement functional integration should be consulted about plans and motivated and supported in their efforts.

5.2 Planning functional integration

Planning should be done to ensure that operational plans for functional integration are developed and implemented appropriately.

Rapid appraisal of services

Joint planning should involve a rapid appraisal of areas of strengths and weaknesses (areas of possible collaboration, co-operation, integration of services), identification of duplication and overlaps and gaps.

PHC package

A service delivery plan using the PHC package as the basis should be developed and gaps and overlaps identified. The aim should be to provide the full PHC package as listed in the PHC Norms and Standards Publication produced by the National Department of Health.

District Health Plans

Once an appraisal is done of provincial and LG services, this information can be used to draw up a joint District Health Plan for service delivery (this plan should also inform the development of the Integrated Development Plans of municipalities). This plan will guide the activities of the joint management teams and set the indicators that will be measured.

5.3 Implementation issues

Joint management teams

Joint management structures need to be formed at district and sub-district levels to facilitate operational planning and implementation of functional integration. These teams should have clear terms of reference which gives guidance as to processes and procedures to be followed to make local agreements. The process should be lead by managers who are skilled leaders, who can negotiate complex changes and who can be proactive with problem solving. These managers will need support and guidance from senior provincial and local government managers in a variety of ways.

This includes:

a) Leading by example, which means there should be good co-operation between provincial and local government at senior management level.

b) Developing and supporting management capacity at district level. This involves helping district managers form joint management structures and systems, defining decision levels and authority levels needed by members representing different authorities and providing management skills training to district managers.

c) Delegating the appropriate level of authority to district level managers to enable them to function effectively in joint management teams.

d) Developing and respecting communication channels with the district. This includes respecting the district health plan and work plans of district managers (e.g. avoiding counter orders, avoid conflicting training timetables, avoid calling unscheduled meetings at short notice etc).

e) Following a stepwise approach to implementation by identifying areas for integration. For example, first establishing a joint health information system, then developing joint systems for drug distribution, laboratory services and transport. This could be followed by joint operation procedures for human resource management and development. A stepwise approach can also apply to focussing on integrating a particular health program across the two health authorities, such as reproductive health services.

Administration and support services

Budget and financial management

Funding for district health services will always come from both province and municipalities. At present, these two sources have different financial management systems, different levels of accountability and delegations, and different financial years. What is important is that joint planning is linked to budgeting that can support the plans and interventions. This will require joint consultation on budgets and joint management. Again the provisions in the National Health Bill suggest how the District Health Council can be a useful forum for agreeing on a single budget.

A joint District Health Plan should have a budget attached, indicating who is responsible for funding what. This should be based on common budget management principles such as whether cost centers are used, whether line items are similar and whether there is a process for quarterly reconciliation of budgets. It is possible that the provincial department of health could contribute resources in kind in the form of drugs, the secondment of personnel etc as is currently occurring in many provinces.

Human resource management

Of particular importance are joint standard operating procedures (JSOP) for personnel management. Several districts have already set out the following joint procedures for staff management which could be replicated elsewhere. These include:

- Joint interview panels for new appointments
- Induction and orientation of new staff and uniforms
- Synchronising work hours & on/off duty (attendance registers) and leave arrangements
- Communication procedures, training & capacity building
- Disciplinary and grievance procedures including roles of facility management, district and regional management
- Indemnity and injury on duty

Logistics (labs/drugs/transport)

The establishment of the National Health Laboratory Service (NHLS) may make it easier to integrate lab services. Both province and municipalities should work together with the NHLS to determine the best way to provide lab services for the district as a whole.

Province and LG should develop a joint drug distribution system to ensure that all facilities get drugs. In addition, both province and LG should use the same Essential Drug List (EDL) and Standard Treatment Guidelines (STGs). This is made easier given the existence of national policies on each of these.

It is important for the district/sub-district to have a single transport plan. This plan includes all the vehicles (owned by both parties) to ensure that these can be deployed efficiently. This will require drivers and passengers of both authorities to have indemnity for using each other's vehicles.

Communication

Building and maintaining good communication at all levels of the management and staff of the two authorities is a critical element of implementing functional integration. For example, there should be clear communication channels between senior management of the two authorities and between district and clinic level management. Further, there should be clear communication channels and procedures for how the joint senior management structure will communicate with the joint district management team and how the joint district team will communicate with clinic level teams. In particular, processes and procedures for problem solving and conflict resolution should be clear to all.

In this situation, one should err on the side of over-communication rather than under-communication. This may mean copying everyone who may have an interest in an issue rather than just the manager in charge. Messages sent out by management of both authorities should be consistent and the timing should coincide. It is advisable to plan joint communications especially about important decisions and events.

5.4 Monitoring and evaluation

Monitoring and evaluation of implementation is essential to guide, support, fine tune and review the process and outcomes of functional integration. Clear indicators for progress should to be set beforehand. These should be both process indicators (e.g. whether joint structures and processes are established and functioning) and outcome indicators (linked to a measurable increase in quality of care).

Examples of process indicators to monitor functional integration are:

- Joint planning of service
- Joint feedback meetings taking place
- Joint supervision of clinics
- Joint ordering of drugs and supplies
- Staff jointly decide on in-service training needs and programmes
- Leave arrangements jointly planned and overtime shared
- Tasks allocated equitably

Examples of outcome indicators are:

- Patient satisfaction (one-stop service, shorter waiting times).
- Patient management systems (more rational drug use, improved referral patterns).

- Integrated, comprehensive services e.g. a comprehensive reproductive health service per sub-district.
- Health service improvement (e.g. improved immunization coverage, improved antenatal coverage).
- Health outcome improvement (e.g. decrease in rates of children with respiratory infections, increase in TB cure rate, etc). Although improvements in health outcomes usually take a long time period to achieve, it should nevertheless remain the focus of any health restructuring efforts.

6. Roles and Responsibilities

6.1 Roles of MECs, Mayors, Provincial Health Councils, and Senior Provincial and Municipal Managers

1. Provide political and top management vision and support.

2. Clarify and communicate the strategic vision for DHS in the province. This includes communication around the future form of the DHS and the likely degree and speed of delegation in the short and medium terms. This will be decided jointly by the MECs for Health, Local Government and Finance.

3. Form joint management structures at senior level to drive and monitor the implementation of functional integration.

4. Provide an implementation strategy, which includes the key requirements. This should include appropriate delegation of powers for the establishment of joint management teams as well as funding mechanisms that can support functional integration.

5. Ensure that a communication strategy is in place at provincial and district level.

6.2 Roles of District Health Councils and District Management Teams

1. Provide district level leadership for implementing functional integration. The district vision and framework should correspond to the mandate from the Provincial Health Council.

2. Establish joint district and sub-district management teams that can take responsibility for the operational planning and implementation of functional integration.

3. Develop joint agreements as well as joint operating procedures for administration and support services. This should involve clarifying roles and responsibilities and the decision levels and authority required to perform these roles.

4. Facilitate, co-ordinate, and monitor the implementation of functional integration. This will include preparation and participation of staff; joint supervision and staff management systems; joint skills development plans and joint communication strategy. These elements should enable the district management team to do functional integration of clinical services at a district, sub-district and clinic level as indicated by the rapid appraisal. Functional integration of clinical services may involve rationalization of mobiles and clinics, sharing and reallocation of staff and other resources, integrating priority health programmes etc. (See **Case studies** for more examples).

6.3 Roles of Facility Managers

1. Support the implementation of functional integration within their district and their clinic. There should be good communication and mutual support between management at facility and district levels.

2. Where there are joint facilities between Province and LG, facility managers should play a leading role in preparation, implementation and maintaining functional integration interventions.

3. In joint facilities, form a joint management team with a clear leader. The leadership role could rotate between province and local government, but there should be consistency of management style.

4. Build a unified team at facility level. This involves applying the joint operation procedures for administration, staff management, as well as promoting joint training and development. Good communication and conflict resolution mechanisms will be essential when implementing functional integration. The result of such efforts should be that most staff perform most of the required PHC clinical services, despite coming from different health authorities with different emphases. In other words, adult and child, curative, preventive and promotive services should be offered in one facility as an integrated, comprehensive service.

7. Key Challenges to be Faced and Conquered

7.1 The absence of a single governance structure

The absence of a single governance structure for PHC is acknowledged as a constraint in developing functional integration. Until there are clear instructions from political principals and generally accepted guidelines for implementation, the degree of functional integration will depend on the vision, commitment and driving force of health managers on various levels. Clear roles and functions should be developed for the political and technical aspects of district coordination and management.

7.2 The commitment, guidance and support of health personnel

Functional integration will stand or fall on the level of understanding, commitment and motivation of frontline health personnel who are expected to implement functional integration at district, clinic and programme level and the leadership provided by politicians and top managers. Whilst health personnel are usually motivated by their commitment to increased quality of patient care, this motivation can easily wane when staff start to experience problems during the implementation phase. Good leadership and management, especially good communication becomes essential to provide the guidance, and support necessary for implementation and sustaining of functional integration.

7.3 Managing change in a transformation context

Against the background of many health service changes, the implementation of any new health restructuring such as functional integration must be handled appropriately, with realistic targets and with participation at all levels. The health service has seen an array of transformation changes in the past few years. This includes the challenge of increased demand for services with no or little growth in resources. This has created an environment of increased stress, uncertainty and even de-motivation. One of the more difficult issues to manage is the different condition of service between staff of LG and province. Successful examples of functional integration have found that staff are able to deal with this and work together if they concentrate on the common goal of improving the quality of care.

7.4 Community participation

Communities should be encouraged to participate in the development of all plans, including those for functional integration. Meaningful community participation should include participation by councilors and other political stakeholders as well as clinic committees and NGOs.

7.5 Sustainability

The above challenges point to the difficulty that needs to be overcome in implementing functional integration. Even if the policy is made clear and formal structures are established, health managers should realize that embarking on functional integration requires a medium to long-term vision, a high level of commitment, good general and change management skills, the goodwill and commitment of frontline health personnel and ongoing monitoring and evaluation.

8. Case Studies

There are several examples across the country, where separate health authorities have developed structures and systems to promote functional integration of services. Some of these examples are described below. Please note that these are highly summarized and more details can be obtained by reading the original publications referenced below.

8.1 Brakpan district, Eastrand, Gauteng

Reproductive health services were integrated to provide a one-stop service for at least one site in the district. Before restructuring, there were three different sources of reproductive health primary care services. These were the provincial family planning services, the local authority preventive and promotive services and the hospital outpatient curative services. LG and provincial mobile services were rationalized to prevent duplication and fragmentation between family planning and child health services. On a facility level, LG provided rent-free space for PG nurse services. Province, in turn, provided LG with free drugs to treat sick babies. There are also examples of LG and PG sharing a clinic building and jointly managing it. A joint transport and travel policy was also developed to cut costs.

8.2 Albany district, Grahamstown, E Cape

Three health authorities, the local authority (old TLC), the district council and the provincial authority embarked on a 2 year process of working

together to consolidate and improve PHC service delivery at a district and facility level. They used external support to implement the planning cycle. This involved consultation with key stakeholders, strategic planning, implementation of work plans and measuring indicators.

8.3 Lejweletputswa (former Tshepo) district, Free State

District and sub-district level management health teams consisting of PG and LG staff were established to provide joint leadership and co-ordination of services. A situational analysis was carried out, health priorities identified and a district health plan developed. The focus was on functional integration between PG and LG clinics, mobiles and hospitals as well as on functional integration of health programmes, with the participation of local councilors, clinic committees and hospital boards. Monitoring and evaluation of functional integration was done on a process level as well as on the outcome in terms of health system indicators. These included monitoring specific programmes e.g. STI and TB, rational drug use and improvement in referral rates. Several tools were used to assist with functional integration, including the District Health Information System, the DISCA tool for STI service quality and the District Health Expenditure Review.

8.4 Belville clinic, Tygerberg sub-district, Cape Town

The Belville clinic is a joint LG and DOH health facility, staffed by health personnel from both authorities. By mutual agreement, it is managed by a facility manager of LG with a DOH deputy. Through a process of needs assessment, gradual phasing in, clinical training and a 'buddysystem', the facility offers a functionally integrated clinical service. Most staff are able to offer most of the services, be it chronic care, mental health services, trauma and emergency care, TB and STI management as well child curative and preventive services.

9. Conclusions

Functional integration is not an end in itself but part of a process in the development of a district health system. Experience has shown that unless key requirements are in place, functional integration will not succeed. Once the key requirements are in place however, problems that arise can be tackled in a systematic way. These guidelines set out these key requirements and provide a basis for both an assessment of where provinces and districts are and also provide guidance on what needs to be done.

10. References

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10.3 Initiative for Sub-District Support (ISDS). Technical Report #5: The Development of the District Health System in South Africa: Lessons Learnt from the Experience of ISDS. Health Systems Trust: Durban, RSA, 1998.

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Appendix

Checklist for Assessment of Functional Integration

Requirements	Province	District	Facility
Political and top management			
▪ Clear vision & framework for FI			
▪ Decentralization programme clarified			
▪ Political support expressed			
▪ Senior management leadership support in place			
▪ Joint senior management structure in place			
▪ Appropriate powers delegated to district management level			
▪ Communication strategy in place at senior management and district level			
Planning			
▪ Rapid appraisal of services			
▪ PHC package being implemented			
▪ Joint Provincial/Local Government District Health Plan formulated with clear targets			
▪ Management capacity & skills development plans developed			
Implementation issues			
▪ Joint district management teams in place and functioning			
▪ Functional Integration interventions identified and implemented with clear targets e.g. immunization and ante-natal services at every facility			
▪ Single skills development plan (clinical & management training) developed			
▪ Joint staff retention strategy			
▪ Joint supervisory system in place			
▪ Appropriate financial management & budgeting systems that allow for functional integration			
▪ Joint standard operation procedures (JSOP) in place for HRD&M			
▪ JSOP for laboratory services			
▪ JSOP for drugs distribution & supplies			
▪ Use of same DHIS by both Province and LG			
▪ Community & political participation & support for plans & interventions			
Monitoring an evaluation			
▪ Process indicators set and monitored (see 5.4)			
▪ Outcome indicators set and monitored (see 5.4)			
▪ Process for reviewing and redesigning of interventions			
▪ Process for affirming successes and addressing obstacles