MINISTRY OF HEALTH AND SOCIAL SERVICES

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NATIONAL REFERRAL POLICY

2013

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National Referral Policy

Directorate: TERTIARY HEALTH CARE AND CLINICAL SUPPORT SERVICES

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FOREWORD

After independence the government of Namibia adopted the primary health care approach with the aim of achieving health for all Namibians. The Ministry of Health and Social Services as the key provider of health care services is responsible for making sure that the health care system is properly managed.

The health care system is divided into three main levels of health care delivery namely primary, secondary, and tertiary. With regard to referral services, currently patients are referred from primary to secondary and tertiary levels. However, the current referral system is not functioning properly due to the absence of a referral policy to guide the referral of patients from one level to another. Therefore there was a need to develop a referral policy that will guide the referral of patients between the different levels of health care provision in an effective, efficiency and systematic way.

I believe that this policy will not only benefit the Ministry of Health and Social Services but also the Namibian nation at large.

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DR RICHARD NCHABI KAMWI (MP)
MINISTER OF HEALTH AND SOCIAL SERVICES

PREFACE

The development *of* this policy seeks to address shortcomings resulting from the absence of a referral policy in the Ministry of Health and Social Services. The absence of the referral policy has negatively impacted on accessibility in health care provision.

This document outlines the following main aspects related to the referral of patients; referral criteria; communication between different levels of health care delivery to facilitate the referral; transportation of referred patients; and equitable distribution of resources to improve the management of referrals.

I wish to appreciate the Department for Regional Health and Social Welfare Services that initiated the process of drafting this policy; Directorate Tertiary Health Care and Clinical Support Services, Directorate Primary Health Care, regional and district staff, technical officers of the Ministry of Health and Social Services and all others who contributed and participated in the development of this policy. I urge all health workers to implement this document with enthusiasm for the benefit of our patients and clients. It is believed that this referral policy will facilitate appropriate and timely management of patients leading to positive health outcomes.

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Mr. ANDREW N. NDISHISHI
PERMANENT SECRETARY

List of Abbreviations

CMOs	- Chief Medical Officers
MOD	- Ministry of Defense
MOHSS	- Ministry of Health and Social Services
MVA Fund	- Motor Vehicle Accident Fund
NGOs	- Non Governmental Organisations
PMOs	- Principal Medical Officers
SOS	- Save our Souls International

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CHAPTER 1. INTRODUCTION

Namibia is a vast country of about 824,000 square km. The country is divided into 13 regions and 35 health districts. Health service in Namibia is delivered to a population of 2.1 million. Regional population densities vary enormously with almost two- thirds of the population living in the northern regions and less than one tenth living in the south. A quarter of Namibian households live within 10km of a government health facility. The majority of the urban households fall in 10-19km group while rural households fall within 25-59km category. However there are some community members who travel for more than 300km to get the closest hospital (Health Systems Review, 2008).

This policy document describes the problems and shortcomings faced by the current referral system of the Ministry of Health and Social Services. These include: non-existence of a referral policy, inadequate communication, especially feedback from higher levels to lower levels of health care and inappropriate and delayed referrals. There is a need to substantially strengthen the provision of transport for referral, ensure sufficient and appropriate skill mix, and ensure availability of adequate and appropriate equipment especially at lower level of health care and remote areas.

The policy highlights the goals, principles, objectives and strategies for its implementation. The document further outlines the institutional framework for implementation by different levels, as stipulated in the "Integrated Health Care Delivery: Challenge of Implementation, 1999", in order to promote medical justice and moral/ethical fairness in health and social services delivery in all thirteen (13) regions.

This policy is the result of a broad consultative process involving representatives of the different levels of the Ministry of Health and Social Services. The consultative meetings on the development of the referral policy were held with the relevant stakeholders including regions.

1.1 Situation analysis

Health and social services in Namibia is facing the challenge of being delivered in a vast country. As of 2012 the Namibian health and social services delivery system consists of 1 national referral hospital, 3 intermediate hospitals, 31 district hospitals, 44 health centers, 268 clinics and more than 1,150 outreach points.

There are major problems that are negatively affecting the smooth running of the referral system, these are: paucity of transport, inadequate communication network, insufficient resources, inadequacy in numbers and skills mix of key health personnel, lack of equipment and insufficient level of infrastructure, and logistics.

1.1.1 Transport:

The Ministry of Health and Social Services (MoHSS) experiences referral system challenges due to old fleet, frequent transport breakdown and lack of skilled personnel for transport management. Although some vehicles have been purchased, the fleet is still insufficient and unsuitable for remote areas of the country. There is a high variability in the availability of ambulance services across hospitals in the country. This situation leads to delays in the

transportation of referred patients from one level to another. Some major constraints highlighted in the Health Systems Review 2008 include lack of infrastructure for ambulance service delivery and lack of budget to maintain ambulances. Old ambulances are not yet equipped with the necessary life support medical equipment and thus not suitable to transport patients who need high care. There is no provision for airlifting of state patients with special emergency conditions that require urgent intervention. Sometimes the Ministry uses private sector airlifting services such as MedRescue and International SOS which is a costly intervention.

1.1.2 Communication

Although there is a communication system in place, there are challenges of inadequate communication tools at some health facilities. As a result information on clients being referred from one facility to the other is not properly communicated to the recipients. The mechanism of providing feedback on referred patients from one level to another is poor, because there is no structured referral system to do so. Sometimes there are patients referred without prior appointments (unbooked cases). This leads to inadequate space at intermediate and national referral hospitals. There is also poor communication and consultation amongst some doctors, nurses and paramedics/allied health workers with regards to referrals of clients, which results in low acceptance rate by facilities and or unnecessary referrals.

1.1.3 Human resources

Presently, the recruitment and placement of health workers especially expatriate needs improvement, to ensure appropriate skill mix. In addition the number of specialists and paramedics is insufficient, especially in remote areas. There is no structured in-service training programme to upgrade the skills of health workers and opportunities for continuing education are limited. The annual average attrition rate for health workers is about 3.2% (2011/12) of the total workforce. The he main reasons were resignations in search of better pay, career growth and advancement, and death. This threatens sustainability and efficacy of the health system.

1.1.4 Equipment

The Ministry has one national and four regional Clinical Engineering Workshops for maintenance and repair of medium and low tech equipment but these workshops lack capacity to carry out those activities. In some facilities equipment are insufficient, inadequate knowledge in use and maintenance of medical equipment as well as general lack of skills in managing equipment among users. Insufficient funds to procure, servicee and repair medical equipment resulting in increased unnecessary referrals. Most high tech equipment are centralised, and there are some difficulties in provision of equipment to the remote areas as some facilities fail to communicate and delay the reporting of faulty equipment.

1.1.5 Current Referral System including criteria used

Currently there are no referral criteria to guide the health workers when referring patients. The absence of referral criteria leads to low acceptance rate, unnecessary and delayed referrals. There is also friction between some referring and accepting doctors which at times puts the patients' lives at risk. There are no clear guidelines on who takes responsibility for documentation of patients who die on their way to referral centres.

Some patients refer themselves from one level to another as they assume that they get better service at other levels. This leads to overcrowding and over burdening of the referral centres which end up handling patients who could otherwise be managed at lower levels of health care.

Public – Private Partnerships (PPP) with private hospitals have been entered into and this reduces the risk of patients being not treated especially in case of emergencies at a particular public health facility.

1.1.6 Management of Referrals

There is lack of involvement in the arrangement or processing of referred patients by some heads of units in health facilities. The arrangement of referrals is left to the staff at the booking offices.

Many patients are referred without initial work up being done. This results in increased length of patients' stay in hospitals and unnecessarily high bed occupancy rates. The specialist support to intermediate and district hospitals is inadequate, leading to unnecessary referrals.

There is poor coordination of referrals between different levels of health service delivery which causes delay in treatment of patients and overloading of patient buses. In addition, some patients overstay in hospitals due to poor coordination between ambulance/transport services and booking offices at different levels.

Very few formal agreements on referral services between state and private health facilities exist, but those health facilities without formal agreements pay high costs to private health facilities when certain specialist services are required.

1.2 Appropriate referral system

A good referral system should ensure that the appropriate equipment and skills are available at district, intermediate and national level to treat complicated cases that cannot be handled at lower levels of care.

Therefore in order for the current referral system to function properly, there is a need for a formal referral policy, improved and strengthened communication strategies (especially feedback between all levels of care), improved transportation of patients by vehicles that are always in a good running condition, and the provision of suitable training opportunities for all health workers at all levels of care.

It is equally important to mention that for the referral system to function properly all referral levels need to be appropriately equipped (having the necessary equipment, personnel with correct skills mix, pharmaceuticals and transport), so that very few emergencies are referred to the national hospital, and emergencies are referred to the nearest competent health facility in the same or nearest region.

The problem of delayed referrals, referral of inadequately managed patients especially emergency needs to be corrected because both contribute significantly to morbidity and mortality in the country.

In order to mininise unnecessary referrals, it is preferable that district hospitals and health centres should be equipped with modern technology (including equipment, information systems), adequate and qualified staff in all thirteen (13) regions.

CHAPTER 2. POLICY FRAMEWORK

2.1 Goal:

The goal of this policy is to bring about a well functioning referral system that is characterized by appropriate health and social services utilization, enhancing access to medical care services within the country.

2.2 Guiding Principles (values)

This policy will be guided by the following principles:

Referral services will be;

a) **available** at all levels of health and social care delivery,

b) made **accessible** to all people,

c) provided to the population **equitably,**

d) Cost **effective**

e) **Affordable** to all clients

f) **Competitive** to both public and private patients

g) actively **involve communities** in services delivery; and

h) ensuring **continuous improvement** of quality of health care.

2.3 Policy objectives

The broad objective of this policy is to provide guidance to the health care providers to implement a structured referral system at all levels of health and social care.

2.3.1 The specific objectives are to:

a) define, achieve and maintain equity/fairness, timely accessibility, and cost effectiveness in health care delivery.
b) develop standards and mechanisms for each level of health and social care delivery.
c) strengthen outreach support visits to all health facilities.
d) establish formal agreements on referral services between public and private health facilities.
e) mobilize and allocate resources appropriately (human, financial and materials).

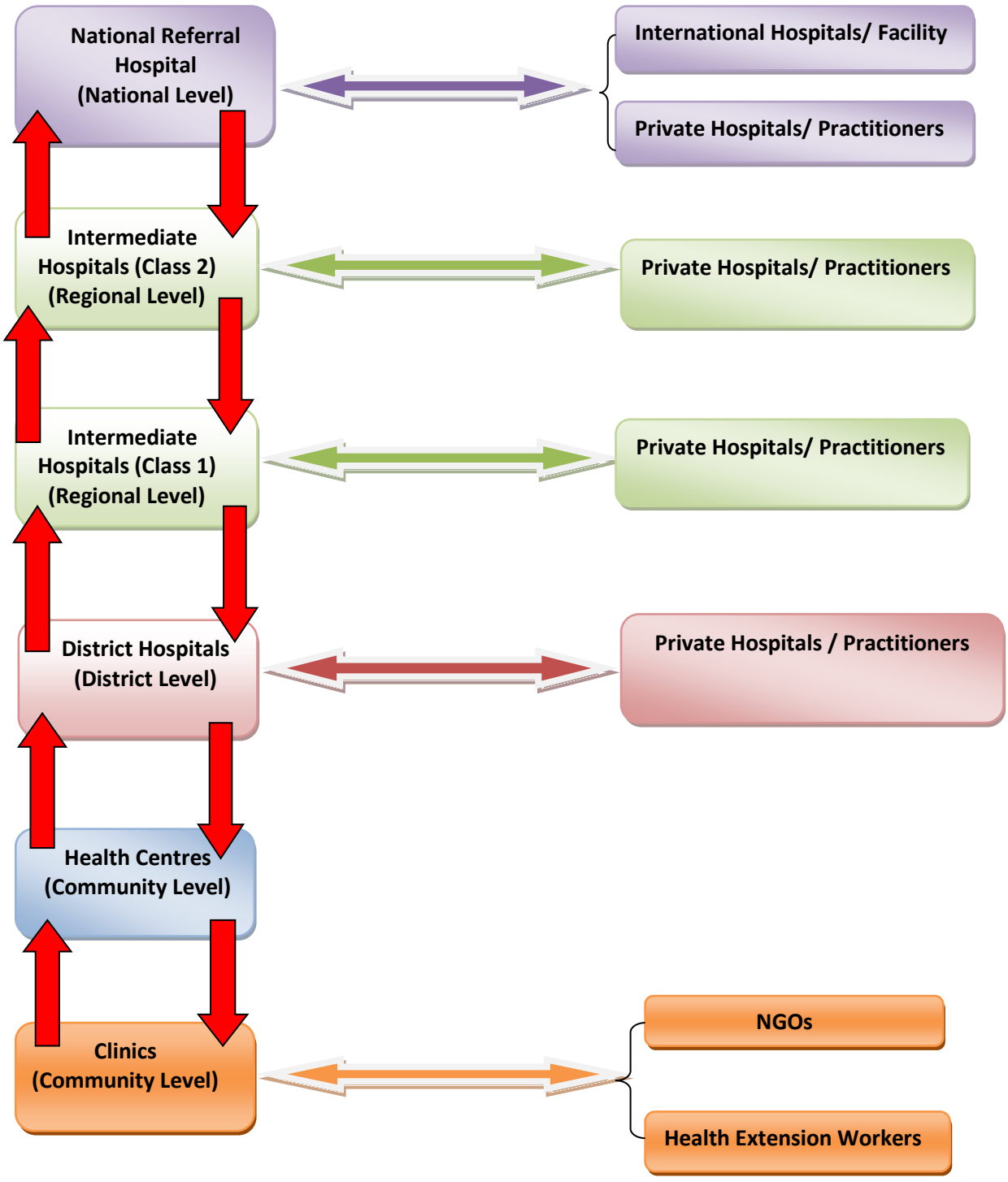
2.4 Strategies

Strategies for the implementation of the policy are :

a) Establishing a working committee to produce referral guidelines and appropriate referral forms.

b) Conducting supervisory support visits and outreach services to all levels of health care system.
c) Developing national protocols on patient management
d) Developing pre- and in-service training programs
e) Enforcing the implementation of the referral policy and adherence to set standards by regional, district, and institutional levels' management.
f) Conducting consultative meetings with private health care providers and other line ministries to establish referral procedures including air transportation of state patients.
g) Establishing public private partnership for effective referral system
h) Introducing new health care technology to improve health facilities' physical infrastructures
i) Staffing health facilities with adequate and skilled personnel

Fig. 1 Flow Chart: REFERRAL OF PATIENTS



Health Extension Workers

CHAPTER 3. INSTITUTIONAL FRAMEWORK FOR POLICY IMPLEMENTATION

The policy will be implemented at the following levels: community, clinics, health centers, district, intermediate, and national referral hospitals. Reporting should be done to the next level of authority.

3.1 Universal functions at all levels

Although there will be functions for each level of health care, there will be functions that are universal to all levels and these are as follow:

a) Render health promotion services
b) Identify training needs and conduct in-service training
c) Collect, analyze, utilize and report relevant health information data.
d) Provide outreach services to the lower facilities.
e) Plan and budget for the facilities' needs

3.2 Specific Functions

3.2.1 Community level

a) Identifies health needs and refer to the clinic
b) Provides home based health care services
c) Plans for services' needs

3.2.2 Clinic level

a) Renders promotive, preventative and rehabilitative services
b) Renders primary and curative services
c) Carrys out health promotion services
d) Renders supervisory support services to community based health care activities.
e) Renders outreach services
f) Conducts continuous in service training
g) Refers patients to the next level of health care according to the set referral criteria and services needs in the community
h) Provides medicine dispensing services

3.2.3 Health Centre

Functions at this level may vary depending on the availability of a doctor and primary diagnostic services e.g. X-ray and laboratory Services.

a) Renders promotive, preventive and rehabilitation services to the communities
b) Renders Primary, curative and medicine dispensing services
c) Renders supportive supervisory services to the community based health care providers
d) Conducts in-service training
e) Conducts operational research
f) Plans and budgets for the facility needs
g) Refers patients to the next level of health care according to the set referral criteria
h) Provides medicine dispensing services
i) Supports Clinics

3.2.4 District Hospital

a) Conducts Clinical diagnosis and treatment
b) Conducts outreach services to health centres/clinics
c) Serves as a referral centre for clinics and health centers
d) Renders preventative, promotive, rehabilitative and curative services
e) Conducts continuous in-service training
f) Identifies training needs and recommend staff for training
g) Conducts operational research
h) Conducts monitoring and evaluation
i) Refers patients to the next level of health care according to the set referral criteria.
j) Conducts consultative meetings with private health care providers and establish referral procedures including air transportation of state patients.
k) Provides medicine dispensing services

3.2.5 intermediate hospital (*General Medical Care –Class 1*)

This is the level between the district and national level which provides both secondary and tertiary health care. It carries out the following functions:

a) Communicates to district and national levels
b) Renders Clinical diagnosis and treatment
c) Renders promotive, preventative, rehabilitative and curative services
d) Provides secondary and tertiary health services
e) Conducts specialist support outreach services to the district level
f) Identifies training needs
g) Provides training (pre and in-service)
h) Conducts operational research for service improvement
i) Promotes networking with other health care providers
j) Conducts consultative meetings with private health care providers and establish referral procedures including air transportation of state patients
k) Refers patients to the next level of health care according to the set referral criteria.
l) Provides clinical and practical training for attached students
m) Conducts scientific research
n) Provides medicine dispensing services
o) Supports District hospitals

3.2.6 Intermediate hospital (*Special and General Medical Care –Class 2*)

This is the level between Class 1 and national level which provides both secondary and tertiary health care. It carries out the following functions:

a) Communicate to Class 1 and national levels
b) Renders clinical diagnosis and treatment
c) Renders promotive, preventative, rehabilitative and curative services
d) Provides secondary and tertiary health services
e) Conducts specialist support outreach services to the Class 1 level
f) Identifies training needs
g) Provides training (pre and in-service)

h) Conducts operational research for service improvement
i) Promotes networking with other health care providers
j) Conducts consultative meetings with private health care providers and establish referral procedures including air transportation of state patients.
k) Refers patients to the next level of health care according to the set referral criteria.
l) Provides clinical and practical training for attached students
m) Conducts scientific research
n) Provides medicine dispensing services
o) Supports Class 1 hospitals

3.2.7 National Referral Hospital

This is the highest level of health care which provides highly specialized health care services. It links up with other national and international health care providers. Its functions include:

a) Provides highly specialized services
b) In consultation with other levels of health and social care, sets national norms and standards for quality patient care
c) Provides specialist outreach support services to intermediate hospitals.
d) Provides clinical and practical training for attached students
e) Conducts specialized forensic pathology services
f) Conducts scientific and operational research.
g) Monitors and evaluates and reviews the functioning of the referral system.
h) Conducts consultative meetings with private health care providers and establish referral procedures including air transportation of state patients.
i) Provides medicine dispensing services
j) Supports intermediate hospitals
k) Refers to private sector using the Special Fund.
l) Supports intermediate Hospitals

CHAPTER 4. IMPLEMENTATION PLAN, MONITORING AND EVALUATION AND RESOURCE IMPLICATIONS

This chapter presents the monitoring and evaluation, implementation plan and resource implications. The overall responsibility of the implementation of this policy lies within the Directorate: Clinical Services (CS)

Table 4.1 Implementation plan

Strategies	Yr1	Yr2	Yr3	Yr4	Yr5	Responsible Unit/Person/s
1. Establish a national referral taskforce. Task medical superintendent, regional chief medical officers and District PMOs to periodically discuss referral issues including un-booked cases						CS
2. Conduct active recruitment medical officers for intermediate and district hospitals						CS
3. Conduct support visits to health centers and clinics including medical officers outreach services						CS
4. Conduct supervisory support visits to health centers and clinics including medical officers outreach services						CS
5. Conduct in-service training in patient management						CS
6. Ensure application of and adherence to set standards						CS
7. Develop and or identify national manuals on patient management						CS
8. Develop national standards and norms for doctors, nurses, paramedics and support services						CS
9. Conduct clinical meetings and seminars with doctors, nurses and paramedics						CS
10. Initiate consultative meetings with private health care providers and line ministries to pave way for establishing formal agreements on referrals including air transport for state patients with special emergency conditions that require urgent treatment						CS
11. Provide adequate an emergency medical rescue/ambulance services						CS

4.2 Indicators

The following indicators will be used to monitor and evaluate the policy implementation:

Objective	Key Performance Indicators	Outputs
1. To develop referral guidelines for each level of health care delivery	- Number of health facilities implementing the Guidelines	- Patient/client satisfaction surveys. - Reduction of self and avoidable referrals.
2. To build the capacity and confidence of health care workers at different levels	- Number of supervisory visits conducted and reports available. - Number of health care workers adhering to set standards. - Number of in service training sessions conducted. - Number of staff trained. - Number of unnecessary referrals. -National standards and norms developed and in use.	- patients management manuals in use. - reduction in referrals
3. To continuously improve the quality of health care services	-Number of clinical meetings/ seminar conducted -Reports available. -number of attendees. - Number of deviations identified and corrected.	-Clinical management skills improved.
4. To allocate adequate resources appropriately (human) in terms of numbers and skill mix, financial, and equipment	-number of health facilities with appropriate skill mix. -number of health facilities allocated with resources according to. allocation criteria	-Reduction in unnecessary referrals.
5. To strengthen specialist outreach support services to intermediate and district hospitals and medical officers support visit to health centres and clinics	-number of visits conducted and reports available. -number of patients attended to. -number of in-service training sessions conducted.	-Reduction in referrals. -patients/clients satisfaction
6. To develop standard mechanism for coordination and communication between different levels of health care.	-number of referred patients with duly completed national referral letter. -Number of patients with feedback reports from receiving facilities	-management of patients improved. -well coordinated referrals
7. To establish formal agreement on referral services between state and private health facilities	-Number of consultative meetings held Minutes of meetings available	-Agreements concluded and/ implemented
8. To introduce air transport for state patients with emergency conditions that requires urgent treatment.	-Number of consultative meetings held with stakeholders (Ministry of oD, SOS, COW, Nampol, Road Authority, MVA Fund, etc. -Minutes available - the number of patients with emergency condition airlifted.	-Agreement concluded and implemented -

4.3 Resource implications

Phase I

a) Launching the policy
b) Introduction of the policy and guidelines

Phase II

a) Training of users on policy and guidelines
b) Supervisory support to intermediate hospitals

Phase III

a) Developing standards and norms /manuals
b) Conducting consultative meetings and workshops
c) Establishing formal agreements with private health care providers
d) Introducing air transportation for state patients

Phase IV

a) Monitoring of the implementation of the referral policy
b) Conducting summative evaluation.