Laying a foundation: The core elements of an effective referral system

Rethinking Referral Systems
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A ‘well functioning’ referral system

- General goal: to ensure provision of effective treatment at the minimum of cost (Stefanini 1994)
  - Demand & supply side costs

- Maternity referral
  - Obstetric treatment for complications can be very effective (save life / restore wellbeing)
  - Effective treatment for major obstetric complications requires reduction of unnecessary delays (Maine 1991)
  - A tracer for analysis of health systems
Approach

• Scoping review to synthesis current thinking (ideas) and evidence on maternity referral systems

• Structured search PubMed, Web of Science, IndMed, WHO regional databases, web sites (12,400 hits / 607 documents selected)

• Narrative thematic synthesis

• Parameters: ‘those structures and processes pertaining to the healthcare delivery organisations and any frontline informal sector with whom a woman has a care-focused interaction’
Caveats

- Drawn as much from evidence on what has contributed to failures as from evaluations of successful interventions.
- Extrapolation from specific social and political contexts may neglect key contextual features.
- Framework implicitly starts at the stage of care-seeking (for biomedical care).
The nine requisites
Source: Murray & Pearson 2006

Effective referral system

- Needs and capabilities assessment
- Resourced referral centre
- Cross-level cross-sector collaboration
- Formalised communications & transport
- Protocols for referrer & receiver
- Accountability & supervision
- Pro-poor protection
- Capacity to monitor
- Policy support

1. Referral strategy informed by assessment of population needs & of health system capabilities

- Estimate population needs
  - Estimate volume of cases of obstetric emergencies
  - Disease profile
  - Cultural and ethnic diversity & what this means for access to healthcare

- Assess health system capabilities
  - Encompass full range of providers & facilities
  - Cross sectoral training
  - Regulatory systems

- Analyse journeys to and through maternity care (self referrals/ bypassing/ traffic corridors / cross-use of private & public etc)

- Plan responsive services according to what is found
  - (eg upgrade / downgrade facilities; maternity waiting homes; normal birth centres at hospitals)
2. An adequately resourced referral centre examples

- Decentralisation of basic EmOC services
- Additional 24 hr comprehensive EmOC
  - Emergency referral / Referral of emerging complications / Elective prophylactic referral
3. Active collaboration across levels and across sectors

examples

• Meetings between contiguous layers of service provision to discuss monthly statistics, problems, training & planning

• Networking across increasingly mixed economy of healthcare
  – Small scale private for profit may rely on govt or NGO sector when complications arise
  – Women may traverse sectors for different elements of their care
4. Formalised communications and transport arrangements

examples

• Increasingly sophisticated technologies to reduce barriers of time and distance

• Motorised transportation (or combined with other methods)
  – Local commercial transport
  – Local ambulance services (public / voluntary / faith based / contracted-out private)

• Audit arrangements - eg condition on arrival by mode of transport / costs to users
5. Agreed setting-specific protocols for referrer and receiver

examples

• Guidance on when to refer on (including partograph) – to reflect local conditions

• Unified records systems

• Receiver:
  – guidance on how to prioritise referred patients
  – Recognition and acceptance of accompanying TBAs / health workers
6. Accountability for providers’ performance and supportive supervision examples

• Creation of an organisational context of accountability (supervision & reporting, reward structures e.g. performance based contracting for front line workers and their managers)

• Methods for collective QoC improvement & improved communications skills

• Identify & challenge gender & class hierarchies among health workers
7. Pro-poor protection against the costs of emergency referral

examples

- Conditional cash transfer schemes to reimburse costs of care / transport and reduce long term debt
- Voucher & accreditation schemes to reduce financial barriers to accessing care
- Removal of user fees
- Universal social insurance
8. Capacity to monitor effectiveness

Examples

• Metrics for local monitoring
  – indicator / marker sets to analyse trends over time

• Alertness to unintended consequences

• Specific in-depth case studies

• Theory-driven evaluations (assumption surfacing & testing (Weiss) / ‘what works for whom, how, in what circumstances’ (Pawson)
9. Policy support

- Strong government policy helps local enactment & linking of levels so that referral is efficient (Koblinsky & Campbell)
- Skilful engagement of political processes at national / state level (Shiffman)
- Locating maternity referral within national and local medical emergency referral plans while protecting its special profile
The ten requisites for maternity referral systems

- Policy support
- Information for potential users
- Capacity to monitor
- Needs and capabilities assessment
- Pro-poor protection
- Accountability & supervision
- Resourced referral centre
- Cross-level cross-sector collaboration
- Formalised communications & transport
- Protocols for referrer & receiver

Effective referral system
A strategy for optimising the capacity for effective maternity referral

Needs

• to consider organisational, technical, and socio-relational features
• to be responsive to local circumstances
• to understand and be responsive to the dynamics of health care provision (not static / rarely a pyramid)
• to recognise the social nature of health systems (behaviours/relationships/values/power)
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