



Referral Hospitals

Vital Services, not Disease Palaces

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In developing countries, referral hospitals have long been thought to consume too great a share of health budgets while making limited contributions to improving the health of the whole population. Referral hospitals include secondary- and tertiary-level hospitals that are usually located in urban centers and are designed to provide specialized care to patients referred from lower levels of the health system.

Although the care offered in referral hospitals is more expensive than that provided in primary health centers—the care is more complex and specialists are usually higher paid—it would be a mistake for policymakers or health advocates to argue for slashing their budgets. Beyond treating patients, referral hospitals train doctors, conduct research, set standards for quality of care, and provide guidance and support to other levels of the health system. Many countries could benefit from restructuring their referral hospitals, but they should do it carefully so as not to destabilize the entire health care system.

Providing Specialist Services to Patients

Though any hospital can receive patient referrals from lower levels of care, *referral hospitals* are those that operate at the secondary (regional or provincial) level or tertiary (national or central) level of the health system. Generally speaking, they provide more complex and specialized services to patients who have been referred from communities where such services are not available.

No international definition exists regarding which services should be offered at referral hospitals in developing countries. In practice, the range of services varies substantially, depending on available resources and how services have evolved over time.

Specialist services in secondary (regional) hospitals typically include:

- internal medicine;
- general surgery, including emergency care;
- obstetrics and gynecology;
- pediatrics; and
- other specialties, such as mental health care, depending on the pattern of medical practice in the country.

Tertiary hospital services may include these services plus:

- full intensive care unit;
- specialized burns intensive care unit;
- specialized diagnostics, such as CT scans and MRIs (advanced medical imaging technologies);
- specialized surgery, such as neurosurgery; and
- other medical specialties such as gastroenterology or oncology.

Need for Care of Last Resort

The indirect contributions of referral hospitals to the health system are nearly impossible to quantify using standard measures of cost-effectiveness or cost-benefit analysis. Cost per disability-adjusted life year (DALY), used throughout *Disease Control Priorities in Developing Countries, 2nd edition (DCP2)*, does not lend itself well to analyzing the outputs and benefits of these hospitals.* Yet, the benefits to society of the functions described above are undeniable.

Moreover, the direct care provided to patients, even if it is costly and benefits a relatively small number of people, is needed and demanded in all societies. For example, people who suffer traumatic injuries and burns in car or railway crashes need life-saving services without having to pay for the catastrophic costs of such care. In practice, the utility of the service is often unrelated to its actual cost; people need the peace of mind of knowing such care is available. The tax-paying public and politicians alike expect the government to provide care of last resort for complex trauma or diseases; therefore, the care is valued because it meets a society's expectations.

THE ROLE OF REFERRAL HOSPITALS

Beyond serving patients, referral hospitals perform broader functions in the health system that only indirectly relate to patient care.

- *Offering Advice and Support to Lower-Level Health Facilities.* Specialist staff members of referral hospitals should ideally devote substantial time to giving advice and support to other health facilities, either in person, by telephone, or by e-mail. They can advise other practitioners on the management of patients' conditions, and whether and when to refer or discharge the patients. They can also coordinate training programs in the use of shared protocols for health care and for referrals.
- *Providing Quality Assurance and Improvement.* Referral hospitals play a pivotal role in setting standards for treatment, thereby ensuring quality of care. Referral hospitals can improve the quality of services elsewhere in the health system by giving advice, offering on-site training, providing services alongside local practitioners, and monitoring the appropriateness of referrals they receive.
- *Education and Training.* Many tertiary hospitals in developing countries are associated with medical schools and may therefore be regarded as teaching hospitals. If students and faculty are involved only in district-based services, they would miss many important advances in biomedical sciences and the care of complex medical and surgical problems.
- *Management and Administration.* Referral hospitals often provide managerial and administrative support to other elements of the health systems, including: managing laboratory services; serving as drug and medical supply depots; managing health information systems; managing central transport fleets; and sometimes managing payroll and human resource support to other units.
- *Research and Innovation.* In developing countries, medical research is generally undertaken in referral hospitals. These are usually the sites for the initial testing and introduction of new technologies that have been developed elsewhere and for evaluating their suitability locally and in the field. Referral hospitals would also be responsible for disseminating such technologies to other parts of the health system once they are proven effective and affordable.

How Distortions Arise in the Health System

Referral hospitals can have a negative impact on the health system when they are either overused or used in ways for which they are not intended. Policymakers should be aware of potential distortions and address them when they arise.

- Some urban residents use referral hospitals for regular health care visits because they prefer them, when it would be more cost-effective for these patients to see general practitioners at lower-level clinics. This can lead to inequitable use of hospitals by better-off people.
- Outpatient departments in particular can become congested with patients seeking primary health care, resulting in long waiting lines of patients who could be successfully treated at other facilities.
- In countries hard hit by the AIDS epidemic, AIDS patients are occupying beds in referral hospitals for long periods when they would be better cared for in lower-level facilities.
- Some referral hospitals may introduce inappropriate or unaffordable technologies.
- Skilled health personnel may find it more attractive and rewarding to work in referral hospitals, depriving rural and district health facilities of the professional expertise they desperately need—also a health equity issue.

Access to Hospitals and Health Equity

By their nature, referral hospitals must be limited in number, and they are usually located in major towns and cities. Many of the poorest people, however, live in rural areas, far from the nearest referral hospital, and therefore they may rarely, if ever, use the services. In addition to the problems of distance and having to arrange for expensive transportation, the prohibitive cost of hospital fees may inhibit the poor from using the services of referral hospitals. Other barriers include low rates of referral and (once they get there) language differences and negative attitudes of the staff.

For many years, studies have repeatedly found that public hospitals disproportionately favor more affluent, urban residents over poorer, rural dwellers. Some health officials have called referral hospitals “disease palaces,” catering mainly to the wealthy.

Policymakers thus face difficult choices in deciding how to spend public funds wisely: Either they redirect funds toward primary health care for the poor, potentially making damaging cuts in the budgets for referral hospitals, or they try to remove the barriers that prevent the poor from using higher-level services, which would probably require increasing spending on all levels of care.

Finding the Appropriate Balance of Care

The appropriate balance of care between referral hospitals and lower levels of care is influenced by many factors, such as the capabilities at the lower levels; the availability of specialists; training capacity; organization; as well as culture, political issues, and traditions. Studies in a number of countries have shown that public hospitals of all types tend to absorb some 50 percent to 60 percent of public health spending, and that referral hospitals often consume about two-thirds of all hospital spending.

If primary health care services are weak, cutting resources for referral hospitals could destabilize the whole health care system. Careful efforts are needed to strengthen lower levels of care while still maintaining the referral services. Where lower-level services are strong, it may be possible to devote relatively fewer resources to the referral hospitals. Still, if lower-level services do their jobs well, they will continue referring patients for specialized care.

Some developing countries have too many specialist doctors, most likely because of the higher salaries and social status associated with these positions. Where this is the case, health officials need to embark on a substantial training or retraining agenda to ensure there are enough family practitioners to serve the population and that these doctors have incentives to work in rural or underserved areas.

Getting Better Value for Money From the Hospital System

Three areas of focus could help health planners improve the efficiency of the hospital system: making changes within referral hospitals, pursuing public-private partnerships, and strengthening the referral chain throughout the health care system.

REDESIGNING REFERRAL HOSPITAL MANAGEMENT

- Reducing inappropriate use of outpatient services and unnecessary referrals for inpatient services (“referring down” patients who could be seen at lower levels of the system);
- Allowing early discharge from the hospital, and keeping bed occupancy rates at optimal levels (85 percent); and
- Ensuring that referral hospitals conform as much as possible with available evidence on economies of scale—that is, no fewer than 200 beds and no more than 600 beds.

INNOVATIVE PUBLIC-PRIVATE PARTNERSHIPS

- Allowing competition among public and private hospitals to encourage higher quality and lower costs;
- Establishing private wards in public hospitals to generate additional income; and
- Contracting out services to private providers, particularly high-cost, low-volume services, to offer these services more efficiently to public patients.

ENHANCING REFERRAL SYSTEM FUNCTIONS

- Improving design by assessing which services should be provided at what level of care, including home- and community-based care; primary health care; and district, secondary, tertiary, and other specialized hospitals;
- Transferring information better between levels of care (whether referring patients up or down in the system) and from a geographic perspective, ensuring patients have transportation arrangements from remote areas when needed; and
- Instilling “referral discipline” by fast-tracking patients who are referred and explaining to nonreferred patients that they need to wait or go to another facility for care.

Some of these steps are more feasible than others and will not necessarily work everywhere. A central authority that is concerned with optimizing the use of care among all levels of the system may be necessary to test new approaches and find the right balance of public health care spending.

Conclusions

Referral hospitals often command a large share of health sector budgets and spending, yet no simple formula exists for assessing what an appropriate share would be. Strong referral hospitals can distort priorities and undermine basic services, but they also provide important health benefits to the patients they treat successfully. Also, the lower levels of the health care system cannot function effectively without access to referrals for more specialized care.

“Referral hospitals should perhaps be seen as the capstone of the health care pyramid: they should not be too heavy, but if they are too light, the levels below them will lose cohesion,” according to the *DCP2* authors. Some restructuring of these hospitals may well be needed to increase referrals and use

by underserved populations and to transfer inappropriate patients to lower-level services. “But restructuring should not be confused with demolition, which will be far more likely to undermine and destabilize the entire health care system.”

For More Information

Martin Hensher, Max Price, and Sarah Adomakoh. 2006. “Referral Hospitals.” In *Disease Control Priorities in Developing Countries*, 2nd ed., ed. D. T. Jamison, J. G. Breman, A. R. Measham, G. Alleyne, M. Claeson, D. B. Evans, P. Jha, A. Mills, and P. Musgrove, 1229-43. New York: Oxford University Press.

*DALY (disability-adjusted life year) is a composite measure that combines the number of years lived with a disability and the number of years lost to premature death.