REPUBLIC OF NAMIBIA

FOLLOW-UP REPORT OF THE AUDITOR-GENERAL ON PERFORMANCE AUDIT STUDY ON THE

MINISTRY OF HEALTH AND SOCIAL SERVICES – REFERRAL SYSTEM

FOR THE FINANCIAL YEARS 2008, 2009 AND 2010

Published by authority

Price (Vat excluded) N$ 32.99
Report no 1046

REPUBLIC OF NAMIBIA

TO THE HONOURABLE SPEAKER OF THE NATIONAL ASSEMBLY

I have the honour to submit herewith my performance audit report of the Referral System in the Ministry of Health and Social Services for financial years 2008, 2009 & 2010 in terms of Article 127(2) of the Namibian Constitution. The report is transmitted to the Honourable Minister of Finance in terms of Section 27(1) of the State Finance Act, 1991, (Act 31 of 1991) to be laid upon the Table of the National Assembly in terms of Section 27(4) of the Act.

JUNIAS ETUNA KANDJEKE
AUDITOR-GENERAL

WINDHOEK, February 2012

TABLE OF CONTENTS

ABBREVIATIONS

EXECUTIVE SUMMARY **1**

CHAPTER 1

1. INTRODUCTION **5**
1.1 The historical background on the Referral System report 5
1.2 Design of the follow-up study on the Referral System 5

CHAPTER 2

2. FINDINGS **6**
2.1 The roles and classification of all health facilities 6
2.2 Revision of the staff establishment and the criteria for the allocation of staff 6
2.3 A strategy for the appointment of more Namibian RMOs and PMOs 7
2.4 Policy for doctors' visits to clinics 8
2.5 Feedback from the referral hospital to the referring hospital 9
2.6 The fee structure 9
2.7 Out-patient departments (OPD) at district hospitals to be turned into clinics 10
2.8 Specialized wards/departments to be opened at the Regional hospitals 10
2.9 Support the establishment of specialized services at the Regional hospitals through the provision of in-service training and regular visits by specialists 10
2.10 Responsibility of transport be decentralized to Regional levels 11
2.11 The booking system at the WHK State Hospital Complex (WSHC) be abolished 11
2.12 Regional hospitals should co-ordinate and monitor referrals from district hospitals 12
2.13 Communication between health facilities 13
2.14 Arrangement of transport for referral and emergency cases 13
2.15 Monitoring the quality of medical services rendered by doctors (including district surgeons and volunteers) at the district hospital by the Regional hospitals 14
2.16 Support to district level could be improved as follows 14
- All kinds of communication on district level 14
- Attend to non-functional radios on district level 14
- Ensure regular visit to clinics by doctors on district level 15
- More support and back-up from Regional hospitals and timeous feedback 15

CHAPTER 3

CONCLUSIONS **16**

CHAPTER 4

RECOMMENDATONS **18**

ANNEXURES

ABBREVIATIONS

AG	Auditor-General
CMO	Chief Medical Officer
HC	Health Centres
KIRH	Katutura Intermediate Referral Hospital
MOHSS	Ministry of Health and Social Services
MOs	Medical Officers
OAG	Office of the Auditor-General
PAC	Public Accounts Committee (Parliamentary Standing Committee on Public Accounts)
PMO	Principal Medical Officer
OPD	Out-Patient Department
PHC	Primary Health Care
RMO	Regional Medical Officer
WCH	Windhoek Central Hospital
WSHC	Windhoek State Hospital Complex

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EXECUTIVE SUMMARY

I am authorized to carry out performance audits in terms of Section 26(1)(b)(iv) of the State Finance Act, (Act 31 of 1991) which reads as follows: The Auditor-General *"may investigate whether any moneys in question have been expended in an efficient, effective and economic manner."* Performance auditing may be defined as examining whether government ministries are ***"doing the right thing"*** and utilizing the resources ***"in the right and least expensive way"***.

This report is based on the Health Referral System in the Ministry of Health and Social Services (MOHSS). The main aim of the Referral System is to achieve health for all Namibians. However, since the initial report was tabled in Parliament during October 1998 pointing out significant shortcomings in the Referral System the audit revealed that the policy itself is not yet finalised at the time of the report. The Public Accounts Committee (PAC) did not undertake fieldwork after the tabling of the initial report to substantiate the findings. However, this follow-up report was at the direct instruction of the PAC which identified issues that need to be followed-up. These issues also include issues from the initial report from the Office of the Auditor-General (OAG).

The findings, conclusions and recommendations are discussed below:

Major *findings* and *conclusions*:

- The roles and classifications of health facilities were outlined as recommended however the auditors found that the MOHSS do not have criteria for resource allocation according to the different classes.

- The staff establishment was revised and only approved on 5th of August 2003 but there is no formal criterion in place for the allocation of staff. Due to the absence of a strategy the current staff establishment is not responsive to the catchment populations. Therefore staff shortage remains a challenge due to the ever increasing population and health programs to be offered. The establishment is under review for a second time since the initial report. The Health Regions however, do provide input when the MOHSS comes up with a new establishment.

- There is still no written strategy in place on how to appoint more Namibians CMOs (formerly RMOs) and PMOs therefore; the majority of these positions are held by expatriates. Due to the absence of a strategy the public health sector will continue to rely on foreign Doctors that are employed on a contractual basis.

- There is no written policy that stipulates that Medical Officers' (MOs-doctors) should visit Clinics which is hampering regular visits being done. Doctors' visits are still not done consistently and interviews revealed that this is due to a shortage of MOs.

- At the time of the audit there was still no approved policy in place, with regard to how feedback should be given. The only means of feedback given was through the patient's health passport or when the referral facility follow-up on referred cases telephonically. The risk of feedback via health passport is that it only reaches the referring facility if the patient goes back for follow-up treatment.

- The fee structure have been amended twice, Government Gazette 2 January 2001 and 15 April 2010. However, the majority of interviews reflected that the fees in itself do not encourage people to follow the referral system but rather the availability of MOs.

- Out-patient department (OPD) at all the district hospitals visited, have not been turned into clinics.

- All intermediate hospitals do have specialist departments/wards with specialist positions catered for on their establishments as well as provide a range of specialist medical services.

- The lack of regular in-service training and visits by specialists may lead to a high number of referrals to the Windhoek Central Hospital (WCH) causing increased transport costs and longer response time due to the vast distance from regions to WCH.

- The transport responsibility has been fully decentralized to regional level.

- The booking system at the Windhoek State Hospital Complex (WSHC) could not be abolished in view of the low and declining number of accepted referrals because the availability of specialists and space for accommodation dictates the number of referrals that can be accepted.

- There is co-ordination of referrals between the Regional hospitals and district hospitals because the district hospitals make the bookings on the specified days with the relevant booking offices at the Regional hospitals. The Regional hospitals also provide feedback on the number of accepted referrals to ensure availability of specialists and space for accommodation. However, the lack of monitoring of referrals by the Regional hospitals result in self-referrals which received treatment at any other health facilities.

- There is proper communication between the Regional hospitals and the WSHC on the availability of specialists, referrals and feedback on diagnosis. However, un-booked referrals are sent without notification to the WSHC and the MOs do not use the formal feedback forms to provide feedback to the referring hospitals but make use of the patient health passport which does not provide sufficient information. The lack of the Regional hospitals to adhere to the list of accepted referrals result in un-booked referrals sent to the WSHC. The MOs non-conformity to make use of the formal feedback forms result in referring hospitals following-up on information with the Regional hospitals to get clarity on treatment and diagnosis.

- The referring hospitals arrange transport of referral and emergency cases to and from the WSHC because transport have been decentralised to all the 13 Regions. However, ambulance services remain a challenge because transport is old and not enough. Most vehicles are not suitable for all conditions in remote areas and have to be converted into ambulances. Also the distance to the WSHC, inadequate communication between the health facilities and the doctors-on-call, inadequate provision of ambulance drivers on the staff establishment and lack of proper ambulance drivers to provide first aid assistance.

- The Regional hospitals do not monitor the quality of medical services by the doctors including district surgeons and volunteers at the district hospitals. The lack of multi-skilled doctors at the district hospitals result in unnecessary cases being referred to the WSHC.

- The support to the district level has improved significantly as most of the health facilities visited are no longer using radios as a mode of communication but use telephone lines, mobile phones, fax and email as well as the introduction of the Health Information System. However, most of the staff interviewed at the health facilities visited did not know the classification of the health facilities and experience problems to get in contact with the doctors-on-call and drivers after-hours when there are emergencies.

- There is not much improvement in support, back-up and timeous feedback from the Regional hospitals to the district hospitals. However, the support and back-up to the district hospitals is not sufficient due to a lack of provision on the organisational structure because the functions are not

streamlined as such for the Regional hospitals to conduct visits to the district hospitals on a regular basis. The shortage of specialist doctors at the Regional hospitals and the lack of equipment's at the districts hospitals also hampers efforts to render effective support and back-up which result in the influx of referrals to the Regional hospitals. Timeous feedback to the district hospitals is not effective because the information provided in the patient health passport is not comprehensive enough as follow-ups have to be made with the Regional hospitals to get clarity on diagnosis and treatment and only reach the district hospitals if the patient goes back for a follow-up treatment or new visit.

In-order to address the above mentioned issues highlighted, the MOHSS should consider the following corrective measures:

Recommendations:

The MOHSS should finalise the referral policy as a matter of urgency which will enable the effective and efficient functioning of the referral system.

- The Ministry should come up with a criterion/standard for staff allocation according to the roles and classifications of the different health facilities.

- The Ministry should finalise the restructuring of the staff establishment to address the on-going shortage of staff within the Ministry and also come up with a criteria to sufficiently allocate staff.

- The Ministry should come up with a formal strategy to promote, encourage/retain and attract Namibians to CMOs and PMOs positions.

- The Ministry must also finalise the long awaited referral system policy which should enforce regular visits to clinics by MOs.

- The policy on the communication between referral facilities should be finalised in-order to improve communication within the referral system and should be adopted throughout all health facilities.

- The MOHSS should assess whether it is a viable option to convert OPDs at district hospitals into Clinics.

- The MOHSS should provide a wide range of specialised health services at intermediate (regional) hospitals.

- The WCH should ensure that specialist support is regularly provided to intermediate hospitals through in-service training and regular visits by specialists. Support of such specialised services will enhance specialised services at intermediate hospitals and reduce the number of referrals to WCH.

- The MOHSS should assess whether the booking system at the WSHC should not be abolished in view of the low and declining number of accepted referrals to ensure the availability of specialists and space for accommodation. However, the Ministry should finalise the Referral System policy and develop other policies to cater for the diverse needs of referral booking such as the exemption of certain categories i.e. chronic diseases and follow-up appointments. The daily inpatient rates should be communicated to the district hospitals to deter un-booked referrals.

- The Regional hospitals should monitor referrals by controlling the number of un-booked referrals through OPDs, casualty departments and from regions by adopting the Referral System policy to

ensure conformity. Also through the promotion of public health education, emphasizing the importance of going through the Referral System and by explaining the significant roles of the Regional hospitals and district hospitals.

- The Regional hospitals should communicate on the availability of specialists, the number of booked referrals with the WSHC and ensure to provide sufficient formal feedback on diagnosis and pass the information thus received to the district hospitals in the Regions.

- The district hospitals should improve ambulance services for referrals to and from the Regional hospitals in order to respond sufficiently to emergencies.

- The MOHSS should develop a policy to ensure that the Regional hospitals monitor the quality of medical services by the MOs including surgeons and volunteers at the district hospitals.

- The support to the district hospitals could be improved as follows:

  The district levels should improve communication to the lowest level to reduce the number of influx to the district hospitals. The Ministry should develop a policy on how the Regional hospitals could provide support, back-up and timeous feedback to the district hospitals.

Comments from the Ministry

The response letter from the office of the Permanent Secretary/Accounting Officer, which was signed on his behalf, indicated that the contents of the report reflect the situation as it is on the ground and that he fully agrees with the report (See Annexure 2).

CHAPTER 1

1. INTRODUCTION

1.1 The historical background on the Referral System report

A performance audit main study on the Referral System in the Ministry of Health and Social Services (MOHSS) was completed during March 1998 and tabled in Parliament during October 1998. It was mandated by Section 26 (1)(b)(iv) of the State Finance Act, (Act 31 of 1991) that reads as follows: The Auditor-General "may investigate whether any moneys in question have been expended in an efficient, effective and economic manner."

The Parliamentary Standing Committee on Public Accounts (PAC) hearing took place on 01 October 1998. During March 1999 the PAC drafted a report which identified issues that needed to be followed-up by the Office of the Auditor-General (OAG). Hence, the OAG conducted a follow-up to evaluate whether the recommendations have been implemented with regards to the Referral System. The issues that were dealt with include findings which formed part of the initial report of the OAG and issues the PAC identified in their report. These findings and the evidence, conclusions and recommendations thereof, are presented in the chapters that follow.

After independence the government of Namibia adopted the primary health care approach with the aim of achieving health for all Namibians. The MOHSS as the key provider of health care services supported by its partners is responsible for making sure that the health care system is managed properly. The health care system is divided into three main levels of health care delivery namely primary, secondary and tertiary. With regard to referral system, 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 the referral policy to guide the referral of patients from one level to another.

1.2 Design of the follow-up study on the Referral System

1.2.1 Time and geographical limits

The time-period under review was for three financial years, from 2007-2010 and the latest information for the year 2011 was also included.

The team visited the Head Office as well as the following health regions being, Khomas, Erongo, Ohangwena, Oshana, Karas and Omaheke Regions for the collection of information. Within these regions, the Windhoek Central hospital and Katutura and Oshakati Intermediatery hospitals, Health Regional offices and district hospitals for the MOHSS were visited.

1.2.2 Methods of data collection

The following methods were used for the collection of information:

- Interviews with officials involved with the referral system and referral of patients;
- Documents related to the Referral System and the review thereof and
- Physical observations at the visited health facilities which included the following:
  - Bed occupancy rate in the wards;
  - number of staff on duty;
  - checking of medical equipment, whether functional or not, or lacking; and
  - number of vehicles and ambulances allocated to each health facility.

CHAPTER 2

2. FINDINGS

This chapter of the report presents findings on the progress of the implementation of the recommendations of the PAC and AG's report tabled on 01 October 1998. The findings will highlight new developments within the Ministry as well as progress made on the implementation of the recommendations.

2.1 It was recommended by the AG that the roles and classification of all health facilities should be clearly defined and resources allocated accordingly

The classifications of health facilities were outlined in Government Gazette dated 7 September 2001. The roles were outlined in GRN Gazette dated 15 April 2010. All health facilities were classed from A to F, ranging from the National (Windhoek Central) hospital as a Class-A facility to Outreach Service Points which are Class-F health facilities.

The auditors found that health centres (HCs) and clinics operated on a similar basis (no stationed doctors and similar operating hours) although the staff compliment is bigger at HCs. As a result clinics directly refer to District hospitals rather than to HCs as there is no doctor/s (only similar level staff) at HCs or the facilities were far apart.

The auditors furthermore found that the MOHSS do not have a criterion for resource allocation.

2.2 It was recommended by the AG and the PAC that the on-going revision of the staff establishment should be finalized (implemented by the year 2000) and the criteria for the allocation of staff must be defined

The staff establishment was revised and approved on 5th of August 2003 instead of 2000 as recommended. However, there are no criteria in place for the allocation of staff as recommended in the main report. According to interviews and document analysis staff shortage remains a challenge, due to the ever-increasing population and health programs, to be offered therefore the establishment is under review for the second time since the initial report. Shortage of staff may lead to work load which causes long waiting time at hospitals.

The health regions however do provide input when the MOHSS comes up with a new establishment. Interviews conducted however revealed that the establishment for the placement of nurses at clinics is not a proper way of allocating staff as some clinics serve bigger catchment populations compared to others. Most of the health facilities visited complained of a shortage of staff. The fact that the staff establishments are not responsive to the catchment population causes work load at the health facilities due to smaller staff establishments. As illustrated in the table below the catchment population for the Rosh Pinah clinic is almost three times bigger than that of the Berseba clinic although both have the same staff compliment. Even the Bethanie HC has a bigger staff establishment with a mere catchment population of 2 862.

Table 2:

	Bethanie HC	**Berseba Clinic**	**Rosh Pinah Clinic**
Registered nurse	3	1	1
Enrolled nurses	5	1	1
Total staff	8	2	2
Catchment population	2862	3937	9150

Auditors furthermore found that there exists shortage of drivers at health facilities, which adversely affects the response-time of transporting referral patients especially for clinics that are situated far from the referral facilities. For example the distance between Luderitz District Hospital and Rosh Pinah Clinic is around 300 kilometres, while the distance between Otjinene HC and Gobabis District Hospital is around 180 kilometres. Interviews with staff revealed that at times other authorized staff assists with the driver responsibilities, due to shortage of drivers. Some clinics have been allocated with vehicles and drivers to improve the response-time; however this has not been done consistently throughout. For example the Oshana health region has no drivers allocated to clinics while the other health regions have allocated drivers to some clinics in remote areas.

Lastly the auditors found that some clinics do not have record clerks on their staff establishments which results in a heavier workload on nurses as they then have an additional responsibility of collecting fees as well.

2.3 It was recommended by the AG that the Ministry should come up with a strategy how to appoint more Namibian RMOs and PMOs

There is no formal written strategy in place on how to appoint more Namibian CMOs (formerly RMOs) and PMOs. Consequently due to the absence of such a strategy, the majority of the CMOs and PMOs are still expatriates/foreigners as shown in the two tables below:

Table 3: Number of Namibian and expatriate CMOs

	CMOs			
Health Region	**Approved posts**	**Filled by Namibians**	**Filled by expatriates**	**Vacant**
National Level	6	1	4	1
WCH	3	2	0	1
Katutura Intermediate Hospital	1	0	0	1
Oshakati Intermediate Hospital	2	1	1	0
Rundu Intermediate Hospital	1	0	0	1
Oshana	1	1	0	0
Otjizondjupa	1	0	1	0
Khomas	1	0	1	0
Omaheke	1	0	1	0
Omusati	1	1	0	0
Karas	1	0	1	0
Kunene	1	0	1	0
Erongo	1	0	1	0
Kavango	1	0	1	0
Hardap	1	0	1	0
Caprivi	1	0	1	0
Oshikoto	1	0	1	0
Ohangwena	1	0	1	0
Total	**26**	**6**	**16**	**4**
Percentage	**100%**	**23%**	**62%**	**15%**

Statistics at the time of the audit

As the table above illustrates currently only six from twenty-two (27%) of the total filled posts of CMOs are Namibian while at the time of the initial report there were 13 CMO (formerly RMOs)

positions of which five was filled. From which four were expatriates and only one (25%) was Namibian.

Table 4: Number of Namibian and expatriate PMOs

	PMOs			
Health Region	**Approved posts**	**Filled by Namibians**	**Filled by expatriates**	**Vacant**
National Level	0	0	0	0
WCH	12	4	4	4
Katutura Intermediate Hospital	10	3	2	5
Oshakati Intermediate Hospital	11	5	4	2
Rundu Intermediate Hospital	6	0	4	2
Oshana	1	0	1	0
Otjizondjupa	4	0	3	1
Khomas	1	1	0	0
Omaheke	1	0	1	0
Omusati	3	1	2	0
Karas	3	1	2	0
Kunene	3	0	1	2
Erongo	4	1	3	0
Kavango	2	0	1	1
Hardap	1	0	1	0
Caprivi	1	0	1	0
Oshikoto	2	1	0	1
Ohangwena	3	1	2	0
Total	**68**	**18**	**32**	**18**
Percentage	**100%**	**26.5%**	**47%**	**26.5%**

Statistics at the time of the audit

The table above shows that only eighteen (36%) of the fifty PMOs throughout the 13 health regions are Namibian.

From the two tables above, it is apparent that expatriates are dominating the CMO and PMO positions within MOHSS. Due to the absence of a strategy the public health sector will continue to rely on foreign doctors that are employed on a contractual basis, this will inhibit continuity within the MOHSS, as these expatriates leave when their contracts expire, without fully implementing prospective plans. One of the reasons according to interviews identified for lack of Namibians in CMOs and PMOs positions are due to the low salaries compared to the private sector.

2.4 The AG recommended that the policy that Doctors should visit clinics needs to be written down for it to become effective in all Regions

There is no formal written policy that stipulates that medical officers' (MOs-doctors) should visit clinics. However, there is a draft referral policy dated June 2004; outline functions of district hospitals which include outreach services to HCs and clinics by MO's.

In the absence of a policy the auditors found that the health regions compile a timetable/rooster, by the PMOs within each district, outlining visits to clinics (which do not have stationed MOs) within that particular district by MOs of that district. Visits are usually scheduled on a monthly or weekly basis depending on the number of clinics and the number of MOs available.

Furthermore the auditors established that doctors' visits are not done according to the roosters due to a shortage of MOs (limited staff establishment) as well as timely filling of vacant MOs positions.

2.5 The AG recommended that feedback from the referral hospital to the referring hospital is important particularly to improve communication and to assist the referring hospitals and should be the responsibility of the referral hospital. There should be a clear policy on how this feedback should be given, i.e. referral letter or passport

At the time of the audit there was still no approved policy in place, with regard to how feedback should be given. Only a draft policy, (Referral system guidelines) dated 2003, which has not been finalized at the time of the audit. The only means of feedback given is through the patient's health passport or when the referral facility follow-up on referred cases telephonically. The risk of feedback via the health passports is that it only reaches the referring facility if the patient goes back for follow-up treatment. Through interviews conducted, nurses informed the auditors that feedback through the health passport is not always clear.

There is also a formal referral letter to be completed by the referring doctor when a patient is referred. However, interviews indicated that this is not done consistently, due to a lack of policy. Upon enquiries done by the auditors, staff explained that to use both the health passport and referral letter is a duplication of work.

2.6 It was recommended by the AG that the fee structure is reviewed in order to encourage the people to go to the clinics first and then through the referral system as required

The fee structure has been amended twice, as illustrated in the Government Gazette dated 02 January 2001 and 15 April 2010. However, the fees payable at the different health facilities were only amended in the Gazette dated 02 Jan 2001 while in the Gazette dated 15 April 2010 there were only exemptions for certain groups as well as amendments to the private individual fee structure.

Table 5: The fees payable according to the Government Gazette dated 15 April 2010 for the different levels of health facilities are as follows:

	Initial audit (1998)		**Follow-up audit (2011)**	
	First visit	**Follow-up**	**First visit**	**Follow-up**
	N$	N$	N$	N$
National Hospital - Class A	24,00	9,00	30,00	15,00
Intermediate/Regional Hospital - Class B 1	9,00	7,00	15,00	10,00
Intermediate/ Regional Hospital - Class B 2	N/A	N/A	8,00	10,00
District Hospital - Class C	6,00	4,50	8,00	6,00
Health Centre - Class D	6,00	4,50	8,00	4,00
Clinics - Class E	3,00	1,50	4,00	2,00
Outreach mobile - Class F	N/A	N/A	3,00	2,00

Figures applicable to state out-patients

It is important to note that a referred patient only pays at the first health facility s/he visits and no further payment is required when the patient is referred to the next level.

However, the majority of interviews reflected that the fees in itself do not encourage people to follow the referral system, but rather the availability of MOs and the preferable location of the health facility. Also the fact that patients do not have to pay if they do not have money further reduces the impact of

the fee structure; however this helps the poor to have access to the health facilities even if they do not have money.

Due to the fact that the fee structure is not effective in motivating patients to follow the referral system, it results in minor cases being self-referred to the next level causing overcrowding and work load at the referred facility.

2.7 It was recommended by the AG that a decision should be made on whether out-patient departments (OPD) at district hospitals should be turned into clinics

The OPD at all of the seven district hospitals (Swakopmund, Omaruru, Eenhana, Engela, Gobabis, Keetmanshoop and Luderitz) visited, have not been turned into clinics. From the district hospitals visited four have clinics at the hospital premises as well as the OPDs at the hospitals. However, the interviews stated that converting OPDs' into clinics is not a viable option because a hospital gets its in-patients from the OPD, as the OPDs are the first point of contact where patients come when referred.

Furthermore, staff elaborated that should OPDs be turned into Clinics, a bigger staff compliment is needed as clinics are divided into different health disciplines which is aimed at providing primary health care (PHC). Interviews further states that OPDs should mainly handle after-hour cases, emergencies, follow-ups and referred patients, it is not meant for first visits of minor cases. Staff further added that having a clinic at the hospital would prevent overcrowding at the OPD, because then only those referred and follow-up cases will be seen at the OPDs.

2.8 It was recommended by the AG that specialized wards/departments are opened at the Regional hospitals

There are three intermediate referral (formerly regional) hospitals countrywide namely; Katutura, Oshakati and Rundu. The Katutura Intermediate Referral Hospital (KIRH) also acts as a national referral hospital as both the Oshakati and Rundu hospitals refer patients to the KIRH. All intermediate hospitals do have specialist departments/wards with specialist positions catered for on their establishments as well as providing a range of specialist medical services. However, if no specialized wards are opened at intermediate hospitals, all the cases requiring specialized treatment will be referred to the WCH (national hospital) which may lead to a high number of referrals causing overcrowding and work load as well as a low acceptance rate due to limited space at the WCH. Observations by the auditors revealed that the Windhoek Central Hospital in the cancer ward (Wing 8 East) where patients had to be accommodated in the corridor because patients were more than the capacity of the ward.

2.9 The Windhoek Central Hospital should support the establishment of specialized services at the Regional hospitals through the provision of in-service training and regular visits by specialists

The Windhoek Central Hospital (WCH) provided support such as:

- Outreach clinics for radiation oncology visits at Oshakati were performed monthly as planned, as well as three month's in-service training orientation that was provided in the basics of anaesthesia to six MOs from district hospitals.

However, apart from the above-mentioned outreach support from the WCH mainly provided to the Oshakati Regional Hospital, the WCH seldom provided support to health facilities in other health regions. Interviews explained that due to a shortage of specialists in some health disciplines, together with financial constraints, are limiting regular outreach visits by specialists. The lack of regular in-

service training and visits by specialists may lead to a high number of referrals to the WCH, causing increased transport costs and longer response time due to vast distance from regions to WCH. It may also cause overcrowding at WCH and long waiting periods for those who are referred.

Furthermore, the Oshakati Intermediate Hospital is assisting with the placing of doctors for specialist services to the Erongo Health Region. The Oshakati Hospital also provides in-service training to doctors and nurses from the Omaheke Health Region.

2.10 The AG recommended that the responsibility of transport be decentralized to Regional levels

The transport responsibility have been decentralized to regional level however, the function of license renewal are still being done in Windhoek at the head office.

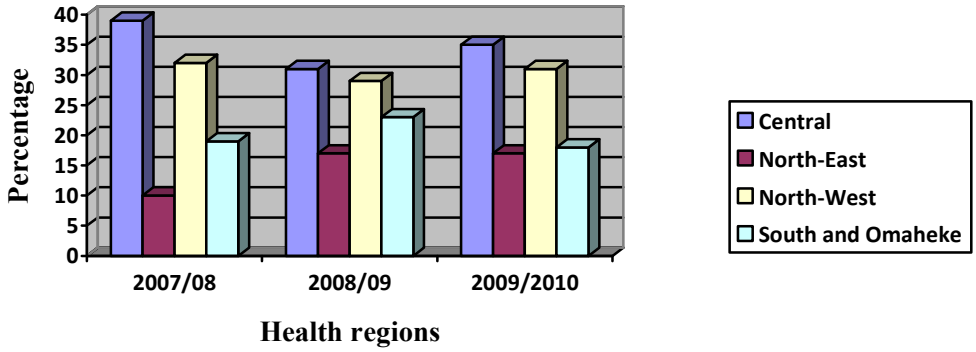
The auditors found that most of the health regions experience a delay with license renewals, which results in vehicles being grounded and unavailable for transporting patients. Factors identified by staff which contributes to the delay of license renewals was the fact that petty cash is only kept at head office, while Natis only accept cash payments. According to interviews with staff in the transport section at head office a delay is also experienced when vehicles do not pass roadworthy tests or when health regions take long to submit the roadworthy certificates to head office. During the observations in the Erongo Health Region, auditors found one ambulance with a license which expired on 30 April 2010 almost a year ago by the time of the visit (which was on 16 February 2011).

2.11 It was recommended by the AG that the booking system at the WHK State Hospital Complex (WSHC) be abolished in view of the low and declining number of accepted referrals

The auditors found that the booking system is still in place at the WSHC and could not be abolished because there is a need to have the system in place to control the number of bookings from the different Health Regions in order to ensure the availability of specialists and accommodation for the referred patients. The booking system at the Katutura Intermediate hospital was introduced in January 2010 to reduce the workload and communication difficulties experienced by the WCH which was solely handling the booking of referrals from all the Regions. However, the staff interviewed indicated that the booking system is not effective because the referring hospitals do not comply with the booking system guidelines and send un-booked referrals though some are self-referred patients to the WSHC, which causes overcrowding.

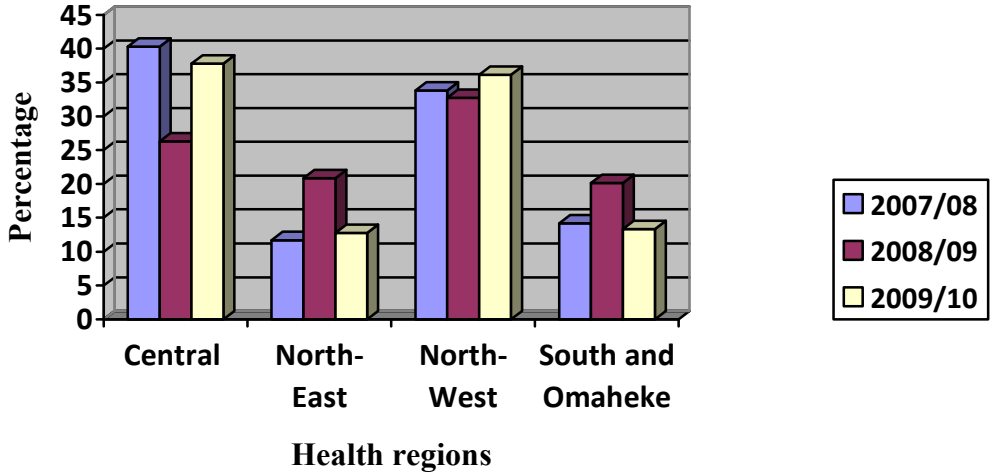
The increase or decrease in the number of referrals booked and accepted at the WSHC is represented as follows:

Graph (a) Increase or decrease in the number of booked referrals at the WSHC for the financial years 2007-2010



The graph above illustrates that the Central health region has the highest booking rate, followed by North-West health region, South and Omaheke health regions and North-East health region for the financial years under review. This indicates that a high number of bookings are received from the Central health region compared to the other Health regions.

Graph(b) Increase or decrease in the number of accepted referrals at the WSHC for the financial years 2007-2010



The graph above illustrates that the Central health region has the highest acceptance rate followed by North-West health region, then South and Omaheke and North-East health regions for the financial years under review. This indicates that the WSHC accept a high number of referrals from the Central health region compared to other health regions.

Furthermore, according to Annexure 1, the analysis indicates an average non-acceptance rate of between 55% and 60% at the WSHC for the financial years under review. There is a slight increase in the number of accepted referrals in financial year 2008/09 and a decrease in the following year. The Central health region has the highest non-acceptance rate followed by North-West, South and Omaheke and North-East health regions for all the financial years under review.

The auditors were unable to determine the impact of self-referrals on service delivery for the years under review because the records of un-booked cases are not kept at the WSHC.

2.12 It was recommended by the AG that the Regional hospitals should co-ordinate and monitor referrals from district hospitals

The auditors found that there are co-ordination of referrals between the district hospitals and the Regional hospitals because the district hospitals make the bookings weekly on the specified days with the relevant booking offices of the Regional hospitals. The Regional hospitals also provide feedback on the number of accepted referrals to the district hospitals to ensure availability of specialists and space for accommodation. However, monitoring by the Regional hospitals cannot be done because of lack of control over un-booked referrals coming through the casualty departments, OPDs and those coming from the regions. This cause an overcrowding at OPDs and hospital wards which result in the booked referrals not receiving the required first health care. This also makes the booking system to be ineffective in the absence of a referral policy.

2.13 It was recommended by the AG that the Regional hospitals should communicate with the WSHC on availability of specialists, referrals and feedback on diagnosis and pass the information thus received to the district hospitals in the region

The auditors found that the Regional hospitals and the district hospitals communicate with the WSHC telephonically and by fax with the relevant booking offices to make bookings on the specified days to ensure the availability of specialists and space for accommodation. The WSHC gives feedback on the number of accepted referrals by fax to the Regional hospitals and the district hospitals which have to pass the information to the relevant district health facilities telephonically or by fax if in place, on the number of accepted referrals. However, the staff interviewed and documentation reviewed at the WSHC indicated that the Regional hospitals sent un-booked referrals without prior notification. This resulted in overcrowding since admission and booking is based on the seriousness of the condition and availability of accommodation at the WSHC. This is also worsened by self-referrals which are coming through the OPD's and casualty departments which compromise the quality of health services at the WSHC.

It was indicated that the MO's at the WSHC are not using the formal feedback letters because of reluctance to use the formal feedback letters due to time constraints due to the number of patients that need to be examined at the hospitals wards, OPD's and casualty departments. Therefore they prefer to use the patient health passport which is easy to handle as it contains the history of the patient since the formal feedback letters need to be attached to the health passport which can easily get lost during the transfer of the referral patients to the WSHC. As a result, there is lack of conformity by the MO's who do not make use of the formal feedback letter to provide feedback to the referring hospitals which is also worsened by the absence of the referral policy.

Furthermore, the staff interviewed at the district hospitals indicated that the feedback provided by the Regional hospitals in the patient health passports is not sufficient and requires follow-ups to get clarity on diagnosis and treatment of referred patients.

2.14 It was recommended by the AG that the Regional hospitals should arrange transport of referral and emergency cases to and from the WSHC

The auditors found that the transport is decentralised to the Regions and therefore each health region is responsible for the transport of referrals to and from the WSHC as well as maintenance of the fleet. The transfer of referrals is taking place on a weekly basis. The transport of cold and emergency cases is discussed below:

Transport for cold cases

Each health region has a regional bus for referral of [1]cold case to the Regional hospitals and the referred patients are transferred on the specified days, North-West and North- East health regions on Mondays and Central, South and East (Omaheke region) health regions is on Wednesdays. Most of

[1] Cold cases are not emergency/urgent cases and thus do not need to be transported immediately.

the Regional busses in the Regions visited were in a running condition except the one for Ohangwena Region which was broken at the time of the audit. As a result pick-up bakkies were used to transfer the referral patients from the district hospitals to the Regional hospital. However, the staff interviewed indicated that the Regional busses were old and overworked and needed replacement.

Transport for emergency cases
The Regional hospitals visited were found to be having a maximum of four ambulances for emergency cases to the Regional hospitals and some were very old. It was indicated that the ambulances are not enough due to frequent breakdown and maintenance because the existing demand surpasses the availability of ambulances.

At the time of the audit there was a pending court case between the Ministry and the contractor with regard to the payment of ten (10) out of a total of fifty (50) panel vans that were converted into ambulances. The dispute also involves issues of specifications and quality of work done by the contractor. The fifty (50) converted ambulances were supposed to be completed and delivered by the end of May 2011. A follow-up on this issue was made with the Office of the Attorney-General which was involved in helping solving the issue but no feedback was received at the time of finalising the report.

Furthermore, the staff interviewed indicated that they need more ambulance drivers at the district hospitals because the current organisational structure does not provide sufficient posts for ambulance services. It was also indicated that ambulance services need skilled ambulance drivers who can provide first aid assistance during emergencies because the current ambulance drivers lack the skills.

2.15 It was recommended by the AG that the Regional hospitals should monitor the quality of medical services rendered by doctors (including district surgeons and volunteers) at the district hospital

The staff interviewed and documentation analysed indicated that the Regional hospitals do not monitor the quality of medical services rendered by doctors at the district hospitals. However, it was indicated that the CMOs at the district hospitals are responsible to supervise the quality of health services and the doctors have to consult emergency cases with the doctors-on-call at the Regional hospitals before transfer can take place. It was indicated that some cases are referred unnecessarily to the Regional hospitals due to a lack of a mixture of skilled doctors at the district hospitals.

2.16 It was recommended by the AG that the support to district level could be improved as follows:

- **Communication on district level**

The improvement of all kinds of communication on district level remains a challenge but is done verbally or in writing. However, most staff interviewed at the health facilities visited did not know the classification of the health facilities illustrating a lack of cascading information by the Regional Health Offices. The staff interviewed indicated that they experience difficulties such as getting contact with the doctors-on-call and drivers after-hours when they have emergencies. Another complained was that feedback is not being provided sufficiently on the referrals unless a follow-up is made with the district hospital or when the patient comes back to the health facilities for a follow-up visit or revisit.

Furthermore, most staff at the health facilities visited was not aware of the report of the AG or the PAC nor were they informed about the auditors visit illustrating lack of sharing of information.

The annual report of the Ministry for the 2008/2009 financial year and the staff interviewed indicated that the Ministry is in the process to install an information system to strengthen human resources for the Health Management information as well as for the sharing of information between the Regions and Head Office.

- **Non-functional radios on district level**

The observations revealed that most of the health facilities visited is using telephone lines as a mode of communication and not radios because they are an out-dated mode of communication. Most of the telephone lines were functional except at two of the twenty-four health facilities visited. The health facilities whose telephones are not functional due to land line problems are assisted with airtime to use their own personal mobile phones to keep in contact with the district hospitals and respective Regional Health Offices. The two clinics not having telephone lines are Otjimanagombe Clinic in Omaheke region and Spitzkoppe Clinic in the Erongo region. The Spitzkoppe Clinic is provided with a contract mobile phone as well as airtime whereas Otjimanagombe Clinic is only assisted with airtime.

Furthermore, the staff interviewed indicated that the telephone lines at the health centres and clinics are directly linked to the doctors' Offices at the district hospitals. Therefore, the health centres and clinics outside the towns have to get doctors-on-calls approval if the emergency is after-hours before a patient can be transferred to the district hospital and emergencies in towns goes directly to the OPD. However, the staff indicated that they experience difficulties to get in contact with the doctors-on-call if they have an emergency case especially when the telephone goes unanswered. As a result the communication using the land line is ineffective and urgent emergency cases may be delayed since most of the remote health facilities are not having stationed transport and have to be provided from the district hospitals on the instruction of the doctor-on-call.

- **Regular visits to clinics by doctors on district level**

The staff interviewed indicated that the PMOs at the district hospitals visited draws-up roosters/ schedules to propose monthly outreach visits to the health centres and clinics for the respective districts. The health centres and clinics are supposed to be visited on a monthly basis by doctors from the different departments' i.e. a general Doctor, Pharmacist, Dentist, Ophthalmologist and Antiretroviral (ARV) doctors. Documentary analysis indicated that the PMOs do compile the monthly rooster/schedules for clinic outreach services. However, since there is no formal policy that the doctors should visit the clinics, the staff interviewed indicated that the doctors' visits are not consistent as planned due to the few number of doctors allocated to a district hospital as well as other commitments of these doctors.

- **Timeous feedback**

The staff interviewed indicated that there is not much supervision and support to district hospitals from the Regional hospitals due to lack of provision on the organisational structure because the functions are not streamlined. As a result the Regional hospitals do not conduct outreach services to the district hospitals apart from invitations if there are Ophthalmology Eye Campaigns and monthly visits at the Oshakati Intermediate Hospital Oncology. The major challenge for the Regional hospitals is to conduct outreach services to the district hospitals because there is a shortage of specialists and the required equipment.

Timeous feedback to the district hospitals remains a challenge because the formal feedback forms are not completed and the feedback provided in the patient's health passport is not comprehensive enough as follow-ups have to be made with the Regional hospitals to get clarity on treatment and diagnosis. Furthermore, timeous feedback to the district hospitals is not effective via the patient health passport as it only reaches the district hospitals if the patient goes back for follow-up treatment.

CHAPTER 3

3. CONCLUSIONS

- The referral system is not functioning effectively due to the failure to finalise the referral policy since the initial audit report.

- The health facilities were classed and their roles were outlined as recommended, however there are no formal criteria for the allocation of resources. Clinics directly refer to district hospitals due to non-availability of MOs at health centre level. Resource allocation to health facilities in the same class differ from each other.

- The staff establishment has been revised and implemented however staff shortage remains a challenge with the MOHSS. There is also a lack of formal criteria for staff allocations therefore the staff compliments' at health facilities are not responsive to the demand of their respective catchment populations'.

- The lack of a strategy have resulted in the majority of CMO and PMO positions still being occupied by expatriates which inhibits the continuity of the public health programmes.

- The absence of a written policy contributes to the non-visits to clinics by MOs however the shortage of doctors also contributes to lack of doctors' visits.

- There is no formal policy with regard to communication within referral system thus there exists loopholes with the communication channels used as well as no clear means of feedback between referral facilities.

- The fee structure have been amended however the fees alone is not the overriding factor to encourage patients to follow the referral system but rather the availability of MOs.

- None of the OPDs at any of the district hospitals visited have been turned into clinics because OPDs and clinics serve two different purposes or functions.

- All intermediate referral hospitals (Regional hospitals) provide specialist services and have specialized wards at the hospitals.

- The WCH only provided in-service training in the basics of anaesthesia to six district MOs and outreach for radiation oncology at Oshakati, resulting in a high number of referrals to WCH which may cause overcrowding and long waiting periods for those patients who are being referred.

- The lack of a transport policy is hampering the efficient use of vehicles. The transport function has been decentralized to the health Regions.

- The booking system at the Windhoek Central Hospital and the Katutura Intermediate Hospital could not be abolished because the availability of specialists and space for accommodation needs to be confirmed through the booking of referrals.

- Lack of monitoring of referrals by the Regional hospitals result in self-referrals which could have received treatment at any other health facilities.

- The lack of Regional hospitals to monitor the quality of medical services rendered by the doctors at the District hospitals result in unnecessary cases being referred to the WSHC.

- Inadequate communication between the health facilities and the doctors-on-call at the district hospitals cause delays when there are needed.

- Shortage of MOs at the district hospitals result in the clinics not being visited as planned and thereby cause an influx of referrals to the hospitals.

- Inadequate support and back-up from the Regional hospitals to the district hospitals result in influx of referrals to the Regional hospitals due to a shortage of specialists and equipment's. Timeous feedback to the district hospitals is not effective because the information provided in the patient health passport is not comprehensive enough as follow-ups have to be made with the Regional hospitals to get clarity on diagnosis and treatment and only reach the district hospitals if the patient goes back for a follow-up treatment or new visit.

CHAPTER 4

4. RECOMMENDATIONS

- The MOHSS should finalise the referral policy as a matter of urgency which will enable the effective and efficient functioning of the referral system.

- The Ministry should come up with criteria for resource allocation according to the roles and classifications of the different health facilities but also take into consideration the catchment population served by a particular health facility.

- Finalise the restructuring of the staff establishment to address the on-going shortage of staff within the Ministry and also come up with a criteria to sufficiently allocate staff among the different level health facilities so as to be responsive to the demand of patients and accommodate new health programs.

- Come up with a formal strategy to promote, encourage/retain and attract Namibians to CMOs and PMOs positions.

- The Ministry must also finalise the long awaited referral system policy which should enforce regular visits to clinics by MOs.

- CMOs and PMOs for the health Regions and districts respectively should ensure that such visits are consistently done which will reduce the number of referrals to district, intermediate-hospitals and ultimately the WCH.

- The policy on the communication between referral facilities should be finalised in-order to improve communication within the referral system. To come with a clear (form or letter) manner of communication that also caters for feedback from the referral to the referring facility. The MOHSS should also ensure that the referral letter is adopted uniformly and consistently by all health facilities.

- The MOHSS should determine whether or not it is a viable option to convert OPDs at district hospitals into clinics.

- The Ministry should provide a wide range of specialised health services at intermediate (regional) hospitals so as to reduce overcrowding and high costs (transport) of referring a large number of patients to the WCH.

- The WCH should ensure that specialist support is regularly provided to intermediate hospitals through in-service training and regular visits by specialists. Support of such specialised services will enhance specialised services at intermediate hospitals and reduce the number of referrals to WCH.

- The booking system at the Windhoek Central Hospital and the Katutura Intermediate Hospital may not be abolished in view of the low and declining number of accepted referrals to ensure the availability of specialists and space for accommodation. However, the Ministry should finalise the Referral System policy and develop other policies to cater for the diverse needs of referral bookings such as the exemption of certain categories i.e. chronic diseases and follow-up appointments. The daily inpatient rates should be communicated to the district hospitals to deter un-booked referrals.

- The Regional hospitals should monitor referrals by controlling the number of un-booked referrals through OPDs, casualty departments and from regions by adopting the Referral System policy to ensure conformity. Also through the promotion of public health education, emphasizing the importance of going through the Referral System and by explaining the significant roles of the Regional hospitals and district hospitals.

- The Regional hospitals should communicate on the availability of specialists, the number of booked referrals with the WSHC and the Katutura intermediate hospital and ensure to provide sufficient formal feedback on diagnosis and pass the information thus received to the district hospitals in the region.

- The district hospitals should improve ambulance services for referrals to and from the Regional hospitals in order to respond sufficiently to emergencies.

- The MOHSS should develop a policy to ensure that the Regional hospitals monitor the quality of medical services by the doctors including surgeons and volunteers at the district hospitals.

- The district levels should improve communication to the lowest level to reduce the number of influx to the district hospitals. The Ministry should develop a policy on how the Regional hospitals could provide support, back-up and timeous feedback to the district hospitals.

Annexure 1 Number of referrals booked and accepted at the Windhoek State Hospital Complex (WSHC)

		Financial year 2007/08				Financial year 2008/09				Financial year 2009/10		
Health region	Number of booked referrals	Number of accepted referrals	Total number of referrals not accepted	% number of referrals not accepted	Number of booked referrals	Number of accepted referrals	Total number of referrals not accepted	% number of referrals not accepted	Number of booked referrals	Number of accepted referrals	Total number of referrals not accepted	% number of referrals not accepted
Central	4,900	2,277	2,623	39	8,675	3,926	4,749	36.2	5,011	2,417	2,594	32.2
North-East	1,290	662	628	9	4,755	3,111	1,644	12.5	2,390	814	1,576	19.6
North-West	3,940	1,910	2,030	30	8,094	4,886	3,208	24.5	4,510	2,311	2,199	27.3
South and Omaheke	2,298	799	1,499	22	6,517	3,003	3,514	26.8	2,530	851	1,679	20.9
Total	**12,428**	**5,648**	**6,780**	**100**	**28,041**	**14,926**	**13,115**	**100.0**	**14,441**	**6,393**	**8,048**	**100.0**
Average	**3,107**	**1,412.00**	**1,695.00**	**0.55**	**7,010.25**	**3,731.50**	**3,278.75**	**0.5**	**3,610.25**	**1,598.25**	**2,012.00**	**0.6**

ANNEXURE 2

9 - 0/0001

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OFFICE OF THE PERMANENT SECRETARY

MR. D.J. KOTZE
ACTIN DEPUTY AUDITOR-GENERAL
WINDHOEK

Dear Mr. Kotze

RE: COMMENTS ON THE FOLLOW-UP PERFORMANCE AUDIT REPORT ON THE REFERRAL SYSTEM.

The contents reflect the situation as it is on the ground. I fully agree with the report.

Some clarification: The head of the district is a PMO and not CMO. CMO's are at regional, referral hospitals and national levels.

I thank you for according this office the opportunity to comment on the report before finalization.

Sincerely yours

pp

MR. K. KAHUURE
PERMANENT SECRETARY

"Health for All"