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Referral System Processes Between Primary and Secondary Hospitals in Albay, Philippines: A Qualitative Case Study

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***Abstract*—** Efficient referral systems are essential to continuity of care, timely access to appropriate services, and improved patient outcomes within integrated health systems. This qualitative case study examined referral system processes between primary and secondary hospitals in Albay, Philippines. Specifically, it described the referral process, explored healthcare providers' experiences in managing referral cases, identified financial, logistical, and communication gaps affecting referral processes, and developed a context-specific referral system framework. Data were gathered through document review and semi-structured interviews with purposively selected healthcare providers directly involved in referral coordination and patient management. Findings showed that although referral policies and governance mechanisms were in place, operational weaknesses persisted in actual practice. Healthcare providers reported point-of-care failures at primary facilities, including staffing gaps and inadequate pre-referral stabilization, as well as breakdowns in referral coordination, limited transport resources, and poor communication between facilities. Financial constraints, including out-of-pocket transport costs and limited operational budgets, further delayed referrals and shifted the burden to patients' families. These gaps contributed to unsafe transfers, delayed care, and poor continuity of care. In response, the study proposed the SOS Framework, which emphasizes stabilization, operationalization, and synchronization as core strategies for strengthening referral processes. The framework offers a context-sensitive guide for improving referral coordination, continuity of care, and patient outcomes in primary and secondary hospitals.

***Keywords*—** referral system, primary hospitals, secondary hospitals, healthcare providers, qualitative case study.

I. INTRODUCTION

An effective referral system is a core component of an integrated health service delivery network because it connects patients to the appropriate level of care according to the complexity of their condition. In principle, referral systems support continuity of care, rational use of resources, timely access to specialized services, and improved patient outcomes. The World Health Organization described referral systems as structured mechanisms that enable patients to move efficiently across levels of care while maintaining coordination between referring and receiving facilities (World Health Organization, 2022). In well-functioning health systems, referral processes do not merely transfer patients from one facility to another; they also ensure that clinical information, responsibility, and continuity of care are preserved throughout the transition. For this reason, the strength of a referral system is often taken as an indicator of the overall responsiveness and integration of a health system.

Across countries, however, referral systems vary widely in structure and performance. In high-resource settings, referrals are often supported by digital documentation, standardized communication channels, tracking systems, and defined feedback mechanisms that improve efficiency and continuity of care. In contrast, referral systems in low- and middle-income countries are more likely to be affected by fragmented communication, transport difficulties, workforce shortages, delayed referrals, and limited institutional capacity (Abor et al., 2020; Nakayuki et al., 2021). These barriers can delay treatment, weaken primary care gatekeeping, and increase the burden on secondary and tertiary facilities. Adams et al. (2020)

further showed that referral inefficiencies may also be shaped by geography and access, particularly among vulnerable populations, where distance and distribution of facilities influence how quickly patients reach appropriate care. These realities suggest that referral systems are not only administrative arrangements but also socially and structurally embedded processes shaped by context.

Recent studies have continued to emphasize that referral inefficiencies remain a major challenge even in systems with formal referral structures. Portela et al. (2024), for example, reported substantial inefficiencies in referrals to vascular surgery services in São Paulo, Brazil, where incomplete referrals and delays reduced the appropriateness and timeliness of specialist care. Similarly, Mailis et al. (2024) found that a large proportion of referrals to a community pain clinic in Canada were rejected because of incomplete information and poor referral quality. In ophthalmology referral systems, Khou et al. (2021) also observed that incomplete administrative information created delays in triage and service access. Together, these studies show that referral quality depends not only on the clinical decision to refer but also on the completeness of documentation, clarity of communication, and readiness of the receiving service. Even where referral pathways formally exist, weak implementation can disrupt care and produce avoidable delays.

The literature also shows that logistical and organizational barriers are central to referral performance. Seyed-Nezhad et al. (2021), in a scoping review, identified technology, organizational management, process design, and patient-centered factors as major influences on referral system effectiveness. Mengist et al. (2024) similarly highlighted how ambulance shortages, misuse of transport resources, and lack of skilled escorts undermined maternal referral systems in eastern Ethiopia. These findings are especially important in settings where transport constraints and long travel distances may turn referral into a high-risk process. Referral, therefore, cannot be understood simply as a decision documented on paper; it is an operational chain that depends on financing, transport, staffing, coordination, and communication. When one link in this chain breaks down, the safety and timeliness of patient transfer are compromised.

Communication and information exchange are particularly critical in referral systems because they determine whether care is coordinated or fragmented. Woodward et al. (2020) demonstrated that human factors engineering approaches and improved system design can enhance referral quality and reduce delays, especially when processes are made more structured and user-friendly. Telemedicine and digital coordination tools have also shown promise in improving referral pathways. Mantese et al. (2021) found that telemedicine-supported regulation of specialist referrals in Brazil improved referral appropriateness and reduced unnecessary transfers, while Sperling et al. (2022) showed that telehealth was useful in prioritizing referrals during the COVID-19 pandemic. Indriani et al. (2020) likewise reported that a maternal referral mobile application system contributed to minimizing childbirth risks by improving communication and coordination. These studies suggest that stronger communication systems, including digital platforms and structured notification procedures, can reduce fragmentation and support timely action. Still, the successful use of such innovations depends on infrastructure, institutional readiness, and context-specific adaptation.

Within Asia and other developing settings, weaknesses in primary care infrastructure also influence referral behavior and system flow. Hasan et al. (2024) argued that strengthening primary care infrastructure is necessary to reduce unnecessary self-referral and to preserve the gatekeeping function of lower-level facilities. Pervez et al. (2024) further emphasized the value of clear referral pathways and context-sensitive clinical guidance in improving coordination across care levels. When primary facilities lack staff, medicines, equipment, or clear pathways, patients may bypass them or be referred late, leading to congestion in higher-level hospitals and delayed access to definitive treatment. This weakens both continuity of care and system efficiency. Accordingly, referral systems should be viewed as essential operational expressions of health system

integration rather than as stand-alone administrative procedures.

In the Philippines, the referral system is especially important because the health system is organized across multiple levels of care, with primary care facilities expected to serve as the first point of contact and to facilitate movement to higher-level institutions when indicated. National reforms under the Universal Health Care framework emphasize integrated service delivery, health care provider networks, and coordinated referral systems as central to equitable and efficient care (Department of Health, 2023; Guinto et al., 2021). The Philippine Health Facility Development Plan 2020–2040 likewise recognizes the need to strengthen service delivery networks and ensure linkages across facilities (Department of Health, 2023). At the same time, the Hospital Licensure Act underscores the need for hospitals to maintain standards related to service capability, patient safety, and organized systems of transfer and referral (Republic of the Philippines, 1965). These national policy directions indicate that referral systems are not optional support mechanisms but required elements of health system functioning.

Despite this policy environment, referral-related problems remain evident in Philippine settings. Rivera and Santos (2023) noted that administrative barriers, paperwork burdens, and slow approval processes complicated referral systems in selected private hospitals in Metro Manila. Guinto et al. (2021) also pointed out that strengthening referral systems under universal health care reforms requires not only policy alignment but also operational capacity, institutional coordination, and local implementation support. Public discussions in the country have similarly highlighted the continuing importance of functional referral systems in healthcare facilities (Philippine News Agency, 2023). These observations suggest that although referral systems are recognized in policy and principle, their actual performance may vary considerably across localities, depending on available resources, infrastructure, geography, and implementation practices.

This issue is particularly relevant in provinces such as Albay, where primary and secondary hospitals operate within a geographically diverse setting and where interfacility coordination is essential for continuity of care. In such contexts, referral processes are shaped by real-world conditions, including staffing, transport availability, documentation practices, communication mechanisms, and the financial capacity of both institutions and patients. If referral processes are delayed, poorly coordinated, or insufficiently supported, the consequences may be serious, especially for emergency, maternal, trauma, and other time-sensitive cases. Yet while international and national studies have examined referral inefficiencies in general, there remains limited evidence focused on how referral system processes operate between primary and secondary hospitals in provincial Philippine settings and how frontline healthcare providers experience these processes in actual practice.

The perspectives of healthcare providers are especially important because they are directly involved in assessing patients, initiating referrals, coordinating with receiving facilities, preparing documentation, arranging transport, and managing continuity of care. Their experiences provide insight into how referral systems function beyond formal policies and how operational problems emerge in real clinical situations. Previous literature has identified issues such as incomplete documentation, poor coordination, transport barriers, and weak feedback systems (Aboelkhir et al., 2022; Seyed-Nezhad et al., 2021; Woodward et al., 2020), but there remains a need for localized qualitative evidence that captures how these factors interact in everyday referral practice. Such evidence is necessary because system weaknesses may not be fully visible in policy documents alone; they often become most apparent in the lived realities of clinicians and staff who navigate referral decisions under constrained conditions.

This study therefore addresses an important gap by examining referral system processes between primary and secondary hospitals in Albay, Philippines through a qualitative case study approach. Rather than focusing only on policy existence or administrative structure,

the study explores how referral processes are actually carried out, how healthcare providers experience challenging referral cases, and what financial, logistical, and communication gaps affect referral practice. This focus is timely and relevant because recent scholarship continues to show that improving referral systems requires both structural clarity and operational responsiveness (AlHarthy et al., 2024; AlHarthy et al., 2024). By grounding the analysis in the experiences of healthcare providers and the context of Albay, the study aims to contribute evidence that is both practically useful and contextually specific.

This study aimed to examine the referral system processes between primary and secondary hospitals in Albay, Philippines, through a qualitative case study approach. Specifically, it sought to: (1) map the existing referral process between facilities; (2) explore healthcare providers' experiences in managing referral cases, particularly in challenging situations; (3) analyze the financial, logistical, and communication barriers affecting referral efficiency and continuity of care; and (4) develop a context-specific referral system framework based on the identified gaps and provider experiences.

II. METHODOLOGY

This study employed a qualitative case study design to examine the referral system processes between primary and secondary hospitals in Albay, Philippines. The case study approach provides an in-depth exploration of referral workflows within their real-life healthcare context to show how referrals were carried out, the challenges encountered by healthcare providers, and the systemic gaps affecting continuity of care. The study site included selected primary and secondary hospitals in Albay, chosen to represent different levels of the local healthcare delivery system. Participants were purposively selected healthcare professionals who were directly involved in referral coordination, patient management, and interfacility communication, and who had at least one year of experience in their current institution.

Data were gathered using two main qualitative instruments: a document review matrix and a semi-structured interview guide. The document review covered referral forms, hospital policies, standard operating procedures, memoranda, and communication logs relevant to the referral process. These documents were analyzed to identify patterns in referral workflows, documentation practices, logistical arrangements, and communication mechanisms. In addition, semi-structured interviews were conducted with selected healthcare professionals to elicit their experiences, insights, and challenges related to referral processes, particularly in terms of financial, logistical, and communication barriers. Interviews were audio-recorded with consent, transcribed verbatim, and supplemented with field notes to capture contextual observations and non-verbal cues.

Data analysis was guided by Yin's case study analytic framework and applied through qualitative content analysis. Interview transcripts, field notes, and reviewed documents were read repeatedly to gain familiarity with the data. Meaningful statements were coded and organized into categories based on the study's major analytic domains, namely financial, logistical, and communication aspects of the referral system. Pattern matching, explanation building, and triangulation of document and interview data were used to strengthen the credibility and depth of the findings. Ethical principles were strictly observed throughout the study, including voluntary participation, informed consent, confidentiality, anonymity, and secure handling of audio recordings and transcripts.

III. RESULTS & DISCUSSION

Referral Process Between Primary and Secondary Hospitals in Albay, Philippines

The referral process between primary and secondary hospitals in Albay, Philippines, was described through document review findings that showed a formally organized referral structure supported by institutional, provincial, and regional policy issuances. The reviewed documents indicated that referral processes were governed by a multi-level framework designed to facilitate coordination, standardize procedures, and strengthen interfacility linkages. At the institutional level, the establishment of a Public Health Unit provided an internal mechanism for coordinating

public health programs and referral-related activities. At the provincial level, the composition of the Provincial Referral Committee clarified oversight roles and accountability in referral governance. At the regional level, the adoption of the Bicol Regional Health Care Provider Network (HCPN) Referral Guidelines institutionalized standardized referral pathways, documentation protocols, and interfacility coordination procedures. These findings suggest that the referral system in Albay is structurally supported by formal policies and governance mechanisms intended to promote continuity of care across levels of service delivery.

Despite the presence of these formal structures, the findings showed that the actual referral process remained only partially operationalized in practice. The reviewed documents demonstrated that while policies clearly defined the organizational structures for referral coordination, important operational details were less consistently articulated. For example, the institutional issuance on the Public Health Unit strengthened hospital-based coordination, yet it provided limited detail on inter-hospital communication pathways. Similarly, the Provincial Referral Committee enhanced accountability and oversight, but the absence of clear monitoring indicators and enforcement mechanisms at the facility level weakened consistent implementation. The regional HCPN guidelines promoted uniform referral documentation and structured network-based coordination; however, implementation varied across primary and secondary hospitals, and documentation of feedback mechanisms between referring and receiving facilities remained limited. These findings indicate that the referral process exists as a structured administrative system, but its practical execution is constrained by gaps in monitoring, enforcement, and feedback.

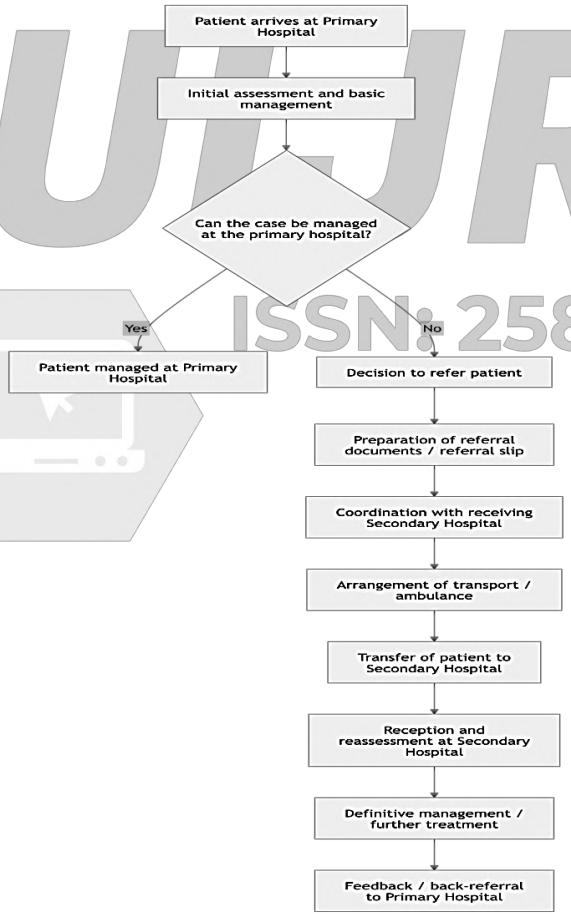

Figure 1. *Referral Process Flow Between Primary and Secondary Hospitals in Albay*

The findings further imply that the referral process in Albay follows a tiered and policy-based pathway from primary to secondary care, but the strength of this process depends heavily on how institutional and interfacility coordination is carried out at the operational level. In principle, the referral process begins at the primary facility, where patients are assessed and referred when their condition requires services beyond the facility's capability. This process is expected to be supported by standardized referral documentation, coordinated endorsement, and network-based linkage with the receiving hospital under the HCPN framework. However, the document analysis suggests that the flow is stronger at the level of policy formulation than at the level of day-to-day implementation. As a result, the referral process may be formally present but unevenly practiced across facilities. This finding underscores the need to strengthen the translation of policy into operational procedures so that referral coordination becomes not only administratively defined but also functionally consistent across the province.

From a discussion standpoint, these results show that the referral process in Albay reflects the characteristics of a structurally compliant but operationally fragile health system. The existence of policy instruments at multiple levels demonstrates alignment with broader healthcare reforms and organized referral governance, yet the limited operational detail, weak monitoring systems, and variable implementation reduce the effectiveness of the referral pathway in actual practice. This means that the process of referral cannot be understood solely as the presence of forms, guidelines, or committees, but rather as the interaction between policy, coordination, and implementation. Therefore, for the referral process between primary and secondary hospitals in Albay to function effectively, greater emphasis must be placed on strengthening communication pathways, enforcing facility-level compliance, and establishing measurable monitoring and feedback systems that can support a more responsive and integrated referral network.

Experiences of Healthcare Providers in Managing Referral Cases

Table 2 presents the experiences of healthcare providers in managing referral cases, particularly in challenging situations, and reveals that referral difficulties are not isolated incidents but interconnected system failures across the continuum of care. The findings show that one of the most critical challenges begins at the level of point-of-care failures at primary facilities, where staffing gaps and lack of clinical intervention prevent adequate patient stabilization before transfer. The absence of a doctor on duty and the inability to perform basic life-saving measures, such as wound packing, fluid resuscitation, or administration of Magnesium Sulfate, indicate that some primary facilities are unable to fulfill their expected gatekeeping and stabilization functions. As a result, patients are referred in already unstable conditions, increasing the likelihood of deterioration even before they reach the receiving hospital.

Table 2. *Experiences of Healthcare Providers in Managing Referral Cases, Particularly in Challenging Situations*

Theme	Subtheme	Illustrative Data	Implication
Point-of-Care Failures at Primary Facilities	Staffing Gaps	No doctor on duty; inability to provide basic life support	Patients not stabilized before referral
	Lack of Clinical Intervention	No wound packing, fluid resuscitation, or Magnesium Sulfate administration	Increased risk of deterioration before transfer
Breakdown of Referral Coordination	Absence of Pre-Referral Communication	No referral slip, no call ahead to receiving hospital	Receiving hospital unprepared
	Non-adherence to Standardized Protocols	Patients transferred without escort or proper endorsement	Weak continuity of care
Transport and Logistical Barriers	Inadequate Medical Transport	Use of tricycles or pickup trucks	Unsafe transport of critically ill patients

	Geographic Challenges	Long distance, rough and unpaved roads	Delayed access to secondary care
Temporal Delays	Delay in Reaching Facility	Prolonged transport due to lack of ambulance	Worsening emergency conditions
	Delay in Receiving Adequate Care	Secondary hospital not informed or prepared	Missed treatment window
Systemic Fragmentation	Incomplete Operationalization of Policies	Policies exist only on paper	Weak implementation of referral system
Consequences of Referral Failures	Preventable Mortality / Physiological Deterioration	Trauma, maternal, and fetal risks during transfer	Poor patient outcomes

The table also highlights a breakdown of referral coordination, particularly through the absence of pre-referral communication and non-adherence to standardized protocols. The lack of referral slips, failure to call ahead, and transfer of patients without proper endorsement or medical escort demonstrate weak coordination between referring and receiving facilities. These findings imply that the receiving hospital is often unprepared for incoming emergency cases, which delays immediate intervention upon patient arrival. This weakens continuity of care and undermines the purpose of a structured referral system, which should ensure timely, organized, and well-communicated transfer of patients requiring higher-level management.

Another major issue shown in the table is the presence of transport and logistical barriers. The use of tricycles or pickup trucks as emergency transport and the presence of long distances, rough roads, and unpaved terrain reflect serious limitations in the actual transfer process. These conditions expose critically ill patients to unsafe transport and significantly delay access to secondary care. In emergency cases, particularly trauma and obstetric referrals, such delays may aggravate the patient's condition during transit. This finding suggests that transport is not merely a support service within referral systems but a central determinant of referral safety and effectiveness.

The theme of temporal delays further emphasizes how referral failures translate into lost opportunities for timely care. The delay in reaching the facility, often due to the lack of ambulance services, and the delay in receiving adequate care, caused by the receiving hospital's lack of preparation, both contribute to worsening emergency conditions. These delays are especially critical because they may result in missed treatment windows for life-saving interventions. In this sense, the referral experience described by healthcare providers reflects not only procedural inefficiency but also a direct threat to patient survival and recovery.

The results also point to systemic fragmentation, as reflected in the incomplete operationalization of policies. Although referral policies and guidelines formally exist, healthcare providers perceived that these policies remain "on paper" and are not consistently translated into actual practice. This indicates weak implementation of the referral system, where institutional protocols are not sufficiently supported by monitoring, enforcement, and operational readiness. The persistence of these gaps suggests that the problem is not the absence of policy, but rather the lack of effective execution at the facility level.

The table shows that the cumulative effect of these failures is seen in the consequences of referral failures, particularly preventable mortality and physiological deterioration during transfer. Trauma, maternal, and fetal risks during referral indicate that adverse outcomes are not solely caused by the severity of illness but are worsened by delays, poor coordination, lack of stabilization, and unsafe transport. Thus, the results of Table 2 demonstrate that healthcare providers' experiences in managing referral cases are

shaped by structural, operational, and communication-related weaknesses within the referral system. Overall, the findings underscore the need for stronger staffing support, improved stabilization capacity, reliable transport systems, stricter protocol adherence, and more effective interfacility coordination to ensure safer and more responsive referral practices.

Financial, Logistical, and Communication Gaps Affecting Referral Processes

Table 3 presents the major financial, logistical, and communication gaps affecting referral processes and shows that referral inefficiencies in primary and secondary hospitals in Albay are rooted in multiple, interconnected system weaknesses. The results indicate that referral problems are not caused by a single factor but by the combined effects of financial limitations, transport and staffing constraints, and breakdowns in communication between facilities. These gaps collectively weaken the continuity, timeliness, and safety of patient transfer from one level of care to another.

Under the financial domain, the results show that out-of-pocket transport costs remain a major burden on patients' families. When ambulances are unavailable, families are forced to shoulder expenses for fuel, vehicle rental, or other forms of transport. This means that the initiation of referral is often dependent on a family's immediate financial capacity rather than purely on clinical urgency. As reflected in the table, this results in delays in transfer and unequal access to care, particularly for economically disadvantaged patients. The finding suggests that financial barriers directly influence referral compliance and timeliness, making emergency referral not only a clinical issue but also a socioeconomic one.

Another important financial issue is the limited operational budget of primary facilities. The lack of funds for ambulance repair, emergency drugs, equipment, and staffing significantly reduces the capacity of these facilities to provide initial stabilization before referral. In effect, primary hospitals are unable to function fully as safe referral entry points because they lack the resources needed to prepare patients adequately for transfer. This gap contributes to the inability of primary facilities to stabilize patients effectively, thereby increasing the risk of clinical deterioration before and during transit. In addition, administrative and reimbursement delays further weaken the referral process. Delayed claims and weak financial accountability mechanisms can lead to incomplete documentation and reduced compliance with referral requirements. These findings imply that financial governance problems do not only affect budgeting but also weaken procedural consistency in the referral system.

In the logistical domain, the results reveal that inadequate emergency transport is one of the most visible and consequential barriers in the referral process. The presence of only a few ambulances, combined with broken vehicles and the lack of trained transport personnel, leads to unsafe transfer conditions and delayed arrival at secondary hospitals. In critical cases, these transport limitations place patients at greater risk because they are transferred without proper medical monitoring or emergency support. This problem is compounded by geographic and terrain barriers, such as long travel distances, mountainous routes, and rough or unpaved roads.

These conditions prolong travel time and worsen patient conditions during transit, especially in trauma and obstetric emergencies where rapid intervention is essential. The findings therefore show that geography and infrastructure are not merely background conditions but active determinants of referral effectiveness.

Table 3: *Financial, Logistical, and Communication Gaps Affecting Referral Processes*

Domain	Gap Identified	Manifestation in the Referral Process	Effect on Referral Process
Financial	Out-of-pocket transport costs	Families shoulder fuel, vehicle rental, or transport expenses when ambulances are unavailable	Delays in transfer and unequal access to care

	Limited operational budget	Lack of funds for ambulance repair, emergency drugs, equipment, and staffing	Primary facilities cannot stabilize patients effectively
	Administrative and reimbursement delays	Delayed claims and weak financial accountability	Incomplete documentation and weakened referral compliance
Logistical	Inadequate emergency transport	Few ambulances, broken vehicles, lack of trained transport personnel	Unsafe transfer and delayed arrival at secondary hospitals
	Geographic and terrain barriers	Long distance, mountainous areas, rough and unpaved roads	Prolonged travel time and worsening patient condition
	Human resource gaps	No doctor on duty, lack of escort personnel, limited 24/7 staffing	Patients transferred without stabilization or monitoring
	Equipment and supply deficiencies	Lack of life support equipment and essential emergency medicines	Increased physiological deterioration before and during transfer
Communication	Absence of pre-referral notification	No call, radio message, or formal endorsement before transfer	Receiving hospitals are unprepared for incoming patients
	Non-adherence to referral protocols	No referral slip or incomplete endorsement	Disrupted continuity of care
	Weak feedback mechanisms	No back-referral or outcome reporting	No quality improvement loop between facilities
	Reliance on informal communication	Personal phone calls instead of institutional systems	Miscommunication, weak documentation, and information loss

The logistical challenges are further intensified by human resource gaps and equipment and supply deficiencies. The absence of a doctor on duty, the lack of escort personnel, and limited 24/7 staffing mean that patients are sometimes referred without adequate stabilization or monitoring. Likewise, the lack of life support equipment and essential emergency medicines prevents facilities from addressing urgent clinical needs prior to transfer. These gaps increase the likelihood of physiological deterioration before and during referral. Together, these results suggest that logistical capacity involves more than transport alone; it also includes the readiness of personnel, equipment, and essential supplies needed to ensure that referral can be carried out safely and effectively.

Within the communication domain, the table shows that the absence of pre-referral notification is a major weakness affecting referral coordination. When no call, radio message, or formal endorsement is made before transfer, the receiving hospital is left unprepared for the arrival of the patient. This delays immediate response and reduces the ability of the receiving team to prepare the necessary personnel, equipment, or treatment area in advance. Similarly, non-adherence to referral protocols, such as the absence of referral slips or incomplete endorsement, disrupts the continuity of care because critical patient information may not be properly handed over. The referral process therefore becomes fragmented, with receiving facilities forced to assess patients without complete background information.

The results also reveal weak feedback mechanisms and reliance on informal communication. The absence of back-referral or outcome reporting means that referring facilities do not receive information about the patient's condition, management, or final outcome after transfer. This prevents the development of a quality improvement loop that could help facilities review and improve their referral practices. At the same time, dependence on personal phone calls instead

of formal institutional systems increases the risk of miscommunication, incomplete documentation, and information loss. These findings suggest that communication gaps are not only procedural lapses but structural weaknesses that undermine accountability, continuity, and system learning.

The results of Table 3 demonstrate that financial, logistical, and communication gaps interact to create layered vulnerabilities in the referral process. Financial constraints weaken transport readiness and resource availability; logistical barriers delay transfer and increase clinical risk; and communication failures disrupt coordination and continuity of care. These domains do not operate separately but reinforce one another, resulting in delayed referrals, unsafe transfers, and poorer patient outcomes. The discussion of this table therefore highlights the need for an integrated response that strengthens financing support, transport and staffing capacity, and institutional communication systems in order to improve the overall efficiency and responsiveness of referral processes between primary and secondary hospitals in Albay.

Context-Specific Referral System Framework

Table 4 and Fig. 2 present the proposed context-specific referral system framework developed from the findings of the study. The framework integrates the three major areas identified in the earlier objectives, namely the referral process, healthcare providers' experiences, and the financial, logistical, and communication gaps affecting referral processes. These major findings served as the foundation for the development of the SOS Framework, which consists of three interrelated components: Stabilize, Operationalize, and Synchronize. Together, these components provide a localized and responsive model for strengthening referral practices between primary and secondary hospitals in Albay.

Table 4. *Context-Specific Referral System*

Framework Component	Basis from the Findings	Purpose
Stabilize	Financial fragility, lack of budget, limited emergency drugs, inadequate staffing, poor pre-referral stabilization	To strengthen financial and clinical readiness before referral
Operationalize	Broken ambulances, lack of medical transport, geographic barriers, staffing shortages, lack of equipment	To improve the reliability and efficiency of transport and referral logistics
Synchronize	No pre-referral notification, incomplete referral slips, weak feedback mechanisms, informal communication	To strengthen communication, documentation, and coordination between facilities

The first component, Stabilize, addresses the financial and clinical readiness required before patient transfer. The findings showed that financial fragility, limited budget, inadequate staffing, lack of emergency drugs, and poor pre-referral stabilization weakened the ability of primary facilities to prepare patients for referral. Because of these deficiencies, patients were often transferred in unstable conditions, increasing the risk of deterioration before reaching the receiving hospital. Thus, the purpose of stabilization is to ensure that referring facilities have the minimum financial resources, workforce support, and clinical capacity needed to provide initial management and prepare patients appropriately for transfer.

The second component, Operationalize, focuses on the actual functionality of referral logistics. This component emerged from findings related to broken ambulances, lack of medical transport, geographic barriers, staffing shortages, and lack of essential equipment. These conditions demonstrate that even when referral is clinically necessary, the process may still fail if transport systems and logistical arrangements are unreliable. Operationalize therefore emphasizes the need to make referral systems work

effectively in real settings by improving ambulance availability, transport readiness, staffing support, and equipment provision. In this way, referral becomes not only a policy directive but an executable process that can be carried out safely and efficiently.

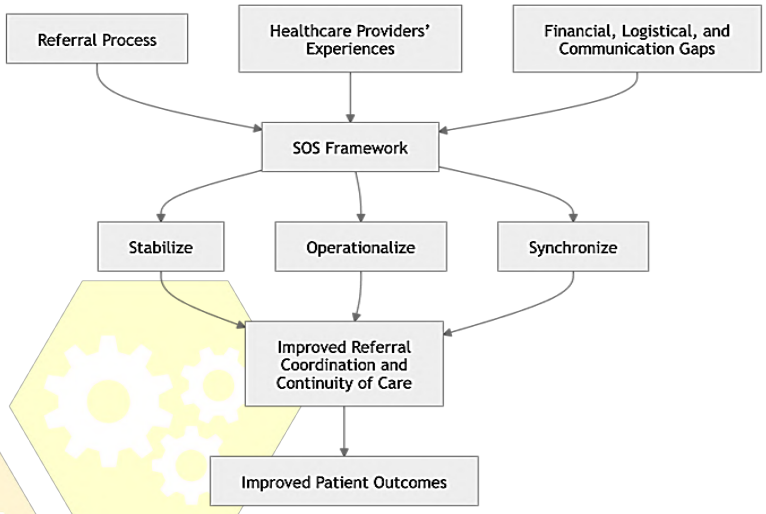

Figure 2. *Context-Specific Referral Diagram*

The third component, Synchronize, highlights the importance of communication, documentation, and interfacility coordination. The findings revealed frequent absence of pre-referral notification, incomplete referral slips, weak feedback mechanisms, and reliance on informal communication. These gaps disrupted continuity of care and left receiving hospitals unprepared for incoming patients. The synchronize component responds to this problem by promoting structured communication pathways, complete referral documentation, timely endorsement, and back-referral mechanisms. This ensures that referral is carried out as a coordinated exchange of patient information and responsibility rather than as a simple transfer of location.

As illustrated in Figure 2, the three framework components are positioned under the central SOS Framework, showing that they function as the core strategies arising from the study findings. These components collectively lead to improved referral coordination and continuity of care, which in turn contribute to improved patient outcomes. The diagram further shows that the framework is not isolated from the study results, but directly grounded in the identified realities of referral practice in Albay. Overall, Table 4 and Figure 2 demonstrate that strengthening referral systems requires an integrated approach that addresses preparedness, operational capacity, and communication at the same time. Through the SOS Framework, the study proposes a practical and context-sensitive model for improving referral processes between primary and secondary hospitals.

IV. CONCLUSIONS

This study concludes that the referral system processes between primary and secondary hospitals in Albay, Philippines are supported by existing institutional, provincial, and regional policies, yet their implementation remains operationally fragile. The findings showed that while a formal referral structure is in place, major weaknesses persist in actual practice, particularly in patient stabilization, transport readiness, interfacility communication, and continuity of care. Healthcare providers' experiences revealed that staffing gaps, limited emergency interventions, lack of pre-referral coordination, inadequate transport, and weak protocol compliance contribute to delays and unsafe transfers. These challenges are further compounded by financial constraints, logistical barriers, and communication breakdowns, which collectively reduce the effectiveness of the referral process and place patients at risk of deterioration and

poor outcomes. The study therefore highlights that referral inefficiencies in Albay are not merely procedural issues but manifestations of broader systemic weaknesses that affect the responsiveness and reliability of the healthcare delivery network.

In response to these findings, primary and secondary hospitals, together with local health authorities, should strengthen referral systems through coordinated and practical interventions. Health administrators should allocate dedicated funding for ambulance maintenance, emergency drugs, equipment, and staffing to ensure that primary facilities can stabilize patients before referral. Hospitals should enforce standardized referral protocols, including complete referral documentation, pre-referral notification, and the provision of medical escorts for critical transfers. Local government and hospital leadership should improve ambulance availability, transport arrangements, and staffing coverage, particularly in geographically isolated areas. At the same time, facilities should establish formal communication and feedback mechanisms, such as structured endorsement systems and back-referral reporting, to improve coordination and continuity of care. The adoption of a context-specific framework, such as the SOS Framework, may guide hospitals in strengthening referral readiness through stabilization, operationalization, and synchronization of referral processes, with the ultimate goal of improving referral efficiency and patient outcomes.

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