

ASSESSMENT OF THE REGULATORY FRAMEWORK FOR HEALTH EMERGENCIES

HEALTH EMERGENCIES AND EMERGENCY CARE REGULATION IN ALBANIA IN THE CONTEXT OF PRIMARY HEALTH CARE (PHC)

PREPARED BY: ALBAN YLLI

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LIST OF ABBREVIATIONS

AFP	Acute Flaccid Paralysis
ARI	Acute Respiratory Infection
CCHF	Crimean-Congo Haemorrhagic Fever
DPEC	Drejtoria e Përgjithshme e Emergjencave Civile (General Directorate of Civil Emergency)
EU	European Union
GOMF	Grupi Operacional i Menaxhimit të Fatkeqësive (Operational Group for the Management of Disaster)
GP	General Practitioner
HC	Health Centre
ILI	Influenza-like Illness
IPH	Institute of Public Health
NGO	Non-governmental Organization
NJVKSH	Njësia Vendore e Kujdesit Shëndetësor (Local Health Care Unit)
NSDEI	National Strategy on Development and European Integration
PHC	Public Health Centre
SARI	Severe Acute Respiratory Infection
SDG	Sustainable Development Goal
SISI	Surveillance System for Infectious Diseases
SMI	System of Incident Management
SOP	Standard Operational Procedures
UN	United Nation
WHO	World Health Organization

1 INTRODUCTION

1.1 DEFINITION OF THE PROBLEM

The concepts of health emergencies and medical emergency care are linked in terms of rapid occurrence and the need for prompt response. An emergency can be described as a type of event or imminent threat that produces or has the potential to produce a range of health consequences, and which requires coordinated action, usually urgent and often non-routine. This includes epidemics, disasters (natural and technological), as well as those involving violence and conflict, which can often last in time.

A medical emergency can be defined as any unscheduled episode of care sought by a patient with an acute health problem of all ages. In Albanian legislation (like in Healthcare Law or Medical Emergency Law) it is defined as a more serious threat to the life of the individual if left untreated.

Primary health care has an essential role to play in preventing, preparing for, responding to, and recovering from any emergency situation. It is also recognized at the international level that emergency care at the primary health care level is vital for reducing overall mortality and disability.

1.2 HEALTH EMERGENCIES

Disasters or catastrophes can be considered large-scale emergencies that result in "a serious interruption of the functioning of a community or the entire society with massive human, material, economic or environmental losses, which exceed the ability of the affected community or society to cope with own resources".

Disasters or public health emergencies can be divided into two main types. Sudden Onset Disaster: A disaster caused by a dangerous event that occurs quickly or suddenly. Disasters with sudden onset can be accompanied by, for example, earthquakes, volcanic eruptions, floods, chemical explosions, serious destruction of infrastructure, or mass transport accidents. These are the most typical situations that have a quick onset and a short period of time, from a few days to a few weeks. Slow-onset disaster: A disaster that occurs gradually over time. Slow-onset disasters can include, for example, prolonged droughts, desertification, rising sea levels, or conflicts within and between countries. These can usually last for several months or even years. The pandemic from Covid-19 proved that it was brought both as a disaster with a quick start, but also as one that has continued for a long time. The health system related to services for non-communicable diseases will have to be prepared for all possible scenarios.

Disasters can have a profound impact on the population's health and well-being, causing injury – both short-term and long-term – and death. The degree to which people are affected will vary significantly depending on the type and severity of the disaster. People affected by disasters can also have an increased risk of mental health and social problems. Psychological first aid can provide basic support for the distressed immediately after an event.

In an emergency, it is generally expected that the demand for healthcare services will rise. In emergency situations, primary health care can provide essential routine health services, identify and manage emergency cases, prevent disease outbreaks with effective public health measures, and play a key role in disease surveillance. A primary healthcare approach develops resilience within health systems and can advance the global aim of achieving universal health coverage and health security.

It is crucial that general practices are able to continue providing essential services during emergencies. In order to accomplish this, it is imperative that they have an up-to-date emergency response plan so that they are prepared, well stocked, and ready to respond to any crisis. Primary care facilities that are prepared for an emergency are more likely to have effective continuity of care for their patients while ensuring that other operations continue to run as smoothly as possible. Furthermore, facilities that have a tested emergency response plan will ultimately be better positioned to respond to the health needs of their communities.

1.3 MEDICAL EMERGENCIES

A medical emergency is often defined as any unscheduled episode of care sought by a patient with an acute health problem of all ages. As for the Albanian legislation (healthcare law 10107/2009), 'the medical emergency is a condition or acute illness which constitutes an immediate danger for the life of the person or its health in the future'.

Emergency care can be provided at the hospital level as well as the pre-hospital level. The 72nd World Health Assembly has recognized that emergency care at the primary health care level is vital for reducing overall mortality and disability. Millions of deaths and long-term disabilities from injuries, infections, mental disorders, and other mental health conditions, acute exacerbations of non-communicable diseases, acute complications of pregnancy, and other emergency conditions could be prevented each year if emergency care services exist and patients reach them in time.

All gate-keeping systems make an exception for emergencies that can be presented directly to hospitals or accident and emergency units. The problem is for medical staff to clearly label a problem as urgent, while it may be difficult to send non-urgent cases away without providing attention. This is a major leakage of gate-keeping systems, especially during evenings and weekends when GP services are less available.

The prevailing regulations for access and use of services may be more difficult to enforce in cities, where there is a more extensive supply of health services. Patients can take problems that would otherwise be presented to general practitioners to the accident and emergency units of hospitals, for example.

EXPERIENCE FROM EU COUNTRIES

In the European Union, the provision of out-of-hours services (night and weekend emergency services) via GP practices or GP cooperatives is available in 11 countries. In other countries, medical needs outside office hours are mostly attended by hospital emergency wards, which is associated with higher healthcare expenditures. In Estonia, the Ministry of Social Affairs is responsible for covering the costs of ambulance care and emergency care for uninsured people, and is also the largest contributor to public health programs. People who are not covered by the health insurance system have to pay for health services themselves, although emergency care for them is guaranteed and paid from the state budget.

In Slovenia, the personal family physician has the responsibility to provide primary care for the patients on the list, including emergency care 24 hours a day. Also, emergency medical services are provided by the family physicians as part of their daily routine, as part of out-of-hours services, or as separate services. In Sweden, according to the Health and Medical Services Act, the counties are obliged to provide health care services to the population during ordinary working hours and access to emergency care at other times. Almost all GPs provide telephone consultations, they usually have a practice website and use an appointment system, but they rarely provide any e-mail consultations.

2 OBJECTIVES OF THE ANALYSIS

THIS REPORT AIMS:

- To screen country 'hard' and 'soft' policies in order to identify all regulatory mechanisms with interest for health emergencies and medical emergency care in Albania, with a special focus on primary health care.
- To analyse the regulatory framework in terms of hierarchy, integration, efficacy, gaps, and needs for adaptation. The policies in the analyses will include parliament laws, government decrees, ordinances of ministers, as well as strategies, plans, standards, protocols and legal contracts. They may be intersectoral or covering only the health sector.
- To assure involvement of key stakeholders in the process of identification and analyses.

METHODS

Eight key informants from the Ministry of Health and Social Protection, Health Insurance Fund, Medical Emergency Centre, Institute of Public Health, Centre for Quality and Accreditation, Association of Family Medicine, and Primary Health Care providers (Tirane, Durres and Puke) have been contacted and interviewed by means of a non-structured guide. Their information and opinions have firstly helped in identifying pieces of regulation and secondly, provided insights on implementation. A draft guide is in the annex.

Legislative acts and other regulations have been further identified in a desk review process. Online searches were facilitated by a list of keywords. More than 40 pieces of legislation, regulation, strategies, standards and protocols were identified. Documents were analysed from the angle of primary health care. Findings were further distributed in a logical matrix to allow for easy identification of their influence in the primary health care processes, gaps and need for adaptation.

3 HEALTH EMERGENCIES PREPAREDNESS IN THE CONTEXT OF SUSTAINABLE DEVELOPMENT GOALS IN ALBANIA

The Sustainable Development Goal (SDG) 3 focuses on ensuring healthy lives and promoting well-being for all at all ages. A well-organized, safe and high-quality emergency care is a key mechanism for achieving a range of related targets – including those on universal health coverage, road safety, maternal and child health, non-communicable diseases, mental health, and infectious disease.

This SDG is particularly relevant to target 3.d. which deals with “Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks”, and targets 3.1 (maternal mortality); 3.2 (infant mortality); 3.8 (universal health coverage) and 3.9 (deaths from chemical contamination).

Two other Sustainable Development Goals, namely SDG 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and Goal 16 (Promote peaceful and inclusive societies for sustainable development, promote access to justice for all and build effective, accountable and inclusive institutions at all levels) won't be achieved without a strong and well-prepared everyday emergency care system, which is vital for mitigating the impact of disasters and mass casualty events and for maintaining delivery of health services in fragile situations and conflict-affected areas.

Investment in health emergency capacity also plays an important role in achieving other SDG goals, such as eliminating poverty and hunger (SDG 1, SDG 2); gender equality (SDG 5); decent work and economic growth (SDG 8); reduced inequalities (SDG 10) and Climate Change (SDG 13).

In 2015, Albania, together with 193 Member States, committed to the adoption of the 2030 Agenda for Sustainable Development (2030 Agenda) and to work towards the achievement of the Sustainable Development Goals (SDGs). Currently, Albania has been selected as one of the countries for the implementation of the Global Action Plan for Healthy Living and Well-Being for All (SDG 3 GAP). It may support the country in its efforts to accelerate and sustain progress towards achieving the health and health-related SDGs and to realize the 2030 Agenda.

The 2019 earthquakes and the Covid-19 pandemic have highlighted the importance of continued efforts to strengthen and build resilient health systems so that Albania can continue to provide quality and essential health and humanitarian services and respond to health emergencies efficiently. Those real-life emergencies also demonstrated the need for multi-sectoral action and support from development partners (Governments, UN and EU) to ensure that Albania is better prepared for the detection of health threats and emergencies, their prevention and appropriate responses, as well as recovery from them.

Joint activities suggested by GAP report (2022) in the framework of the SDGs for implementation in all sectors and in cooperation with international partners include:

- Strengthening health systems so that they can continue to provide all essential health services during health emergencies and natural disasters.

- Supporting the Government to better prepare, prevent, detect and respond to future outbreaks, as described in the International Health Regulations.
- Supporting long-term planning for recovery and creating resilient structures.

4 THE EXPERIENCE WITH DRASTIC MEASURES DURING PANDEMIC EMERGENCY IN ALBANIA

Covid-19 pandemic turned out to be a health emergency of unprecedented scale. Extreme legislative instruments were applied during the efforts to contain the infections and protect the lives of the citizens. Analysing the measures and policies undertaken during pandemic may of interest for any future health program with a focus on health emergencies.

4.1 POLICIES TO CONTAIN THE FIRST WAVE OF PANDEMIC

After the surge of cases in Northern Italy in late February 2020, special measures were introduced for all travellers from Italy. As the two first cases were confirmed on the 8th of March, the Government was quick to react with nationwide measures, starting with schools, which were closed on March 9th. One day later, all flights from Italy were suspended and by March 14-15th, after WHO declared the pandemic, all national borders were close. Self-quarantine was required for all those who entered the country in the first week of March. Some services and activities were already closed by the 10th of March. The measure was followed on 15th of March by a decree of the Government to close around 50 business categories. From March 12th to March 18th, all travel between main cities was limited or banned. In the second week of March, the Government introduced first limits of moving out of home. Then, on the third week, all essential activities were limited to 05:00-13:00. During weekends almost, total curfew was strictly enforced. On the 24th of March, the Government raised the emergency situation to the highest possible catastrophe (No.243, date 24.3.2020). Later, on the 16th of April, that decision was approved by Parliament, as required by the Albanian Constitution. Further on, the Council of Ministers requested the Parliament to extend the validity of the Decision 243 of 24th March 2020, until 23rd of July 2020. This was done by the Assembly on 21st of April 2020.

To be mentioned that Albania had introduced a partial emergency situation only a few months ago as the existing emergency was preceded by the November earthquake emergency which left without homes almost 20 000 people.

Since the 15th of March, measures were introduced to minimize contact with health services, while planed surgeries were postponed and private health services were requested to adapt to the emergency rules. Since 10th of March, strict rules were introduced to avoid contagion of residential institutions. On the other hand, two ordinances on 10th and 11th of April 2020 by Minister of Health and Social Protection, approved protocols about assuring undisrupted provision of services by emergency shelters for women and for all those working with most at risk children to continue their work during Covid-19 crisis.

4.2 LEGISLATION AND POLICIES DURING THE REOPENING PHASE

The first policies and interventions in the face of the coming pandemic were basically government decrees and Minister of Health Ordinances. Later during the preparation for the reopening phase, it was necessary to involve the Albanian parliament, on one hand to finalize the legal framework of the “Natural Disaster Emergency” and on the other hand, to introduce new harsher rules for longer-term control of infection. As the early measures of March and April were being gradually lifted, parliament approved changes in the penal code. On 16 April 2020, the Assembly introduced by urgent procedure two new Articles in the Criminal Code. These Articles sanctioned specifically “Non-compliance with the measures of the state authorities during the state of emergency or during the state of the epidemic” (Art. 242/a) and “Spread of infectious diseases” (Art. 89/b). Albanian Criminal law previously had a regulatory vacuum in both regards. These amendments allowed for heavy sanctions, of up to 8 years imprisonment in specific cases of deliberately breaking the quarantine and spreading the infection. In

addition, Parliament approved again on 15 July, the decision of Council of Ministers no 3 date 15.03.2020 “For extraordinary administrative measures during the period caused by COVID-19 infection, changed” (Law no 29 15.07.2020).

The Ministry of Health and Social Protection lead the process of developing the ‘normalization’ strategy. The Council of Ministers coordinated the process, as other Ministries were involved as well.

The strategy included the following principles: The gradual normalization of activities to be accompanied by extra sanitary measures to be kept in place during the phases. Health risk to prevail over economic rationale. The activities and businesses with the highest public health risk to be normalized the last. The health system to be prepared for all scenarios. Public health and epidemiology capacities for case finding and testing to be strengthened.

As of May 2020, the government put the de-confinement process in place to open the economy step by step, including the reopening of trade, retail and touristic activities under health and safety protocols and completely removing its curfew. On 1 June, Albania opened land borders with all neighbouring countries. As of 9 June, the number of new cases started rising, putting the reopening process into question. As the situation continued, on 19 June, the government announced an increased monitoring of the measures (keeping distance, wearing masks etc.) and a zero-tolerance policy towards those who fail to comply. On 23 June, the state of natural disaster ended, enabling public transportation to resume the next day. However, the government reiterated their statement, that there shall be a strict monitoring of the implementation of the measures. By middle July, Albania reached another high record of new COVID-19 cases in a day. In response to this, on 15 July, the government made the wearing of masks obligatory in closed environments. On 20 July, the government announced the closing of nightclubs, discos and lounge bars and a ban on music after 20:00 in all public facilities. Failure to comply with this obligation by operators is punishable by a fine of 3 million Leke and suspension of activity for a period of one year. In addition, it prohibited music after 20:00 in all facilities of any kind. Non-compliance with this obligation is punishable by a fine of 1 million Leke, and in case of repetition, the suspension of activity for a period of six months. From 1 June, beaches opened for hotels only, and from 10 June, for all tourists.

With the exception of pre-school education services in early June, schools and universities remained closed during all of 2020. The Minister of Education issued an order about the protocols to be observed in all categories of education in the country. The Ministry of Education and Sports has developed a range of televised school programs.

5 ANALYSIS OF THE REGULATORY FRAMEWORK ON HEALTH EMERGENCIES AND MEDICAL EMERGENCY SERVICES IN ALBANIA

More than 40 documents containing laws, bylaws, regulations, strategies, standards and protocols were included in the analyses. The analysis is presented in two sections; health emergency policies and medical emergency services. Nonetheless, this is only for operative purposes. As a matter of fact, it is impossible to provide a clean-cut division between the two concepts as many laws and regulations have covered them in an integrated way. In those cases, the document is described in the first or in the second section of the report based on the judgment of the author. Still, at the end of the two narrative sections, a structured matrix provides the integrated analyses of all pieces of legislation regulating health emergency in Albania.

5.1 REGULATORY FRAMEWORK ON HEALTH EMERGENCIES: ADDRESSING HEALTH EMERGENCIES IN ALBANIAN LEGISLATION AND POLICY DOCUMENTS

5.1.1 THE CONSTITUTION

Emergencies and natural disaster that threaten human life or health are mentioned around 15 times in the constitution, but no specific health measures are proposed in this context.

Article 26	Forced labour during states of emergency
Article 81	Approval procedures for state emergency
Article 84	Procedures for laws entering into force
Article 101	Normative acts during emergencies
Article 151	No referendums for emergency states
Article 170	Extraordinary measures during emergencies
Article 173, paragraphs 1,2 and 3	Extraordinary measures during emergencies
Article 174, paragraphs 1 and 2	Length of state of emergency
Article 175, paragraphs 1,2 and 3	Freedoms during emergencies

5.1.2 LAWS ON CIVIL EMERGENCIES

Within the last 20 years, the Albanian parliament has passed two laws to address the emergencies and disasters. The old law (no 8756/2001) 'On Civil Emergencies' is repealed by the new law (no 45/2019) on 'Civil Protection'. There is no a separate definition for 'health emergencies' in the law, while 'civil emergencies' are defined as situations created by natural, industrial, social (including war) which cause immediate and grave damage to life and health of citizens, among other damages. 'Disasters' are defined as serious interruptions of community life with potential loss of life. In fact, 'state of health emergency' is defined in the Healthcare Law (no 1010/2009) as an 'unexpected situation threatening the life, integrity and health of people or affecting the continuation of health institutions' (see below in the other section). 'Health emergency' is mentioned also in the new law on prevention of infectious diseases (no 15/2016) in the context of epidemics (see below in this section).

The organization of health structures and regulation of health care activities during emergencies are included in the Law on Civil Protection. The Article 22 (ministries and national institutions), part 3, paragraph 'd' of that law, requires the ministry responsible for health to assure the readiness of regional hospitals and health centres, as well as the full capacity of emergency care in terms of personnel, medicines etc. Additionally, in the third chapter of that law, article 32, paragraph ç and article 37, medical emergency care and other health care structures are included among operational civil protection structures in case of emergencies. Article 43 in chapter 5, lists hospitals, health centres and ambulances as 'critical infrastructure'.

The law has given specific powers and responsibilities to prefects of the regions in relation to emergencies. While the risk assessments and emergency contingency plans for municipalities are approved by city councils, the prefect is responsible for approving them at the regional level. Article 28 of the Law, defines the prefect role in emergencies as 'primary' and lists its specific powers in relation to emergency preparedness and management. Prefects of the regions can block budgets of the municipalities under their jurisdiction if no funds have been earmarked to disaster risk mitigation. They lead and coordinate all preparedness activities, including but not limiting to risk assessment, emergency contingency plan, monitoring and early warning systems, distribution of international aid in case of disasters, priority investments for risk mitigation and information management between local governments and other public structures.

5.1.3 LAW ON PUBLIC HEALTH

The law on public health (10 138/2009) includes preparedness, planning and mitigation measures for health emergencies among essential public health activities (article 5). Also, in article 9 the law includes the services for management of civil emergencies in the 'public health network' of institutions and services.

5.1.4 LAW OF INFECTIOUS DISEASES

The law on prevention and fight against infections and communicable diseases, known as Law No. 15/2016, has superseded a previous law enacted in 1993. This current law governs various aspects including the notification, reporting and response to health threats, preparedness response and planning, patient safety, antimicrobial resistance, cross border health threats, childhood vaccination, influenza vaccination, one health concept, and it also defines the responsible institutions for its implementation. This law refers frequently to 'emergencies', 'health emergencies' and 'public health emergencies of international concern'. The public health emergencies of international concern, are defined after the International Health Regulation 2005, which is a legally binding agreement, endorsed by Albania. The 'health emergency' is not clearly defined by this law, as it is the case of the civil protection law. Article 21, second paragraph, classifies epidemics as 'health emergencies'. The start and the end of an epidemic are officially declared by the Minister responsible for health after being informed by the Institute of Public Health (IPH). The public health emergencies of regional or international concern are also declared by the Minister of Health in collaboration with IPH. Other health emergencies are implied in the law, but not explicitly defined. The law on prevention of communicable diseases, in its chapter 4, in addition to 'biological threats', covers other serious threats of chemical or environmental nature.

Chapter 3, on 'responsible structures for infectious diseases control', describes the Institute of Public Health, National Epidemic Intelligence Service, National Service of Infectious Diseases, and Local Governments, but no specific reference is given to the role and position of primary health care. They are implied in the article 14, which states that all health providers under the Ministry of Health must know and report about infectious diseases in the territory they cover. Operator of Healthcare is a new health structure, set up after this law was introduced, and its role would need to be clarified in relation to responsible structures for infectious diseases control, including National Epidemic Intelligence Control, or specific issues such as information flow or vaccination.

5.1.5 ORGANIZATION OF EPIDEMIC INTELLIGENCE SERVICE

The epidemic intelligence service is based on the Law 15/2016 and operates on 5 levels of information flow:

1. General practitioners, specialists and laboratories (public or private);
2. Primary care and secondary care services (public or private);
3. District epidemic intelligence unit based within local units of health care (NJVKSH) (36 units covering 61 municipalities);
4. Participatory surveillance (NGO, community, etc.);
5. Institute of Public Health (Epidemic intelligence coordination unit).

All levels are centralized at the Ministry of Health and Social Protection:

There is a functional digitalized network for communicable disease surveillance reporting at the national level and district level, called SISI, including all health structures and public and private microbiology laboratories. This is an integrated digitalized system that includes reporting, case based and laboratory investigation, outbreak investigation, contact tracing, syndromic and event-based surveillance, developed and piloted in 2018, used for Covid-19 in 2020 and fully established in 2021. There are different specific case-based or laboratory-based disease surveillance for Hepatitis, CCHF, vaccine preventable diseases, zoonoses, respiratory diseases, etc. There are syndrome-based reporting systems such as for ARI, AFP, ILI and SARIs or rash and fever, etc.

All surveillance systems are integrated into one digitalized system based on a national guideline approved by IPH based on law 15/2016. IPH coordinates all surveillance systems in collaboration with the epidemic intelligence network service in local health care units.

5.1.6 CONTROL OF NOSOCOMIAL INFECTIONS

An updated protocol for prevention and control of infections caused by the health system is endorsed by the Ministry of Health and Social protection in January 2021. The document is an instrument for all health providers, including primary health care and emergency units to assure quality in service and minimize the risk of infection at the contact with the services. It has especially updated the measures related to Covid-19 infection control.

5.2 POLICY DOCUMENTS COVERING PREPAREDNESS ABOUT HEALTH EMERGENCIES

5.2.1 NATIONAL STRATEGY ON DEVELOPMENT AND EUROPEAN INTEGRATION

The National Strategy on Development and European Integration (NSDEI) is the major policy document of the Albanian state guiding progress and reforms in most fields. The new document (2021-2030) was approved only a few months prior to this report (February 2023) and it is the third update of the policy since when it started in 2007. In the chapter on civil protection and emergencies, some progress is acknowledged, especially the setting up of the National Agency of civil protection within the Interior Ministry.

The strategic objectives until 2030 include strengthening of national and local capacities of structures responsible for emergencies, developing a new national training structure for existing and future personnel, setting up a network of voluntaries, development of the National Plan for Emergencies and National Strategy for Risk Reduction. The preparation of the National Plan for Emergencies has been one of the unfulfilled objectives of the last NSDEI 2015-2020. One national plan on the subject was developed almost 20 years ago. Nonetheless, the working group for the new plan is already appointed and work has started in the second half of 2022.

Another strategic objective is the harmonization of standards and membership to European Union Civil Protection Mechanism.

Emergencies are covered in the NSDEI also under the health care system chapter. The 3rd strategic objective, 'the strengthening of the integrated health system' envisages, among others, the assuring national/regional preparedness and coordinated reaction in the face of health emergencies.

Interestingly, the previous NSDEI 2015-2020, shed lighter and gave a more detailed analysis on challenges concerning medical emergency services. There seems to be tangible progress about the major objective, namely 'the establishment of a National Emergency Service'.

Under the chapter 'Development of integrated social services' there is identified among priorities for the future, the transformation of residential services into community services, emergency care services, etc. There are no detailed models or actions about that priority.

5.2.2 HEALTH SECTOR STRATEGY

The new National Health Sector Strategy 2021-2030, was developed during the Covid-19 pandemic and reflects some of the experiences related to that context. There are 5 strategic goals (investment in health during all life cycles, universal health coverage, integrated care, preparedness in the face of emergencies, and digital health) and emergency response is one of them.

There is a large number of specific objectives, measures, and indicators in the policy while their structure is quite complex, but they can be narrowed into the following main priority actions of interest for the scope of this analyses

Policy Goal III – Integration of health care system:

- Strengthening the role and capacities of Primary Health Care services in response to emergencies;
- Policy Goal IV - Emergency Preparedness;
- Development of Plans of Preparedness for Emergencies at national and regional level;

- Development of measurable capacities, standards, procedures, and accountability for national health institutions which should be treated as part of national security;
- Supporting public health laboratories at IPH and NJVKSH to increase the capacities for testing and diagnoses during emergencies;
- Strengthening the National Centre for Medical Emergency Services, especially by increasing the fleet of ambulances for emergencies, the posts, and territorial coverage;
- Setting up a National Centre for Crises management and strengthening instruments of integration and coordination in the health sector during emergencies;
- Supporting the digitalized epidemiologic surveillance at all levels of the health system;
- Continuing to develop capacities for risk communication to the general public.

5.2.3 PLANS OF MINISTRY OF HEALTH FOR MANAGEMENT OF EMERGENCIES

Since 2011 Ministry of Health and Social Protection possessed a written General Platform or plan for the management of health emergencies and a full-time officer responsible for the monitoring and coordination. There were more than 10 specific documents supporting the 'General Platform', which were organized as a plan for the Ministry of Health to guide the preparedness efforts in the face of emergencies. The plan, which was approved by an ordinance of the Minister of Health (No 2584/2011), includes detailed descriptions and instruments about:

- Planning for disasters;
- Rapid health evaluation;
- Increasing capacities and skills;
- Chain of command and transferring of command during pandemics;
- Operational group for the management of disaster (GOMF);
- Standard procedures for GOMF;
- Coordination with different institutions and levels of the health system;
- Coordination between GOMF and National Mechanism for civil emergencies (DPEC);
- Alert management and prompt activation of health services;
- Procedures of response in an emergency;
- Management of the information system;
- Regulation of financial procedures in case of a civil emergency;
- Evaluation of the disaster and the capacities for response.

Similar general plans for hospital response in case of civil emergencies have also been approved by ordinances of the Minister of Health (No 2276/2010 and No 4137/2011). There are also several specific documents, including some guidelines and protocols for preparedness and risk assessment in case of 'chemical disasters', 'haemorrhagic fevers', 'meningitis', etc., which are related to the 'General Platform' but not part of the main document. The plan of response for the Influenza pandemic is another document developed by the Institute of Public Health in 2018 and covers preparedness and response in relation to a potential influenza pandemic.

Following the approval of the new Law 'On Civil Protection' (no 45/2019) and in compliance with Article 14 (paragraph 8) and Article 22 (paragraph 2. a), the Ministry of Health and Social Protection developed and approved an 'Operation Plan for all Emergencies' (Ordinance no 71, 05/02/2020). The new Plan for Emergencies was approved right before the Covid-19 was declared a pandemic by the World Health Organization and the first cases were reported from Albania. The operational plan is expected to be used by all health institutions to facilitate the processes of institutional emergency plans. The new Plan for Emergencies is developed in line with the new national System of Civil Protection and covers all relevant issues, including:

- Preparedness for emergencies (responsibilities, main actions, surveillance and monitoring, contingency plans);
- Alert and early warning systems, risk rapid assessment, and setting the phases of response;
- Response to emergency – The system of incident management (SMI). Operational Concept 1 (KO1), Local level. Operational Concept 2 (KO2), Regional level. Operational Concept 3 (KO3), National level;
- Phasing out the emergency response;

- Transition towards recovery.

The Plan for Emergencies of 2020 states on page 18 that it does not repeal but operates in coordination with the above-mentioned General Platform for risk and disaster management and the protocols for rapid risk assessment.

The document encloses a detailed analysis of emergency risk in Albania and lists statistics and prior experiences with various emergencies, which may have an impact on the health of the population.

It also describes the position of the Ministry of Health and Social Protection in the context of the national structures responsible for civil protection. The emergencies are categorized as 'local', 'regional', and 'national'. For each of those potential situations, organizational schemes are described, with health sector agencies position in relation to other civil protection structures. Intra-sectoral structures are also presented in the case of surveillance and monitoring of risks (i.e. Institute of Public Health with Veterinary and Food Safety Authorities).

While at the national level, responsibility for emergency response lays over Ministry and national agencies, at the regional and local levels the main stakeholders are Regional Operators of Healthcare and NJVKSH. At all those levels, specific 'commissions for planning and coping with civil emergencies' should be built, along with 'operational groups for public health emergency response'. Those commissions and operational groups function in accordance with a Decision of Council of Ministers No 965 of 2nd December 2015.

The role of health facilities of primary health care system is not explicitly described but is implied under the role of regional operators and NJVKSH. The Plan defines the key positions at national, regional, and local levels; 'medical officials' and 'medical managers' for emergencies. Officials are the Minister/deputy minister, director of regional operators, and director of NJVKSH. They appoint managers at each level.

Recently, in response to the emergency from Covid-19 pandemic, the Ministry of Health and Social Protection has approved a number of policies;

- Action plan against Covid-19 pandemic;
- Strategy of the Reopening health care system;
- Action plan for the period autumn-winter 2020-2021;
- Vaccination plan;
- Plan for the 2022-2023 phase of pandemic.

These documents were analysed in more detail in the section above about pandemic policies and measures. Although they are specifically developed to guide actions and measures in the face of the Pandemic, they may also serve as future preparedness documents at the national level.

5.2.4 CLIMATE CHANGE PREPAREDNESS POLICIES

Albania has developed and approved by the Minister of Health ordinance (No 3989/2011) the Strategy for the Health System Adaptation to the Climate Change. Among its seven priorities, there are included two pertinent to the scope of this analysis:

- Better integration of the health system into the national emergency structures responsible for floods, fires, landslides and heat waves;
- Equipment of emergency and primary health care facilities with appropriate quality standards and infrastructure, as well as training of emergency care specialists, primary health care doctors and nurses on emergency management during heat waves/other extreme weather events.

In that strategy, there are also included priorities about integrated surveillance of infectious diseases and health information in general. The plan has triggered some action at the national level, but it is hardly known or applied at health provider level.

Another document with interest in the field of emergencies is the '*Regulation for radioactive emergencies*'. It was developed by the National Radiation Office at the Institute of Public Health in 2017 and approved by the Council of Ministers. It includes preparedness, risk assessment at population level and personal level, as well as measures for control. The role of physicians is described in terms of identifying

the signs of radioactive poisoning, alerting the system and coordination with regional and national actors.

5.3 REGULATORY FRAMEWORK ON MEDICAL EMERGENCY CARE

5.3.1 HEALTHCARE LAW

Healthcare Law 10107/2009 defines ‘the medical emergency’ as a condition or acute illness, which constitutes an immediate danger for the life of the person or its health in the future.

Article 11 in the Healthcare Law (amended in 2019) states that emergency medical services include clinical and pre-hospital services for cases when the life of an individual is in danger. The need for the emergency care, according to this law, ends when the health condition is stabilized or when the patient is admitted to hospital.

Healthcare Law gives the most complete definition of a ‘State of Health Emergency’ in Albanian legislation. It dedicates a full chapter to regulations and responsibilities during situations of health emergencies. The Ministry of Health should develop plans, preparedness mechanisms and early warning systems. The National Plan of Health Emergencies is defined by this law as the bases for all collaborations between institutions during emergencies.

5.3.2 EMERGENCY MEDICAL SERVICE LAW

Law (no 147/2014) on emergency medical service in its articles 5, 6 requires those services to be provided during 24 hours at all levels of the national health system, including primary health care.

Articles 7-9 regulate the National Centre of Medical Emergency Care. It is the responsible institution for development of the services of medical emergency (direct provision of first aid, coordination and prioritization of phone calls over all national territory, training of medical and non-medical personnel, transport, reporting and information system, quality assurance, emergency services during disasters, etc.). Article 10 defines the check and command systems together with the unique national phone line.

Article 11 defines the collaboration of emergency medical services with other key stakeholders including police, firefighters, Red Cross, etc. The collaboration exists at multiple levels; in the case of individual cases in the territory, in the case of civil emergencies, etc.

Article 12 regulates emergency care exclusively at primary health care. Selection of health centres where service is provided, as well as related standards (infrastructure, equipment, personnel), are regulated by the Minister responsible for the health sector. Local governments, ‘in collaboration with local health structures’, are responsible for the provision of emergency care at the primary care level, as defined by this article, but not specific responsibilities are mentioned. Essential services at primary health care include: prompt reaction to the calls, provision of first aid, and treatment of patients on the scene of an accident.

The law in its articles 5, 6 and 11 refers to ‘health and civil emergencies’ although no definition is given for them. The Medical Emergency Service provides ‘first aid’ and ‘specialized medical care’ during health and civil emergencies. At all its levels it collaborates with other structures with a role in emergencies, including General Directory of Civil Emergencies, Police, Fire Department, Red Cross, etc. during of civil emergencies. Article 5 mentions the need for a National Plan of Health Emergencies and institutional plans for emergencies as a base for coordination during civil emergencies.

There seem to be some gaps in the legislation about relations of primary health care centres operating 24 hours 7 days a week, with National Centre of Emergency Medical Services. While there is a short reference in article 14 (The service of hospital emergency care), which regulates coordination of medical emergencies between hospitals and the National Medical Emergency Centre, there is not such a clarification in the law for the emergency care at the level of 24/7 health centres. Also, the system of check and command as described in article 10, does not specify the position of primary health care providers in the medical emergency system.

Paragraph ‘dh’ in article 8 (Responsibilities of National Centre of Medical Emergency Services) states that emergency medical service is assured to ‘all’ patients who ask for it, without specifying the range

of services. For instance, does the centre assure the totality of emergency care, including hospital emergency care or only pre-clinical emergency services?

Finally, this law gives a slightly altered definition of ‘emergencies’ (urgjenca in Albanian) compared to that given by the Healthcare Law which talks about ‘medical emergencies’ (urgjenca mjekesore in Albanian), which may create some confusion in the English version of the text, where the same term (emergencies) is used for medical emergencies and for civil or health emergencies.

5.3.3 HOSPITAL CARE LAW

According to hospital care law 55/2022 (article 15, referring mechanisms) patients are directed to hospitals in two ways; either as medical emergencies, or by means of referring from a lower level of the health system to a higher level. The medical emergency care is provided to all residents in Albania, including foreign citizens, irrespective of their health assurance status.

5.3.4 LAW ON SOCIAL CARE SERVICES

The Law on social care services in the Republic of Albania (no 121/2016) includes the concept of emergency situation and may affect the PHC services in the context of the recent introduction of integrated social and health care.

Emergency situation in this law is defined as a critical, whether or not temporary, situation created by social factors which cause or might cause immediate, serious harm, or which are seriously harmful to life, health or well-being of the person unless emergency and preventive measures are taken.

Article 7 lists among categories not entitled to social care services, ‘the Albanian citizens, aliens or stateless persons who need emergency assistance, because of natural disasters and wars’. They are supposed to be covered by social services in emergency situations described in article 8. The role of structures responsible for assessment and referral on the emergency situation is described in article 18. Treatment of children in emergency situations is coordinated by social workers of local government. No specific role is given by the law to primary health care professionals, including psychologists or social workers, operating at that level. In fact, the new reforms aiming at integration of care (health and social care) at PHC level necessitate clearer legislative mechanisms for collaboration or referral of cases between institutions (for instance health centre and municipalities).

The referral pathway in the health system is defined in the Healthcare Law (10107/2009) and the Ordinance of the Minister of Health and Social Protection ‘On referral system and tariffs in public healthcare’. (493/2019). The existing legislation has a vacuum about referral of patients between health and social systems of care.

5.3.5 REGULATION OF NATIONAL EMERGENCY MEDICAL SERVICE

The regulation of the National Emergency Medical Service is developed in 2018. It is approved by the Director of National Centre of Emergency Medical Service, but there is confusion in the document about National Emergency Medical Service and National Centre of Emergency Medical Services. Most of the document seems to be a regulation limited to the agency, rather than fully covering all national levels of the service. The first five articles are adaptations from the Law of Medical Emergencies. In article 4 of the regulation, ‘health centres in districts’ are listed among other ‘specialized structures’ such as hospitals. The same article in the regulation seems to be almost the same as the article 8 in the Law. Paragraph 5 of that article has been adapted; the medical emergency care is provided for all persons in pre-hospital level.

5.3.6 STANDARDS OPERATIONAL PROCEDURES (SOP) AND CLINICAL PRACTICE PROTOCOLS FOR HEALTH EMERGENCIES AND MEDICAL EMERGENCY CARE

A detailed document with clinical protocols and organizational elements is approved by the Minister of Health and Social protection in December 2022 (Ordinance No 189/7 16.12.2022). These SOPs and protocols basically serve for the National Emergency Medical Service at hospital level and their coordination with the National Centre of Emergency Medical Services. Primary health care centres 24/7 are

not mentioned in the document and there is not a single reference about applying protocols, medicines, technology, and even coordination in primary health care. In the Annexes, when describing the ‘organization of emergency services’ again only hospitals are mentioned.

5.3.7 INFORMATION SYSTEM OF MEDICAL EMERGENCY SERVICE

The emergency care information system (hotline) is an electronic tool designed to improve operational efficiency by assisting coordination and management of the patients. The system is in place under the national centre of emergency medical services. There is a potential to develop additional services such as telemedicine care attached to the hotline 127. Data gathered in the system from incoming calls can also be linked to the national information system.

5.3.8 NATIONAL PLAN OF HOSPITALS

National Plan of Hospitals approved by a government decree on February 2023. It has a chapter dedicated to medical emergency care. A priority in this field is the strengthening of pre-hospital emergency care, which is not limited to modernization of ambulances fleet, but also to training and continuous education of the paramedical personnel. Also, a priority in the plan is continuous improvement of the coordination centre. A specific project on Vlorë back up coordination centre is under way and the new centre is planned to be finished within 2025.

5.3.9 PACKAGE OF SERVICES AT PHC

The Basic Service Package of Services at Primary Health Care was developed in 2015 and approved by a Government decree (No 101/2015). It was upgraded in 2018 and approved by the Government decree no 352/2018. The package is a key instrument that provides the necessary range of services at the PHC level for the entire population. There are seven categories of services included in the existing package, from emergency care to health promotion and education. The package does not specify services provided at health posts or health points (ambulances) implying the same standards of services as for health centres. All health centres are committed to providing integrated services in the package, although they have variable capacities, skills staff, and access to laboratory tests. ‘Healthcare in emergencies’ is the first category of services listed in the package. Health centre should provide first aid, referral and transport in case of medical emergencies as well as in the situation of natural disasters. The emergency service can be provided in direct contact or online, in health centres operating continuously 24 hours a day, or those operating 8 hours a day. The so called 24/7 health centres are assigned by the Ministry of Health and Social Protection in collaboration with the National Fund of Compulsory Health Insurance. The service also can be provided outside the health centre. Medical emergencies include a wide range of conditions, from physical traumas to heat shock, from choking to febrile seizures, from cardiac arrest to psychiatric emergencies. The category also includes education of patients on prevention of accidents or infections. Among skills and competencies family doctor should have, is implementation of ‘principles of medical care during mass accidents and disasters’. Within that category of services are described also the services of health risk evaluation in the frame of routine regular check-up. The skills and competencies required for the nurse are similar to those for the physician and even include some extra services such as management of cases of family violence.

A shorter list of services with most common medical emergency cases to be treated at the health centre is included in one of the annexes of the package. In that list are included:

- Initial management and stabilization;
- Asthma attacks;
- Angina pectoris;
- Fractures;
- Wounds.

Another annex in the document lists medicaments and equipment, including those for emergency care, a health centre should have.

The decree approving the package of services does not assure the quality standards of service provision. It is not clear however, to what degree the ‘essential services’ listed in the package are offered to the public. The contract of health centre with the Health Insurance Fund (see below) refers to the Basic

Service Package as a base for the services to be provided. The contract includes the 'Package' as an Annex.

5.3.10 QUALITY STANDARDS FOR ACCREDITATION OF PRIMARY HEALTH CARE PROVIDERS

The most recent update of the quality standards by the National Centre for Quality, Safety and Accreditation of Healthcare Institutions is done in 2021 (approved by Ordinance of Minister of Health and Social Protection No 35 22/01/2021). There are essential/compulsory standards to be fulfilled 100%, optimal standards to be fulfilled 70% and standards of the future to be fulfilled 40%.

Health emergency service has only one essential standard, and it concerns only 24/7 health centres. Those centres should guaranty a functional emergency service by assuring the presence of 'qualified personnel' '24 hours per day'. The 'number of personnel' should be appropriate to 'the expected flux' of patients. The criteria is applied to all primary health care centres, but may be fully matched only by 24/7 health centres. Other health centres may only partially achieve it.

The optimal standards for emergency services include appropriate training of physicians and formal contract for transporting of patients. Training should include especially first aid, stabilization of patients and referral to specialized care. A plan for continuous training is required. Nurses are not specifically mentioned in the standards, although as mentioned above, according to the Package of Services at Primary Health Care, nurses should provide a similar range of medical emergency care as the physicians. The formal contract about transporting of patients should make sure that there is an ambulance available when it is needed and it is equipped with a list of necessary equipment.

The 'standard of the future' for that category of services is having an emergency plan for treating many patients at the same time, as in the case of natural disasters. The plan should allow the health centre to remain functional and efficient in emergency situations. Minimally, it should include contingency plans for substitution of missing or exhausted personnel and list of specialized care institutions for referral of cases.

The standards are in use and almost all 24/7 primary health centres are accredited. The completion of the requested files is in process by some centres. The 24/7 component of health centres is not uniform for all of them. In some of the facilities, like in the case of health centre no. 8 in Tirana, the third shift is regulated by an ordinance of the Minister. The National Agency for Quality and Accreditation reports that 24-hours services are being accredited separately.

5.3.11 STATUTE OF HEALTH CENTRES

The most recent 'Statute' of health centres in Albania was approved by an ordinance of the Minister of Health and Social Protection on 13 July 2022 (no 413). This ordinance repealed the version issued in 2019 (no 389/2019) after the introduction of the Operator of Health Care and also the first version approved in 2014 (no 534/2014). The new statute clarifies the position of the health centre as a public institution under direct supervision of Local Units of Health Care (NJVKSH). It should comply with regulations and guidelines approved by the Operator of Healthcare and Health Insurance Fund.

In addition to traditional health centres, the new statute of 2022 has clearly defined for the first time three new models of primary health care centres; 'socio-health centres' which provide 'integrated care', '24/7 health centres' which provide '24 hours emergency health care' and 'health centres of specialities', which provide among others, laboratory, imaging and rehabilitative services. The 24/7 health centres are divided into type A and type B categories according to size of catchment, human resources they have and the access to national road networks.

Interestingly, the 2019 statute in its article 3 listed in the third paragraph the services provided by health centre and there it was not mentioned at all the medical emergency care. In an earlier paragraph, the same article states that the health centre provides primary health care services in accordance with an essential package of services. The discrepancy may have created confusion for the delivery of emergency health care, especially during the monitoring or accreditation of the services. The new statute of 2022 fills the previous gaps and avoids any confusion by providing detailed description about the level of emergency care at each of new categories of health centres and ambulances. The 'health centre of

specialities' is the only type not to have emergency care among their services. All other categories of health centres are required to provide some form of emergency medical care. The table below describes in detail the level of emergency care to be offered at every type of PHC facilities according to their newly established categorization. Type A 24/7 health centres are the only ones deemed to have emergency service with beds. Type B 24/7 health centres and Type B ambulances should only offer 'nurse level' emergency care (according to protocols). Nonetheless, the detailed differences in level of care are not included in the statute. Neither are they described in standards of care analysed above. Protocols of emergency care are yet to be developed.

Table 1: Medical Emergency Services and the Categories of Health Centres

PHC FACILITY CATEGORY	PROVISION OF EMERGENCY CARE	LEVEL OF EMERGENCY CARE	RESOURCES
Health centre (Base)	Yes	First aid in medical emergencies	Physician and nurse
Ambulance Type A	Yes	First aid in medical emergencies	Physician and nurse
Ambulance Type B	Yes	First aid in medical emergencies, but only at nurse level (according to protocols)	Mainly nurse
Socio-HC	Yes	First aid in medical emergencies	Physician and nurse and psychologist
24/7 HC type A	Yes	Service with beds. At physician and nurse level	Physician and nurse
24/7 HC type B	Yes	Nurse level emergency care	Physician and nurse
HC of specialities	No	NA	Specialist, GP and nurse

Distribution of specific services according to typology of health centres as regulated in the Statute, is presented in the matrix below. 24/7 Type A health centres are expected to provide all possible PHC services (especially when they are simultaneously designed as socio-health centres and can provide psycho-social care. They are the only PHC facilities with clinical and biochemical lab facilities. 24/7 type B centres may provide all the services included in the Type A with the exception of any laboratory, imaging or physiotherapy.

Table 2: Services according to typology of health centres

PHC SERVICES	HEALTH CENTRE BASE	AMBULANCE TYPE A	AMBULANCE TYPE B	SOCIO HEALTH CENTRE	24H/7 TYPE A	24/7 TYPE B
Child and reproductive care	Yes	Yes	Yes	Yes	Yes	Yes
Adult health care	Yes	Yes	Yes	Yes	Yes	Yes
Older people health care	Yes	Yes	Yes	Yes	Yes	Yes
Mental Health care	Yes	Yes	Yes	Yes	Yes	Yes
Home care	Yes	Yes	Yes	Yes	Yes	Yes
Health education	Yes	Yes	Yes	Yes	Yes	Yes
Emergency care	Yes	Yes	Yes	Yes	Yes	Yes
Infectious diseases surveillance	Yes	Yes	Yes	Yes	Yes	Yes
Check up	Yes	Yes	Yes	Yes	Yes	Yes
Vaccination	Yes	Yes	Yes	Yes	Yes	Yes
Basic Clinical laboratory	Yes	Yes	No	Yes	No	No
Clinical and biochemical	No	No	No	No	Yes	No
Basic Imaging	Yes	Yes	No	Yes	Yes	No
Physiotherapy	Yes	Yes	No	Yes	Yes	No
Psycho-social care	No	No	Yes	Yes	No	No
Community integrated care	No	No	No	Yes	Yes	Yes

The Statute regulates reorganization of the services in population to cover lack of personnel or address absenteeism. Nonetheless, the powers of the Director of the health centre are very limited and in all cases, permission or authorization from the Regional Operator of Healthcare is required. Also, a health centre cannot keep medicaments or equipment other than those in the package of essential primary health care services, without permission from the Operator of Health Care.

In the document are stated the territorial organization of primary health services, the continuous training requirements and the working hours of the personnel during 6 days of the week without specifying about organization of 24/7 health centres. The Minister of Health is responsible for territorial distribution of health facilities, as well as standards of infrastructure, equipment and human resources for emergency care at primary health centres, after planning from Health Care Operator (article 6, paragraph 3). The number of inhabitants registered at one general practitioner should comply with standards approved by the Operator.

There are 31 health centres 24/7 type A and B approved by Ministry of Health Social Protection. It seems that newly designated 24/7 health centres are being established over the existing PHC centres which have been functioning for past decades as emergency care facilities.

The role and responsibilities of the Director of the health centre are outlined in the statute, but other essential positions such as those of the Head nurse are not specified.

For the time being, the directors of 24/7 health centres are trying to make use of an article in the statute which allows a form of pooling of resources from all PHC centres in the area/region, where the 24/7 emergency service is being provided. Key informants underline the fact that their resources are limited, and night shifts put them under serious strain. A rotation system extended to physicians from other neighbouring health centres would spread more fairly the burden.

A health centre is required 'to accomplish standards approved by the Ministry of Health' without specifying the standards and without specifying repercussions in case of non-compliance with standards. In another paragraph, the health centre is required 'to work for accomplishing of the accreditation standards' again without elaborating more on the mechanisms for assuring the standards of the service.

Health centres have already developed detailed 'regulations' for their institution, and Operator have assisted them in the process by providing 'formats' for each category of PHC facility.

There are no explicit references to civil disasters or emergencies in the statute, but all health categories of health centres have to provide appropriate service in case of epidemics.

5.3.12 HEALTH CENTRE CONTRACT OF SERVICE

The contract of service between the health centre and regional branches of the Health Insurance Fund is signed every year by the Director of the health centre and is the base for financing of the services. After the year 2019, the contract is signed also by the Regional Operator of Healthcare. The contract is formulated based on 57 pieces of laws, bylaws and ordinances and the format is approved periodically by the Administrative Board of Health Insurance Fund.

This document is one of the most important legal frames to assure the provision of the services, as one of the few legal frames with direct and clear consequences for the personnel of the centre.

The contract includes indicators of performance as well as several specific requests and restrictions, which are systematically monitored by the Health Insurance Fund.

The responsibilities of physicians and nurses of the health centre are clearly described in the contract. For the first time in the contract of 2023, there are listed in a separate article the general tasks of social worker/psychologist of the health centre. The document states that medical services should be provided in quantity and quality according to package of essential services (annex B) and several others specific requirements as described in the contract.

Among many annexes of the contract, there are detailed lists with indicators of services and indicators of performance. No indicators related to medical emergency services are included.

There is a particular format of the contract signed between 24/7 health centres and the Health Insurance Fund. In addition to the services, those centres are required to provide service 24 hours a day for 7

days of the week for residents of the catchment area. Under the contract, the health centre may force their doctors to work in the emergency unit of the local hospital when requested by the Regional Operator of Healthcare.

5.3.13 STRATEGY OF PRIMARY HEALTH CARE

The National Plan for Primary Health Care was approved with a decree of Government no 405 in 2020. It does not include medical emergency care among priorities but underlines the need for improved long-term postgraduate training programs for general practitioners and family doctors, and the development of training modules for new skills such as medical emergencies. It is planned an upgrade of the education quality during the specialization in Family Medicine. Interns are expected to take care of patients in internal medicine and emergency medical care. They should spend 1 year of clinical experience in internal medicine, 6 months in emergency care and 1 year in Family Medicine care. Regular training for family doctors on medical emergencies is planned to be delivered in cooperation with the National Centre for Medical Emergency and the new University Centre of Family Medicine.

Policy no 4 of the Plan focuses on PHC information system. It acknowledges problems such as lack of data or poor validity in certain areas, or low use of data analysis. Most data is required by and reported to the Insurance Fund, while the Operator of Healthcare and Institute of Public Health receives other data in different formats. Rarely do health centres receive feedback on the relevant outcomes of the shared information, and rarely do they use the information to assess the community's needs or to plan. The strategy foresees the re-conception of the object, template, and reporting pathways for most of the existing information systems.

5.3.14 GUIDELINES/PROTOCOLS DEVELOPED DURING THE PANDEMIC FOR REFERRAL OF CHRONIC PATIENTS TO SPECIALS CARE

There are statistical data about a significant decrease in utilization of some health services during the 2020 pandemic year. These data are confirmed by healthcare providers who report among main reasons for the decrease, care provision disruptions, and increased perceived risk during utilization of care by the public.

Health providers at PHC and representatives of Operator of health care informed about a package of essential services for non-communicable disease in the emergency situation caused by the Covid-19 pandemic. The documents were issued in May 2020 by the Ministry of Health and Social Protection. In the package are short protocols to be followed by general practitioners and family doctors for referral in case of:

- Cardiovascular diseases;
- Cancers;
- Diabetes;
- Respiratory diseases;
- Kidney conditions and dialyses;
- ORL related conditions;
- Dermatology related conditions;
- Neurological conditions;
- Eye conditions.

The protocols, which are concise and not more than 1 to 2 pages long, aim to regulate the flow of patients from PHC clinic to specialists. Besides infectious control measures, they provide specific and detailed clinical criteria to prioritize patient categories or situations in which a patient should be referred to higher levels of the health system. Although not in use anymore, these instruments may be adapted for routine application at PHC settings.

Doctors report other instruments used during emergencies to assure the continuation of care and minimization of nosocomial risk. The two main recommendations have been:

- online communication with patients in need; and
- application of triage to prioritize the services during peak hours.

There has not been applied centralized system to facilitate clinical data collection about chronic conditions among Covid-19 patients or about long Covid.

5.3.15 REGULATION FOR ORGANIZATION AND FUNCTIONING OF HOME CARE

This document is endorsed very recently by the Ministry of Health and Social Protection in its efforts towards integrated care at PHC level. It covers the home care for chronic patients in advanced state of disease, who have special needs and difficulties in activities of daily living. It is not directly linked to medical emergency care, but 24/7 health centres are designated as centres of integrated care and are expected to adapt their services to the new context. Coordinator of care at the health centre is a new position in PHC, and according to the regulation, will take a leading role in the home care. Evaluation of needs is standardized by means of a scale (Karnofsky scale). Coordination with Municipality social services is regulated through referral to the unit of needs evaluation and referral.

5.3.16 REGULATION OF 24/7 HEALTH CENTRES

The new regulation of individual 24/7 health centres was developed during the second half of 2022 by regional operators of health care in collaboration with directors and staff of health centres. It does not add many essential elements, which are not already included in the 'contract of service' with Insurance Fund. In article 6 are listed 8 essential services, starting with 'care in cases of emergency'.

The regulation includes the organizational chart of the centre as an institution, quality improvement mechanisms, work ethics, maintenance, management of complaints and absenteeism. It describes as well, the detailed tasks for all the positions of the technical and administrative staff. In addition to directors' tasks and responsibilities, those for general practitioner, nurse, head nurse, lab technician and so on are included.

The director of the centre is responsible for setting up a special board on emergencies, which should develop the centre's emergency plan and notify the personnel about tasks, coordination, and so on. It is also the director's responsibility to coordinate and divide tasks for doctors in terms of providing medical service 24 hours a day, seven days a week. Nurses are not mentioned as part of the medical emergency service.

Table 3: Logical matrix for health emergencies regulation analyses

REGULATION	CATEGORY OF REGULATION: LEGISLATION, PLAN, STANDARDS ETC	HEALTH SECTOR ONLY OR INTERSECTORAL	EMERGENCY MEDICAL CARE	HEALTH EMERGENCY MANAGEMENT	PRIMARY HEALTH CARE ROLE	IMPLEMENTATION EXPERIENCE	GAPS, DISCREPANCIES, INCONGRUENCE	PARTICULARITIES
Constitution	Special law approved by 2/3 of parliament	Intersectoral	No	Yes	No	Most of the specific laws issued make direct reference to the constitution	NA	15 articles of the constitution cover emergencies/disasters
Civil protection Law (No 45/2019)	Law	Intersectoral	Not specifically mentioned	Yes	Mentioned but not specific responsibilities	Under implementation. Proved a key legal frame and tested during recent disasters. New structures are being built	No definition of 'Health emergency'. Only 'civil emergency' and 'disasters' defined.	Minister of Health is responsible for preparedness of health structures. Prefects have a 'primary' role in regions.
Public Health Law (no 10 138/2009)	Law	Mainly health sector with few intersectoral elements	Not specifically	Yes	May be implied under the 'public health network of services'	Not among important laws used during emergencies	Medical emergency care is not mentioned among public health activities	Health emergencies' related measures are essential public health activities
The law on prevention and fight against infection (No 15/2016)	Law	Mainly health sector but with important intersectoral effects	Not specifically mentioned	Yes; 'emergencies', 'health emergencies' and 'public health emergencies of international concern'	Not specific reference but their role in information and reporting is implied	Key legislation used during pandemic and other public health emergencies	Epidemics are classified as 'health emergencies' but both not clearly defined. Operator of Healthcare created after the law and its role in relation to 'responsible structures for infectious diseases control must be clarified	'public health emergencies of international concern', is defined after the International Health Regulation 2005 and declared by the Minister of Health after being informed by IPH
Protocols for digitalized surveillance of infectious diseases	Instruments developed and approved by IPH	Health sector. Public and private	Some individual episodes (for example, child infections, pneumonias, meningitis, etc.) may be medical emergencies and need to be treated as such.	Yes	PHC providers are key in identifying, managing, referring and reporting of cases	Key instruments regulating the surveillance of infectious diseases. Proved effective and important during pandemic	Continuously adapted to the situation	Includes case-based reporting, laboratory, and outbreak investigation, contact tracing, syndromic and event-based surveillance
Protocol for prevention and control of infection caused by health system	Protocol developed by University hospital and approved by the Minister of Health	Health sector	To be applied at all health care providers including emergency medical services	Measures to be followed for risk mitigation during epidemics	Yes	During 2021-22, health centres have been supported to develop structures and plans	No specific measures for 24/7 health centres	Explicitly includes PHC services, despite acknowledging the lower risk in PHC settings

REGULATION	CATEGORY OF REGULATION: LEGISLATION, PLAN, STANDARDS ETC	HEALTH SECTOR ONLY OR INTERSECTORAL	EMERGENCY MEDICAL CARE	HEALTH EMERGENCY MANAGEMENT	PRIMARY HEALTH CARE ROLE	IMPLEMENTATION EXPERIENCE	GAPS, DISCREPANCIES, INCONGRUENCE	PARTICULARITIES
National Strategy on Development and European Integration 2021-2030	Strategy approved by Council of Ministers	Multisectoral	No.	Yes, emergencies are covered in the NSDEI also under the health care system chapter	Not specifically identified	Only recently approved.	The previous NSDEI 2015-2020, had more focus on health emergency medical services	Developing a new national training structure and setting up a network of volunteers are among priorities
Health Sector Strategy 2021-2030	Strategy approved by Council of Ministers	Health sector with some intersectoral dimensions	Yes. Increasing the fleet of ambulances, the posts and territorial coverage	Yes. A full major Policy Goal is dedicated to emergency preparedness.	Yes. Strengthening the role and capacities of PHC in response to emergencies	It is beginning to guide the actions of stakeholders	No specific actions planned for 24/7 h health centres	Among 7 priorities of emergency preparedness: Measurable capacities, standards, procedures and accountability
Operational Plan of Emergencies (2020)	Plan approved by the Minister of Health	Health sector. Also included guidelines about working with local authorities	Yes. The role of medical emergency services is described	Yes. A set of guidelines for emergency preparedness in health sector institutions	There are specific structures for health sector response in case of civil emergencies but the role of primary health care is implied under Operator of healthcare and NJVKSH	Not clear description for primary of roles for health centres and 24/7 health centres	Roles and responsibilities for PHC and especially the 24/7 health centres are not provided.	A large set of guidelines to facilitate the health sector preparedness at Ministry or Hospital Level but no clear role for PHC emergency services.
Healthcare Law (No 1010/2009 amended in 2019)	Law	Health sector only	Yes. It provides the legal definition to the medical emergency	Yes. Responsibilities and roles in case of 'state of health emergencies' are defined	The law describes clinical and pre-hospital services	It is a major legislation frame for the health sector regulation and organization	There is no direct reference in the law to PHC in the context of emergency medical services	The amendment of the law in 2019 constitutes a legal basis for the introduction of standards of health care and clinical audit
Emergency Medical Service Law (No 147/2014)	Law	Health Sector with some intersectoral implications	Yes. It is the main legal framework regulating the medical emergency services	Yes. Emergency medical services role and responsibility during civil emergencies are made clear in the law	Yes. Primary health care emergency services are covered by this law	Law is considered as a successful development of the National Medical Emergency System	The role of local governments, although implied, is not clear. PHC providers are mentioned but their relation with National Medical Emergency Centre not fully clear	The emergency care hotline 127 is part of the law. The law requires for a large number of standards to be approved by the Minister of Health, in relation to various aspects of service provision.
Hospital Care Law (No 55/2022)	Law	Health sector	Yes	No	In the context of patient referral	Marginal	NA	Not an important law related to medical emergency care
Law on Social Care Services (No 121/2016)	Law	Social protection	Only emergency situations in social context	Only in the context of regulating emergency social assistance created by 'natural disasters and wars'	No reference	Regulates social protection services only, and it is not used in healthcare services.	Health system and social system remain separate and this law or Healthcare Law provide no bases for facilitating the introduction of integrated care	Not a single reference to health institutions is made in the law

REGULATION	CATEGORY OF REGULATION: LEGISLATION, PLAN, STANDARDS ETC	HEALTH SECTOR ONLY OR INTERSECTORAL	EMERGENCY MEDICAL CARE	HEALTH EMERGENCY MANAGEMENT	PRIMARY HEALTH CARE ROLE	IMPLEMENTATION EXPERIENCE	GAPS, DISCREPANCIES, INCONGRUENCE	PARTICULARITIES
Regulation of National Emergency Medical Service 2018	Regulation approved by director of National Centre of Emergency	Health Sector. Medical Emergency Service	Yes	Yes	'Health centres in districts' are listed among other 'specialized structures' such as hospitals	Serves as a regulation or statute of the national Centre of Medical Emergencies	No explicit details about the check and command between the Centre and PHC facilities	A detailed set of rules for the functioning of the National Centre of Medical Emergencies instead of the whole National Service
National Plan of Hospitals (2023)	National Strategy approved by Council of Ministers	Health Sector	Yes.	No	No.	Just approved, and it is expected to lead the reforms of hospital system reorganization and autonomy	Although strengthening of pre-hospital emergency care is a priority, the focus remains only on paramedical personnel	Vlora Coordination Centre, planned to be completed by 2025
Package of services at PHC (last update 2018)	Service Standards approved by Council of Ministers	Health sector, specifically PHC	Yes. There is a detailed list of conditions to be treated at PHC and competences required for the care provider	Yes. Healthcare in disasters' is the first category listed in the package	Yes. It is a document focusing exclusively on PHC centres	It is a key legal reference for contracts of services between each HC and the Assurance Fund	Not clear about services to be provided at ambulances. No specific services, equipment or competencies mentioned about 24/7 HCs	Comprehensive lists of emergency medical situations to be treated at PHC as part of universal care covered by the Insurance Fund
SOP and clinical practice protocols for medical emergency care	Service standards approved by the Minister of Health	The health sector, hospitals and national emergency centre	Emergency medical care	Although specifically mentioned in the title of the document, there is no clear relation to health emergencies	No primary health care reference	Very detailed procedures for emergency care and coordination between hospitals and national medical emergency centre	No role reserved for 24/7 health centres and not even mentioned them in the territorial organization	Substantial document for Hospital medical emergency care protocols
Quality standards for accreditation of primary health care providers (latest update 2020)	Standards approved by the National Centre of Healthcare Quality and Accreditation	Health Sector. PHC	Yes. Standards can be essential/compulsory, optimal and of the future	Yes. Standard of the future: to have an emergency plan for treating many patients at the same time, in natural disasters	Yes, covering exclusively PHC	Standards are in use and most HCs are accredited, but there are still unclarity related to the 24/7 component	Nurses are not specifically mentioned in the standards	Compulsory standard: qualified personnel 24 hours per day. In appropriate numbers to the expected flux of patients
Statute of HC (latest version 2022)	Regulation approved by ordinance of the Minister	Health sector, specifically PHC	Yes. 24/7 health centres are specifically mentioned for the first time in the statute of PHC centres	Yes. The response to epidemics is listed among services to be provided by all categories of health facilities	Yes. Covering exclusively PHC	A key document, structuring for the first time different categories of health centres and regulating their role and responsibilities	'Nurse level' emergency care for type B 24/7 health centres is not clear. The role of head nurse not specified.	Personnel from other local health centres may work temporarily in 24/7 ones when requested by NJVKSH.

REGULATION	CATEGORY OF REGULATION: LEGISLATION, PLAN, STANDARDS ETC	HEALTH SECTOR ONLY OR INTERSECTORAL	EMERGENCY MEDICAL CARE	HEALTH EMERGENCY MANAGEMENT	PRIMARY HEALTH CARE ROLE	IMPLEMENTATION EXPERIENCE	GAPS, DISCREPANCIES, INCONGRUENCE	PARTICULARITIES
Contract of service between HC and Insurance Fund	Contract signed by HC, the branches of Insurance Fund and Regional Health Operator	Health Sector, PHC health centres	Yes. It refers to a package of essential services	No	Yes. Exclusively PHC facilities	It is one of the most important legal frames to assure the provision of the services with direct and clear consequences.	No indicators of performance related to medical emergency services. Directors of health centres complain about lack of power and control on the process	A particular format of the contract for 24/7 HC requires they provide medical emergency services 24/7 for residents of the catchment area. Upon request, they should offer doctors to work in emergency unit of the local hospital.
National Plan for PHC (2020)	National Strategy approved by Council of Ministers	Health Sector. PHC	Yes. Training and information systems are two areas with interest in the context of emergencies	No	Exclusive PHC focus	Under application but not much influence on medical emergency care development	No priorities or measures other than those in the field of training of personnel	Postgraduate training programs and continuous education for family doctors to include appropriate modules on medical emergencies
Protocols for referral of chronic patient's during pandemic (2020)	Protocols approved by the Ministry of Health	Health sector.	Yes, there are included clinical criteria for management of cases, which could be considered medical emergencies.	Yes. The protocols aim to regulate the flow of patients in a pandemic and minimize the risk of infection	The protocols regulate PHC cooperation with specialist doctors and hospitals	Used during pandemic crises	It could be completed and adapted for use in other emergencies.	Clinical criteria for 9 specific medical categories of conditions for which GPs could take decisions to treat themselves or refer
Regulation of home care (2023)	Regulation approved by the Ministry of Health and Social Protection	Intersectoral	Not directly, but the service will be integrated within 24/7 health centres	No	Yes. PHC health centres will have the main role in the home care	Just approved, but has been piloted in some areas of the country	It lacks an emergency situation annex with criteria and procedure for management of the case	New service with new professionals still being recruited in the frame of integrated care at PHC
Regulation of 24/7 health centres (2022)	Regulation approved by regional Operator of Healthcare and Director of the HC	Health care only	Yes. Medical emergency services to be provided 24 hours, 7 days a week	Yes, setting up the civil emergencies board is included among the director's responsibilities	Exclusive PHC regulation	Developed for the first time during the second half of 2022, as a requirement of the new HC status.	Very few details about the organization of medical emergency services. No role for nurses in emergency care.	Although it is supposed to be tailored according to the capacities/resources of the HC, the 'regulation' seems to be a standard document for all PHC centres

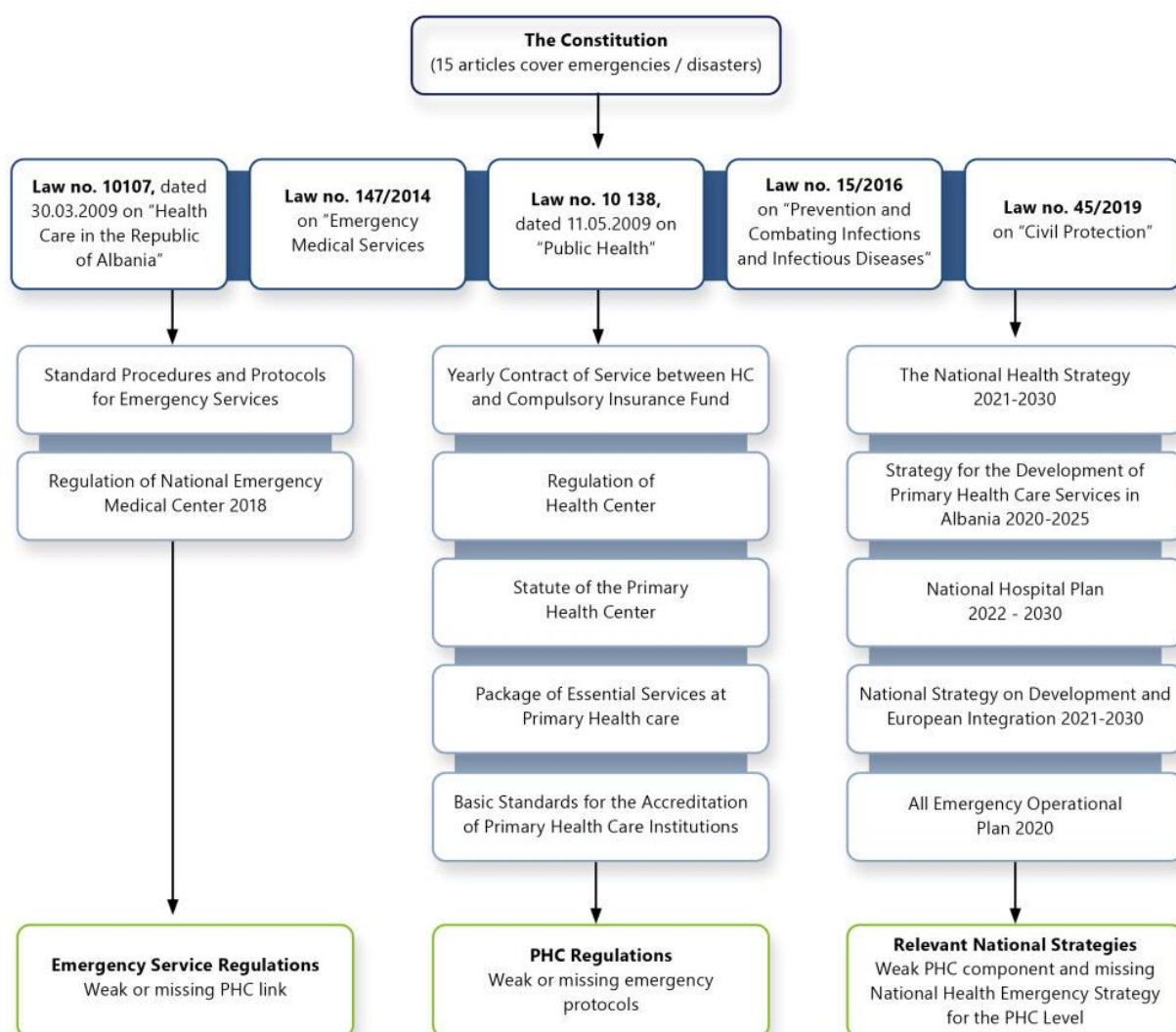


Figure 1: Summary of key regulation on health emergencies and medical emergency care in Primary Health Care (PHC) context

6 CONCLUSIONS AND RECOMMENDATIONS

Medical emergency care has been included among priorities of the health care system in national policies in Albania (including the National Strategy for Development and Integration), while the relevant regulatory frame is extended in several documents covering all levels of the health system. At the same time, the Covid-19 pandemic has put health emergency preparedness and response at the top of the health policy agendas (including the National Strategy of Health System).

In this analysis, there were included more than 40 old and new laws, by-laws, standards, and policies regulating emergency medical care and health emergency preparedness at primary health care in Albania. It seems that gradually, and especially during last years, the priorities, roles, responsibilities and operational standards in the field of medical emergency care are being detailed in a number of legal documents. There are identified only few gaps, incompleteness or incongruences in the general legal frame. They can be divided into two main categories, following the two dimensions of the focus of this analysis;

- Needs related to improving preparedness capacities of PHC facilities and especially 24/7 health centres in the face of local or national civil disasters;
- Needs related to improving medical emergency services at PHC facilities and especially 24/7 health centres.

6.1 NEEDS RELATED TO IMPROVING PREPAREDNESS CAPACITIES OF PHC FACILITIES AND ESPECIALLY 24/7 HEALTH CENTRES IN FACE OF LOCAL OR NATIONAL CIVIL DISASTERS

Some of the main issues revealed during review of legislation and discussions with key informants, in connection to strategies for continuation of services during emergencies were:

- Clear guidelines about service prioritization;
- Regulations about online health services;
- Protocols about medical emergency care in emergency;
- Rules about recruiting additional personnel and assuring preparedness in case of massive sickness or exhaustion.

The key issue in service prioritization during a civil emergency is about identifying clinical situations, which are more urgent than others are. Doctors and nurses at PHC centre should be provided with protocols, which provide details about the priority health conditions to be dealt with, considering the threat to the life of the patient, the capacities of the facility to treat, and the burden of the problem in the population.

For instance, serious asthma crisis, diabetic keto-acidosis, heart attacks, or strokes need immediate care; instable angina, type I diabetes and some problems of pregnancy can wait a few days, while dyslipidaemias, hypertension, chronic lung disease management, or cancer screening may be delayed for weeks or even months. Decisions about treatment in 24/7 HC or referral to hospital should also be facilitated by protocols which take into account the emergency situations.

Another form of prioritization is according to the type of emergency; those of sudden beginning (floods, industrial disasters, or even epidemics) and those starting more gradually (draughts, political crises). For each of the different packages of services could be designated (basic or full package). Covid-19 pandemic proved to be of sudden beginning, but that continued for more than two years. Health centres should be prepared for all potential scenarios. The protocols developed during Covid-19 for referral of patients with chronic conditions can be adapted and completed for that purpose.

The protocol developed for preventing or minimizing infection in the health system during a pandemic is appropriate to support health centres to keep the services open in an epidemic. Approaches, such as triage of patients, increasing the length of prescriptions (i.e. from 1 month to 3 months) and introduction of online services should be specified and added to the protocol. They help with minimizing the

contacts with HC and risk of infection for personnel or patients. Part of the preparedness should be the contingency plan for assuring the necessary personnel during a period of higher than usual demand for health care services. It may include measures for recruiting of retired or new personnel, rules about working hours and actions for protecting the morale of personnel.

The list of essential equipment and emergency medicines should be updated and continuous verification of the operational state and expire dates should be made by dedicated personnel.

Emergency plans for health facilities close to national borders or near main border passes should take into account cross border health threats.

Finally, preparedness plans for health centres should include simple indicators of operating ability of services during the disaster or health emergency. They should include the number of health centres, which are inaccessible because of a given natural disaster, or the number of health centres where there is insufficient staff/ equipment/ infrastructure.

6.2 NEEDS RELATED TO IMPROVING MEDICAL EMERGENCY SERVICES AT PHC FACILITIES AND ESPECIALLY 24/7 HEALTH CENTRES

From analyses of the documents guiding the medical emergency services of PHC centres and especially those of 24/7 typology, it seems that they lack specific clinical guidelines and protocols appropriate for primary health care. Interestingly, in Albania, during last 10 years there have been developed a large number of guidelines and protocols, some of them for PHC services. An inventory of guidelines and protocols prepared in 2019 unveiled that from 2005 to 2019 almost 60 clinical guidelines and protocols were issued in Albania. Only for diabetes and hypertension management, there were developed almost 10 clinical documents. Most of those protocols were appropriate for hospital level, but not for primary health care. This seems to be also the case with the standard operational procedures and clinical protocols for medical emergency services approved last year.

The concept of medical emergency care is described in the package of PHC essential services, statute of health centres and in other legal documents, but general practitioners would need standard operational procedures, protocols or guidelines adapted to their level of service/equipment/drugs.

These instruments:

- would allow harmonization and standardization of care for all patients;
- assist the clinical activity for young doctors and for those with experience;
- assure monitoring and clinical audit; and
- facilitate temporary moving of personnel from one HC to a 24/7 one building of local networks of medical emergency care.

The medical emergency care guidelines/protocols may include procedures for

- utilization of essential emergency medicine (for instance epinephrine) and essential emergency equipment (for instance oxygen mask);
- management of syncope, acute anaphylaxis, asthma attacks, angina pectoris, fractures, haemorrhage/shock, etc.;
- periodical drills or mock exercises.

The guidelines/protocols should provide specific and separate operational procedures for general practitioners and nurses.

The nurse standard of medical emergency care for 24/7 health centres should be clarified during this process.

6.3 OTHER NEEDS RELATED TO ORGANIZATION AND COORDINATION OF MEDICAL EMERGENCY SERVICE

DRILLS

The legislative frames as well as approved standard procedures very likely will not be fully effective if not tested during *exercises and drills* with personnel at primary health care level.

24/7 primary health care facilities have responsibility in emergency situations. Not only they need to keep personnel and key stakeholders safe, but also the top priority remains the patient's safety. It is crucial that health centres are prepared 24/7/365, because it is hard to know when an emergency will present itself. Some professionals, especially the younger ones, may not have had the chance to operate in conditions of a health emergency. During the emergency it is crucial to know how to promptly react and how to quickly communicate/coordinate. It is important not only to have a detailed plan of response but also to have tested the plan in 'mock emergency event'. Drills for different types of emergencies would help physicians, nurses and other personnel to know exactly what to do when a real event happens. The drill will help to prevent panic and lead to a quicker answer to the situation. For these reasons, after trainings and workshops, drills, functional exercises, and full-scale exercises would be recommendable.

NETWORK MODELS

As described in the 'Statute of Health Centres' it is now possible some form of pooling of personnel from different health centres to fill the gaps of 24/7 health centres. It will lay the foundations for developing a *network-based medical emergency care model* at PHC level. It is an appropriate model for medical emergency services because it can broaden and scale up the services provided. Furthermore, it also may address professional isolation in small centres. For the moment, it can be experimented only on case-by-case bases in separate areas. Managerial procedures remain unclear or untested. Standards, criteria and monitoring instruments may facilitate the work of directors of 24/7 health centres or responsible at NJKVSH. This standard may include the number of doctors and nurses actually working in 24/7 centre, number of doctors and nurses in neighbouring health centres, experience and training, distances and geography.

Part of the networking model may be the *telemedicine*. Organization models and procedures to be followed, may assist 24/7 centres to coordinate better with other health facilities, especially hospital emergency units.

FINANCIAL ARRANGEMENTS

Financial arrangements for night shifts or holiday work during 24/7 could be revisited in order to update the mechanisms for *motivating the professionals and improving the work satisfaction*.

SOCIAL PROTECTION AND LONG-TERM CARE

The new regulation of home care may need to be completed with a short section about potential *medical emergency care in the frame of long-term care and coordination with municipality services* and hospital care. Roles and responsibilities during any potential health/social emergencies should be clarified for the whole integrated team made of the coordinator of care (social worker or psychologist) and nurses. The roles and responsibilities of social workers at the Municipality Unit of needs evaluation and referral should also be specified in this context.

TRANSITIONAL CARE

Additional concepts of interest which may be included to the 24/7 list of services are 'transitional care' and 'intermediate care'. They refer to *services during the transitions from hospital to home, from home to hospital, and from illness or injury to recovery and independence*. In contrast to chronic case management, the service is shorter (usually weeks) and has the clear objectives of preventing readmission, shortening hospital stays, and reducing delays in the transition to post-acute care. Some research has shown that half of readmissions to hospital occur when physicians are not available for "hospital at

home”; transitional care services are required to cover evenings and weekends to decrease attendance at emergency departments.

ROLE OF THE HEAD NURSE

Head nurse is a key position in the HC. This position should be institutionalized in health centres with at least more than 10 nurses. They may be given some role in health emergencies and medical emergency care. Some of the required criteria or competencies for the head nurse in 24/7 HC may include:

- Knowledge on emergency healthcare;
- Knowledge on organization of PHC services;
- Administrative capacities (decision-making, reporting, and communicating);
- Community health evaluation and monitoring;
- Health emergency knowledge.

INFORMATION SYSTEM

Information system rationalization: After an analysis of the various information systems efficacy, an agreement should be needed about the data to be collected, the reporting format and reporting time. It should try to avoid unnecessary information, duplication and overloading for the doctors. Any rationalization or upgrade of the information system should take into consideration the need for preparedness in case of emergencies. In this case, 24/7 health centres or other local and national stakeholders must be able to know the prevalence of chronic diseases in the catchment area and estimate the volume of services that will be needed in a given period of time. For example, extrapolation from national data may give an idea of the cases in need for service in 100000 inhabitants; around 20000 persons with hypertension, around 5000 persons with diabetes, 3500 cardiovascular diseases, 2000 chronic obstructive pulmonary diseases, 1000 asthma and 15 cancers. They would produce in emergency situation 1000 medical emergencies because of diabetes, 500 related to cardiovascular disease and hypertension and 200 related to pulmonary diseases.

INDICATORS OF PERFORMANCE

While detailed *indicators of services and performance* are included in the ‘contract of services’ between health centres and the Health Insurance Fund, medical emergency for 24 hours, seven days a week is not covered by any of them. It makes it, therefore, hard to monitor or evaluate this service component of specially designated health centres. It would be recommendable to include among indicators at least one, which informs about:

Option 1: The ratio of medical emergencies taken care of at the PHC level to those referred to higher levels of health system;

Option 2: The proportion of medical emergencies after usual working hours among the total number of medical emergencies.

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ANNEX: DRAFT INTERVIEW GUIDE WITH KEY INFORMANTS OF THE HEALTH SECTOR ON HEALTH EMERGENCIES AND MEDICAL EMERGENCY SERVICES LEGISLATION

1. Position and experience
2. Scope of work in connection with health emergencies and emergency services
3. Known legislation standards policies guiding work and services in relation to emergencies
4. Application of legislation, standards in practice
5. General opinions about the gaps and discrepancies
6. Experience during the Covid-19 emergency