Emergency Care as an Essential Component of Universal Health Coverage in the Eastern Mediterranean Region

Contents

Summary

Emergency care encompasses a range of time-sensitive healthcare services provided for acute medical, surgical and obstetric conditions. Coordinated delivery of pre-hospital and facility-based emergency care is essential in the Eastern Mediterranean Region (EMR), given the regional heterogeneity, high rates of mass emergency events, and the mixed epidemiologic burden, where high rates of injuries and cardiovascular emergencies co-exist with the persistent challenges of infectious disease and maternal and child health. Available data show critical organizational and implementation gaps in the region, even in high-resource areas—a lack of *system*, even where *services* exist—and these gaps cost lives every day.

Emergency care systems

Emergency care encompasses a range of time-sensitive healthcare services provided for acute medical, surgical and obstetric conditions, from injuries and infections, to asthma, heart attacks and complications of pregnancy. The Emergency Care System (ECS) that delivers these services extends from care at the scene of illness or injury, through transport and emergency unit care, to early operative and critical care. Emergency care is the first point of contact with the health system for many people, and is an essential component of Universal Health Coverage, providing timely recognition, resuscitation and referral for severely ill patients, and the delivery of definitive care for many others.

No fewer than 10 of the Sustainable Development Goal (SDG) targets are directly addressed by emergency care:

3.1 Reduce by three quarters, between 2015 and 2030, the maternal mortality ratio
Treatment for obstetric emergencies

3.2 Reduce by three quarters, between 2015 and 2030, the under-five mortality rate
Treatment for acute paediatric conditions including diarrhea and pneumonia

3.3 Reverse the incidence of malaria and other major diseases and reduce deaths by half by 2030
Treatment of acute infections and sepsis

3.4 By 2030, reduce by one-third premature mortality from NCDs
Treatment of acute exacerbations of NCDs

3.6 Halve the number of global road traffic crash fatalities and serious injuries by 2020
Post-crash emergency care

3.8 Achieve UHC including financial risk protection and access to quality essential healthcare
Emergency care is an essential component of universal health care

3.9 By 2030, substantially reduce deaths and illnesses from hazardous chemicals
Treatment for acute exposure to hazardous materials

3.13 Strengthen capacity for early warning, risk reduction and management of health risks
Prepared and resilient emergency care systems with surveillance capacity

11.5 By 2030, significant reduce the number of deaths caused and people affected by disasters
Disaster preparedness and response

16.1 Significantly reduce all forms of violence and related death rates everywhere
Treatment for victims of violence

We are unlikely to meet the SDG targets without strong and resilient ECS. In addition to addressing the individual health needs reflected in SDG 3, a strong and well-prepared ECS is also critical to mitigate the impact of mass casualty events associated with SDG 11 (disasters) and SDG 16 (violence). During armed conflict, natural disasters and outbreaks, emergency care systems can be overwhelmed by increased demand or directly compromised by the impact of such events. When emergency care systems collapse, both direct mortality from the acute event, and preventable mortality from everyday conditions ('secondary mortality'), increase dramatically. Besides meeting everyday population health needs, a well-organized, prepared and resilient ECS has the capacity to maintain essential emergency care delivery throughout a mass event, limiting direct mortality and avoiding secondary mortality altogether.

Existing challenges in the Eastern Mediterranean Region

The Eastern Mediterranean Region (EMR) spans an enormous range of epidemiologic, demographic and economic conditions, and this heterogeneity creates challenges for coordinated regional action. Even within countries, the gap between urban and rural areas can be enormous. The ongoing toll of road traffic injury and cardiovascular emergencies, which remain among the leading causes of death in the EMR, co-exist with persistent high rates of infectious disease and maternal and infant mortality. Timely, quality emergency care prevents death and disability from all of these conditions, but ECS are still underdeveloped in many EMR countries.

While we have limited information on the reality of emergency care the region, available data show that there is often a fragmentation of ECS governance, with control of various system components disseminated across multiple agencies. The lack of coordination and integration of prehospital and facility-based emergency care means that organizational gaps remain even in the face of high resources—a lack of *system*, even where *services* exist. For the most part countries face these challenges with only a few young leaders, many foreign-trained, as in-country training pathways are still limited in the EMR.

Compounding the challenges above, is the increasing number of mass emergency events that now affect most EMR countries, either directly or indirectly. The EMR has the highest number of countries in Grade 2 and 3 emergencies in the world, and the result is increasing rates not only of conflict-related injuries, but also of other acute conditions, as longitudinal care delivery systems are disrupted. Surging migrant and refugee populations further increase the heterogeneous demands on the ECS, and rapidly-changing government structures constrain strategic system planning.

WHO Response

In response to Member State demand, WHO/EMRO has embarked on a regional initiative to reinforce its support for ECS development by:

1. Scaling up the health system capacity for delivery of emergency care services in all countries; and
2. Strengthening context-relevant emergency care delivery in countries with complex mass emergencies.

In order to identify priorities and critical actions for strengthening ECS, a two-part expert consultation was convened and a comprehensive assessment undertaken using the WHO Emergency Care System Assessment tool. Seventy emergency care experts from 12 countries –including a wide range of policymakers, prehospital and facility-based clinicians and administrators, and professional society leaders— contributed responses, and these results were used to identify gaps and derive priorities for both country and WHO action. These efforts will be expanded and the results used to inform country-specific priority planning meetings in the coming year.

Findings from the Emergency Care System Assessment

Countries in the EMR have a number of strengths that will facilitate ECS development across the region. There is a high rate of countries with national legislation ensuring access to emergency care,

which suggests substantial political will, and several well-resourced tertiary hospitals that can serve as flagship sites from which to disseminate emergency care development activities. However, many countries in the region, across all income levels, share the following challenges:

- Lack of a designated lead office or agency to coordinate integrated prehospital and facility-based ECS, and their linkage to emergency response structures
- Absence of a national status reports on emergency care
- No explicit integration of prehospital and facility-based emergency care into National Health Strategic Plans
- Limited coverage of prehospital systems, and substantial emergency care service gaps at first level hospitals, and in rural areas
- Limited data on emergency care delivery and limited linkage of data to system planning and quality improvement efforts
- Lack of standardized clinical documentation in pre-hospital and facility settings
- Gaps in dedicated emergency care training across the system, especially regarding integration into formal curricula and ongoing certification requirements
- Insufficient funding, and lack of dedicated funding streams.
- Lack of security for pre-hospital and facility-based emergency care staff.

Critical areas for priority action

There are 8 key areas for high-yield near-term action that are critical to ECS development.

1. **Conduct a standardized national assessment of the ECS** (eg, WHO ECSA) and convene meeting to develop associated priority action plan
2. **Establish a dedicated government lead agency** at the national level (such as a ministry directorate) to coordinate integrated prehospital and facility-based emergency care, including development of SOPs and a mechanism for accreditation and monitoring.
3. **Increase access to emergency care**
    a. Mandate universal access to emergency care free of payment at the point of care
    b. Explicitly integrate pre-hospital and facility-based emergency care into NHPSP and any national pre-payment health funding scheme
4. **Collect standardized emergency care data**, including integration into existing NHIS, and link to system planning, resource-allocation and quality improvement activities.
5. **Ensure at every first-level hospital a 24-hour dedicated emergency unit** with fixed trained staff and formal triage.
6. **Develop key components of prehospital emergency care**
    a. Establish a single universal access emergency call number
    b. Establish a mechanism for centrally-coordinated dispatch of ambulances and providers
    c. Establish a dedicated certification pathway for pre-hospital providers
    d. Establish a formal lay emergency care provider programme and legislation to protect bystanders who provide help to the acutely ill or injured
7. **Strengthen dedicated emergency care training across the health system**
    a. Establish emergency medicine specialist programmes and post-graduate nursing programmes.
    b. Incorporate dedicated emergency care training into initial and ongoing certification for all providers who care for emergency patients.

c. Incorporate emergency care training into undergraduate medical and nursing curricula

8. **Ensure preparedness and security**
    a. Establish a national coordinated multi-agency all-hazard preparedness and response plan with regular training and monitoring of emergency care system readiness.
    b. Develop pre-hospital and facility-level security plans to protect staff, patients and infrastructure from violence.

Conclusion and way forward

WHO and Member States have expressed great commitment to scale up emergency care. There is an urgent need to build on this commitment with action towards implementing an emergency care model that takes into consideration the diversity of the region and the state of crisis in many countries. Efforts must address improved coordination of and access to emergency care services, assessment of gaps in care delivery, unified standards of practice, and investment in training.

WHO is committed to providing technical guidance for implementation and has a range of assessment, planning and training tools relevant to each of the listed priorities. In particular, near-term WHO commitments include:

- Providing administrative and technical guidance for ECS assessments (at the national system and service delivery levels).
- Ongoing expansion of the components of the ECS development toolkit to facilitate system planning and strengthening.
- Formal establishment of a network of international and regional experts in ECS to support country efforts. This network will provide relevant models for legislation, SOPs and accreditation schemes, as well as identifying partners for training and research initiatives.

Member States are encouraged to designate and empower focal points to coordinate the above priority actions, in particular initiating ECS assessment and convening of related stakeholders to set country-specific priorities.

Endorsement of the 8 priority actions would serve to launch an active collaboration between Member States and WHO towards critically-needed strengthening of emergency care in the EMR.