II. Executive Summary

1. INTERNATIONAL LAWS

A. Obligations under the International Covenant on Economic, Social and Cultural Rights (ICESCR)

India's obligations under international law to realising the right to health stems principally from its accession to international treaties and declarations. In particular, India acceded to the International Covenant on Economic, Social and Cultural Rights (ICESCR) on 10 April 1979, which outlines in Article 12(1) "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Right to Health).[4] Once a state ratifies, accedes or succeeds to a treaty, it has legal obligation to take steps under its jurisdiction to ensure that such rights are protected, unless reservations and declarations were made at ratifications, accession or succession. Examples of such steps to be taken by state parties to achieve the full realisation of this Right to Health are given under Article 12(2)(d) of the ICESCR, which includes "the creation of conditions which would assure to all medical service and medical attention in the prevention of sickness." No reservation was made with respect to Article 12 of ICESCR by India at the time of its accession.[5]

Overview of the right to emergency medical care under the ICESCR:

The Right to Health under Article 12 of the ICESCR was provided in General Comment 14[6] adopted on 11th August 2000 at the Twenty-second Session of the Committee

4 "International Covenant on Economic, Social and Cultural Rights."Office of the United Nations High Commissioner for Human Rights, 1967. https://treaties.un.org/doc/treaties/1976/01/19760103%2009-57%20pm/ch_iv_03.pdf

5 India." Reservations, declarations, objections and derogations - CCPR." Accessed February 10, 2023. http://www.bayefsky.com/html/india_t2_ccpr.php

6 "General Comment 14." Economic and Social Council, the United Nations, August 11, 2000. Accessed on February 14, 2023. https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1AVC1NkPsgUedPlF1vfPMJ2c7ey6PAz2qaojTzDJmC0y%2B9t%2BsAtGDNzdEqA6SuP2r0w%2F6sVBGTpvTSCbiOr4XVFTqhQY65auTFbQRPWNDxL

on Economic, Social and Cultural Rights. While General Comment 14 is not legally binding, it has by and large been accepted as an authoritative interpretative guide to the scope of Article 12 of the ICESCR, as a customary international law.[7]

Under General Comment 14, the Right to Health is broadly defined as: (i) freedom to control one's health and body free from interference; and (ii) entitlement to a system of health protection and access to essential medications. Rights to care in emergency situations fall under the scope of the latter. Emergency medical care and any dialogue surrounding its scope also falls under several explicitly listed items for which emergency medical care should be provided, including: (a) "timely and appropriate health care"; (b) "access to health-related education and information"; and (c) "participation of the population in all health-related decision-making at the community, national and international levels."

Right to Health comprises the availability, accessibility, acceptability and quality of healthcare provision[8]. While the acceptability of healthcare systems (i.e., a healthcare system respectful of medical ethics and culturally appropriate to the local context) and quality of healthcare systems (i.e., ensuring that facilities, goods and services be scientifically and medically appropriate and of good quality) are deserving of a fuller exposition beyond the scope of this Report. A more in-depth discussion of the scope on availability and accessibility of healthcare is contained in Part 2 (Federal and State Laws or Guidelines to Right and Access of Trauma Care) of Section III (Overview of the Right to Emergency Medical Care in Each Jurisdiction) of this Report.

As covered by General Comment 14, India's non-derogable core obligations under Article 12 of the ICESCR include: (i) respect for the right of health, including refraining from discrimination in healthcare provision; (ii) protection of the right of health,

7 Hogerzeil HV;Samson M;Casanovas JV;Rahmani-Ocora. "Is Access to Essential Medicines as Part of the Fulfilment of the Right to Health Enforceable through the Courts?" Lancet. U.S. National Library of Medicine, July 22, 2006. https://pubmed.ncbi.nlm.nih.gov/16860700/

8 "The Right to Health." Office of the United Nations High Commissioner for Human Rights, World Health Organisation. Accessed February 10, 2023. https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf

including through government provision of healthcare or ensuring privatisation does not constitute a threat to this right and access to information; and (iii) fulfilment of the Right to Health by facilitation, provision, and promotion of healthcare "preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realising the right to health," as contained in Section III (Overview of the Right to emergency medical care in each jurisdiction) of this Report.

India is obligated to take steps "to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present ICESCR by all appropriate means, including particularly the adoption of legislative measures" (Article 12(1) of the ICESCR). As per General Comment 14, this means that India is obligated to: (i) ensure a specific core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights from; and (ii) a continuing progressive realisation of fuller rights to healthcare based on its resource availability.

General Comment 14 lists the core obligation as at least "to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence" and, of priority, "to provide appropriate training for health personnel, including education on health and human rights." Please refer to Section III (Overview of the right to emergency medical care in each Jurisdiction) of this Report for the discussion on India's core obligations with respect to the provision of emergency medical care under Article 12 of the ICESCR. To aid the discussion on India's progressive obligations, this report also collates and analyses laws in the Jurisdictions to stimulate discussion on the progressive obligations and what can be achieved in India.

B. General Right to Health

Arguments can be made that there is a general right to health under international law, albeit one without specific mention of emergency medical care. The right to health as a concept can be traced back to the Constitution of the World Health Organisation in 1946, under which states should ensure the "highest attainable standard of health

4 Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?, Hogerzeil HV, Samson M, Casanovas JV, Rahmani-Ocora L Lancet. 2006 Jul 22; 368(9532):305-11

as a fundamental right of every human being," where health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This was signed by India on 22 July 1946, and accepted on 12 January 1948.[9]

In addition, India's commitment to the Right to Health can be seen from its accession and travaux preparatoires in relation to the UN Universal Declaration of Human Rights (UDHR). India not only was amongst the first signatories as a founding member of the United Nations, but also significantly contributed to its drafting process. At the Third Committee and in the General Assembly, as India's representative, Hansa Mehta played a key role in the formation of the UDHR[10], which includes Article 25(1), under which "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family".[11]

This commitment to the Right to Health is consistent across many other international treaties that allude to or explicitly mention such a right, including: (i) Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, 1965[12]; (ii) Article 1.1(f) and Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, 1979[13]; and (iii) Article 24 of the Convention on the Rights of the Child, 1989. The United Nations Commission on Human Rights, the Vienna Declaration and Programme of Action, 1993 and other international instruments have proclaimed the Right to Health along with other human rights in the International Bill of Rights, such as the rights to food, housing, employment, education, human dignity, life, non-discrimination, equality, prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.

9 "CHAPTER IX HEALTH." United Nations. United Nations, n.d. Accessed January 24, 2023. https://treaties.un.org/Pages/ShowMTDSGDetails.aspx?src=UNTSONLINE&tabid=2&mtdsg_no=IX-1&chapter=9&lang=en

10 "Universal Declaration of Human Rights." United Nations. Accessed February 24, 2023. https://www.un.org/en/about-us/universal-declaration-of-human-rights

11 "Universal Declaration of Human Rights." United Nations. United Nations, n.d. Accessed January 24, 2023. https://www.un.org/en/about-us/universal-declaration-of-human-rights

12 "Article 5: International Convention on the Elimination of All Forms of Racial Discrimination." United Nations Human Rights, December 21, 1965. Accessed February 14, 2022. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial

13 "Convention on the Elimination of All Forms of Discrimination against Women New York." United Nations, December 18, 1979. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women#:~:text=On%2018%20December%201979%2C%20the,twentieth%20country%20had%20ratified%20it.

While the Sustainable Development Goals (SDG)[14] have no legal effect, they do not exist in a normative vacuum and are indicative of global priorities expressed in various international agreements and other soft law instruments.[15] In relation to emergency medical care, Goal 3.6 of the SDG specifically addresses the goal to "halve the number of global deaths and injuries from road traffic accidents." Emergency medical care is also more broadly subsumed under Goal 3 and 3.8 of the SDG to generally "ensure healthy lives and promote well-being for all at all ages" and "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

14 Kim. E. Rakhyun "The Nexus between International Law and the Sustainable Development Goals." Research Gate, April 2016. https://www.researchgate.net/publication/301666563_The_Nexus_between_International_Law_and_the_Sustainable_Development_Goals

15 "The Sustainable Development Agenda - United Nations Sustainable Development." United Nations. United Nations, October 21, 2015. https://www.un.org/sustainabledevelopment/development-agenda/

2. JURISDICTION-SPECIFIC

Specification	Country	India	Australia	Brazil
Guaranteed/Statutory right to emergency medical care	Written statutes	Partial	Partial	Yes
	Systems available	Partial	Yes	Yes
Access to Bystander Care/ System Activation	Written statutes	Yes	Yes	Yes
	Systems available	Yes	Yes	Yes
Transfer from Scene to Facility: Protocols regarding ambulances and hospital care	Written statutes	Yes	Partial	Yes
	Systems available	Yes	Partial	Yes
At the Facility: Early advance care and decisive care (emergency room)	Written statutes	Partial	Yes	Yes
	Systems available	Partial	Yes	Yes
Emergency care funding: State, insurance and privately-sourced funding	Written statutes	Partial	Yes	Yes
	Systems available	Partial	Partial	Yes
Mechanism at the Federal and State level to regulate referrals at hospitals/ trauma care centres	Written statutes	No[17]	Yes	Partial
	Systems available	Partial	Yes	Partial
Specific Guidelines/Regulations to address Highway Trauma	Written statutes	Partial	No[19]	Yes
	Systems available	Partial	Partial	Yes

Note: *While no separate highway code was found, a comprehensive system for EMC exists in the German, Malaysian, South African and Pakistani laws. Further, in Japan, all doctors have a duty to respond to emergency cases. Therefore, the systems available are in the category "partial." This report shall be further updated if such evidence is found in the future.*

16 Loh, Jason and Todi, Juhi "Improving First Aid In Malaysia: Difference Between A Life Saved And Lost." CodeBlue, February 14, 2023. https://codeblue.galencentre.org/2023/02/14/improving-first-aid-in-malaysia-difference-between-a-life-saved-and-lost-jason-loh-juhi-todi/

17 No statutory framework exists. Only guidelines exist at the national level and some states.

England & Wales	Germany	Japan	Malaysia	Pakistan	South Africa	USA
Yes	Yes	Partial	Yes	Yes	Yes	Yes
Yes	Yes	Partial	Partial	Partial	Partial	Partial
Partial	Yes	Yes	No[16]	Partial	Partial	Yes
Yes	Yes	Yes	Partial	Partial	Partial	Yes
Yes	Yes	Yes	Yes	Partial	Yes	Partial
Yes	Yes	Partial	Partial	Partial	Yes	Partial
Yes	Yes	Partial	Partial	Partial	Yes	Partial
Yes	Yes	Yes	Partial	Partial	Partial	Yes
Yes	Partial	Partial	Partial	Partial	Partial	Partial
Yes	Partial	Partial	Partial	Partial	Partial	Partial
Yes	No[18]	Partial	Yes	Partial	Partial	Partial
Yes	Partial	Partial	Yes	Partial	Partial	Partial
Yes	No	No	No	No	No	Partial
Yes	Partial	Partial	Partial	Partial	Partial	Partial

18 The Order of the First Senate of 16 December 2021- 1 BvR 1541/20 -Risks of disadvantages for persons with disabilities in triage situations." Government of Germany. Accessed February 27, 2023. https://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/EN/2021/12/rs20211216_1bvr154120en.html

19 Protocols for Midland Highways does not include trauma care. https://www.parliament.tas.gov.au/Ctee/Joint/PWC/Roads/Submissions/Midland%20Highway%2010%20Year%20Action%20Plan-Final%20Stages-Department%20of%20State%20Growth%20Submission.pdf

A. Australia

Australia has a federal system with powers divided between the Commonwealth Government and Australia's six states and two mainland self-governing territories. The Australian Constitution lists the matters over which the Australian Commonwealth Parliament has legislative powers, with the majority of these powers being concurrent (i.e., shared between the Australian Commonwealth Parliament and State/territory parliaments). However, in case of conflict between Federal legislation and State/territory legislation, the Federal legislation prevails.

While the right to healthcare is not enshrined as a fundamental right under the Australian Constitution, the right to certain healthcare services is guaranteed as a federal statutory right under Australia's National Health Act of 1953. The right to emergency care is neither enshrined either as a fundamental right under the Australian Constitution, nor as a statutory right under any Federal, State or territory act.

The Australian Federal government is primarily responsible for funding the healthcare system, with a 41% contribution registered in 2016-17, while states and territories are responsible for other matters relating to healthcare. Based on its principal responsibility to fund healthcare , the Australian Federal government adopted the Health Insurance Act of 1973, pursuant to which Medicare, Australia's publicly-funded Federal health insurance scheme was created. Through Medicare, Australian citizens and residents have access to most primary health care services in the public and private healthcare system, including emergency care, with full coverage of the cost. In addition, international visitors from several countries are granted subsidised access to certain necessary medical services pursuant to reciprocal agreements with relevant countries.

20 "How does Australia's health system work?." Australia's health series no. 15. Cat. no. AUS 199. Canberra:Australian Institute of Health and Welfare 2016. https://www.aihw.gov.au/getmedia/f2ae1191-bbf2-47b6-a9d4-1b2ca65553a1/ah16-2-1-how-does-australias-health-system-work.pdf.aspx

B. Brazil

In Brazil, the right to health and healthcare access is recognised as a fundamental right established in Articles 196 to 200 of the Constituição da República Federativa do Brasil de 1988 (Constitution of Brazil). The Brazilian Constitution also establishes a unified public health system, the Sistema Único de Saúde (SUS), financed by the Brazilian government. The SUS is free and must be accessible to all those in need of healthcare, including emergency care.

The Brazilian legal framework that supports health care includes laws, decrees and other guidelines based on the Constitution of Brazil. The laws and decrees provide legal regulations that guarantee that the fundamental right of health is accessible to the entire population of Brazil. Law n. 8.080 of 1990 regulates the SUS in all national territories[21], while Law n. 8.142 of 1990 provides for community participation in the management of SUS and for intergovernmental transfers of financial resources related to health[22]. Decree n. 7.508 of 2011 regulates Law No. 8080, to provide for the organisation of the Unified Health System - SUS, health planning, health care and interfederative articulation, and other measures[23].

The SUS is primarily composed of public hospitals, clinics and health care facilities, but Article 199 of the Constitution of Brazil allows for private health care entities to be included under the umbrella of SUS.[24] These entities provide free public health care on a contractual basis and are remunerated by the State and are applicable to both emergency and non-emergency cases. Many private hospitals provide

21 "Law No. 8.080." Planalto. Presidency of the Republic Civil House Chief of Staff for Legal Affairs, September 19, 1990. http://www.planalto.gov.br/ccivil_03/leis/l8080.htm

22 "LAW No. 8.142." Planalto. Presidency of the Republic Chief of Staff for Legal Affairs, December 28, 1990. http://www.planalto.gov.br/ccivil_03/leis/l8142.htm

23 "DECREE No. 7.508." Planalto. Presidency of the Republic Civil House Deputy Director for Legal Affairs, June 28, 2011. http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/decreto/d7508.htm

24 "TITLE VIII - THE SOCIAL ORDER." Brazil: Constitution, 1988 with 1996 reforms, title VIII. Accessed February 10, 2023. https://pdba.georgetown.edu/Constitutions/Brazil/brtitle8.html#:~:text=Article%20199.&text=Paragraph%201%20%2D%20Private%20institutions%20may,philanthropic%20and%20non%2Dprofit%20entities

public emergency care through governmental contracts. For example, out of the approximately 11,000 entities and facilities providing emergency care under the SUS, 1,814 are private.[25]

Denying emergency health care is a crime under Brazilian criminal law. Furthermore, according to the Brazilian Code of Medical Ethics, doctors have an obligation to provide emergency health care whenever another doctor or health care facility is not available to provide such services. Private health care entities that are not part of the SUS in any capacity are also affected by this prohibition on denying emergency care. By the fundamental right of health, the emergency care services are fully-regulated by the State. The Ministry of Health Decree No. 2048 of 2002 provides the technical regulations for the urgency and emergency state systems, applicable to all SUS and non-SUS entities that provide emergency care[26]. This decree establishes that the system operates under the "spot zero" concept, which determines that emergency care is to be provided even if there are no vacant hospital beds in a particular facility[27].

Other public services that are very important to emergency health care in Brazil are the Serviço de Atendimento Móvel de Urgência (SAMU) and Unidade de Pronto Atendimento (UPA). The SAMU is a free emergency transportation service that can be used by anyone who has suffered an accident or a medical emergency.[28] Through SAMU, first responders provide first aid, and the victim is taken to the closest hospital. The UPA is a 24x7 unit for immediate medical care that has an emergency room and also provides non-urgent medical care.

Brazilians also benefit from public insurance–Danos Pessoais por Veículos Automotores Terrestres, established by Law n. 6.194 of 1974,[29]–that covers every crash occurring on

25 "Informaes em Sade (TABNET)." Ministry of Health, Brazil, n.d. Accessed January 24, 2023. http://tabnet.datasus.gov.br/cgi/deftohtm.exe?sim/cnv/obt09uf.def

26 Filho, Cunha, Rodrigues da, Amado, Gilberto et al. "Medical Planning for Mass Gathering Sports Events in Brazil." Rev Bras Med Esporte – 2023; Vol. 29 – e2021_0404, April 4, 2021. https://www.scielo.br/j/rbme/a/xHX4WzbJ7TQcD33BvMDvnWr/?format=pdf&lang=en

27 "Ordinance No. 2.048 of November 5, 2002." Ministry of Health, Government of Brazil. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt2048_05_11_2002.html

28 "O Que É?: Samu 192." O que é? | SAMU 192. Accessed February 10, 2023. https://samues.com.br/sobre.php.

29 Planalto.gov.br. Accessed February 10, 2023. https://www.planalto.gov.br/ccivil_03/leis/l6194.htm.

the national roads, independent of the party responsible for the crash. Paid annually by every vehicle owner, it covers medical expenses, permanent disability and death. Public centres for urgent, emergency health care and trauma follow Ministry of Health protocols. Established in a manual published by the Ministry, it includes guidelines for emergency and urgent health care and establishes emergency room protocols for trauma and medical care.

When it comes to roadside crashes specifically, the free emergency transportation system provided by the SAMU and the services provided by emergency rooms in public hospitals guarantee that a victim will have proper and free medical care, independent of their medical insurance status.

C. England and Wales

In England and Wales, the general legal framework has led to an efficient operative medical system ensuring that road crash victims are provided almost immediate medical emergency care, including on-site emergency care and rapid transfer to hospital. The applicable laws provide that anyone in medical need must be admitted to a suitable hospital, and emergency patients are prioritised. Emergency care services in England and Wales are state-funded and the rules governing such funding are generally aligned with how each of those health care systems allocate the cost of other treatments for patients.

D. Germany

In Germany, the legal framework directs an efficient operative medical system, to ensure that victims of road crashes are provided almost immediate medical emergency care, including on-site care followed by rapid transfer to hospital. The Federal Republic of Germany consists of a Federal government and 16 constituent States (Länder – Federal German States). In this system, both the federal government and the state governments have their own power and can enact laws and regulations. Hence, applicable healthcare regulations, including EMS are not stated in a uniform law. Rather, the respective

regulations are widespread in numerous federal, state and municipal laws, including the German Social Security Code V, and the state laws on rescue services and hospitals.

In contrast to common law jurisdictions such as in the United States of America or England and Wales, there are generally no case law precedents in Germany. The system established at the German Länder and the municipalities ensures that road crash victims receive immediate professional medical assistance within a period of approximately 10 to 15 minutes[30] from the moment of the notification of a crash via emergency call. The details may vary on a local level, in particular concerning the organisation of the authorities involved, but are comparable as regards the level of assistance and the period within which the assistance is provided.

Furthermore, other authorities such as the police also have an obligation to assist. In addition, any person passing by a crash has an obligation to assist victims; and a failure to do so may constitute a severe criminal offence. The applicable laws provide that anyone in medical need must be admitted to a suitable hospital, and emergency patients are prioritised.

Emergency services at the hospital level are typically provided by centralised interdisciplinary EMS units capable of providing–depending on their level of infrastructure–services ranging from general stabilising EMS services to specialised medical treatments. The personnel at these EMS units carry out a first assessment of the patient to refer them to the most appropriate unit. Statutory law provides that hospitals shall ensure a certain minimum level of emergency care infrastructure. A failure to do so may lead to less monetary funding when treating emergency patients. Funding of EMS is mainly based on the German statutory health insurance system (applicable to the vast majority of the population) and, to a certain extent, on public funding by public authorities.

30 Bos, Nanne, Krol Marteen, Veenvliet, Charlotte, Plass, Marie, Anne. "Ambulance care in Europe." NIVEL, 2015. https://www.nivel.nl/sites/default/files/bestanden/Rapport_ambulance_care_europe.pdf

E. India

In India, while the courts have provided an expansive interpretation to the fundamental Right to Life under Article 21 of the Constitution of India; there are no binding guidelines on emergency healthcare, except protection of Good Samaritans to enable bystander care. India lacks a unified federal legislation on emergency care that is applicable across states. There are certain local state-specific laws that prescribe provisions relating to emergency health care by hospitals, clinics and medical establishments.

The doctors and physicians in India have a legal obligation to treat a patient and respond to any request for his/her assistance in case of an emergency. Section 134 of the Motor Vehicles Act, 1988 also imposes an obligation on the driver (responsible for the crash) to take all reasonable steps to secure medical attention for the injured person by transferring him to the nearest hospital and/or medical care unit. Section 134 also obligates every registered medical practitioner or doctor on duty in the hospital to immediately attend to the injured person and render medical aid or treatment without waiting for procedural formalities, unless the injured person, or guardian in case the person is a minor, desires otherwise.

F. Japan

Japan does not have a unified legislation on emergency care. Doctors have a legal obligation to not refuse a request for medical treatment without justifiable reason. This duty to respond is understood to be a duty owed to the government, a violation of which may lead to the revocation of the individual's medical licence. The legal schemes in relation to the emergency medical system were first established in 1963 through the Fire Service Act and evolved into their current form in 1977. The Fire Service Act requires each prefecture to set and disclose standards for the transportation of injured or sick persons as well as the reception of them at hospitals. It is understood that it is the obligation of municipal governments to establish an Emergency Medical System. Fire departments of municipal governments operate the EMS.

G. Malaysia

In Malaysia, it is mandatory for public and private hospitals to provide emergency health services to anyone in need.[31] In practice, however, disadvantaged individuals such as migrant workers have trouble obtaining access to emergency health services due to issues that include the lack of documentation, discrimination, and language barriers.[32]

Emergency medicine was officially recognised by the Malaysian government in 2002,[33] which led to the setting up of EMS departments in hospitals, training and certifications at universities and the eventual issuance of an Emergency Medicine and Trauma Service (EMTS) Policy by the Ministry of Health in 2012. The EMTS Policy is aimed at providing operational guidance and outlining quality standards at the prehospital stage (system activation, ambulances) as well as at the emergency department of the hospital.

Health clinics and hospitals provide basic emergency services managed by paramedics and 90% of clinics are equipped with ambulances. Facilities are linked to the national emergency call centre network, which directs emergency calls from the public in parts of urban Malaysia, coordinates ambulance services (Ministry of Health, Red Crescent, St Johns' Ambulance, Civil Defence Department), arranges communications between hospital emergency departments, organises telemedicine activities and has mobile medical teams. Larger hospitals have emergency departments and emergency medicine specialists have been trained in Malaysia since 2003[34]. There is a national referral system structured to provide comprehensive health care, from primary to tertiary levels, to individuals in need in every region of the country.

Malaysia's EMS is still at a relatively early and developing stage with various avenues for improvement, including the funding and training of more EMS professionals to

31 The Implication of Legislative Controls on Private Hospitals in Malaysia, page 63; JH Pek et al, Emergency medicine as a specialty in Asia, Acute Medicine & Surgery 2016, volume 3, page 67.

32 Tharani Loganathan et al, Breaking down barriers: understanding migrant workers' access to healthcare in Malaysia (2019).

33 JH Pek et al, Emergency medicine as a specialty in Asia, Acute Medicine & Surgery 2016, volume 3, page 67.

34 Section 5.6 of the "Malaysia Health System Review, Health Systems in Transition, Volume 3."Asia Pacific Observatory on Health Systems and Policies. Accessed January 24, 2023. https://apps.who.int/iris/bitstream/handle/10665/206911/9789290615842_eng.pdf

deal with an increased workload and influx of patients, more integrated cooperation between the NGOs and the government in coordinating emergency services, and equipping doctors and nurses with more expertise in EMS sub-specialties.[35] Malaysia does not have any specific EMS guidelines to address highway trauma[3637].

H. Pakistan

The National Health Care Act 2017 enshrines Pakistanis' right to healthcare without advance payment[38] (in both the Islamabad Capital Territory and in Federal institutions around the country). The Federal Government of Pakistan is not responsible for the provision of healthcare (emergency or otherwise) in the non-Federally administered regions, i.e., the four principal provinces of Sindh, Punjab, Balochistan and Khyber Pakhtunkhwa. Other than this clear divide across the nation in terms of emergency care provisions, especially with regard to supportive legislative framework, there exist differences in geography, infrastructure, and demographics within and across provinces and federal territories, which have resulted in significant inequalities in the provision of emergency response services.

While Pakistan does not as yet have a licensing and accreditation system for EMS providers, its Rescue 1122 in Punjab has gained international recognition for its emergency medical technician training program by the Prehospital Emergency Care Council of Ireland.[39]

35 Hisamuddin, Nik, N.A.R. et. al. "Prehospital Emergency Medical Services in Malaysia." The Journal of Emergency Medicine, Volume 32, Issue 4, May, 2007. 10.1016/j.jemermed.2006.08.021

36 Said N Mohd, Sukonthasarn, A. Wangsrikhun S, and Chanpransit C. Mohd Said N et al, "Assessing and Exploring the Competency of Prehospital Emergency Medical personnel in Klang Valley, Malaysia: a Mixed Method Approach.", The International Medical Journal Malaysia, Volume 13(2), (December, 2014. https://www.researchgate.net/publication/281389857_Assessing_and_Exploring_the_Competency_of_Prehospital_Emergency_Medical_Service_Personnel_in_Klang_Valley_Malaysia_a_Mixed_Method_Approach

37 Pek JH;Lim SH;Ho HF;Ramakrishnan TV;Jamaluddin SF;Mesa-Gaerlan FJC;Tiru M;Hwang SO;Choi WM;Kanchanasut S;Khruekarnchana P;Avsarogullari L;Shimazu T;Hori S; "Emergency Medicine as a Specialty in Asia." Acute medicine & surgery. U.S. National Library of Medicine Volume 3, page 67, August 27, 2015. https://www.researchgate.net/publication/281489198_Emergency_medicine_as_a_specialty_in_Asia

38 "National Healthcare Act, 2017." Government of Pakistan, April 10, 2017. https://senate.gov.pk/uploads/documents/1491817817_181.pdf

39 Rescue 1122 was established under the Punjab Emergency Service Act 2006 to manage the full spectrum of emergencies, and involves emergency health and fire response capabilities. It is supported by the Emergency Services Academy in Lahore which has so far trained 20,000 emergency services personnel. Initially focused in Punjab province, we understand that regional legislation has paved the way for the service to be rolled out across Pakistan.The extent to which this has begun to be implemented is not yet clear, although the intention seems to be for this to become a nationwide emergency service provider.

Whilst a range of private medical insurers offer medical insurance policies within Pakistan, significant developments have, however, been made in the funding of Pakistanis' treatment such as the *Sehat Sahulat programme*. According to the International Labour Organisation, 7.29 million families have been enrolled in the *Sehat Sahulat programme*[40], a family-based health benefit scheme that provides an annual coverage of PKR 7,20,000 per family for a range of medical issues. It is specifically for people falling below the poverty line.

I. South Africa

South Africa has a guaranteed right to emergency medical care under Section 27(3) of the country's Constitution[41]. EMS in South Africa is governed by:

1. The National Health Act No. 61 of 2003 (Emergency Medical Services Regulations)[42];
2. The Health Professions Act[43]; and
3. The Health Professions Council of South Africa[44].

The level of care provided under the Acts listed above include: Basic Life Support (BLS) which includes Cardiopulmonary Resuscitation (CPR), preventing bleeding, helping women in labour and other non-invasive procedures; and Intermediate Life Support (ILS) which includes IV therapy (drips), bronchodilators, defibrillation (shock), chest decompression and others. BLS and ILS are to be provided by Emergency Care Technicians (ECTs) who should have two years of formal training. Further support is provided by Advanced Life Support Paramedics capable of handling advanced airway management, IV drug therapy, advanced midwifery, resuscitation, aviation and marine medicine.

40 A social protection profile of Pakistan Building an inclusive social protection system." International Labour Organisation, 2021. https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-islamabad/documents/publication/wcms_802498.pdf

41 Section 27 (3) of the " Constitution of the Republic of South Africa, 1996." South African Government, December 4, 1996. https://www.gov.za/documents/constitution/chapter-2-bill-rights#27

42 "The National Health Act No. 61 of 2003: Regulations Relating Standards for Emergency Medical Services." Government of South Africa, February 16, 2021. https://www.gov.za/sites/default/files/gcis_document/202102/44161gon94.pdf

43 "Health Professions Act, 1974." Department of Health, Government of South Africa, August 4, 2006. https://www.gov.za/sites/default/files/gcis_document/201409/29079b.pdf

44 "Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act, 1974."." Health Professions Council of South Africa, August 4, 2006. Accessed February 10, 2023. https://www.gov.za/sites/default/files/gcis_document/201409/29079b.pdf

J. United States of America

In the United States of America, on the federal level there is no written guaranteed right to healthcare, including emergency care, under the US Constitution. The protection of health, safety and welfare are understood to be part of the powers reserved to the states under the Tenth Amendment to the US Constitution. Rather, the protection of health, safety and welfare are understood to be part of the powers reserved to the States. Close to a third[45] of the States, accordingly, recognise a right to health care in their state constitutions. EMS are provided on a state-by-state basis in coordination with Federal agencies (i.e., the National Highway Traffic Safety Administration), which provides guidance and sets standards for State and local services.[46] These guidelines act as a minimum to ensure that "persons incurring traffic injuries (or other trauma) receive prompt emergency medical care under the range of emergency conditions encountered."[47] Highway trauma is generally covered by State emergency medical laws and systems.

Approaches to Emergency Medical Services vary on a State-by-State basis (and sometimes on a city-by-city basis) and incorporate a mix of private, public and volunteer systems. Funding for such services also varies on a State or locality basis, although Federal grants or other funding may be available for emergency services. With respect to Emergency Medical Services, the US Federal Statutory law requires federally-funded hospitals to provide certain services to anyone coming to the emergency department of that hospital (i.e., to be stabilised and treated), regardless of their insurance status or ability to pay.[48] Many states also have legislation requiring hospitals to provide emergency care regardless of the patient's ability to pay for such services.

45 Leonard, Weeks, Elizabeth. "State Constitutionalism and the Right to Health Care." Journal of Constitutional Law, June 2009. https://www.researchgate.net/publication/256001866_State_Constitutionalism_and_the_Right_to_Health_Care

46 For example, the NHTSA has issued guidelines for highway safety programs, which are to be implemented and adopted by each individual state as part of their emergency medical services program. "UNIFORM GUIDELINES FOR STATE HIGHWAY SAFETY PROGRAMS." Highway Safety Program Guideline. Accessed January 24, 2023. https://one.nhtsa.gov/nhtsa/whatsup/tea21/GrantMan/HTML/05h_ProgGuidlines1.html#11

47 See id.

48 Examination and treatment for emergency medical conditions and women in labour, 42 U.S.C. §1395dd." Legal Information Institute. Accessed January 24, 2023. https://www.law.cornell.edu/uscode/text/42/1395dd