

Global Comparative Research on Right to Emergency Medical Care

2023



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DISCLAIMER

This report is based on information as available in the public domain. For some countries, detailed information with regard to certain aspects related to the parameters studied herein are not readily available. This report shall be updated if such evidence is found in the future.

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TABLE OF CONTENTS

I.	INTRODUCTION	05
II.	EXECUTIVE SUMMARY	07
	International Laws	07
	Jurisdiction-specific	12
III.	OVERVIEW OF THE RIGHT TO EMERGENCY MEDICAL CARE IN EACH JURISDICTION	24
	Guaranteed/statutory right to emergency care	25
	Summary of federal and state laws or guidelines on right and access to trauma care (including how they are harmonised and enforced)	31
	Emergency Care Funding: State, insurance and privately-sourced funding	69
	Mechanism at the federal and state level to regulate referrals at Hospitals/ Trauma Care Centres (including protocols established for such referrals)	83
	Specific Guidelines/Regulations to address Highway Trauma	93
IV.	RECOMMENDATION: A "RIGHT TO EMERGENCY MEDICAL CARE ACT" FOR INDIA	97
	Call to Action: The RIGHT to emergency medical care Act	100
	ANNEXURE 1	111
	DEFINITIONS AND ABBREVIATIONS	145

I. Introduction

The Right to Health is universally recognized as an inherent human right, encompassing the provision of emergency medical care, which plays a critical role within this framework. Emergency medical care is focused on delivering immediate or urgent medical interventions required to preserve life.

According to the World Health Organization (WHO), the objective of emergency medical care is to stabilize patients who are facing life-threatening or limb-threatening injuries or illnesses. The two primary components of emergency medical care are medical decision-making and the actions necessary to prevent death or disability resulting from time-critical health concerns, regardless of the patient's age, gender, location, or condition.

Many countries around the world have established emergency medical care (EMC) laws or developed corresponding high-standard systems to ensure competent emergency medical care for all individuals in need. This report presents selected international jurisdictions as case studies, providing a comparative analysis of emergency medical care statutes and systems.

In India, for instance, the judiciary, through various landmark judgments, has interpreted Article 21 of the Indian Constitution to include the Right to Healthcare. However, specific rights to emergency medical care and associated standards, particularly standards for commensurate systems, are not comprehensively established in the country. There is no explicit constitutional provision or statutory right under any legislation or court judgment.

This report has been commissioned by SaveLIFE Foundation (SLF), a non-profit organization committed to saving lives on roads in India and beyond. SaveLIFE Foundation (SLF) has demonstrated that by helping governments target and diagnose dangerous roads using compelling evidence and providing a set of proven solutions to fix them, governments actually implement these improvements, roads become safer, and road crash deaths and injuries decline. Their efforts have already led to the institution of India's first-ever Good Samaritan Law and an average 40% reduction in deaths across multiple highways in India, part of the foundation's *Zero-Fatality Corridor* program.

SaveLIFE Foundation collaborated with the Trust Law network to develop this report, documenting the status of emergency medical care as a right in various jurisdictions worldwide. The report compiles and analyzes laws from different countries regarding emergency medical care, including those that guarantee it as a fundamental right. The jurisdictions studied include Australia, Brazil, England and Wales, Germany, India, Japan, Malaysia, Pakistan, South Africa, and the United States of America. The report sections pertaining to each jurisdiction were prepared by reputable law firms and reviewed by medical and legal experts.

The Vital Statistics of India based on the Civil Registration System 2020 report stated that approximately 45% of registered deaths in 2020 occurred without any medical attention. A recent NITI Ayog study titled "Emergency and Injury Care at Secondary and Tertiary Level Centres in India" further reveals that although 91% of hospitals had in-house ambulances, only 34% of these ambulances had trained paramedics, and most hospitals lacked a pre-hospital arrival notification system.

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 14⁶ 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=4slQ6QSmIBEDzFEovLCuW1AVC1NkPsgUedPIF1vfPMJ2c7ey6PAz2qaojTzDJmC0y%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 provision⁸. 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-Ocra 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 préparatoires 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 UDHR¹⁰, 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, 1965¹²; (ii) Article 1.1(f) and Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, 1979¹³; 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 territories²¹, 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 health²². 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 measures²³.

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 "DECRETE 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://pdpa.georgetown.edu/Constitutions/Brazil/btitle8.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 care²⁶. 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 facility²⁷.

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/defctohtm.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 minutes³⁰ 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 2003³⁴. 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^{36,37}.

H. Pakistan

The National Health Care Act 2017 enshrines Pakistanis' right to healthcare without advance payment³⁸ (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;Khrukaranchana 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 Constitution⁴¹. 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 Act⁴³; and
3. The Health Professions Council of South Africa⁴⁴.

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 third⁴⁵ 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_ProgGuidelines1.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>

III. Overview of the Right to Emergency Medical Care in Each Jurisdiction

This section addresses the following questions in relation to each jurisdiction:

A

Is there a guaranteed/statutory right to emergency medical care?

B

Are there separate Federal and State laws and/or guidelines on right and access to trauma care? How are they harmonised and enforced?

C

Status of emergency care funding, including state, insurance and privately-sourced funding

D

Is there any mechanism at the Federal and State level to regulate referrals at hospitals/trauma care centres? If yes, what protocols have been established?

E

Are there any specific guidelines/regulations to address highway trauma at all three levels of trauma care, i.e., Scene, Transfer, Facility?

A. Guaranteed/Statutory Right to emergency medical care

AUSTRALIA

Is there a guaranteed/statutory right to emergency medical care?

PARTIAL

Summary of Key Legislations/Case Laws: The right to emergency medical care is not enshrined either as a fundamental right under the Australian Constitution, or as a statutory right under any Federal, State, or Territory act. However, it is worth noting that through Medicare, Australia's Federal health insurance scheme, 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 the relevant countries.

BRAZIL

Is there a guaranteed/statutory right to emergency medical care?

YES

Summary of Key Legislations/Case Laws: The right to health and healthcare is a constitutional right according to Section II under Articles 196-200 of the Brazilian Federal Constitution (Constituição da República Federativa do Brasil de 1988)⁴⁹.

Article 198 of the Brazilian Federal Constitution also establishes the Unified Health System, or the Sistema Único de Saúde (SUS). Financed by the Brazilian government⁵⁰, the SUS is free and accessible to all those in need of health care, including emergency medical care.

⁴⁹ CONSTITUIÇÃO DA REPÚBLICA FEDERATIVA DO BRASIL DE 1988." Planalto.gov.br, n.d.http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm

⁵⁰ "Federal Supreme Court Constitution ." Supremo Tribunal Federal. Accessed January 25, 2023.https://www.stf.jus.br/arquivo/cms/legislacaoConstituicao/anexo/Brazil_Federal_Constitution_EC_125.pdf

"Brazil: Summary." Columbia University. Accessed February 1, 2023. [https://www.publichealth.columbia.edu/research/comparative-health-policy-library/brazil-summary#:~:text=The%20Sistema%20%C3%9Anico%20de%20Sa%C3%BAde%20\(SUS\)%20is%20Brazil's%20national%20health,the%20state%20and%20municipal%20level.](https://www.publichealth.columbia.edu/research/comparative-health-policy-library/brazil-summary#:~:text=The%20Sistema%20%C3%9Anico%20de%20Sa%C3%BAde%20(SUS)%20is%20Brazil's%20national%20health,the%20state%20and%20municipal%20level.)

ENGLAND AND WALES

Is there a guaranteed/statutory right to emergency medical care?

YES

Summary of Key Legislations/Case Laws: The primary legislations governing the provision of medical services in England and Wales are the National Health Service (NHS) Act 2006, the Health and Social Care Act 2012 and the Health Act 2009. Section 1 of the NHS Act 2006 sets out the primary duty of the Secretary of State to promote a comprehensive health service and to exercise their functions to secure the provision of services for that purpose. The section goes on to state the default rule that services provided as part of the health service must be provided free of charge.

For further details please refer to Annex 1a (Page 111)

GERMANY

Is there a guaranteed/statutory right to emergency medical care?

YES

Summary of Key Legislations/Case Laws: The provision of healthcare is a constitutional right. According to Art. 2 para. 2 sent.⁵¹ in conjunction with Art. 20 para.1⁵² of the German Constitution, the state is obligated to implement and operate a functioning health care system.⁵³ In addition, there are various regulations on state and federal state level which ensure emergency medical care.

INDIA

Is there a guaranteed/statutory right to emergency medical care?

PARTIAL

Summary of Key Legislations/Case Laws: The right to emergency medical care is provided neither under the Constitution of India nor within any federal act or statute covering the entire gamut of EMS. However, in certain judgements passed by Indian courts, emergency medical care has been interpreted as a part of Article 21 of the Constitution of India (*Fundamental Right guaranteeing Protection of Life and Personal Liberty*)⁵⁴. The courts though have noted that there exists a legislative lacuna to guarantee the same⁵⁵.

⁵¹ Art. 2 para. 2 sent. 1 of the German Constitution reads as follows: "Everyone has the right to life and physical integrity."

⁵² Art. 20 para. 1 of the German Constitution reads as follows: "The Federal Republic of Germany is a democratic and social federal state."

⁵³ Constitution and Administration. "Basic Right to Healthcare." German Bundestag, April 21, 2015. <https://www.bundestag.de/resource/blob/405508/4dd5bf6452b5b3b824d8de6efdad39dd/wd-3-089-15-pdf-data.pdf>

⁵⁴ Article 21 of the Constitution of India provides as follows: "Protection of life and personal liberty: No person shall be deprived of his life or personal liberty except according to procedure established by law."

⁵⁵ Pravat Kumar Mukherjee v. Ruby General Hospital & Ors. Original Petition No. 90 of 2002. <https://indiankanoon.org/doc/173553/>

The relevant judicial precedents are set out below:

- » In *Pt. Parmanand Katara v. Union of India and Ors*⁵⁶, the Supreme Court of India held that Article 21 of the Constitution cast an obligation on the State to preserve life.
- » In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal & Anr*⁵⁷, the Supreme Court of India held that failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of the Right to Life under Article 21 of the Constitution.
- » In *Pravat Kumar Mukherjee v. Ruby General Hospital*,⁵⁸ the National Consumer Disputes Redressal Commission held that emergency treatment was required to be given to the deceased who was brought in a seriously injured condition. It cited the *Parmanand Katara* case and held that there was deficiency in service under the Consumer Protection Act.

Further, the relevant legislations/regulations include:

- » Regulations 2.1 and 2.4 of the Indian Medical Council's (Professional Conduct, Etiquette and Ethics) Regulations 2002, which are statutory and binding, provide that a physician must treat a patient in case of an emergency, and respond to any request for assistance in an emergency.
- » Additionally, Section 12(2) of the Clinical Establishments⁵⁹ Act, 2010⁶⁰ provides that for registration and continuation, every clinical establishment must undertake to provide, within the staff and facilities available, such medical examination and treatment as may be required to stabilise the emergency medical condition (as defined in the Act) of any individual who comes or is brought to such establishment.
- » Section 134 of the Motor Vehicles Act, 1988⁶¹ states that the driver of a motor vehicle should take all reasonable steps to secure medical attention for the injured person by conveying him to the nearest hospital/medical practitioner.

⁵⁶ *Parmanand Katara v. Union of India and Ors.* 1989 CSR (3) 997. <https://main.sci.gov.in/jonew/judis/7839.pdf>

⁵⁷ *Paschim Banga Khet Mazdoor Samity v. State Of West Bengal & Anr* (1996) 4 SCC 37 <https://indiankanoon.org/doc/1743022/>

⁵⁸ *Pravat Kumar Mukherjee v. Ruby General Hospital & Ors.* Original Petition No. 90 of 2002. <https://indiankanoon.org/doc/173553/>

⁵⁹ 'Clinical Establishment' is defined inter alia to include hospitals, clinics, and nursing homes, be it public or private, except those owned, controlled or managed by the Armed Forces.

⁶⁰ The Clinical Establishments Act, 2010 is in force since 2012 in the states of Arunachal Pradesh, Sikkim, Mizoram, Himachal Pradesh, and all union territories (except Delhi). Some other states such as Uttar Pradesh, Bihar, Rajasthan, Jharkhand, and Uttarakhand have also adopted the Act by passing required resolutions in the state assemblies "Questions Related to the Clinical Establishments Act ." <http://www.clinicalestablishments.gov.in/WriteReadData/847.pdf>

⁶¹ "Section 134 of The Motor Vehicles Act, 1988." pg. 101. Ministry of Law and Justice, Government of India, October 14, 1988. <https://morth.nic.in/motor-vehicles-act-1988>

While there exists some frameworks received from the abovementioned judgements, among others, laid down by Indian courts, it is insufficient to save lives. Neither are different aspects and parameters related to emergency medical care defined in a clear manner nor there exist frameworks and structures necessary to put in action a chain of survival necessary in the case of an individual requiring emergency medical care.

For further details please refer to annex 1b (Page 113)

JAPAN

Is there a guaranteed/statutory right to emergency medical care?

PARTIAL

Summary of Key Legislations/Case Laws: Doctors have a legal obligation to not refuse a request for medical treatment without justifiable reason under Article 19 of Medical Practitioners' Act of Japan 1988⁶². This obligation is generally called "duty to respond." What constitutes a "justifiable reason" is a matter of interpretation. The old interpretation by the Ministry of Health, Labor and Welfare (MHLW) issued on August 12, 1955 is that the justifiable reasons are limited to cases where medical treatment is practically impossible due to the absence of a doctor or the doctor's illness. Duty to respond is understood to be a duty to the government, its violation can result in the revocation of a medical licence.

Several judicial precedents have recognised the liability of doctors to indemnify patients for damages caused by their refusal to respond to requests for medical treatment.

For further details please refer to annex 1c (Page 116)

MALAYSIA

Is there a guaranteed/statutory right to emergency medical care?

YES

Summary of Key Legislations/Case Laws: A statutory obligation to provide emergency care to anyone who needs it is expressly imposed on private hospitals, healthcare facilities and clinics under regulation 38⁶³ of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006⁶⁴ and regulation 75(3)⁶⁵ of

⁶² "Article 19, Medical Practitioners' Act." Government of Japan, July 30, 1948 https://www.japaneselawtranslation.go.jp/en/laws/view/3992/en#je_ch5at3

⁶³ 38. (1) Every licensed and registered private healthcare facility or service shall at all times be capable of instituting, and making available, essential life saving measures and implementing emergency procedures on any person requiring such treatment or services. (2) The nature and scope of such emergency measures, procedures and services shall be as prescribed.

⁶⁴ "Laws of Malaysia - Rehda Selangor." Accessed February 8, 2023. <https://rehdaselangor.com/wp-content/uploads/Act-586.pdf>

⁶⁵ All private medical clinics or private dental clinics shall provide immediate emergency care services which include life-saving procedures when life, organ or limb is in jeopardy and management of emergency psychiatric conditions.

the Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations 2006⁶⁶. Both regulations provide (in identical wording) that [a]ll private healthcare facilities or services, “shall provide immediate emergency care services which include life-saving procedures when life, organ or limb is in jeopardy and management of emergency psychiatric conditions.” There are no equivalent statutory provisions in relation to the public healthcare sector, presumably since a patient’s impecuniosity (which had been the main factor for private institutions refusing emergency care) is not an issue if the patient is brought to a public hospital or clinic (since impecunious patients are treated without charge). In any event, public hospitals in Malaysia have a “do not reject patients” policy⁶⁷.

Further, the Ministry of Health’s EMTS Policy⁶⁸ (which applies to all public and private healthcare providers in Malaysia – section 2.5) provides that “any individual presenting with perceived or real emergencies arising from any injury or illness has the right to attend an Emergency Trauma Department” (section 7.2) and that ‘the Emergency Trauma Department shall extend and not refuse care that is deemed clinically necessary to any patient presenting with genuine emergencies to the emergency department’ (section 7.3).

For further details please refer to annex 1d (Page 117)

PAKISTAN

Is there a guaranteed/statutory right to emergency medical care?

PARTIAL

Summary of Key Legislations/Case Laws: The Constitution of Pakistan ensures that the principles of democracy, freedom, equality, tolerance and social justice implicitly mandate an inclusive society for all. Section 28 of the National Health Care Act 2017 provides the right to receive life-saving care without advance payment. It states that, “a health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason whatsoever.”

Aside from this right and provisions related to the founding of a national healthcare commission, the National Health Care Act 2017 contains a range of healthcare-related rights including, the right to treatment in time, informed consent, privacy and express grievances.

⁶⁷ “Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations 2006.” Accessed February 7, 2023. <http://www.clinicplus.com.my/downloads/PHCFASC2006.pdf>

⁶⁸ Michal C S , Nadirah S, Praneetha P, Juhanah G, and Mohan G. “Redirection of non-critical patients in the Emergency Department of Hospital Tuaran to the Primary Care Unit (Klinik Kesihatan).” *Borneo Journal of Medical Sciences* volume 10, issue 2, pp: 47-59, 2016. Accessed February 23, 2023. <https://drive.google.com/file/d/1PAAt0cyQFJqyh3obi3egbaZwV4rvXIAog/view?usp=sharing>

⁶⁹ “Medical Development Division, Emergency Medicine and Trauma Services Policy.” Accessed February 2, 2023. https://www.moh.gov.my/moh/images/gallery/Polisi/EMTS_Book.pdf

SOUTH AFRICA

Is there a guaranteed/statutory right to emergency medical care?

YES

Summary of Key Legislations/Case Laws: The Constitution of the Republic of South Africa provides that no one may be refused emergency medical treatment by any health care provider or health institution (clinic, private or public hospital). Section 27(3) of the Constitution, regarding the right to health care, food, water and social security, states: "No one may be refused emergency medical treatment." It should be noted that while the Constitution guarantees emergency medical treatment, it also allows for socio-economic rights such as the right to healthcare, to be limited if it is justifiable to do so in terms of its Section 36. Section 36 of the South African Constitution states the following: "36. Limitation of rights

1. The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:
 - a. the nature of the right;
 - b. the importance of the purpose of the limitation;
 - c. the nature and extent of the limitation;
 - d. the relation between the limitation and its purpose; and
 - e. less restrictive means to achieve the purpose.
2. Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights."⁶⁹

For further details please refer to annex 1e (Page 118)

UNITED STATES

Is there a guaranteed/statutory right to emergency medical care?

YES

Summary of Key Legislations/Case Laws: On a federal level, there is no guaranteed right to healthcare, including emergency care, under the US Constitution.⁷⁰ The protection of health, safety and welfare are understood to be part of the powers reserved to the states

⁶⁹ "Constitution of the Republic of South Africa, 1996 - Chapter 2: Bill of Rights." Government of South Africa. 1996. Accessed March 24, 2023. <https://www.gov.za/documents/constitution-republic-south-africa-1996>

⁷⁰ There have been various proposals to expand the U.S. Constitution to provide a right to health. For example in 2011, Representative Jesse L. Jackson Jr. introduced H.J.Res. 30 on February 14, 2011, a bill which proposes an amendment to the U.S. Constitution ensuring a right to health care. The proposed amendment reads, "Section 1. All persons shall enjoy the right to health care of equal high quality. Section 2. The Congress shall have power to enforce and implement this article by appropriate legislation." In 2017, Representative Betty McCollum introduced a similar amendment, which reads: "Section 1. Health care, including care to prevent and treat illness, is the right of all citizens of the United States and necessary to ensure the strength of the Nation. Section 2. The Congress shall have power to enforce and implement this article by appropriate legislation." No such proposed amendment has been adopted to date.

under the Tenth Amendment to the US Constitution⁷¹. However, with respect to emergency services, the Emergency Medical Treatment and Labor Act (EMTALA) is a federal statute⁷² that requires anyone coming to an emergency department at a hospital (that receives federal funding through the federal Medicare program) to be stabilised and treated, regardless of their insurance status or ability to pay. The EMTALA applies to emergency medical and childbirth services. Once stabilised, the hospital must either provide further medical treatment required or otherwise transfer the patient to another medical facility (in accordance with specific rules and restrictions). The EMTALA includes assistance to patients seen anywhere on hospital property, including ambulances owned and operated by the hospital.

Various US States specifically provide for a right to health care in their State constitution while others have been interpreted to provide for such a right. These constitutional provisions address health or health care broadly and do not specifically address emergency care in the text of the State constitution. One state, Mississippi, however, expressly limits the state's constitutional authority to the indigent in hospitals.⁷³

B. Summary of federal and state laws or guidelines on right and access to trauma care (including how they are harmonised and enforced)

At the Scene: Access to care (bystander response, system activation, bystander care)

AUSTRALIA

Summary of State Guidelines and Legislation

1) The Civil Liability Act, 2002⁷⁴

- a. Provides immunity from any personal civil liability in respect of any act or omission done or made by a Good Samaritan, without expectation of payment or other reward, in an emergency when assisting a person who is apparently injured or at risk of being injured (s57).
- b. Standard of Care: reasonable care and skill in connection with the act or omission (s58).

⁷¹ Please note, however, that U.S. law recognizes a constitutional right to healthcare for prisoners under the 8th Amendment's prohibition on cruel and unusual punishment. See *Brown v. Plata*, 563 U.S. 493 (2011) (finding that "[a] prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society."). Under the 14th Amendment to the U.S. Constitution, U.S. law also recognizes certain limited rights to reproductive care but does not provide that the government has an obligation to pay or provide for such reproductive care. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

⁷² "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>

⁷³ "The Constitution of the State of Mississippi, Section 86". Mississippi, November 1, 1890. https://www.sos.ms.gov/content/documents/ed_pubs/pubs/Mississippi_Constitution.pdf

⁷⁴ "Civil Liability Act, 2002." Government of NSW, Australia, last modified June 16, 2022. Accessed February 14, 2023. <https://legislation.nsw.gov.au/view/html/inforce/current/act-2002-022#pt.8>

For further details please refer to annex 2a (Page 119)

Commentary: The Civil Liability Act and any immunity thereunder applies to Good Samaritans only, without prejudice to any other person's vicarious liability for the Good

Samaritans' actions or omissions. Furthermore, if the Good Samaritans' deliberate or negligent act or omission caused the injury, danger of injury, or if the Good Samaritans were under the influence of drugs, protection from personal liability conferred by this Act shall not apply. The Act does not exempt a person from personal liability for any act or omission done or made while impersonating a healthcare or emergency services worker or a police officer, or while otherwise falsely pretending to have skills or experience in connection with the provision of emergency assistance.

Queensland

1) The Civil Liability Act 2003⁷⁵

- a. Provides that a person shall not be held liable in relation to an act done or omitted when rendering first aid, other aid, or assistance to a person in distress if the first aid or other aid or assistance is provided by the person while performing duties to enhance public safety for an entity prescribed under a regulation that provides services to enhance public safety and provides first aid or other aid or assistance in circumstances of emergency (s26).
- b. Standard of Care: the act must be in good faith and without recklessness (s26(c)).
- c. Extends protection from liability to entities that provide services to enhance public safety in relation to an act done or omitted in the course of providing first aid or other aid or assistance to a person in distress if:
 - i. First aid or other aid or assistance is given by the entity while performing duties to enhance public safety; and
 - ii. First aid or other aid or assistance is given in circumstances of emergency and the act is done or omitted in good faith and without reckless disregard for the safety of the person in distress or someone else.

2) Law Reform Act 1995⁷⁶

- a. Provides that when rendering medical care, aid, or assistance to an injured person in an emergency, near the scene of the incident, or other event constituting an emergency, a medical practitioner, nurse, or other person prescribed under a regulation shall not be liable for an act performed or omitted in the course of rendering medical care, aid, or assistance to an injured person or while the injured person is being transported from the incident scene to a hospital or other place at which adequate medical care is available,

⁷⁵ "Civil Liability Act 2003." Government of Queensland, Australia, current as at March 2, 2020. Accessed February 14, 2023. <https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2003-016>

⁷⁶ "Law Reform Act 1995." Government of Queensland, Australia, July 1, 2010. Accessed February 14, 2023. <https://www.legislation.qld.gov.au/view/pdf/2010-07-01/act-1995-lra>

provided that the services are performed without fee or reward or expectation of fee or reward (s16).

- d. Standard of Care: to avoid liability, the act must be performed in good faith and without gross negligence (s16(d)).

For further details please refer to annex 2b (Page 120)

Commentary: Entities providing services to enhance public safety include emergency service providers such as CareFlight Queensland, Surf Life Saving Queensland, rural fire brigades, the Queensland Fire and Rescue Service, and the Queensland Ambulance Service (QAS).

South Australia

1) The Civil Liability Act 1936⁷⁷

- a. a. Provides that Good Samaritans and medically qualified Good Samaritans shall not incur any civil liability for assistance, advice, or care provided to another person in an emergency, where there is no expectation of payment by money or other means.
- b. Standard of Care: to avoid liability, the Good Samaritan must act in good faith and without recklessness (s74(2)). The medically-qualified Good Samaritan must exercise reasonable care and skill (s74(4)).

For further details please refer to annex 2c (Page 121)

Commentary: A “medically qualified” person is someone who: (i) is a registered medical practitioner; (ii) holds professional qualifications in a field of healthcare that is statutorily recognised; or (iii) works or has worked as an Ambulance Operator (AO), or in some other recognised paramedical capacity (s74(1) of the Civil Liability Act 1936). AOs are volunteers, who can provide intermediate life support, utilising a wide range of Clinical Practice Protocols, which include advanced skills and medications.

Tasmania

1) The Civil Liability Act 2002⁷⁸

- a. Provides protection to Good Samaritans who provide assistance, advice, or care at the scene of the emergency or crash. A Good Samaritan is not liable in any civil proceeding for anything done, or not done, by him/her in good faith and without recklessness (s35B).
- b. Standard of care: to avoid liability, the Good Samaritan must exercise reasonable care and skill (s35C(1)).

⁷⁷ “Civil Liability Act 1936.” Government of South Australia, Australia, August 1, 2022. Accessed February 14, 2023. https://www.legislation.sa.gov.au/_/legislation/lz/c/a/civil%20liability%20act%201936/current/1936.2267.auth.pdf

⁷⁸ “Civil Liability Act 2002.” Government of Tasmania, Australia, December 19, 2002. Accessed February 14, 2023. <https://www.legislation.tas.gov.au/view/whole/html/inforce/current/act-2002-054>

2) Ambulance Service Act 1982⁷⁹ Provides the powers of the ambulance services, as well as the authorities and functions of the Commissioner of Ambulance Services. It also addresses volunteer AOs, in which the Commissioner may appoint an individual he views as necessary to be a volunteer AOs.

For further details please refer to annex 2d (Page 121)

Commentary: The Civil Liability Act 2002 does not exempt a person from personal liability for any act or omission done or made while impersonating a healthcare emergency services worker, a police officer, or while otherwise falsely pretending to have skills or experience in connection with the provision of emergency assistance.

Victoria

1) The Wrongs Act 1958⁸⁰

- a. Provides protection for Good Samaritans who provide assistance, advice, or care to another person in relation to an emergency or crash, in circumstances in which they expect no money or other financial reward for the same (s31B).
- b. In any civil suit, a Good Samaritan is not liable for anything done, or not done, when offering assistance, advice, or care at the scene of an emergency or crash or in providing advice to a person at the scene of an emergency or crash by telephone or other means of communication.
- c. Standard of Care: good faith (s31B(2)).

For further details please refer to annex 2e (Page 121)

Commentary: The Wrongs Act, 1958⁸¹ applies even if the emergency or crash was caused by an act or omission of the Good Samaritan.

Western Australia

1) The Civil Liability Act 2002⁸²

- a. Provides protection for Good Samaritans as well as medically qualified Good Samaritans.
- b. Standard of Care: To avoid liability, the Good Samaritan or medically qualified Good Samaritan must exercise reasonable care and skill (s5AE).

Commentary: A "medically qualified" person is someone who: (i) is registered in a health profession under the Health Practitioner Regulation National Law; (ii) is licenced, registered, or

79 "Ambulance Service Act 1982." Government of Tasmania, Australia, version current from 24 October 2022 to date, Accessed February 28, 2023. <https://www.legislation.tas.gov.au/view/whole/html/inforce/current/act-1982-105>

80 "Wrongs Act 1958." Government of Victoria, Australia, latest version April 6, 2020. Accessed February 14, 2023. <https://content.legislation.vic.gov.au/sites/default/files/2020-04/58-6420aa127%20authorised.pdf>

81 Section 31B of "Wrongs Act, 1958 including the amendments on April 6 2020 ." Government of Victoria. Accessed February 13, 2023. <https://content.legislation.vic.gov.au/sites/default/files/2020-04/58-6420aa127%20authorised.pdf>

82 "Civil Liability Act 2002." Government of Western Australia, as of July 1, 2018. Accessed February 14, 2023. [https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_41135.pdf/\\$FILE/Civil%20Liability%20Act%202002%20-%20%5B04-g0-01%5D.pdf?OpenElement](https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_41135.pdf/$FILE/Civil%20Liability%20Act%202002%20-%20%5B04-g0-01%5D.pdf?OpenElement)

authorised under a written law to practise in some field of healthcare; or (iii) has qualifications as an AO. Pursuant to Section 5PB of the Civil Liability Act, a health professional shall not be considered negligent if the act is in accordance with a practice that, at the time of the act or omission, is widely accepted by the professional's peers as competent professional practice.

For Territorial Legislation (Australian Capital Territory and Northern Territory) refer to annex 2f (Page 122)

BRAZIL

It is important to look at federal, state and county laws, as well as the resolutions issued by the "Conselho Federal Medicina" (National Medicine Counsel) that provide guidelines and rules regarding emergency medical care services. Listed below is the overview of key federal and state laws or guidelines:

- » Federal Law n. 8.080 of 1990 – A federal law enacted in order to regulate the SUS. This law regulates public health in the national territory.⁸³
- » Federal Law n. 8.142 of 1990 – Provides for community participation in the management of the Unified Health System (SUS) and for intergovernmental transfers of financial resources in the area of health and other measures.⁸⁴
- » Decree n. 7.508 of 2011 - Establishes the organisation of the SUS and also the role of the states.⁸⁵
- » Resolution n. 1451/1995 of the "Conselho federal Medicina" (National Medicine Counsel) – Article 1 defines what is considered a medical emergency and a medical urgency. Article 2 establishes which medical specialties must be present at the Emergency Room.⁸⁶
- » Denying assistance or the failure to provide assistance, whenever possible, to those who need emergency care is considered a crime under Brazilian Criminal Law (Article 135).⁸⁷

83 "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

84 "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

85 "DECREE No. 7.508." Planalto.gov.br. 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

86 "Resolução CFM Nº 1451/1995." Conselho Federal de Medicina, March 17, 1995. https://sistemas.cfm.org.br/normas/arquivos/resolucoes/BR/1995/1451_1995.pdf

87 "DECREE-LAW No. 2,848 ." Planalto.gov.br. Presidency of the Republic, Chief of Staff for Legal Affairs, December 7, 1940. http://www.planalto.gov.br/ccivil_03/decreto-lei/del2848compilado.htm

- » Law no 12.653 of 2012 - it is considered a crime to ask for any payment or guarantee, or even to request forms to be filled out, before emergency health care is provided.
- » Code of Medical Ethics– Article 33 states that doctors cannot fail to provide emergency health care to a patient in need whenever there is no other doctor or health care facility available.⁸⁸

ENGLAND AND WALES

There are no statutes in England and Wales that impose a duty on individuals to take affirmative action to help others in need (with the exception of certain legislation in relation to employer-employee statutes). Additionally, common law does not impose liability for what are called “pure omissions,” i.e. no liability is incurred by a defendant for the mere omission or failure to act if there is no prior duty to act to safeguard the relevant interest of the person suffering the emergency.⁸⁹

Provision of facilities for bystander care - There is no UK legislation stipulating that facilities for bystander care such as Automated External Defibrillators (AEDs) must be provided in public areas, so not providing them is unlikely to result in a claim under statutory law.

Commentary: In the absence of special reasons (such as a parent-child relationship⁹⁰), neither a private individual nor a public service owes a duty of care to respond to an emergency by attempting a rescue. However, once a bystander volunteers to help, they are then considered to have a duty of care to assist the person as far as they are able to. Additionally, the Social Action Responsibility and Heroism Act (England and Wales) 2015⁹¹ was introduced to encourage ‘volunteering and involvement in social action’. This statute requires that, when considering a claim brought for negligence or for breach of statutory duty, the court must have regard to whether the defendant was:

- » acting for the benefit of society or any of its members;
- » demonstrating a predominantly responsible approach towards protecting the safety or interests of others; or
- » was acting heroically. It remains to be seen how this statute will be applied by the courts.⁹²

⁸⁸ “Code of Medical Ethics”. Resolution CFM Nyzat of September 27, 2018. <https://portal.cfm.org.br/images/PDF/cem2019.pdf>

⁸⁹ Smith v Littlewoods Organisation Ltd [1987] A.C. 241. <https://www.casemine.com/judgement/uk/5a8ff8ca60d03e7f57ecd7ca>

⁹⁰ Surtees v Kingston-upon-Thames Borough Council, 1991, 2 FLR 559. <https://vlex.co.uk/vid/surtees-v-kingston-upon-792880221>

⁹¹ “Social Action, Responsibility and Heroism Act 2015.” Government of the United Kingdom (England and Wales), February 12, 2015. <https://www.legislation.gov.uk/ukpga/2015/3/contents/enacted>

⁹² “Cardiopulmonary resuscitation, automated defibrillators and the law”, Resuscitation Council UK April 2018 <https://www.resus.org.uk/sites/default/files/2020-05/CPR%20AEDs%20and%20the%20law%20%285%29.pdf>

In relation to the provision of facilities for bystander care, we note that, for example, the use of AEDs by the public has proved very successful and has become a strategy widely recommended in international resuscitation guidelines. Therefore, it remains to be seen whether failure to provide such facilities can result in a common law claim for negligence.⁹³

Additionally, an employer is under a statutory duty to provide adequate and appropriate equipment, facilities and personnel to ensure their employees receive immediate attention if they are injured or taken ill at work.⁹⁴ These regulations apply to all workplaces including the self-employed⁹⁵. These first-aiders must undergo training to an approved standard in a specified list of competencies. As such, an individual who takes on this role as part of their job description could be argued to owe a duty of care to their fellow employees to render first aid.

GERMANY

As per section 323c of the German Criminal Code (Strafgesetzbuch – StGB),⁹⁶ a person's failure to render assistance in case of an accident may constitute a criminal offence under German law, unless there is a significant personal risk for such person, or he/she would violate other important obligations by rendering assistance. In addition, it may constitute a criminal offence if someone hinders another person to provide assistance to a third party. The sentence for such criminal offence is imprisonment of up to one year or a fine.

Article 6 of the Directive 2002/22/EC of the European Parliament and the Council of 7 March 2002 on universal service and users' rights relating to electronic communications networks and services (Universal Service Directive)⁹⁷ states that emergency services can be reached via the free-of-charge telephone number 112 throughout Germany, at any time.

For further details please refer to Annex 2g (Page 124)

⁹³ "Cardiopulmonary resuscitation, automated defibrillators and the law", Resuscitation Council UK April 2018 <https://www.resus.org.uk/sites/default/files/2020-05/CPR%20AEDs%20and%20the%20law%20%285%29.pdf>

⁹⁴ Regulation 3, Health and Safety (First Aid) Regulations 1981.

⁹⁵ Regulation 5, Health and Safety (First Aid) Regulations 1981.

⁹⁶ "Strafgesetzbuch (Stgb)§ 323c Unterlassene Hilfeleistung; Behinderung Von Hilfeleistenden Personen." § 323c StGB - Einzelnorm. Accessed February 1, 2023. https://www.gesetze-im-internet.de/stgb/_323c.html

⁹⁷ "DIRECTIVE 2002/22/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 7 March 2002 on Universal Service and Users' Rights Relating to Electronic Communications Networks and Services (Universal Service Directive)," March 7, 2002.

INDIA

- » Guidelines for Protection of Good Samaritans⁹⁸ which inter alia provides that “a bystander or a Good Samaritan including an eyewitness of a road crash may take an injured person to the nearest hospital, and they can leave immediately except after furnishing the address by the eyewitness only and no questions shall be asked to the bystander or Good Samaritan.” It further states that “A bystander or Good Samaritan, who makes a phone call to inform the police or emergency services for the person lying injured on the road, shall not be compelled to reveal his name and personal details on the phone or in person.” Importantly, the guidelines provide that a bystander or Good Samaritan “shall not be subject to civil or criminal liability”. Furthermore, all public and private hospitals are required to publish a charte⁹⁹ at the entrance or at a conspicuous location¹⁰⁰. In 2016, MoRTH further notified Standard Operating Procedures (SOPs) for examination of Good Samaritans by the police or during trial.¹⁰¹
- » In pursuance to the Standard Operating Procedures (SOP) issued by MoRTH via notification No. RT-25035 /101/2014-RS dated 12th May 2015 based on Supreme Court directions¹⁰², the Ministry of Health and Family Welfare issued guidelines on 24 August 2015 which,¹⁰³ inter alia provide that all registered public and private hospitals are not to detain a bystander or a Good Samaritan or demand payment for registration and admission costs unless he is a family member or relative of the injured. Orientation training should be undertaken for all staff members on the gazette notifications during joining, along with refresher training. The guidelines state that they shall be binding on all hospitals including public and private hospitals, and shall be implemented immediately, with appropriate action taken by concerned authorities in case of non-compliance or violation. The responsibility for compliance would be of the State government/Union Territory.
- » Section 134A was inserted in the Motor Vehicles (Amendment) Act, 2019¹⁰⁴ to define a Good Samaritan and provide for their protection. A Good Samaritan shall not be liable for any civil or criminal action for any injury to or death of the victim resulting from his negligence in acting or failing to act while rendering emergency medical or non-medical

98 “Notification No. 25035/101/2014-RS.” Ministry of Road Transport and Highways, May 12 2015. <http://egazette.nic.in/WriteReadData/2015/164095.pdf>

99 “Good Samaritan Rights and Duties of the Hospitals/Police.” Ministry of Road Transport and Highways. Accessed February 15, 2023. <https://morth.nic.in/sites/default/files/Good-Samaritan.pdf>

100 “Notification No. G.S.R. 594(E),” Ministry of Road Transport and Highways. September 29, 2020. https://morth.nic.in/sites/default/files/notifications_document/GSR%20594%28E%29%2029th%20September%202020%20Good%20Samaritan.pdf

101 “Notification No. 25035/101/2014-RS.” Ministry of Road Transport and Highways, January 21, 2016. https://morth.nic.in/sites/default/files/circulars_document/Notification_dated_21.01.2016_regarding_Good_Samaritan.pdf

102 Supreme Court order on 29th October 2014 in WP 235 of 2012 in SaveLIFE Foundation v. Union of India.

103 “Notification No. Z.28015/1/2015-H.” “Guidelines for Protection of Good Samaritans”, Ministry of Health and Family Welfare, 24 August, 2015. https://www.mca.gov.in/Ministry/pdf/Guidelines_07sep2015.pdf

104 “THE MOTOR VEHICLES (AMENDMENT) ACT, 2019, NO. 32 OF 2019,” Ministry of Law and Justice. August 9, 2019. <https://egazette.nic.in/WriteReadData/2019/210413.pdf>

care or assistance. The rules under Section 134A of MVAA 2019 were notified on 29th September 2020¹⁰⁵.

For further details please refer to Annex 2h (*Page 124*)

Commentary: While these guidelines intend to minimise disincentives for Good Samaritans there does not appear to be a similar focus on their training or the provision of facilities, which might make their interventions more effective and potentially less prone to bonafide errors of judgement. Further, steps towards generating awareness amongst the public are also critical for dispelling any apprehensions.

JAPAN

In case of a traffic crash, the driver who caused the crash has the obligation to call for emergency care. Further, Article 698 of the Japanese Civil Code has been interpreted as the Good Samaritan Law.

Commentary: The driver who does not call for emergency medical care would be charged with abandonment of a person in custody under the Criminal Code. Since Japan does not have legislation prescribing bystanders' obligation or bystander care, it is widely understood that a bystander does not have a legal obligation to call for emergency care.

MALAYSIA

Malaysia does not have any bystander care laws. In terms of the prevailing practice, a small local study indicated that bystander CPR was only performed in 8.7% of out-of-hospital non-traumatic adult cardiac arrest cases¹⁰⁶.

The Ministry of Health's (MOH) EMTS Policy provides guidance on system activation (section 8), including that the Medical Emergency Coordination Centre (MECC) shall act as a command, control, coordination and communication centre for prehospital care. Its role includes:

- » operating 24 hours a day and providing '999' emergency call management systems (including structured caller interrogation and needs prioritisation, acquiring mandatory information to guide ambulance team, carry out post-dispatch activities, recommendation of appropriate pre-arrival instructions for the caller/victim – e.g. CPR)

105 "Notification No. G.S.R. 594(E),"Ministry of Road Transport and Highways. September 29, 2020. https://morth.nic.in/sites/default/files/notifications_document/GSR%20594%28E%29%2029th%20September%202020%20Good%20Samaritan.pdf

106 Sheng, Keng, Chew et al. "How frequent is bystander cardiopulmonary resuscitation performed in the community of Kota Bharu, Malaysia?" Singapore Med J 2008; 49(8) : 636. <http://smj.sma.org.sg/4908/4908a7.pdf>

- » ambulance dispatching
- » control and coordination of ambulance resources
- » intra and inter-agency coordination
- » operational support and management for major disasters

Commentary: Pre-hospital care services in Malaysia are managed by hospital emergency departments. Ambulance services are mainly run by government hospitals and clinics under the supervision of the Medical Emergency Coordinating Centre (MECC) (90% of ambulances are run by the MOH). They also receive support from agencies including Red Crescent, St. John's ambulance and the Civil Defense. All emergency medical departments have emergency coordinating call centres with control of ambulances. A universal call system or '999' system is used for Computer Assisted Dispatching and emergency dispatches through the MECC.¹⁰⁷

PAKISTAN

In 2010, the 18th Constitutional Amendment of Pakistan devolved health administration to the provinces, granting provinces legislative as well executive authorities in the health sector, which were previously within the purview of the federal government. The principal pieces of provincial legislation with respect to emergency healthcare are as follows:

- » Punjab Emergency Service Act 2006 (Punjab Emergency Act), which was established to maintain a state of preparedness to deal with emergencies¹⁰⁸.
- » Sindh Injured Persons Compulsory Medical Treatment (Amal Umer) Act¹⁰⁹(2019) (Sindh Medical Act), which provides for the duty of citizens to assist injured persons and also for hospitals to each maintain two fully-equipped ambulances.
- » In Khyber Pakhtunkhwa, the Khyber Pakhtunkhwa Injured Persons and Emergency (Medical Aid) Act, 2014 has a very similar scope to the Sindh Medical Act (2019). It further mandates Rescue 1122 as responsible for providing medical, fire and rescue services in the province.
- » For the previously called "Northern Territories" of Gilgit Baltistan, there is the Gilgit Baltistan Emergency Service Act 2012, which has a very similar scope to the other legislation set out above, providing a broad framework for the region within which improved emergency medical services may be provided.

¹⁰⁷ Lee, Sharon. "Disaster Management and Emergency Medicine in Malaysia." *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*, March 16, 2011. <https://escholarship.org/uc/item/9gv4h27b>

¹⁰⁸ "The Punjab Emergency Service Act, 2006." Government of Punjab, Pakistan, June 19, 2006. Accessed February 15, 2023. <http://punjablaws.gov.pk/laws/484.html>

¹⁰⁹ "The Sindh Injured Persons Compulsory Medical Treatment (Amal Umer) Act, 2019." Provincial Assembly of Sindh, March 19, 2019. <http://www.pas.gov.pk/uploads/acts/Sindh%20Act%20No.VIII%20of%202019.pdf>

- » In Balochistan, there does not appear to be an overarching legislative framework for the provision of any medical care, emergency or otherwise. The Government of Balochistan is however, establishing the Rescue 1122 model on major national highway routes.

Commentary:

- » The Punjab Emergency Act does not provide specifically for access to care at the scene, but rather sets out the framework within which the Emergency Medical Services are formed.
- » The Sindh Medical Act similarly does not expressly provide for access to care at the scene, but does require all hospitals to maintain two emergency ambulances and for doctors to administer medical treatment without needing to obtain the consent of the injured person.
- » The KP Emergency Act does not provide for access to care at the scene, however it does provide for the non-harassment of any person who brings an injured person to a hospital.
- » The GB Emergency Act does not contain express provisions related to the access to care at the scene. In each case, the scope of the relevant act is broad and there is little detail with respect to providing an injured person with access to EMS at the scene.

SOUTH AFRICA

A current South African definition of a medical emergency can be found in Regulation 7 of the Medical Schemes Act 1998¹¹⁰ which describes it as: “the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s life in serious jeopardy.” The Constitutional Court then redefined it as “a dramatic, sudden situation or event which is of passing nature in terms of time”¹¹¹, which can be cured by way of medical treatment.¹¹² On this basis, emergency medical treatment can therefore be referred to as acute experiences that can be remedied, versus chronic incurable illnesses.

Duty of the Medical Profession

The National Health Act 61 of 2003¹¹³ (as amended) (NHA) also provides that no one may be refused emergency medical treatment by any health care provider or health institution, as can

110 “Medical Schemes Act 1998.” Department of Health, Government of South Africa, as on June 30, 2004. Accessed February 15, 2023. <https://www.medicalschemes.com/files/Acts%20and%20Regulations/MSREGS19July2004.pdf>

111 Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC) at 778. https://www.escri-net.org/sites/default/files/Soobramoney_Decision.pdf

112 Mason, D M. “Emergency Medical Treatment and ‘Do Not Resuscitate’ Orders: When Can They Be Used?” South African Medical Journal 13, January 23, 2013. <https://doi.org/10.7196/samj.6672>

113 “National Health Act 61 of 2003.” Government of South Africa, July 18, 2004. Accessed February 14, 2023. <https://www.safmh.org/wp-content/uploads/2020/09/National-Health-Act-61-of-2006.pdf>

be seen from the relevant extracts below:

- » Section 5 of the National Health Act states that a healthcare provider, health care worker or health establishment may not refuse a person emergency medical treatment.
- » The Health Professions Council of South Africa (HPCSA) – ethical guidelines for good practice in health care professions. **Booklet 1**¹¹⁴ - Guideline 5.7 provides that all healthcare practitioners shall be obliged to provide care to a person in an emergency situation in order to stabilise them and then arrange for an appropriate referral to another practitioner or facility. **Booklet 2**¹¹⁵ - Guideline 21 prevents a health care practitioner from performing a professional act which they are not adequately educated, trained and sufficiently experienced in. However, an exception is made for emergency situations.
- » The National patient's rights charter provides for the following; 2.3(a) - Everyone has the right to access health care services that include receiving timely emergency care at any health care facility that is open regardless of one's ability to pay. **Booklet 7**¹¹⁶ - Guideline 9.4 provides that if a patient satisfies all the criteria for admission, but cannot be admitted because of limited resources at a particular institution, the health care practitioner must transfer them to another institution where such resources exist. However, this should be done only after the necessary emergency treatment has been instituted. **Booklet 10**¹¹⁷ - This booklet deals with guidelines relating to telemedicine. It provides that the health and wellbeing of the patient are the determining factors with regard to stabilising the patient and having the patient referred for thorough medical care. It sets out how the practitioner should provide care by telemedicine in emergency situations.

UNITED STATES

Federal: Emergency Medical Services are regulated by the National Highway Traffic Safety Administration (NHTSA), a part of the US Department of Transportation. NHTSA was created under the National Traffic and Motor Vehicle Safety Act¹¹⁸, which gave the US federal government the power to set and administer safety standards for motor vehicles and road

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- ¹¹⁴ Booklet 1: "Ethical guidelines for good practice in the health care professions." Health Professions Council of South Africa. Accessed February 14, 2023. <https://aestheticdoctors.co.za/hpcs-a-ethics-good-practice/>
 - ¹¹⁵ Booklet 2: "Ethical guidelines for good practice in the health care professions." Health Professions Council of South Africa. Accessed February 14, 2023. <https://aestheticdoctors.co.za/hpcs-a-ethics-good-practice/>
 - ¹¹⁶ Booklet 7: "Ethical guidelines for good practice in the health care professions." Health Professions Council of South Africa. Accessed February 14, 2023. <https://aestheticdoctors.co.za/hpcs-a-ethics-good-practice/>
 - ¹¹⁷ Booklet 10: "Ethical guidelines for good practice in the health care professions." Health Professions Council of South Africa. Accessed February 14, 2023. <https://aestheticdoctors.co.za/hpcs-a-ethics-good-practice/>
 - ¹¹⁸ "An Act to Provide for a Coordinated National Highway Safety Program through Financial Assistance to the States to Accelerate Highway Traffic Safety Programs, and for Other Purposes. (1966 - S. 3052)." GovTrack.us, September

safety. NHTSA sets the minimum standards that all state emergency medical providers must meet.¹¹⁹ EMS are regulated more strictly by individual state governments. All 50 states and the district of Columbia have Good Samaritan Laws¹²⁰.

State: Although NHTSA sets minimum standards for emergency medical care throughout the United States of America, emergency medical care is handled and regulated on a state-by-state basis. While various approaches and models exist across states, there are certain commonalities. For example, each state has a lead agency for Emergency Medical Services that regulates and oversees local and regional systems and personnel.¹²¹ As of 2011 there were 21,283 credentialed EMS agencies in the USA, comprising a mix of private, public, and volunteer systems.¹²²

Transfer from Scene to Facility: Protocols regarding ambulances and hospital care

AUSTRALIA

Summary of State Guidelines and Legislation

New South Wales (NSW)

1. The Ambulance Service of NSW issued protocol T1¹²³: Pre-hospital Management of Major Trauma, provides criteria for different levels of injury and trauma, with the necessary actions to be taken. It provides the definition of a major trauma patient in the pre-hospital environment; a patient that meets any of the criteria of the Trauma Triage Tool. The Trauma Triage Tool provides actions that must be taken based on the stipulated criteria, including:
 - i. The type of blunt force (differs according to the incident);
 - ii. Type of penetrating injury (for example, blast, shooting, or stabbing); and
 - iii. Signs and symptoms of the injury.
- a. If a patient meets the Major Trauma Criteria, paramedics are authorised to commute up to 60 minutes (Metropolitan) and 90 minutes (Regional) from the scene to reach the

119 "What Is Ems?" EMS.gov. Accessed January 24, 2023. <https://www.ems.gov/what-is-ems/>

120 West, Brian and Varacallo, Matthew. "Good Samaritan Laws." National Library of Medicine, September 12, 2022. Accessed March 14, 2023. <https://www.ncbi.nlm.nih.gov/books/NBK542176/>

121 "Section 2: History and Current State of EMS National Academies of Sciences, Engineering, and Medicine. 2007. Emergency Medical Services: At the Crossroads. Washington, DC: The National Academies Press, 2007. <https://nap.nationalacademies.org/read/11629/chapter/4>

122 "Part 4: America's Incomplete Trauma System." American College of Surgeons. Accessed January 24, 2023. <https://www.facs.org/quality-programs/trauma/systems/trauma-series/part-iv/>

123 "Prehospital Management of Major Trauma." Government of New South Wales. Accessed February 15, 2023. https://aci.health.nsw.gov.au/_data/assets/pdf_file/0005/243779/ASNSW-Protocol-T1-Revised-July-2018.pdf

appropriate destination. If no Trauma Service is available within 60/90 minutes from the scene, paramedics must request the Control Centre to notify the ACC of a major trauma patient requiring immediate care and seek direction on the appropriate destination.

- b. An injured patient may be delivered to the trauma system in two ways:
 - i. Non-ambulance transport: the patient arrives at a hospital outside of the ambulance/emergency services arrangements. For example, a patient may arrive at the hospital by private vehicle; and
 - ii. Ambulance/helicopter transport: the patient has been subjected to a trauma triage process whereby a decision is reached which determines which hospital is the most appropriate for the patient. By preference this will be direct transport from the scene or by the most efficient transfer or retrieval means possible.

Commentary: Supported non-emergency transport is regulated by Section 67FA of the Health Services Amendment (Ambulance Services) Act¹²⁴. It provides that a person must not provide direct or indirect transport or take part in the delivery of supported non-emergency transport for fee or reward, unless the person has taken all reasonable steps to ensure that any vehicles or other methods of transportation used to provide the supported non-emergency transport are equipped in a manner that ensures patient safety, and clinical care or monitoring provided as part of that transport is delivered in a manner that ensures patient safety. The Protocol T1 provides a framework for the management of major trauma patients. It covers the assessment, transport, and decisionmaking to determine the patient's level of risk for severe injury, and to enable making the necessary assessment to ascertain the subsequent transport decisions and destination. To deliver the patient in time, a helicopter may be dispatched at the location of the patient or may meet the ambulance en route.

Queensland

1) The Ambulance Services Act 1991¹²⁵

- a. Provides that an authorised officer, in providing ambulance services, may take any reasonable measures to protect persons from any danger or potential danger associated with an emergency situation and to protect persons trapped in a vehicle, receptacle, vessel, or otherwise endangered, and to protect themselves or other officers or persons from danger, potential danger, or assault from other persons (s38).

¹²⁴ "Ambulance Service Act 1991." Government of Queensland, Australia, current as on March 1, 2017. Accessed February 15, 2023. <https://www.legislation.qld.gov.au/view/pdf/2017-03-01/act-1991-036>

¹²⁵ "Clinical Practice Guidelines: Trauma/Pre-hospital trauma by-pass." Clinical Quality & Patient Safety Unit, QAS, February, 2021. https://www.ambulance.qld.gov.au/docs/clinical/cpg/CPG_Pre%20hospital%20trauma%20bypass.pdf

2) Clinical Practice Guidelines (CPG) and Clinical Practice Procedures (CPP)

- a. CPGs and CPPs are a collection of instructions and guidelines designed to help clinicians make better clinical decisions and improve patient care and safety. In most cases, the CPGs are based on a thorough analysis of applicable clinical literature along with an evaluation of the potential benefits and risks.
- b. Three elements are considered when assessing the triage of a trauma patient:
 - i. Vital signs (such as heart rate, respiratory rate, conscious state);
 - ii. Mechanisms of injury; and
 - iii. Patterns of injury.
- c. If any vital signals criteria are present, the patient is immediately transported to a Major Trauma Service (MTS) within 60 minutes. If the transport duration to the MTS is more than 60 minutes, the patient should be transported to the highest Regional Trauma Service (RTS) hospital, available within 60 minutes. If an RTS¹²⁶ hospital is not available within 60 minutes, the patient is taken to the closest local hospital and the Retrieval Services Queensland must be notified through the appropriate operations centre to ensure early transport.

For further details please refer to Annex 3a (Page 126)

South Australia

1) Health Care Act 2008¹²⁷

- a. The Act provides the functions and authorities of South Australia Ambulance Service (SAAS). The main function of SAAS is to provide emergency ambulance services, which is defined as responding to requests for medical assistance (whether made by emergency telephone calls or other means) for persons who may have injuries or illnesses requiring immediate medical attention in order to maintain life or to alleviate suffering and to provide the required medical assistance while transporting the person to a hospital.
- b. A triage method is used by nurses and physicians to determine the clinical urgency of a patient. Using a nationally agreed-upon scale, all incoming patients are allocated to a triage group based on their specific health needs.
- c. The ATS is used to categorise ED patients in all of SA's metropolitan hospitals. For each group, the ATS contains wait time guidelines.

¹²⁶ "Clinical Practice Guidelines: Trauma/Pre-hospital trauma by-pass." Clinical Quality & Patient Safety Unit, QAS, February, 2021. https://www.ambulance.qld.gov.au/docs/clinical/cpg/CPG_Pre%20hospital%20trauma%20bypass.pdf

¹²⁷ "Health Care Act 2008." Government of South Australia, as of December 8 2022, Accessed February 15, 2023. https://www.legislation.sa.gov.au/_/legislation/lz/c/a/health%20care%20act%202008/current/2008.3.auth.pdf

Tasmania

1. Tasmania uses a triage system¹²⁸, comprising three phases within the ED care pathway-input, throughput, and output. In the throughput phase, the ED triages the patients (i.e. sorts and prioritises patients based on urgency). The level of urgency is dictated by the patient's condition when they arrive at the ED.

Victoria

1. The Ambulance Services Act 1986¹²⁹

The Act was issued to restructure the delivery of emergency services and allow future reform, to provide for education and training related to ambulance and related services, and to issue general provisions relating to ambulance services.

2. The Victoria Trauma System

- c. Victoria Metropolitan Trauma Services (VMTS) hospitals have dedicated trauma teams comprising clinicians with a variety of specialised experience to receive major trauma patients and oversee the initial response.
- d. The management of major trauma response is coordinated through the Adult Retrieval Victoria (ARV)¹³⁰ and the Paediatric Infant Perinatal Emergency Retrieval (PIPER).
- e. Triage and transfer protocols prescribe clear medical and anatomical requirements, as well as how major trauma patients can be transferred through the trauma system. For major trauma patients, the target should be a scene time of 20 minutes¹³¹ or less as a general rule. If a patient needs emergency transport to a hospital other than an VMTS, Ambulance Victoria will notify ARV, and ARV will contact the primary receiving hospital within 60 minutes to determine if advice or assistance, as well as retrieval or transfer to a VMTS¹³², is needed. If a patient is more than 45 minutes away from an VMTS, he or she will be driven to the highest level of trauma care available during the 45-minute transport window.

¹²⁸ Emergency Care." Government of Tasmania. Accessed February 15, 2023. https://www.health.tas.gov.au/sites/default/files/2021-12/OHS_supplement_4_emergency_care_DoHTasmania2014.pdf

¹²⁹ "Ambulance Services Act 1986." Government of Victoria, Australia, current version November 30, 2022. Accessed February 15, 2023. <https://content.legislation.vic.gov.au/sites/default/files/2022-11/86-114aa048%20authorised.pdf>

¹³⁰ "Adult Revival Victoria." Government of Victoria, Australia. Accessed February 15, 2023. <https://www.ambulance.vic.gov.au/about-us/our-services/adult-retrieval-victoria/>

¹³¹ "Clinical Practice Guidelines: ALS and MICA Paramedics." Government of Victoria, Australia, 2019. Accessed on February 16, 2023. https://www.ambulance.vic.gov.au/wp-content/uploads/2020/09/avcpg_mica_als.pdf

¹³² "Adult Retrieval Victoria, Annual Review- 2014-15." Government of Victoria, Australia, November 6, 2015. Accessed February 16, 2023. <https://www.ambulance.vic.gov.au/wp-content/uploads/2016/03/arv-annual-review-2014-15.pdf>

- d. When a major trauma patient appears to be in a life-threatening condition, the patient should be taken to the nearest designated trauma centre for stabilisation before being transferred to a VMTS as soon as possible. If the travel time is longer than 45 minutes and the patient has signs of recurrent hypovolemic shock after resuscitation, VSTS allows for the use of a helicopter, and a blood transfusion may be initiated pre-hospital¹³³.
 - e. ARV coordinates the trauma advice and referral telephone line, which offers clinical assistance and advice to clinicians caring for major trauma patients¹³⁴. It also arranges for patient referrals and transfers to VMTS hospitals. Emergency medical personnel responding to the scene will notify ARV and the receiving facility that a trauma patient is on their way. This may be a major, metropolitan, or regional trauma centre, or an urgent care centre, depending on the distance, resources available, and the patient's condition.
 - f. Following the initial notification, the following steps should be taken:
 - i. Gathering vital information from the notifier using the MIST mnemonic:
 01. mechanism of injury;
 02. injuries found or suspected;
 03. signs: respiratory rate, pulse, blood pressure; and
 04. treatment given¹³⁵.
 - ii. Activating the trauma team and any other support departments that are available (medical imaging, pathology)
 - ii. Setting up the trauma bay, including equipment reviews, paperwork, medications, and resuscitation equipment, in preparation for the patient's arrival
7. Pre-hospital Triage¹³⁶:
- In the pre-hospital environment, triage decisions are made based on anatomic, physiological, and high mechanism risk requirements, available resources, as well as time and distance considerations to the hospital. Since the quality of treatment available at the destination hospital has a direct effect on the outcome,

133 "Pre- Hospital Triage." Trauma, Government of Victoria, Australia. Accessed February 16, 2023. <https://trauma.reach.vic.gov.au/guidelines/pre-hospital-triage/transport-time#:~:text=Helicopter%20transfer&text=If%20the%20flight%20time%20is,can%20be%20commenced%20pre%2Dhospital.>

134 "Telephone Advice, Ambulance Victoria." Government of Victoria, Australia. Accessed February 16, 2023. <https://www.ambulance.vic.gov.au/about-us/our-services/adult-retrieval-victoria/>

135 "Obstetric Trauma Guideline." Trauma, Government of Victoria, Australia. Accessed February 16, 2023. https://trauma.reach.vic.gov.au/sites/default/files/Obstetric%20Trauma%20Guideline_Ver%201.0_25092014_complete.pdf

136 "Identification of Potential Major Trauma." Trauma, Government of Victoria, Australia. Accessed February 16, 2023. <https://trauma.reach.vic.gov.au/guidelines/pre-hospital-triage/identification-of-potential-major-trauma>

it is preferable to provide access to the highest level of trauma care possible under logistical and safety constraints. Major trauma in the pre-hospital setting in Victoria can be identified when there is a minimum of one out of three criteria present. These include:

Commentary: The Victoria State Trauma System¹³⁷ (VSTS) is overseen by the Ministerial Advisory Committee, the State Trauma Committee, and its sub-committees, which provide guidance on policy formulation, finance, system efficiency and quality control, and the overall governance model. The Trauma (Case Review Group) CRG advises on major trauma patient transfer policies, studies, and best practices. The CRG's mission is to improve major trauma treatment by reviewing cases that do not meet Victorian major trauma guidelines and have an unsatisfactory patient journey.

Western Australia

1. At full volunteer-run locations, there are approximately 100 sub centre committees that oversee operations on behalf of St. John Ambulance (SJA)¹³⁸. There are also 15 country sub-centres where Ambulance Operators (AOs) and Career Paramedics operate together. This model ensures that most towns have an emergency service.
2. SJA employs the "proQA"¹³⁹ computer-based system used by call centre employees to guide callers through a structured set of questions and enter their answers. This helps generate a code that assigns a priority for ambulance dispatch. Priorities vary from Priority 1 (life-threatening emergency) to Priority 4 (non-life-threatening emergency). These codes determine how quickly ambulances need to arrive at the scene. Ambulances either retrieve injured or ill people from community settings, transport them to the hospital (primary transport), or transport patients between hospitals (inter-hospital patient transport or secondary transport).
3. Emergency services include first aid, assessment, and emergency ambulance services with access to rapid transport to access EMS. For those in rural areas, there may be a need for primary retrieval from the incident site as well as secondary retrieval to major trauma centres.

Commentary: The provision of ambulance services is not regulated by legislation, thus there is no legal definition of what constitutes ambulance services. Moreover, the Health Clinical Services Framework provided by the Department of Health, is silent

137 "Victoria State Trauma System." Trauma, Government of Victoria, Australia, September 28, 2015. Accessed February 16, 2023. <https://trauma.reach.vic.gov.au/sites/default/files/VSTS%20guideline%20Ver%202.0.pdf>

138 "Country Ambulance Service." St John, Australia. Accessed February 16, 2023. <https://stjohnwa.com.au/ambulance-and-health-services/country-ambulance-service>

139 "Delivering Western Australia's Ambulance Services." Western Australian Auditor General's Report, June, 2013. Accessed February 16, 2023. https://audit.wa.gov.au/wp-content/uploads/2013/06/report2013_05.pdf

on the role of ambulances. SJA, which contracts with the Ministry of Health to provide ambulance services throughout the province, is a non-profit organisation that is part of the international Order of St John. Since 1922, it has been the sole provider of emergency services in WA. In this respect, WA and NT differ from the rest of Australia, where emergency services are rendered by government agencies and are governed by legislation. Moreover, it is challenging to get WA's emergency services to rural areas since the population is dispersed over a vast area. As a result, volunteer services are essential for providing emergency coverage in the region.

For Territorial Legislation (Australian Capital Territory and Northern Territory) refer to annex 3b (Page 126)

BRAZIL

The following ordinances govern the Serviço de Atendimento Móvel de Urgência (SAMU) and Unidade de Pronto Atendimento (UPA):

- » **SAMU** – Regulatory Ordinance n. 1.010 of 2012¹⁴⁰, which redefines the guidelines for the implementation of the Mobile Emergency Care Service (SAMU 192) and its Emergency Regulation Center.” SAMU 192 is a free service, which operates 24 hours a day, providing guidance and sending vehicles manned by a trained team, accessed by the number “192” and activated by an Emergency Regulation Center.¹⁴¹ In the SAMU, first aid is provided by first responders and the victim is taken to the closest hospital.

ENGLAND AND WALES

Any person in England and Wales requiring emergency medical care may dial the number “999”¹⁴². The 999 service is free for the public to call and is available 24 hours a day, 7 days a week, to respond to the population with a personalised contact service. Patients may also be passed to 999 via other NHS healthcare systems, including NHS 111¹⁴³. Upon receiving the call, the patient's needs are assessed to provide the most appropriate and timely response. A telephonic or face-to-face patient triage is documented on an Electronic Patient Report.

¹⁴⁰ “Ordinance No. 1.010.” Ministry of Health, Government of Brazil, May 21, 2012. Accessed on February 15, 2023. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt1010_21_05_2012.html

¹⁴¹ “Emergency mobile care service: About SAMU 192.” Ministry of Health, Government of Brazil. Accessed February 7, 2023. https://www.gov.br/translate.google/saude/pt-br/assuntos/saude-de-a-a-z/samu-192?_x_tr_sl=pt&_x_tr_tl=en&_x_tr_hl=en&_x_tr_pto=sc

¹⁴² “When to call 999.” NHS, United Kingdom. Accessed February 16, 2023. <https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-call-999/>

¹⁴³ “Service Specification.” NHS, England. <https://drive.google.com/file/d/1R80rg2GY8XCOURPRYMFV9126T-HU5DNx/view?usp=sharing>

In England and Wales two call assessment systems are used¹⁴⁴: NHS Pathways and the Advanced Medical Priority Dispatch System which require the ambulance service call handler to ask the caller a series of key questions to determine which of the following categories the call falls into (and therefore the corresponding level of response by the ambulance service):

1. **Category 1 “Life-threatening”**: calls requiring an immediate response to a life threatening condition, such as cardiac or respiratory arrest;
2. **Category 2 “Emergency”**: calls requiring response to a serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport;
3. **Category 3 “Urgent”**: calls requiring response to urgent problems, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting; and
4. **Category 4 “Less Urgent”**: calls requiring response to non-urgent problems.

Ambulance Service Trusts provide emergency and urgent care services for 54 million people in England¹⁴⁵. In addition the Welsh Ambulance Service, Scottish Ambulance Service, and Northern Ireland Ambulance Service provide care for Wales, Scotland, and Northern Ireland, respectively.

Established in 2011, the NHS-funded National Ambulance Resilience Unit¹⁴⁶ acts as a central support unit for all UK ambulance services by working with all NHS ambulance trusts to help strengthen national resilience and improve patient outcomes in a variety of challenging pre-hospital environments. The unit comprises highly experienced ambulance service professionals and works with ambulance trusts to support the development of properly trained, equipped and prepared ambulance responders to deal with hazardous or difficult situations.

In addition, NHS England recommends¹⁴⁷ that each emergency department should consider establishing an Ambulatory Emergency Care (AEC) facility resourced to offer emergency care to patients in a non-bedded setting. The aim of AEC is to manage as many patients as possible who, in the absence of an ambulatory care facility, would need to be admitted into an inpatient ward. Hospitals introducing AEC for the first time should expect to convert 25% of their adult acute medical admissions to ambulatory care episodes. The aim should be to consider all patients for AEC management as a first line unless they are clinically unstable. Patients should be streamed to AEC based on fulfilling four simple rules.

144 “Ambulance Response Programme Evaluation of Phase 1 and Phase 2.” The University of Sheffield and NHS, United Kingdom, July 2017. Accessed February 16, 2023. https://www.england.nhs.uk/wp-content/uploads/2017/07/ARPreport_Final.pdf

145 “Commissioning Framework: A Framework for the Commissioning of Ambulance Services.” <https://www.england.nhs.uk/wp-content/uploads/2018/09/commissioning-framework-and-national-urgent-and-emergency-ambulance-services-specification.pdf>

146 “National Ambulance Resilience Unit.” North East Ambulance Service, NHS Foundation Trust. Accessed February 16, 2023. <https://www.neas.nhs.uk/our-services/emergency-planning/national-ambulance-resilience-unit.aspx>

147 “Transforming urgent and emergency care services in England - Safer, faster, better: good practice in delivering urgent and emergency care.” UEC Review Team and ECIST, NHS England, August 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf>

1. The patient is sufficiently clinically stable to be managed in AEC.
2. The patient's privacy and dignity will be maintained in the AEC facility.
3. The patient's clinical needs can be met in the AEC facility.
4. The patient requires emergency intervention.

The AEC facility should have immediate access to a senior doctor responsible for agreeing to the case management plan. The timeframes for initial assessment and medical review in the AEC facility should be similar to those in the main emergency department.

For further details please refer to Annex 3c (Page 128)

GERMANY

The emergency doctor decides to which hospital the patient should be taken with the ambulance based on the following criteria¹⁴⁸:

- » distance to the hospital
- » health condition of the patient
- » capacity of the hospital
- » respective specialist department most appropriate for the treatment of the patient

The specific protocols when arriving at the hospital depend on the health condition of the patient. In general, the patient is required to fill out an admission form when arriving at the hospital. If the patient is unable to fill out the form due to the emergency this is done at a later point in time or carried out by a family member or nurse.

Initial care is provided in the emergency room. Once the final examination results are available, the physicians decide together with the patient or family member, the next steps. If no further inpatient treatment is necessary, the patient receives a report with all important results for further treatment by the physician upon discharge from hospital. If the patient has to continue to receive inpatient treatment, he/she will be assigned a bed for further therapy.

INDIA

In 2004, the National Human Rights Commission of India identified pre-hospital care of emergency cases as being the weakest link in the EMS at all levels of healthcare delivery.¹⁴⁹ Currently, India has multiple sets of emergency helpline numbers.¹⁵⁰ For instance, 112 was

¹⁴⁸ "hospital admission by the ambulance service." Hospital, Germany. Accessed February 24, 2023. <https://www.krankenhaus.de/aufenthalt/krankenhauseinlieferung-durch-den-rettungsdienst/>

¹⁴⁹ Rep. Emergency Medical Services in India - Present Status and Recommendations for Improvement 3. Vol. 3. New Delhi: Journal of the National Human Rights Commission, 179-198, 185, 2004.

¹⁵⁰ Chandra, Priyank. "Response to Universal Single Number Integrated Emergency Communication." Home | Telecom Regulatory Authority of India | Government of India. Accessed February 2, 2023. https://tra.gov.in/sites/default/files/Priyank_Chandra_0.pdf

introduced as the single pan-India number for Emergency Response Support System (ERSS) by the Ministry of Home Affairs under the Nirbhaya Fund.¹⁵¹ Under the National Health Mission, 108 and 102 were introduced to respond to emergency situations, primarily to attend to patients requiring critical care, and trauma and crash victims, among others¹⁵². Similarly, 1033 was introduced as the road crash helpline number for national highways by the federal Government¹⁵³. Several state governments have launched their own ambulance projects and toll-free numbers for the provision of emergency medical care. Some of these include:

1. **EMRI 108 Model** - The most widespread EMS model in India is the 108 Emergency service managed by Emergency Management and Research Institute (EMRI)¹⁵⁴. Presently, it operates in more than 17 Indian States with over 8,000 ambulances¹⁵⁵. A public-private partnership model between state governments and EMRI, this ambulance service provides complete pre-hospital emergency care from event occurrence to evacuation to an appropriate hospital.
2. **Tamil Nadu Health Systems Project**, which was established in 2005, is an initiative by the Government of Tamil Nadu in partnership with the World Bank. The aim of this initiative is to create a system that is "highly accessible, equitable and effective."¹⁵⁶
3. **Janani Express Scheme** - Launched by the Department of Health and Family Welfare, Government of Madhya Pradesh, which can be accessed through the no. 102, as envisioned by the National Rural Health Mission, the Janani Express scheme is a public-private partnership model, where the contract is signed between the Government (at the district/block level) and the private vehicle provider who is generally a local transporter. The model utilises government vehicles and private ambulances,¹⁵⁷ to manage requests for emergency transport received at a 24/7 district-level call centre.

¹⁵¹ Emergency Response Support System in India. Accessed February 2, 2023. <https://112.gov.in/>

¹⁵² "ERS/Patient Transport Service :: National Health Mission." National Health Mission. Accessed February 2, 2023. <https://www.nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1217&lid=189>

¹⁵³ "Government Helpline Numbers for All over in India: Indian Skills Development Council." Indian Skills Development Council | Mission "Earn Better by Skilling Better". Accessed February 2, 2023. <http://www.isdcouncil.org/government-helpline-numbers-for-all-over-in-india/>

¹⁵⁴ "About Us: Emergency Management and Research Institute Green Health Services" GVK Emergency Management and Research Institute (GVK EMRI). Accessed January 31, 2023. <https://www.emri.in/about-us/>

¹⁵⁵ "EM Care October, November and December 2021." GVK EMRI. Accessed February 8, 2023. <http://www.emri.in/wp-content/uploads/2022/06/National-EM-CARE-Oct-to-Dec-2021.pdf>

¹⁵⁶ "About Us." Tamil Nadu Health Systems Project, Department of Health and Family Welfare, Government of Tamil Nadu. Accessed February 6, 2023. <https://tnhsp.org/tnhsp/index.php>

¹⁵⁷ "Janani Express Madhya Pradesh." Janani Express Madhya Pradesh | The Center for Health Market Innovations. Center for Health Market Innovations. Accessed January 31, 2023. <https://healthmarketinnovations.org/program/janani-express-madhya-pradesh>

4. **Bihar Model**¹⁵⁸ - In Bihar, ambulances and hospitals are connected through the toll-free number 102. In addition, doctors are also empanelled to provide services on conference calls and for visiting patients who need immediate assistance through another toll-free number, 1911.
5. **West Bengal Ambulance Public Private Partnership (PPP) Model**¹⁵⁹ - In this PPP model the West Bengal government procured and equipped ambulances, and handed them over to select NGOs, while retaining their ownership. This was facilitated by entering into agreements with various NGOs/CBOs/Trusts by the respective District Health and Family Welfare Samiti (DHFWS) for a five-year period. These NGOs operate the ambulance in the designated area on a user-fee basis.
6. **Referral Transport System in Haryana (Haryana Ambulance Services)** - Referral Transport Scheme was introduced to "provide pre-hospitalisation care and transport to the emergency patients, and to increase institutional delivery by transporting pregnant women to health facilities, tertiary care health facilities and back-home services within the districts."¹⁶⁰ To reduce maternal and neonatal deaths, on 14 November 2009, the Government of Haryana launched a scheme to provide a referral transport service branded as "Haryana Swasthya Vahan Sewa No.102".¹⁶¹ This scheme, available to all districts in Haryana¹⁶², also offers: (a) transportation from the site of crash or home or any other place to the nearest appropriate medical facility in case of medical requirement; and (b) transportation from a medical facility to a higher medical facility. Free transportation services are provided to any patient in emergency, pregnant women and victims of road crashes, among others.
7. **In 1991, the National Capital Territory of Delhi** became the first Indian state to introduce a state-funded emergency medical system, called the Centralised Accidents and Trauma Services (CATS),¹⁶³ which has attended more than 8 lakh calls from 1991 to 2013.¹⁶⁴ CATS functions through a network of ambulances connected with the CATS Control Room. On a 24x7 basis, these ambulances provide first aid at the crash site and transport patients to the hospital, if needed. They attend to all emergencies such as crashes, trauma, pregnancies,

158 Emergency Medical Service (EMS) in India: A Concept." National Health Systems Resource Centre, Ministry of Health & Family Welfare, Government of India. Accessed 9, February 2023. https://nhsrcindia.org/sites/default/files/2021-02/Emergency_Medical_Service_in_India_Concept_Paper.pdf

159 "Public Private Partnership." Health and Family Welfare Department, Government of West Bengal. Accessed February 9, 2023. <https://www.wbhealth.gov.in/pages/ppp>

160 "Referral Transport." National Health Mission, Haryana. Accessed January 31, 2023. <http://nhmharyana.gov.in/programDetails?id=14>

161 ibid

162 ibid

163 "About Centralised Accident and Trauma Services." Government of NCT of Delhi. Accessed February 2, 2023. [http://web.delhi.gov.in/wps/wcm/connect/doi_cats/CATS/Home/About+CATS#:~:text=CATS&text=Centralised%20Accident%20and%20Trauma%20Services%20\(CATS\)%20is%20an%20Autonomous%20body,ambulances%20and%20well%20trained%20manpower](http://web.delhi.gov.in/wps/wcm/connect/doi_cats/CATS/Home/About+CATS#:~:text=CATS&text=Centralised%20Accident%20and%20Trauma%20Services%20(CATS)%20is%20an%20Autonomous%20body,ambulances%20and%20well%20trained%20manpower).

164 "Achievements." Centralised Accident & Trauma Services (CATS). Accessed January 23, 2023. http://web.delhi.gov.in/wps/wcm/connect/doi_cats/CATS/Home/Achievements

neonatal emergencies, free of cost, and can be reached through toll-free numbers 102 and 1099¹⁶⁵.

8. **The Gujarat Emergency Medical Services Act, 2007**¹⁶⁶ provides Emergency Medical Services in the state of Gujarat. It inter alia provides for certain requirements that the licence holder of an ambulance needs to satisfy in order to provide Basic Life Support and Advanced Life Support, along with the staffing of such ambulances. The staff for Advanced Life Support Ambulances remain on duty round the clock. The Act also provides for the establishment of a Gujarat Emergency Medical Services Authority to *inter alia* ensure provision of EMS in the state and lays down some offences and penalties for violations/non-compliance.

Through an amendment in 1994 to the Motor Vehicles Act, 1988, Section 134 states that in the event that an individual is injured as a result of a crash involving a motor vehicle, the driver of such a vehicle shall take all reasonable steps to secure medical attention for the injured, by conveying them to the nearest medical practitioner or hospital.

For further details please refer to annex 3d (Page 130)

Commentary:

- » The multiple helpline numbers in existence in India, at times, become a cause of concern as they lead to confusion in distress situations. This is all the more alarming given the widely acknowledged Golden Hour rule that prompt medical attention in the first 60 minutes following any injury or trauma has a critical and profound impact on a person's chances of survival.
- » While the Government of India has also launched and revised a course to train pre-hospital trauma technicians, with advisories issued to all states to implement the said course curriculum for capacity building and training of para-medical personnel for ambulances,¹⁶⁷ a mechanism to check its implementation is yet to be devised.
- » Despite the fact that the 1994 amendment to Section 134 of the Motor Vehicles Act, 1988, makes the driver of the impact vehicle accountable for taking the victim to the hospital in the event of a crash, there is no mechanism to check or penalise the driver in the event that he/she fails to do so.

The federal government and states have taken several standalone initiatives to improve the emergency medical care system in India. However, there is no well-defined mechanism or legislation in place guaranteeing mandatory EMS to a victim in need of the same.

165 "Frequently Asked Questions." Centralised Accident & Trauma Services (CATS). Accessed January 23, 2023. http://web.delhi.gov.in/wps/wcm/connect/doi_cats/CATS/Home/Frequently+Asked+Questions%28FAQ%29

166 "Gujarat Emergency Medical Services Act, 2007." India Code. Government Of Gujarat, April 4, 2007. <https://www.indiacode.nic.in/bitstream/123456789/4462/1/emergencymedicalservices.pdf>

167 "Capacity building for developing Trauma Care Facilities in Govt. Hospitals on National Highways, Operational Guidelines." National Traumacare Programme, Government of India. Accessed January 23, 2023. https://dghs.gov.in/WriteReadData/userfiles/file/Operational_Guidelines_Trauma.pdf

JAPAN

Based on the Fire Service Act¹⁶⁸, each prefecture has established a table of criteria for classifying the status of patients according to the severity of their symptoms and degree of urgency. In addition, each prefecture prepares a list of medical institutions that the emergency team should request for acceptance according to each classification, and establishes the criteria for determining the order in which the request for acceptance should be made.

The emergency medical system in Japan consists of a three-tier structure. The first tier of hospitals provide night and holiday care to patients who can walk to the hospital on their own. As of April 1, 2019, there were 568 “Night and Holiday Medical Centers” nationwide and rotating home duty systems were in operation. As of December 1, 2020, there were 295 emergency medical centres in Japan¹⁶⁹. There are a total of 8,300 hospitals in Japan (2021). Among which 7,246 hospitals are general hospitals, and 3,882 include emergency departments¹⁷⁰.

MALAYSIA

The MOH’s EMTS Policy¹⁷¹ provides a series of guidelines for ambulance services (section 8, and appendix 13), including:

- » Training requirements for the ambulance staff
- » Communication and coordination with the MECC (e.g. departure and arrival time, assessment of victim outcome, etc.)
- » Provision of medical assistance at the scene
- » Time frames for responses (primary response should be between 15-30 minutes for a 5 km radius after emergency call received by MECC; average return journey is one hour; secondary response team should arrive to assist less than 30 minutes after the primary team)
- » Minimum number of ambulances for hospitals (4 for district hospitals, 5 for minor specialist hospitals, 7 for major specialist hospitals, 12 for state hospitals).

168 “Fire Service Act.” Japanese Law Translation, Government of Japan, July 24, 1948. <https://www.japaneselawtranslation.go.jp/en/laws/view/3772/en>

169 “Chapter 2: Health and Medical Services, Annual Health, Labour and Welfare Report 2021.” Ministry of Health, Labour and Welfare, Government of Japan, 2021. <https://www.mhlw.go.jp/english/wp/wp-hw14/dl/02e.pdf>

170 “Handbook of Health and Welfare Statistics 2021 Contents: Part 2- Health.” Ministry of Health, Labour and Welfare, Government of Japan, 2021. <https://www.mhlw.go.jp/english/database/db-hh/2-2.html>

171 “Medical Development Division, Emergency Medicine and Trauma Services Policy.” Accessed February 2, 2023. https://www.moh.gov.my/moh/images/gallery/Polisi/EMTS_Book.pdf

The MOH has also issued a 'Policy on Safety of Land Ambulances,¹⁷²' which sets out guidelines on the types of vehicles that should be used, protocols if the ambulance is involved in a crash, driving policies etc.

Commentary:

As per Prehospital Emergency Medical Services in Malaysia published in the *Journal of Emergency Medicine* (2007)¹⁷³

- » One of the ongoing limitations of pre-hospital care in Malaysia is the deficient integration between agencies such as ambulance services, police and fire departments during an emergency. The difficulties in integrating the system are partly attributed to lack of interest from various agencies and administrative coordination at higher levels.
- » Individual provider agencies rely on their own call-receiving and dispatch communication systems, typically via phone calls made directly to the hospital ambulance station or hospital emergency department. These calls may be answered by a variety of personnel, some with little training. There exists no system for call screening, interrogation, or prioritisation, and pre-arrival instructions are not provided. Identifying patient location and gaining call-back information can also be extremely difficult due to insufficient information from the caller. Automatic number and location identifiers are incorporated only in tertiary referral centres.

PAKISTAN

- » The Punjab Emergency Service Act 2006¹⁷⁴ provides for a general framework within which Rescue 1122 was founded as a state-funded emergency service operating ambulance, fire, rescue and community safety services. The act regulates what constitutes an ambulance and also provides for practical steps to be taken and rules to be abided by in the provision of emergency services, such as appointing "Rescuers" who must fit certain criteria (for example, being not older than thirty years of age), establishing an emergency service fund and an emergency service academy, as well as the right of way enjoyed by ambulances.
- » The Sindh Injured Persons Compulsory Medical Treatment (Amal Umer) Act, 2019¹⁷⁵ provides that hospitals shall each maintain two fully equipped ambulances at any time.

172 "Policy on Safety of Land Ambulances." Ministry of Health Malaysia, 2019. https://www.moh.gov.my/moh/resources/Arkib/Policy_of_Ambulance_Safety.pdf

173 Hisamuddin, N.A.R. Nik, M. Shah Hamzah, and C. James Holliman. "Prehospital Emergency Medical Services in Malaysia." *The Journal of Emergency Medicine*, June 2007. https://www.researchgate.net/publication/6331837_Prehospital_Emergency_Medical_Services_in_Malaysia

174 "The Punjab Emergency Service Act, 2006." Government of Punjab, Pakistan, June 19, 2006. Accessed February 15, 2023. <http://punjablaws.gov.pk/laws/484.html>

175 "The Sindh Injured Persons Compulsory Medical Treatment (Amal Umer) Act, 2019." Provincial Assembly of Sindh, March 19, 2019. <http://www.pas.gov.pk/uploads/acts/Sindh%20Act%20No.VIII%20of%202019.pdf>

The Act does not provide any further prescription with respect to transferring patients from the crash scene to a hospital. The Sindh Government has made an agreement with the Aman Foundation (an NGO established in 2008) to provide EMS in rural Sindh, initially in the Thatta and Sajawal districts¹⁷⁶.

- » ¹⁷⁷The Khyber Pakhtunkhwa Emergency Rescue Service Act, 2012 does not contain express provisions with respect to transferring injured persons from the scene of a road crash to a hospital, but does contain provisions with respect to moving patients between hospitals in the event the doctor is of the opinion that the treatment will be preferable.
- » The GB Emergency Act¹⁷⁸ is similar to the Punjab Emergency Service Act in that it contains general provisions with respect to establishing an emergency service staffed with rescuers who must fit certain criteria (for example, being not older than thirty years of age). In addition, this Act regulates what constitutes an ambulance and provides that such vehicles shall have a right of way when being used for an emergency.

In each case, the scope of the relevant Act is broad and there is little detail with respect to providing an injured person with a transfer from the scene of an emergency to a hospital.

SOUTH AFRICA

The first ambulance service in South Africa, known as St John's Ambulance Brigade, was started in 1877 and was originally used in the industrial and coal-mining regions¹⁷⁹. The Emergency Medical Assistant (EMA) Course was the first medical training for prehospital situations consisting of more advanced training than first aid¹⁸⁰. EMS was offered in conjunction with the provincial fire services. The Health Act of 1977¹⁸¹ made ambulance services the responsibility of the provincial administration. Some provinces ran the ambulance service as an independent health service whereas others stuck to the combined service. There are both state and private ambulance services available to persons in South Africa. There are also air ambulance services in cases of extreme emergency.

¹⁷⁶ "Sindh Peoples Ambulance Service launched in Thatta and Sujawal." The Express Tribune, Pakistan, March 18, 2017. <https://tribune.com.pk/story/1358246/sindh-peoples-ambulance-service-launched-thatta-sujawal>

¹⁷⁷ "The Khyber Pakhtunkhwa Emergency Rescue Service Act." Government of Khyber Pakhtunkhwa, 2012. Accessed February 16, 2023. http://kpcode.kp.gov.pk/uploads/THE_KHYBER_PAKHTUNKHWA.pdf

¹⁷⁸ "Gilgit- Baltistan Emergency Service Act, 2012." Gazette of Pakistan, June 6, 2012. Accessed February 16, 2023. <https://pakistanlawyer.com/2016/06/23/gilgit-baltistan-emergency-service-act-2012/>

¹⁷⁹ "History of St John." St John Ambulance, South Africa. Accessed February 16, 2023. <https://stjohnambulance.co.za/history/>

¹⁸⁰ Huyssteen, van, Nina. "A Legal Analysis of the Emergency Medical Services in South Africa." University of Pretoria, 2015-16. https://repository.up.ac.za/bitstream/handle/2263/60108/VanHuyssteen_Legal_2017.pdf?sequence=1

¹⁸¹ "Health Act No. 63 of 1977." Government of South Africa, May 17, 1977. Accessed February 16, 2023. https://www.ehrn.co.za/download/act_health.pdf

UNITED STATES OF AMERICA

While the NHTSA sets guidelines for EMC¹⁸² for road traffic injuries or other for emergency medical care throughout the United States of America, emergency medical care is ultimately handled and regulated on a state-by-state basis. States employ both publicly operated Emergency Medical Services and private and/or for-profit Emergency Medical Services. For example, both models are used for ambulance services. It is very common for ambulances to use a “fee-for-transport” reimbursement model that pays by the mile¹⁸³.

At the Facility: Early advance care and decisive care (emergency room)

AUSTRALIA

New South Wales (NSW)

The NSW Trauma System is composed of three levels: Major Trauma Service (MTS), Regional Trauma Service (RTS), and local hospitals¹⁸⁴. The primary goal of the NSW Trauma System is to ensure injured patients are able to receive timely access to suitable level of care, in addition to the optimisation of patient survival and recovery after severe injury¹⁸⁵. MTS provides the full continuum of treatment for the most severely wounded patients, from immediate resuscitation to definitive care, recovery, and discharge. RTS provides, in conjunction with the MTS, all aspects of treatment to patients with mild to moderate trauma, as well as definitive care to a limited number of severe trauma patients¹⁸⁶. When clinically appropriate, the RTS may facilitate transfer to an MTS and provide initial assessment, stabilisation, and definitive treatment.

Queensland

Upon a patient's arrival to the Emergency Department (ED), a medical assessment is carried out to assess the patient's level of risk. A patient is given a rating from 1 to 5.

- a. **Rating 1:** immediately life-threatening (critical injury or cardiac arrest);
- b. **Rating 2:** imminently life-threatening (critical illness, very severe pain, serious chest pains, difficulty in breathing or severe fractures);

¹⁸² “Highway Safety Programme Guideline no. 11: Emergency Medical Services.” National Highway Traffic Safety Administration. Accessed March 17, 2023. <https://icsw.nhtsa.gov/nhtsa/whatsup/tea21/tea21programs/pages/EMS.htm>

¹⁸³ “Trauma Programs, Part 4: America's Incomplete Trauma System.” American College of Surgeons. Accessed January 23, 2023. <https://www.facs.org/quality-programs/trauma/systems/trauma-series/part-iv/>

¹⁸⁴ “NSW trauma services.” Government of NSW, Australia. Accessed February 16, 2023. https://aci.health.nsw.gov.au/networks/institute-of-trauma-and-injury-management/clinical/trauma_system/nsw_trauma_system/nsw_trauma_services

¹⁸⁵ “Improving the Quality of Trauma Care in NSW: Trauma Services Model of Care.” Government of New South Wales, 2019. Accessed February 16, 2023. https://aci.health.nsw.gov.au/__data/assets/pdf_file/0010/521749/Improving_the_quality_of_trauma_care_in_NSW.-Trauma_services_model_of_care_final_clean.pdf

¹⁸⁶ “Selected Specialty and Statewide Service Plans.” NSW Trauma Services, December 2009. Accessed February 16, 2023. https://aci.health.nsw.gov.au/__data/assets/pdf_file/0003/244236/NSW_Trauma_Services_Plan_Dec_2009.pdf

- c. **Rating 3:** potentially life threatened patients (severe illness, bleeding heavily from cuts, have major fractures, dehydrated);
- d. **Rating 4:** potentially serious (less severe symptoms or injuries, such as foreign body in the eye, sprained ankle, migraine or earache); and
- e. **Rating 5:** less urgent patients (minor illnesses or symptoms, rashes, minor aches and pains)¹⁸⁷.

South Australia

The trauma team collaborates closely with the ED, by overseeing trauma patient care in the ED as well as providing follow-up care for admitted patients, as required. Both Level 1 and 2 (high risk) trauma patients who report to the ED are admitted to the Trauma Service. They are assigned to a “home team” appropriate for their condition. A multi-disciplinary clinical governance and audit scheme is in place at the Trauma Service¹⁸⁸.

Tasmania

An ED’s job is to assess, diagnose, and treat patients who have a serious illness or were in a serious accident or road crash that could result in severe complications if not treated quickly. Patients are seen in the order of clinical priority, not necessarily in the order of arrival, with those who need immediate treatment attended to first. For each patient in the ED, there are three distinct stages within the ED care pathway, these stages include the following:

- a. **Input:** how and why the patient arrived at the ED.
- b. **Throughput:** this stage consists of two components;
 - i. Triage Placement: sorting and prioritising patients based on urgency.
 - ii. Diagnostic testing, treatment, disposition decision, and planning.
- c. **Output:** discharging patients out of the ED into inpatient areas or discharging patients with appropriate follow ups¹⁸⁹.

Victoria

1. The Victoria State Trauma System (VSTS)¹⁹⁰ provides support and retrieval services for critically injured patients requiring definitive care, transfer, and management.

187 “What to Expect.” Queensland Government, Australia. Accessed February 16, 2023. <https://www.qld.gov.au/health/services/emergency/what-to-expect>

188 “Trauma Service.” Government of South Australia. Accessed February 16, 2023. <https://www.rah.sa.gov.au/health-professionals/clinical-services/critical-care-services/trauma-service>

189 Emergency Care.” Government of Tasmania. Accessed February 15, 2023. https://www.health.tas.gov.au/sites/default/files/2021-12/OHS_supplement_4_emergency_care_DoHTasmania2014.pdf

190 “Key Messages.” Trauma, Government of Victoria, Australia. Accessed February 16, 2023. <https://trauma.reach.vic.gov.au/guidelines/early-trauma-care/key-messages>

2. The paramedics¹⁹¹ have a formal handover to the treating team as they arrive at the emergency room. Timing of the handover is determined by the patient's health needs and stability.
3. Receiving and resuscitating major trauma victims necessitates simultaneous assessment and treatment, with numerous tasks taking place at the same time. The severity of the injury, the care given or not given, and other factors such as the patient's age and medical comorbidities can all influence the patient's reaction to resuscitation. Primary and Secondary surveys are then carried out. The initial assessment and treatment of a trauma patient is the primary survey. It is carried out to diagnose and treat real or potential life threats, as well as to prevent complications from becoming more severe.
4. After the patient has been resuscitated and stabilised¹⁹², the Secondary survey is conducted. It entails a more detailed head-to-toe inspection with the aim of detecting other serious yet non-life-threatening injuries. If any deterioration is discovered during the examination, clinicians shall re-evaluate the primary survey.

Western Australia

Each patient is assigned a triage category based on the triage nurse's evaluation of their presenting conditions, with triage 1 being the most urgent and triage 5 being the least urgent. Patients are always seen in order of clinical urgency¹⁹³.

For Territorial Legislation refer to annex 4a (Page 132)

BRAZIL

With the objective to provide health care in urgent and emergency situations, the Emergency Care Network in Brazil includes the following components:

1. Health Promotion, Prevention and Surveillance
2. Primary Care
3. SAMU 192
4. Stabilisation Room
5. SUS National Force
6. UPA 24h (Emergency Care Unit)
7. Hospital Units and Home Care¹⁹⁴

¹⁹¹ "Early Activation." Trauma, Government of Victoria, Australia. Accessed February 16, 2023. <https://trauma.reach.vic.gov.au/guidelines/early-trauma-care/early-activation>

¹⁹² "Secondary Survey." Trauma, Government of Victoria, Australia. Accessed February 16, 2023. <https://trauma.reach.vic.gov.au/guidelines/early-trauma-care/secondary-survey>

¹⁹³ "Guide to interpreting Emergency Department Dashboards." Department of Health, Government of Australia, 2019. Accessed February 16, 2023. <https://ww2.health.wa.gov.au/~media/Files/Corporate/Reports-and-publications/Emergency-activity/ED-Guide-for-Interpretation.pdf>

¹⁹⁴ "Unidade De Pronto Atendimento (UPA 24h)." Ministério da Saúde. Accessed February 8, 2023. <https://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/u/upa-24h>

The UPA 24h operates for 24 hours a day and seven days a week to address health care emergencies. The health conditions include clinical, surgical, traumatological nature etc. Under the scope of the UPA, facilities such as electrocardiography, X-rays, paediatrics, examination laboratory and observation beds are provided for.

ENGLAND AND WALES

Overview of organisations and frameworks governing protocols regarding emergency room care:

- » The NHS Commissioning Board (NHS England), was created to promote a comprehensive health service, holding this duty concurrently with that of the Secretary of State.¹⁹⁵
- » Alongside directly commissioning some services, NHS England regulates the commissioning activities of Clinical Commissioning Groups (CCG) that commission the majority of NHS services.
- » Integrated Care Boards were created under the Health and Care Act 2022¹⁹⁶ with Integrated Care Systems (ICSs) responsible for arranging for medical services other than primary medical services, dental services other than primary dental services, hospital accommodation, nursing and ambulance services, to name a few.
- » Guidance was published by the Royal College of Emergency Medicine (RCEM Guidance)¹⁹⁷ and NHS England to support clinical streaming in the Accident and Emergency (A&E) departments of hospitals.¹⁹⁸
- » The “A&E Clinical Quality Indicators, Best Practice Guidance for Local Publication” sets out best practice guidance for presentation and publication of the A&E clinical quality indicators. A&E sites following this guidance will ensure that locally published information on the indicators provides an accurate, transparent and comparable reflection of their performance¹⁹⁹.

As per RCEM Guidance, patients attending A&E should be registered within 5 minutes and as per the Streaming Guidance, streaming (e.g. ‘majors’, ‘minors’, ‘resuscitation’, children’s

¹⁹⁵ “Health and Social Care Act 2012.” October 1, 2012. <https://www.legislation.gov.uk/ukpga/2012/7/section/974>. “Initial Assessment of Emergency Department Patients.” The Royal College of Emergency Medicine. Accessed January 24, 2023. https://rcem.ac.uk/wp-content/uploads/2021/10/SDDC_Intial_Assessment_Feb2017.pdf

¹⁹⁶ Section 21 of the “Health and Care Act 2022”. Government of the United Kingdom, 2022. <https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/integrated-care-boards-functions>

¹⁹⁷ “Initial Assessment of Emergency Department Patients.” Royal College of Emergency Medicine. Accessed February 3, 2023. https://rcem.ac.uk/wp-content/uploads/2021/10/SDDC_Intial_Assessment_Feb2017.pdf

¹⁹⁸ “Clinical Streaming in the Accident and Emergency (A&E) Department.” Principles for clinical streaming - NHS England, July 2017. <https://www.england.nhs.uk/wp-content/uploads/2017/07/principles-for-clinical-streaming-ae-department.pdf>

¹⁹⁹ “A&E Clinical Quality Indicators – Best Practice Guidance for Local Publication.” Accessed February 3, 2023. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/557096/prov-ae-qual-indi-eng-June_2016-rep2.pdf

'majors' and 'minors') should be performed within 15 minutes of arrival. This includes a trained clinician taking a brief history of the patient and undertaking basic observations. Streaming should include calculation of an early warning score²⁰⁰ for appropriate patients and follow the RCEM Guidance for rapid assessment systems.

For further details please refer to annex 4b (Page 132)

GERMANY

The German health care system has three crucial components including outpatient care, inpatient care (the hospital sector), and rehabilitation facilities.²⁰¹ Section 28(1) of the Federal State Hospital Act of Baden-Wuerttemberg states that anyone who needs inpatient care has a right to be admitted to a suitable hospital²⁰²

Most hospitals in Germany treat all patients, regardless of whether they have statutory²⁰³ or private²⁰⁴ health insurance. Large hospitals usually have public backing, and are financed by the state or municipality. Charity-run or church-run hospitals are operated by organisations like the Red Cross and similar institutions.²⁰⁵ There are also many privately-run hospitals, some of which only treat patients who are privately insured. These hospitals are typically smaller and more likely to be specialised.²⁰⁶

If one has to stay overnight in a hospital for treatment, it is referred to as "inpatient treatment" (*stationäre Behandlung*).²⁰⁷ Additional fee is charged for accommodation and meals that are not covered by statutory insurers.²⁰⁸ The fee is stipulated in a "contract" between the patient and the hospital before the treatment is carried out.²⁰⁹

In addition to inpatient treatment in hospitals, there is also inpatient medical rehabilitation.²¹⁰ Rehabilitation facilities provide treatments that help people regain independence and improve

200 "National Early Warning Score(NEWS)." NHS choices. NHS. Accessed February 3, 2023. <https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/>

201 "Health Care in Germany: The German Health Care System - NCBI Bookshelf." Accessed February 8, 2023. <https://www.ncbi.nlm.nih.gov/books/NBK298834/>

202 GmbH. "Landesrecht BW Bürgerservice." Landesrecht BW Suche nach: KHG+BW. Accessed February 3, 2023. <https://www.landesrecht-bw.de/jportal/?quelle=jlink&query=KHG+BW&psml=bsbawueprod.psml&max=true&aiz=true#jlr-KHGBW2008pP28>

203 Everyone must have statutory health insurance ("gesetzliche Krankenversicherung" – GKV) provided that their gross earnings are under a fixed limit ("Versicherungspflichtgrenze")

204 Anyone who earns more than that can choose to have private insurance ("private Krankenversicherung" – PKV)

205 ibid

206 ibid

207 ibid

208 ibid

209 ibid

210 ibid

their fitness after recovering from a serious illness and intensive treatment.²¹¹ These include physiotherapy, psychological care and help learning how to use medical aids and appliances.²¹² This is often done immediately after a hospital stay, for instance following surgery.²¹³ There are also rehabilitation facilities for people with mental illnesses and addictions.²¹⁴

Aside from the obligation for hospitals to administer treatments to any emergency patient, the German Social Security Act provides for an obligation for every hospital to implement a certain level of emergency care services. Hospitals failing to meet these EMS levels may receive lesser compensation for the treatment of patients. The Federal Joint Committee (G-BA), a public legal entity in which are represented the National Associations of Statutory Health Insurance Physicians and Dentists, the German Hospital Federation, and the Central Federal Association of Health Insurance Funds, has set out the following levels of emergency structures²¹⁵:

- » **Level 1:** Basic Emergency Care
- » **Level 2:** Extended Emergency Care
- » **Level 3:** Comprehensive Emergency Care

The different emergency care levels set out specific requirements as regards the structures participating hospitals need to maintain in terms of type and number of specialised departments, number and qualification of medical personnel, capacities for intensive care patients, medical-technical equipment, structures and processes for acceptance of emergency cases.

Level 1 hospitals²¹⁶

- » Have at least a surgery or trauma surgery department and a department for internal medicine; one physician and one caregiver with specific qualifications who are clearly assigned for emergency cases, specialists for internal medicine, surgery and anaesthesia are available within a maximum of 30 minutes; the aforementioned personnel regularly attends training in emergency care;
- » An ICU with a minimum of 6 beds, 3 of which must be suitable for ventilated patients; and in particular, have a shock room and computed tomography available 24-hours a day; and

²¹¹ *ibid*

²¹² *ibid*

²¹³ *ibid*

²¹⁴ *ibid*

²¹⁵ "Rules of the Federal Joint Committee on a Staggered System of Emergency Care Structures in Hospitals" Section 136c para. 4, the Fifth Book of the Social Security Code (SGB V) as amended on November 20, 2020. https://www.g-ba.de/downloads/62-492-2340/Not-Kra-R_2020-11-20_iK-2020-11-01.pdf

²¹⁶ "Rules of the Federal Joint Committee on a Staggered System of Emergency Care Structures in Hospitals", Sections 8- 12, the Fifth Book of the Social Security Code (SGB V) as amended on November 20, 2020. https://www.g-ba.de/downloads/62-492-2340/Not-Kra-R_2020-11-20_iK-2020-11-01.pdf

- » A centralised emergency acceptance unit; a structured and validated system for the prioritisation of emergency patients ensuring that such patients are assessed at the latest 10 minutes post arrival, and that caregiving is sufficiently documented.

Level 2 hospitals²¹⁷ *Inter alia* have, in addition to the level 1 requirements,

- » At least 4 additional specialised departments as defined in the rules (e.g. neurosurgical, orthopaedical, neurological, cardiological, paediatric departments);
- » Specific medical-technical equipment (i.e. for Percutaneous Coronary Intervention (PCI), magnetic resonance tomography, specific equipment for the primary diagnosis of strokes and the administration of stroke specific initial therapy), and a landing area for helicopters; and
- » The centralised emergency acceptance unit has an observation unit with at least 6 beds.

Level 3 hospitals²¹⁸ *Inter alia* have, in addition to the level 1 and level 2 requirements:

- » At least seven additional specialised departments as defined in the rules (e.g. neurosurgical, orthopaedical, neurological, cardiological, paediatric departments); and

For further details please refer to annex 4c (Page 135)

INDIA

The Supreme Court judgement in *Parmanand Katara v. Union of India and Ors.*, states that hospitals and medical practitioners have a duty to provide emergency medical care²¹⁹. Below mentioned are other laws and policies pertaining to emergency medical care at healthcare facilities in India:

- » The National Consumer Disputes Redressal Commission in *Pravat Kumar Mukherjee v. Ruby General Hospital and Ors.*²²⁰ ruled that a hospital is duty-bound to accept crash victims and patients who are in critical condition. Treatment cannot be refused on grounds that the victim is unable to meet expenses, or that there are no close relations of the victim available to give consent for medical treatment.
- » The Charter of Patients' Rights,²²¹ framed by the National Human Rights Commission was produced with the aim to act as a guidance document for the federal and state governments

²¹⁷ "Rules of the Federal Joint Committee on a Staggered System of Emergency Care Structures in Hospitals", Sections 13- 17, the Fifth Book of the Social Security Code (SGB V) as amended on November 20, 2020. https://www.g-ba.de/downloads/62-492-2340/Not-Kra-R_2020-11-20_iK-2020-11-01.pdf

²¹⁸ "Rules of the Federal Joint Committee on a Staggered System of Emergency Care Structures in Hospitals", Sections 18- 22, the Fifth Book of the Social Security Code (SGB V) as amended on November 20, 2020. https://www.g-ba.de/downloads/62-492-2340/Not-Kra-R_2020-11-20_iK-2020-11-01.pdf

²¹⁹ *Parmanand Katara v Union of India and Ors.* 1989 SCR (3) 997. <https://main.sci.gov.in/jonew/judis/7839.pdf>

²²⁰ *Pravat Kumar Mukherjee v Ruby General Hospital & Ors.* Original Petition No. 90 of 2002. <https://indiankanoon.org/doc/173553/>

²²¹ "Charter of Patients' Rights for Adoption by NHRC." Accessed February 3, 2023.

to formulate concrete mechanisms to make the guidelines legally binding. The Charter, which was put up for consultation by the Ministry of Health and Family Welfare, includes the right to emergency medical care.

- » As per the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002²²², even though a physician may ordinarily refer a patient to another physician, in case of emergency, the physician must treat the patient. The physician must respond to any request for their assistance in an emergency and once having undertaken the case, must discharge their duties without neglect. Moreover, the physician should not withdraw from the case without giving adequate notice to the patient as well as the patient's family.
- » Section 134 of the Motor Vehicles Act, 1988²²³ levies responsibility upon a medical practitioner or a doctor on duty in a hospital to render the medical care required by a crash victim immediately without waiting for any procedural formalities to be completed. Failure to do so is punishable under Section 187 of the Act with imprisonment or fine or both²²⁴
- » The health workers employed with health sub-centres are required to provide emergency and first-aid care for crashes, under the Indian Public Health Standards Guidelines for sub-centres.²²⁵ Such guidelines also exist for Primary Health centres²²⁶, Sub-District Hospitals²²⁷, and District Hospitals²²⁸. If the cases are beyond their competence, they should refer such cases to Primary Health centres, which have 24-hour emergency services as mandated under the Indian Public Health Standards Guidelines for Primary Health Centres.²²⁹
- » The Clinical Establishments (Registration and Regulation) Act, 2010 provides that clinical establishments shall undertake to provide within the staff and facilities available, such medical examination and treatment as may be required to stabilise the emergency medical condition of any individual who comes or is brought to such clinical establishment.²³⁰ Standards under the Act for level 1A and 1B hospitals advise that each general hospital should have an emergency department to deal with immediate and urgent care, whereas specialised hospitals may have trauma centres.²³¹

For further details please refer to annex 4d (*Page 136*)

Commentary: According to a recent report by the All India Institute of Medical Sciences (AIIMS), Delhi the quality of care differs between different government centres. Further, district hospitals often lack trained staff, adequate infrastructure, and supply of consumables. Triage

²²² Regulation 2.1 and 2.4, "Indian Medical Council (Professional Conduct, Etiquette and Ethics ...," March 11, 2002. <https://wbconsumers.gov.in/writereaddata/ACT%20&%20RULES/Relevant%20Act%20&%20Rules/Code%20of%20Medical%20Ethics%20Regulations.pdf>

²²³ "Section 134(a) of The Motor Vehicles (Amendment) Act, 2019." pg. 102. Ministry of Law and Justice, Government of India, August 9, 2019. <https://egazette.nic.in/WriteReadData/2019/210413.pdf>

²²⁴ "Section 187 of The Motor Vehicles Act, 1988." pg. 147. Ministry of Law and Justice, Government of India, October 14, 1988. <https://morth.nic.in/motor-vehicles-act-1988>

²²⁵ "Guidelines for Sub-Centres." National Health Mission. Directorate General of Health Services Ministry of Health & Family Welfare Government of India, 2012. <https://nhm.gov.in/images/pdf/guidelines/iphs/iphs-revised-guidelines-2012/sub-centers.pdf>

is rarely practised. There is also a lack of designated trauma centres and dedicated trauma surgeons in India. In the absence of defined roles amongst specialists, clinical decisions are often delayed, thus putting particularly multi-system injury patients at great risk. India has only 1 doctor for every 1,700 patients. Thus, there are a number of gaps that need to be addressed in India's decisive care²³².

Further the punitive measures with regard to Section 134 of the Motor Vehicles Act, 1988²³³ levies responsibility upon a medical practitioner or a doctor on duty in a hospital to render the medical care required by a crash victim immediately without waiting for any procedural formalities to be completed. Failure to do so is punishable under Section 187 of the Act with imprisonment or fine or both.

JAPAN

Hospitals are required to provide appropriate information and emergency care corresponding to the patient's condition, under the Notice on Medical System for Diseases, Programs and Home Care, by the Ministry of Health, Labour and Welfare of Japan (MHLW) on March 31, 2017. In Japan, there are three designated levels of emergency hospitals based on the perceived acuity of the patient.²³⁴ These are primary emergency centres that deal with patients who can be managed as outpatients; secondary emergency centres that deal with patients who can be managed as inpatients on a general medical floor; and tertiary care that deals with patients who need to be managed in the operating room or the ICU.²³⁵

MALAYSIA

Emergency departments in Malaysia are divided according to clinical zones based upon a triage system (i.e. a three-tier system where the cases are categorised by acuity). The triaging services counter is the first point of contact for all patients accessing the emergency department of a hospital²³⁶. The purpose of the triage system is to ensure brevity, include early clinical intervention or appropriate investigation, strategic utilisation of resources and integrate

²³² "Emergency and Injury Care at District Hospitals in India, A Report of Current Status on Country Level Assessment." All India Institute of Medical Sciences, New Delhi, and NITI Aayog, 2021. https://www.niti.gov.in/sites/default/files/2021-12/AIIMS_STUDY_2_0.pdf

²³³ "Section 134(a) of The Motor Vehicles (Amendment) Act, 2019." pg. 102. Ministry of Law and Justice, Government of India, August 9, 2019. <https://egazette.nic.in/WriteReadData/2019/210413.pdf>

²³⁴ Shimizu, K. et al. "Emergency medicine in Japan: Past, present, and future," International Journal of Emergency medicine, BioMed Central. Springer Berlin Heidelberg, 2021. Accessed: February 8, 2023. <https://intjem.biomedcentral.com/articles/10.1186/s12245-020-00316-7#:~:text=EMS%20training%20is%20stratified%20into,Emergency%20Life%2DSaving%20Technician%5D>.

²³⁵ *ibid*

²³⁶ "Section 9.1.1.1, Emergency Medicine and Trauma Services Policy." Accessed February 2, 2023. https://www.moh.gov.my/moh/images/gallery/Polisi/EMTS_Book.pdf

efficient time management techniques²³⁷. Emergency clinical care includes resuscitation and stabilisation, diagnosis and management of life-threatening conditions, early definitive care management and patient disposition²³⁸.

For further details please refer to annex 4e (*Page 138*)

PAKISTAN

- » The Punjab Emergency Act contains broader provisions for the creation of an EMS 'council' to oversee and implement EMS care. This does not deal with the specifics of emergency room or early stage health care provision.
- » The Sindh Medical Act states that no person shall be denied healthcare at a hospital and the costs will be borne, at least in the first instance, by the hospital, provided that the Health Department will indemnify the hospital and the injured person shall be shifted to a Government hospital as soon as they are stable. It also provides that no doctor requires the consent of the injured person in the event immediate medical care is required.
- » The Sindh Government has made an agreement with the Aman Foundation (an NGO established in 2008) to provide EMS in rural Sindh, initially in the Thatta and Sajawal districts..
- » The Khyber Pakhtunkhwa Emergency Act provides that hospitals shall have a dedicated trained doctor in emergency care and medico legal procedures, although it is not clear what such procedures are.
- » As with the Punjab Emergency Act, the Gilgit Baltistan Emergency Act contains broader provisions for the creation of an EMS 'council' to oversee and implement EMS care. It does not deal with the specifics of emergency room or early stage healthcare provision. In each case, the scope of the relevant Act is broad and there is little detail with respect to providing an injured person with early-stage medical treatment.

²³⁷ "Section 9.1.1.4, Emergency Medicine and Trauma Services Policy." Accessed February 2, 2023. https://www.moh.gov.my/moh/images/gallery/Polisi/EMTS_Book.pdf

²³⁸ "Section 9.1.2.1, Emergency Medicine and Trauma Services Policy." Accessed February 2, 2023. https://www.moh.gov.my/moh/images/gallery/Polisi/EMTS_Book.pdf

SOUTH AFRICA

The Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, 1974²³⁹, includes an annexure dealing with rules of conduct pertaining specifically to emergency medical care. The EMS regulations listed under the National Health Act, set out the services to be provided as well as the necessary licensing processes for these services. The regulations also list powers of the emergency medical personnel and penalties in the event of contravening the same.

The South African Triage Scale (SATS)²⁴⁰, developed by Western Cape Government, serves the purpose of prioritising patients based on medical urgency in contexts where there is a mismatch between demand and capacity (i.e. patient load overwhelms the available resources). The implementation of SATS has numerous benefits such as expediting the delivery of time-critical treatment for patients with life-threatening conditions, ensuring that all patients are appropriately prioritised according to their medical urgency, and improving patient flow.

In *Soobramoney v. Minister of Health*²⁴¹, Justice Sachs noted, right to emergency care provided reassurance to the public that accident and emergency departments would be available to deal with unforeseeable catastrophes that could befall any person, at any place and at any time.

For further details please refer to annex 4f (Page 140)

Commentary: While there are legislation and guidelines in place which make access to emergency care a right to all persons in South Africa, there are practical issues with actual enforcement of the right. There is much concern regarding the availability of resources to provide the necessary Emergency Medical Services to all persons in need.

UNITED STATES OF AMERICA

Federal: With respect to emergency services, the EMTALA is a federal statute that requires anyone coming to a hospital emergency department (that receives federal funding through the federal Medicare program) to be stabilised and treated, regardless of their insurance status or ability to pay²⁴². The EMTALA applies to emergency medical and childbirth services. Once

239 "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

240 "The South African Triage Scale, Training Manual." Western Cape Government. Accessed February 24, 2023. <https://emssa.org.za/wp-content/uploads/2011/04/SATS-Manual-A5-LR-spreads.pdf>

241 *Soobramoney v. Minister of Health, KwaZulu-Natal*, (1) SA 765 (CC) at 778, November 27, 1997. https://www.escri-net.org/sites/default/files/Soobramoney_Decision.pdf

242 "Understanding EMTALA." American College of Emergency Physicians. Accessed February 17, 2023. <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/>

stabilised, the hospital must either provide further medical treatment required to stabilise the patient or otherwise transfer the patient to another medical facility (in accordance with certain rules and restrictions). The EMTALA has expanded to cover patients seen anywhere on the hospital property, including ambulances owned and operated by the hospital.

State: Many states have legislation requiring hospitals to provide emergency care regardless of the patient's ability to pay for such services. Similar to the EMTALA, other states require patients to be in stable condition before being transferred to another hospital.²⁴³

C. Emergency Care Funding: State, insurance and privately-sourced funding

AUSTRALIA

The Australian federal government

Funding the Australian Health System: Medicare

The sources of funding for the Australian health system consists of both government and non-government funders. Governmental funders include the Australian federal government, States, territories, and local governments. Non-governmental funders include private health insurers, individuals who pay out of pocket, and any other non-governmental funders²⁴⁴. The Health Insurance Act of 1973²⁴⁵ provides payments of medical benefits and for hospital services through the Medicare scheme which is Australia's universal healthcare scheme. It guarantees low or no-cost access to various health and hospital services, including emergency room visits in public hospitals. However, Medicare does not cover the cost of emergency transport or any other ambulance services²⁴⁶. All states have various insurance schemes for their ambulance services, with the exception of Queensland and Tasmania, in which the state government covers ambulance services.

The Australian government contributes a significant amount of money to medical care and subsidised medications, with the rest coming from the private sector. The majority of support for community health programmes comes from state and territory governments. Significant portions of the funding for aids and equipment, some prescriptions, and other health provider services come from non-government sources (such as private health insurers and individuals), as well as private hospitals.

²⁴³ See, e.g., Mass. Gen. Laws c. 17 §21; Cal. Health & Safety Code §1317(a); Karen H. Rothenberg, Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care (Houston Law Review 1989).

²⁴⁴ "Cost of healthcare in Australia: The Australian health system." Government of Australia. Accessed February 17, 2023. <https://www.health.gov.au/about-us/the-australian-health-system>

²⁴⁵ "Health Insurance Act 1973." Government of Australia, June 17, 2022. <https://www.legislation.gov.au/Details/C2022C00174>

²⁴⁶ "Ambulance Costs." Government of Tasmania. Accessed February 17, 2023. <https://www.health.tas.gov.au/hospitals/ambulance/ambulance-costs>

The National Health Reform Agreement

The National Health Reform Agreement²⁴⁷ is an agreement between the Australian government and all State and territory governments. It aims at delivering organised and comprehensive health care in the community, and ensuring the long-term viability of the health system in Australia. It is the pillar of Australia's public hospital system's accountability, governance, and funding. The Australian government provides funds to the states and territories for public hospital facilities under this arrangement. The agreement involves programmes offered for EDs, clinics, and community-based health centres. Based on the agreement, States provide health and emergency services through the public hospital system, in accordance with Medicare principles. The agreement further establishes that access to public hospital facilities must be focused on clinical necessity, must be delivered within a clinically reasonable time frame and should include arrangements for equitable access to healthcare services for all eligible persons.

State Legislation

New South Wales

1. Ambulance dispatch and usage are not free of charge, and Medicare does not cover these costs. The NSW government offers a 49% subsidy, and residents are charged 51% of the actual cost²⁴⁸.
2. Private health funds manage ambulance coverage in NSW. However, if the patient has private health insurance, an ambulance's expense may not be covered by their programme since this depends on the extent of coverage²⁴⁹.
3. NSW Ambulance charges for services rendered in compliance with the Health Services Act, such as scene assessment and/or transportation. Regardless of who called the ambulance, the patient will be charged for the service rendered²⁵⁰. There are certain exemptions from ambulance charges²⁵¹. Commonwealth Seniors Healthcare Card holders, patients covered by a private health fund, a school, or community donation, a worker's compensation, motor crash, or third-party insurance claims are eligible for free ambulance services.

²⁴⁷ "National Health Reform Agreement." Council of Australian Governments. Accessed February 17, 2023. <https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-08/national-agreement.pdf>

²⁴⁸ "NSW Ambulance." NSW Government. Accessed February 17, 2023. <https://www.ambulance.nsw.gov.au/our-services/accounts-and-fees>

²⁴⁹ "NSW Ambulance." NSW Government. Accessed February 17, 2023. <https://www.ambulance.nsw.gov.au/our-services/accounts-and-fees/ambulance-coverage-if-you-are-a-nsw-resident>

²⁵⁰ "NSW Ambulance." NSW Government. Accessed February 17, 2023. <https://www.ambulance.nsw.gov.au/our-services/accounts-and-fees/ambulance-coverage-if-you-are-a-nsw-resident>

²⁵¹ "NSW Ambulance." NSW Government. Accessed February 17, 2023. <https://www.ambulance.nsw.gov.au/our-services/accounts-and-fees/exemptions-from-nsw-ambulance-fees>

4. Depending on the type of health services rendered, the funding allocation between the government and the non-government sector varies. The state and territory governments finance public hospitals, but they are mostly owned and operated by the state and territory governments. Private (non-government) organisations, whether for-profit or not-for-profit, own and run the vast majority of private hospitals.

Queensland

1. Ambulance Service Act

An individual whose principal place of residence is Queensland is not liable to pay a charge for ambulance services (s53B)²⁵².

2. The majority of the annual health budget is distributed by Service Agreements to hospital and health services, and other organisations, to provide frontline hospital and health facilities, with the remaining balance supporting better patient outcomes through centralised state-wide services. Queensland's health funding is provided from the following sources:
 - a. State government
 - b. Commonwealth government
 - c. Grants and contributions
 - d. Own source revenue²⁵³

South Australia

1. The South Australia Ambulance Service (SAAS) is required by law to charge a fee for emergency services under the South Australian Healthcare Act 2008. This fee is determined by the type of service rendered, such as attendance with treatment but no transportation, attendance with treatment and transportation to/from a hospital, and so on. Standard fees apply when transportation is provided²⁵⁴.
2. SAAS charges for its ambulance services relating to treatment and/or transport of persons except in the following cases²⁵⁵:
 - a. The person holds a valid and current Ambulance Cover membership
 - b. The service is for the initial attendance at a motor vehicle crash
 - c. Payment for the invoice is the responsibility of another party and such party has acknowledged responsibility for payment of the invoice.

²⁵² "Ambulance Service Act 1991." Government of Queensland, Australia, March 1, 2017. <https://www.legislation.qld.gov.au/view/pdf/2017-03-01/act-1991-036>

²⁵³ Health Funding Principles and Guidelines 2017-18 financial year." Government of Queensland. Accessed February 17, 2023. https://www.health.qld.gov.au/__data/assets/pdf_file/0021/707133/funding_guidelines.pdf

²⁵⁴ "Fees and Charges." South Australia Ambulance System. Accessed February 17, 2023. <https://saambulance.sa.gov.au/what-we-do/fees-and-charges/>

²⁵⁵ "Fees and Charges." South Australia Ambulance System. Accessed February 17, 2023. <https://saambulance.sa.gov.au/what-we-do/fees-and-charges/>

Tasmania

Ambulance Tasmania offers a free service to Tasmanian residents. Only cases involving a motor vehicle or occupational injuries, for which insurance arrangements cover expenses, and cases involving veterans, for which the Department of Veterans Affairs pays for emergency transportation, are chargeable²⁵⁶.

Victoria

Ambulance charges may be covered either through private health insurance or Ambulance Victoria membership²⁵⁷.

Concession patients receive free, clinically necessary ambulance coverage throughout Australia. This coverage provides free emergency and medically authorised non-emergency ambulance transport to the nearest and most appropriate hospital. For the purpose of ambulance transport, the Concession classification includes:²⁵⁸

1. A person holding a current Victorian Pensioner Concession Card (includes dependent children listed on the card but not spouses)
2. A current Health Care Card holder and their dependents including spouses listed on the card (does not include Health Care Card for carer allowance and foster care issued in the name of the child)
3. A child holding a current Child Disability Health Care Card or Foster Child Health Care Card, but not their guardians/families listed on the card
4. A child under a Family reunification, Care by Secretary or Long-term care order including children on interim accommodation orders
5. A person who is subject to an order under the Mental Health Act 2014, Sentencing Act 1991, or Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 requiring them to be compulsorily assessed or treated in a designated mental health service. This includes compulsory, security and forensic patients.
6. Asylum seekers who are clients of one of the 16 nominated agencies for asylum seeker support.

²⁵⁶ "Ambulance Tasmania: Candidate Information: Chief Executive." Tasmanian Government, January 2021. Accessed February 17, 2023. <https://drive.google.com/file/d/1HorK5r7uTCKbE71-UvIfei6IU5FW0jHP/view?usp=sharing>

²⁵⁷ "Ambulance cover." Department of Health, Victoria, Australia. Accessed February 17, 2023. <https://www.health.vic.gov.au/patient-care/ambulance-cover>

²⁵⁸ "Ambulance payment responsibilities, authorisations and concessions." Government of Victoria, Australia. Accessed February 17, 2023. <https://www.health.vic.gov.au/patient-care/ambulance-payment-responsibilities-authorisations-and-concessions>

Western Australia

The cost of calling an ambulance varies depending on the situation. Coverage is obtained by private insurers and is the responsibility of the patient for transfers between public to private hospitals²⁵⁹.

For Territorial Legislation (Australian Capital Territory & Northern Territory) refer to annex 5a (Page 141)

BRAZIL

Brazil provides for a universal health care system.²⁶⁰ The SUS offers many services free of charge such as preventative services, primary care, outpatient care, inpatient care, maternity care, mental health services, pharmaceuticals, dental care, vision care, and physical therapy for residents and visitors, including undocumented individuals.²⁶¹ Public hospitals in Brazil offer free, high-quality care at the point of delivery and the private health insurance is voluntary and supplementary to the SUS.²⁶²

Brazilians also benefit from public insurance that covers crashes that happen on national roads, regardless of who caused the crash. This insurance is called *Danos Pessoais por Veículos Automotores Terrestres (DPVAT)* and was established by Law n. 6.194 of 1974²⁶³. DPVAT is paid annually by every vehicle owner and covers medical expenses, permanent disability and death. The indemnities have a limit and depend on the case of the victim.

Commentary: Accessible to the population, with medical assistance provision for emergencies and urgent cases, and a system for consultations, prescriptions, medications, therapies and other non-urgent medical care, SUS often suffers due to a lack of governmental investment²⁶⁴. Depending on the SUS alone without independent health insurance, may result in inefficient medical care compared to the care received in private hospitals. This does not, however, diminish the importance and relevance of the SUS in Brazil. 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.

259 "WA Health Patient Fees and Charges Manual 2022/23." Government of Western Australia, January 2023. Accessed February 17, 2023. <https://ww2.health.wa.gov.au/~media/Corp/Documents/Reports-and-publications/Fees-and-charges/WA-Health-Fees-and-Charges-Manual.pdf>

260 "Brazil: Summary." publichealth.columbia.edu. Accessed February 14, 2023. [https://www.publichealth.columbia.edu/research/comparative-health-policy-library/brazil-summary#:~:text=HEALTH%20%26%20HEALTH%20SYSTEM,-Brazil%20has%20a&text=The%20Sistema%20%C3%9Anico%20de%20Sa%C3%BAde%20\(SUS\)%20is%20Brazil's%20national%20health,federal%2C%20state%2C%20and%20municipal.](https://www.publichealth.columbia.edu/research/comparative-health-policy-library/brazil-summary#:~:text=HEALTH%20%26%20HEALTH%20SYSTEM,-Brazil%20has%20a&text=The%20Sistema%20%C3%9Anico%20de%20Sa%C3%BAde%20(SUS)%20is%20Brazil's%20national%20health,federal%2C%20state%2C%20and%20municipal.)

261 ibid

262 ibid

263 "Seguradora Líder Sobre o Seguro DPVAT." Link para o site da Seguradora Líder. Accessed January 23, 2023. <https://www.seguradoralider.com.br/Seguro-DPVAT/Sobre-o-Seguro-DPVAT>

264 Pasternack, Jacyr. "What is the future of the Brazilian Public Health System?" *Einstein* (Sao Paulo); 16(4):eED4811, November 29, 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6276808/>

ENGLAND AND WALES

The health care systems in England and Wales (NHS England and NHS Wales, respectively) are state-funded through a combination of funds received from general taxation, National Insurance Charges (which are paid by employees and employers) and user charges (i.e., patients at the point of service). At a local level, the health care services are organised and provided by Clinical Commissioning Groups (CCGs) and NHS Trusts in England and Local Health Boards (LHB) in Wales²⁶⁵.

The general rule in England is that the cost of treatment for any specific patient is borne by that patient's local CCG²⁶⁶. However, there are exceptions to this rule, including with respect to emergency care (i.e. emergency ambulance services, A&E services and urgent treatment centres (including minor injury units and walk-in))²⁶⁷. The following applies to those services:

1. For emergency ambulance services, the responsibility for payment is with the local CCG based on the location where the patient's ambulance journey commences. For emergency ambulance transfers between hospitals, it is based on the location of the transferring hospital.
2. For A&E services and urgent treatment centres (including minor injuries units and walk-in centres), responsibility for payment is generally with the local CCG based on the location of where the patient is registered with a general practitioner (GP) or, if unregistered, where the patient is usually a resident²⁶⁸.

The rules in Wales are similar to those in England. The general rule in Wales is that the cost of treatment for any specific patient is borne by that patient's local LHB²⁶⁹. However, there also are exceptions to this rule, including with respect to emergency care (i.e. emergency ambulance services and A&E services). The following applies to those services:

1. For emergency ambulance services, responsibility for payment is with all LHBs through the Welsh Health Specialised Services Committee. Specifically in the case of emergency

²⁶⁵ "Local Health Boards." NHS Wales, United Kingdom. Accessed February 17, 2023. <https://law.gov.wales/public-services/health-and-health-services/local-health-boards>

²⁶⁶ Paragraph 4.4. of "Who Pays? Determining which NHS commissioner is responsible for making payment to a provider." NHS Contracting and Incentives Team, NHS England, August 2020. Accessed January 24, 2023. <https://www.england.nhs.uk/wp-content/uploads/2020/08/Who-Pays-final-24082020-v2.pdf>

²⁶⁷ Schedule 1, paragraph 2a of "The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012." National Health Service, United Kingdom, April 1, 2020. <https://www.legislation.gov.uk/ukssi/2012/2996/schedules?view=extent>

²⁶⁸ Paragraphs 10.2. And 17.3. of "Who Pays? Determining which NHS commissioner is responsible for making payment to a provider." NHS Contracting and Incentives Team, NHS England. Accessed January 24, 2023. <https://www.england.nhs.uk/wp-content/uploads/2020/08/Who-Pays-final-24082020-v2.pdf>

²⁶⁹ Paragraph 2.3. of the "Responsible Body Guidance for the NHS in Wales." National Health Services, Welsh Government, 2013. Accessed January 24, 2023. <https://www.gov.wales/sites/default/files/publications/2019-06/responsible-body-guidance-for-the-nhs-in-wales.pdf>

ambulance transfers between hospitals, responsibility for payment is with the local LHB based on the location of the referring hospital²⁷⁰.

2. For A&E services, responsibility for payment with respect to all persons present in an area is with the local LHB, regardless of those persons' residence or registration²⁷¹.

There are also rules to determine cross-border responsibility for the cost of emergency care. In England, the following applies:

1. Where a patient, usually a resident of Wales, attends an English A&E department, urgent treatment centre, minor injury unit or walk-in centre, the responsibility for payment falls on the local CCG based on the location of the A&E or centre.
2. Where a patient, usually a resident of Wales, is transported by an English emergency ambulance service, the responsibility for payment is with the local CCG based on the location where the patient's ambulance journey commences.
3. Where a patient, usually a resident of Wales, requires emergency inpatient admission to a hospital, responsibility for payment falls to the relevant NHS body in Wales, not to a local CCG.²⁷²

Similar cross-border rules apply in Wales for patients usually resident of England²⁷³. Additional arrangements have been agreed upon between NHS England and the Welsh Government to address responsibility for persons living in specific areas on the England/Wales border.

GERMANY

In Germany there is statutory health insurance which is mandatory unless certain exceptions apply (e.g. if the salary of an employee exceeds a specific threshold). In addition to statutory health insurance, private health insurances exist. Emergency services ensuring the first assistance and transport to a hospital can be provided by public or private entities (if awarded with a public contract by the competent local authorities).

²⁷⁰ Paragraph 8.1. And 8.2. of the "Responsible Body Guidance for the NHS in Wales." National Health Services, Welsh Government, 2013. Accessed January 24, 2023. <https://www.gov.wales/sites/default/files/publications/2019-06/responsible-body-guidance-for-the-nhs-in-wales.pdf>

²⁷¹ Paragraph 4.1 of "Responsible Body Guidance for the NHS in Wales" (2013), Welsh Government. Accessed February 1, 2023. <https://gov.wales/sites/default/files/publications/2019-04/responsible-body-guidance-for-the-nhs-in-wales.pdf>

²⁷² Paragraph 19.10 of "Who Pays? Determining which NHS commissioner is responsible for making payment to a provider" NHS Contracting and Incentives Team, August 2020, NHS England. Accessed February 1, 2023. <https://www.england.nhs.uk/wp-content/uploads/2020/08/Who-Pays-final-24082020-v2.pdf>

²⁷³ Paragraph 19.1. of "Who Pays? Determining which NHS commissioner is responsible for making payment to a provider." NHS Contracting and Incentives Team, NHS England. Accessed January 24, 2023. <https://www.england.nhs.uk/wp-content/uploads/2020/08/Who-Pays-final-24082020-v2.pdf>

²⁷⁴ Paragraph 19.2 of "Who Pays? Determining which NHS commissioner is responsible for making payment to a provider." NHS Contracting and Incentives Team, August 2020, NHS England. Accessed February 1, 2023. <https://www.england.nhs.uk/wp-content/uploads/2020/08/Who-Pays-final-24082020-v2.pdf>

Structural funds have been implemented for the funding of federal state projects to improve structures in hospital care. Laws pertaining to the same include:

- » Social Security Code V (Sozialgesetzbuch V – SGB V)²⁷⁵
- » Sec. 12 – 15 Hospital Financing Act (Krankenhausfinanzierungsgesetz– KHG)²⁷⁶

INDIA

Indian healthcare suffers from low public contribution to healthcare expenditure, comprising only one-third of the total spending²⁷⁷. The share by the private sector constitutes around 70% of the overall expenditure²⁷⁸, creating a divide in healthcare funding and leading to an increased monetary burden on individuals. Private funding includes private insurance, tie-ups with NGOs and businesses as well as out-of-pocket expenditure. There is also a low penetration of private health insurance. Consequently, Indians incur a very high monetary burden owing to out-of-pocket expenditure on healthcare. However, there are sources of funding which exist at both the federal and state levels, including:

Federal government

Section 162 of the Motor Vehicles (Amendment) Act, 2019 (MVAA) empowers the federal government to make a scheme for the cashless treatment of crash victims, during the Golden Hour, and such a scheme may contain provisions for creation of a fund for their treatment.

Section 164 of the MVAA, states that, “the owner of the motor vehicle or the authorised insurer shall be liable to pay in the case of death or grievous hurt due to any accident arising out of the use of motor vehicle, a compensation, of a sum of five lakh rupees in case of death or of two and a half lakh rupees in case of grievous hurt to the legal heirs or the victim, as the case may be.” Sub-clause 2 of the provision further states that, “In any claim for compensation under sub-section (1), the claimant shall not be required to plead or establish that the death or grievous hurt in respect of which the claim has been made was due to any wrongful act or neglect or default of the owner of the vehicle or of the vehicle concerned or of any other person”²⁷⁹

²⁷⁵ “Sozialgesetzbuch (SGB) Fünftes Buch (v) - Gesetzliche Krankenversicherung - (Artikel 1 Des Gesetzes v. 20. Dezember 1988, BGBl. I s. 2477).” SGB 5 - nichtamtliches Inhaltsverzeichnis. Accessed January 23, 2023. https://www.gesetze-im-internet.de/sgb_5/

²⁷⁶ “Gesetz Zur Wirtschaftlichen Sicherung Der Krankenhuser Und Zur Regelung Der Krankenhauspflegestze.” KHG - nichtamtliches Inhaltsverzeichnis. Accessed January 23, 2023. <https://www.gesetze-im-internet.de/khg/>

²⁷⁷ “India Health System Review, Health Systems in Transition, Volume 11 No.1, 2022.” Asia Pacific Observatory on Health Systems and Policies. Accessed January 24, 2023. https://drive.google.com/file/d/1jlpV7rRaUZyobDz-Cw_oN-YxeuPVsLUS/view?usp=sharing

²⁷⁸ Only one third of the health spending in India is borne by the government. “India Health System Review, Health Systems in Transition, Volume 11 No.1, 2022.” Asia Pacific Observatory on Health Systems and Policies. Accessed January 24, 2023. https://drive.google.com/file/d/1jlpV7rRaUZyobDz-Cw_oN-YxeuPVsLUS/view?usp=sharing

²⁷⁹ Sections 162(2) and 164B of the “Motor Vehicles (Amendment) Act, 2019.” Ministry of Law and Justice, Government of India, August 9, 2019. <https://egazette.nic.in/WriteReadData/2019/210413.pdf>

The federal government has also notified the following schemes for cashless treatment of road crash victims²⁸⁰

- » The Motor Vehicle Accident Fund (MVAf) established under Section 164B²⁸¹ of the MVAA, 2019 has been created for the purpose of providing compulsory cashless coverage to all road crash victims in India. The MVAf includes the following:
 - Account for Insured Vehicles²⁸²;
 - Account for Uninsured vehicles/Hit and Run Accident²⁸³; and
 - Hit and Run Compensation Account²⁸⁴
- » In 2014, the Ministry of Health and Family Welfare launched the National AYUSH Mission²⁸⁵ to provide cost-effective medical services, improve the quality of healthcare and strengthen institutional capacity. Ayushman Bharat was also introduced in 2018 as a Central scheme to provide medical benefits, medical expenses, and medical treatment to around 100 million poor and underprivileged families.
- » The National Rural Health Mission (NHRM) was launched on 12th April 2005, as a sub-mission of an overarching National Health Mission, to provide accessible, affordable, and quality healthcare to the rural population, especially the vulnerable groups. The Union Cabinet on 1 May 2013, also approved the launch of the National Urban Health Mission, as another sub-mission of the National Health Mission.
- » In Union Budget 2020–21²⁸⁶, the Government of India has announced INR 69,000 crore (US\$ 9.87 billion) outlay for the health sector that is inclusive of INR 6,400 crore (US\$ 915.72 million) for Pradhan Mantri Jan Arogya Yojana, a scheme that aims to provide free access to healthcare.

²⁸⁰ "Notification no. G.S.R. 163(E): Compensation to Victims of Hit and Run I Motor Accidents Scheme, 2022." Ministry of Road Transport and Highways, February 25, 2022. <https://static.pib.gov.in/WriteReadData/specificdocs/documents/2022/feb/doc20222720301.pdf>

²⁸¹ "Notification no. G.S.R. 162(E): Central Motor Vehicles (Motor Vehicle Accident Fund) Rules, 2022." Ministry of Road Transport and Highways, February 25, 2022. <https://static.pib.gov.in/WriteReadData/specificdocs/documents/2022/feb/doc20222720501.pdf>

²⁸² "Account for Insured Vehicles" means such part of the Fund that is utilised for the cashless treatment of victims of motor accidents caused by insured vehicles in accordance with the scheme framed under section 162 of the Act;

²⁸³ "Account for Uninsured Vehicles or Hit and Run Motor Accident" means such part of the Fund that is utilised for the cashless treatment of victims of motor accidents caused by uninsured vehicles or hit and run motor accidents in accordance with the scheme framed under section 162;

²⁸⁴ "Hit and Run Compensation Account" means such part of the Fund that is utilised for the payment of compensation for victims of hit and run motor accidents as per section 161, read with the Compensation to Victims of Hit and Run Motor Accidents Scheme, 2022;

²⁸⁵ National AYUSH Mission (NAM). Accessed February 8, 2023. <https://namayush.gov.in/>

²⁸⁶ "Healthcare Industry in India." India Brand Equity Foundation. Accessed January 24, 2023. <https://www.ibef.org/industry/healthcare-india>

- » The National Highways Authority of India (NHAI)²⁸⁷ is set to launch a cashless treatment scheme covering the immediate hospitalisation costs for the treatment of road crash victims. The scheme will cover up to Rs. 30,000 of the cost incurred within the first 48 hours from the time of hospitalisation.

State Schemes:

- » The *Karnataka Good Samaritan and Medical Professional (Protection and Regulation during Emergency Situations) Act, 2016* provides for the constitution of a Good Samaritans Fund to make grants and loans for carrying out the purposes of the Act, including that of supporting reasonable expenses incurred by a Good Samaritan²⁸⁸.
- » The *CM Santwana Harish Scheme Yojana* in Karnataka²⁸⁹ was launched in 2017 to provide immediate and instant medical treatment to road crash victims. Under the scheme, all road crash victims in Karnataka can avail cashless treatment for the first 48 hours up to Rs. 25,000/-.
- » The scheme for cashless treatment for road crash, acid attack, and thermal burn injury victims in Delhi²⁹⁰ has been launched as a part of Delhi Arogya Kosh. Between April 2021 and March 2022, 5,483 victims of road crashes, acid attack, thermal burn and other injuries availed cashless treatment in private hospitals²⁹¹.
- » Since 2018, the Gujarat Government has been providing up to Rs. 50,000 to cover the medical expenses of all road crash victims in the state within 48 hours of the time of hospitalisation²⁹². The notification for the scheme called "Vahan Akasmat Sahay Yojana" was issued on February 16, 2018²⁹³.

287 "Cashless treatment for Road Accident Victims." Press Information Bureau, Ministry of Road Transport and highways, Government of India, March 31, 2022. <https://pib.gov.in/Pressreleaseshare.aspx?PRID=1811831#:~:text=This%20will%20cover%20the%20immediate,recorded%20in%20the%20Control%20Room.>

288 Section 11 of "The Karnataka Good Samaritan and Medical Professional (Protection and Regulation during Emergency Situations) Act, 2016." Karnataka Legislative Assembly (Act 26 of 2018). Government of Karnataka, August 24, 2018. [https://dpal.karnataka.gov.in/storage/pdf-files/acts%20alpha%20and%20dept%20wise%20acts/26%20of%202018%20\(E\).pdf](https://dpal.karnataka.gov.in/storage/pdf-files/acts%20alpha%20and%20dept%20wise%20acts/26%20of%202018%20(E).pdf)

289 "Mukhyamantrigala Santwana - 'HARISH' Scheme(MSHS)." Suvarna Aarogya Suraksha Trust, Government of Karnataka. Accessed March 17, 2023. <http://arogya.karnataka.gov.in/sast/english/index.php/using-joomla/extensions/components/content-component/article-categories/29-park-site/fruit-shop-site/72-mukhyamantrigala-santwana-harish-scheme-mss>

290 "Notification No. F.No. E. 4125/ to66 S- t066l." Delhi Arogya Kosh, Government of NCT of Delhi, February 15, 2018. <http://health.delhigovt.nic.in/wps/wcm/connect/a0643180463cb19db144f79f4cfcc4fd/OMC.pdf?MOD=AJPERES&mod=1841286421&CACHEID=a0643180463cb19db144f79f4cfcc4fd>

291 "Delhi Government Performance: 2015-2022." Dialogue and Development Commission of Delhi, June 2022. https://ddc.delhi.gov.in/sites/default/files/2022-06/Health_Report_2015-2022.pdf

292 "Gujarat road accident victims to get Rs 50,000." Business Standard, May 9, 2018. https://www.business-standard.com/article/news-ians/gujarat-road-accident-victims-to-get-rs-50-000-118050901341_1.html

293 "Notification No. HSP/122018/N.B. 31/" Department of Health and Family Welfare, Government of Gujarat, February 16, 2018. <https://drive.google.com/file/d/1egREGTZzwEXfa-hyCGbtkVu7bPGmloL/view>

- » In Odisha, all road crash victims can avail cashless treatment within 48 hours of hospitalisation²⁹⁴. The guidelines for Free Treatment for Trauma Patients state that private hospitals need to submit the claims to the Directorate of Medical Education and Training (DMET) Odisha, which examines the claims, and releases each settled claim amount accordingly to the relevant private hospital.
- » In Tamil Nadu²⁹⁵, under the scheme titled “Innuyir Kappom Thittam-Nammai Kaakkum 48,” all road crash victims in the state are eligible to avail cashless treatment with a coverage of up to Rs. 1 lakh, up to 48 hours from the time of hospitalisation.
- » In Maharashtra, the “Balasaheb Thackeray Accidental Insurance Scheme” provides cashless treatment for all road crash victims up to 72 hours of hospitalisation with a coverage of Rs. 30,000²⁹⁶.
- » In Andhra Pradesh, under the “YSR Aarogyasri Scheme”, cashless treatment is provided to all road crash victims for up to 72 hours. In November 2022, this scheme, which was earlier available only to Andhra Pradesh residents, was extended to all road crash victims who were injured in a road crashes in the state²⁹⁷.
- » The West Bengal government launched the Swastha Sathi Scheme on 30 December 2016. The main features²⁹⁸ of this scheme include:
 - Paperless, Cashless, Smart Card based
 - All pre-existing diseases are covered
 - There is no cap on the family size and parents of both spouses are included. All dependent physically-challenged persons in the family are also covered.
 - The entire premium is borne by the State government and no contribution from the beneficiary is required.

For further details please refer to 5b (Page 142)

294 “Notification No. HFW-SCH-TRAUMA-0001-2017 7086 /H.” Health and Family Welfare Department, Government of Odisha, October 28, 2019. <https://dmetodisha.gov.in/files/Govt%20Notification%20FTTF%20guidelines%2027086.pdf>

295 “G.O.(Ms)No.46: “Innuyir Kappom Thittam - Nammai Kaakkum 48.” Health and Family Welfare Department, Government of Tamil Nadu, February 3, 2022. http://cms.tn.gov.in/sites/default/files/go/hfw_e_46_2022.pdf

296 “State Approves Free Treatment Upto INR 30,000 For Road Accidents Under Balasaheb Thackeray Accidental Insurance Scheme.” Mumbai Live, September 16, 2020. <https://www.mumbailive.com/en/politics/late-balasaheb-thackeray-road-accident-insurance-scheme-approved-in-maharashtra-cabinet-meeting-55494>

297 “Notification: G.O.M.S. No. 303.” Health, Medical and Family Welfare Department, Government of Andhra Pradesh, November 28, 2022. https://images.hindustantimes.com/telugu/img/2022/11/29/original/GOMS_303_ROAD_ACCIDENT__1669708182572.pdf

298 “Swasthya Sathi at a Glance.” Swasthyasathi, Government of West Bengal, India. . Accessed February 15, 2023. <https://swasthyasathi.gov.in/>

Commentary:

- » In the event of a victim being taken to a private hospital there exist no schemes at the national level that guarantee funding for his/her immediate care. Also, while most of these schemes that have come up in the last few years, have attempted addressing certain aspects of immediate care, long-term assistance and rehabilitation have largely gone unaddressed.
- » While the above mentioned schemes do exist, prima facie, based on the desk research only about 8 out of 28 states and 8 Union Territories in India have schemes available for funding of emergency medical care. Also, most of these schemes pertain to road crash victims and do not cater to the needs of the other people requiring urgent medical assistance²⁹⁹.
- » The total health spending (i.e. public and private) in India is an estimated 2.1% of the total GDP³⁰⁰ of the country. This is lower than the average health spending for Low and Middle Income Countries (LMIC) where average share of GDP spent on healthcare is around 5.2%³⁰¹.
- » The National Health Policy of 2002³⁰² acknowledged that the public health investment in the country has been comparatively low and planned to raise it over the next decade. Since not much progress has been made, it is now time to explore alternate mechanisms of financing for emergency care.

JAPAN

The Emergency Medical Care fees is funded by Japan's National Health Insurance System in which every Japanese citizen is required to enrol under the Health Insurance Act³⁰³. Under the National Health Insurance System, patients must bear 30% of the medical costs themselves, which can be covered by the medical insurance purchased voluntarily by them³⁰⁴.

299 "States and Union Territories." Know India, Government of India. Accessed March 17, 2023. <https://knowindia.india.gov.in/states-uts/#:~:text=There%20are%2028%20states%20and,dress%2C%20festivals%2C%20language%20etc>.

300 "Share of Government Health Expenditure in Total Health Expenditure Increases from 28.6 per cent in FY 14 to 40.6 per cent in 2019." Press India Bureau, Ministry of Finance, January 31, 2023. <https://pib.gov.in/PressReleasePage.aspx?PRID=1894902#:~:text=In%20keeping%20with%20this%20objective,1.6%20per%20cent%20in%20FY21.&text=The%20ratios%20to%20GDP%20at,12%20base%20till%202021%2D22>.

301 "India Health System Review, Health Systems in Transition, Volume 11 No.1, 2022." Asia Pacific Observatory on Health Systems and Policies. Accessed January 24, 2023. https://drive.google.com/file/d/1jlpV7rRaUZyobDz-Cw_oN-YxeuPVsLUS/view?usp=sharing

302 "India Health System Review, Health Systems in Transition, Volume 11 No.1, 2022." Asia Pacific Observatory on Health Systems and Policies. Accessed January 24, 2023. https://drive.google.com/file/d/1jlpV7rRaUZyobDz-Cw_oN-YxeuPVsLUS/view?usp=sharing

303 "Health Insurance System." Japan Health Policy NOW Accessed February 6, 2023. <https://japanhpn.org/en/hs1/>

304 "Article 9." The Ministry of Foreign Affairs Japan. Accessed February 17, 2023. https://www.mofa.go.jp/policy/human/econo_rep2/article9.html

MALAYSIA

Malaysia's public hospitals are heavily subsidised by state funds (via general revenue and taxation), with a 2020 budget of around RM 30.6 billion (USD 7.5 billion)³⁰⁵. Malaysia's private hospitals are funded through private health insurance and out-of-pocket payments from patients³⁰⁶.

For further details please refer to 5c (Page 142)

PAKISTAN

The right to receive life-saving care without advance payment is enshrined under the National Health Care Act 2017.

Commentary:

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. According to the International Labour Organisation, 7.29 million families have been enrolled in the *Sehat Sahulat* programme³⁰⁷. The programme is 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.

SOUTH AFRICA

EMS in South Africa is regulated by the National Health Act 61 of 2003 and its health structure is managed and implemented at a provincial level. South Africa's EMS is funded at a national level, and the federal government allocates funds for use by each of the nine provinces. While South Africa's health system is mainly funded and provided by the government, private organisations also provide EMS. Among others, these private organisations include Axis Medical, Atlantic Medical Response, Destination Medicine (Pty) Ltd – Medical Rescue Services and Alert SA Ambulance Services³⁰⁸.

305 "Ministry of Health allocation up 7% to RM 30.6b." The Edge Markets, October 11, 2019. <https://www.theedgemarkets.com/article/ministry-health-allocation-7-rm306b>

306 "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

307 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

308 "List of Private Ambulance Services in South Africa 2023." Newshub360. Accessed February 17, 2023. <https://www.newshub360.net/private-ambulance-services-in-south-africa/>

In 2019, President Cyril Ramaphosa said that South Africa has two parallel healthcare systems, including a public and a private one and that while approximately ZAR 220 billion is spent on the former annually, ZAR 250 billion is spent on the latter. It was reported that about 16% of the population makes use of the private healthcare system through the use of various medical aids, while the rest of the population relies on the public healthcare system³⁰⁹.

The National Health Insurance Bill (NHI Bill)³¹⁰ was introduced in August 2011 and is defined as a health financing system designed to pool funds for the purposes of providing equitable access to personal health services for all South Africans based on their health needs and irrespective of their socio-economic status. It is intended to ensure that the use of health services does not result in financial hardship for individuals and their families.

The Road Accident Fund (RAF) Act, 1996 was introduced with the purpose of providing compensation for loss or damage wrongfully caused by the driving of motor vehicles. The RAF provides compulsory cover to all users of South African roads, citizens and foreigners, against injuries sustained or death arising from accidents involving motor vehicles within the borders of South Africa³¹¹.

For further details please refer to 5d (Page 143)

UNITED STATES

Federal: Federal grants provide a limited amount of funding to State and local Emergency Medical Services. Federal funding is also provided through reimbursements from the federal Medicare program, a national health insurance program³¹².

State: Funding varies on a state-by-state basis. Some states directly fund Emergency Medical Services through vehicle or driver licensing fees, motor vehicle violations or other taxes. States also provide reimbursement through various insurance programs. Other services may function as private entities that bill for their services (e.g., private hospitals)³¹³.

Costs for patient care will ultimately be the responsibility of the patient (potentially covered by insurance, as applicable). Few states also provide "charity care" through non-profit hospitals.

309 "NHI – Social Saviour or Business Killer?." Acumen Magazine, November 20, 2019. Accessed February 17, 2023. <https://www.acumenmagazine.co.za/articles/nhi-social-saviour-or-business-killer-10579.html>

310 "National Health Insurance Bill." Government of South Africa, as on July 26, 2019. Accessed February 17, 2023. https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf

311 "Road Accident Fund." National Government of South Africa. Accessed March 17, 2023. [https://nationalgovernment.co.za/units/view/152/road-accident-fund-raf#:~:text=The%20Road%20Accident%20Fund%20\(RAF,the%20borders%20of%20South%20Africa.](https://nationalgovernment.co.za/units/view/152/road-accident-fund-raf#:~:text=The%20Road%20Accident%20Fund%20(RAF,the%20borders%20of%20South%20Africa.)

312 "Emergency Medical Services at the Crossroads." Institute of Medicine of The National Academies Press. Accessed January 24, 2023. <https://nasemso.org/wp-content/uploads/EMS-at-Crossroads.pdf>

313 *ibid*

D. Mechanism at the federal and state level to regulate referrals at Hospitals/Trauma Care Centres (including protocols established for such referrals)

AUSTRALIA

Each of Australia's six states and the two mainland territories have jurisdictional control over their public hospital systems and trauma services. Each state has several public hospitals that serve as trauma centres and a retrieval system that ensures timely access to appropriate services for patients.

New South Wales (NSW)

In order to provide definitive trauma care to all injured patients across NSW, its trauma system is based on a hospital network authorised to provide varying degrees of trauma management across metropolitan, regional, and rural locations.³¹⁴ Each Major Trauma Service (MTS) is networked with Regional Trauma Service (RTS) and associated with referring Local Health Districts.³¹⁵ Hence, when clinically appropriate, the RTS may facilitate transfer to the MTS to provide initial assessment, stabilisation, and definitive treatment. The NSW trauma networks and NSW Critical Care Tertiary Referral Networks are closely linked.³¹⁶ The networks are mostly dictated by the MTS's location and the need for early clinical attention for injured patients in accordance with the NSW Ambulance Service Protocol T1³¹⁷ The NSW trauma system is coordinated by the NSW Institute of Trauma and Injury Management, which provides guidelines for the referral of patients with major trauma injuries.

Summary of Protocols:

- » The Critical Care Tertiary Referral Networks and Transfer of Care (Adults) Policy Directive applies to severely ill adult patients who require referral and transfer, as well as patients who are in danger of serious deterioration³¹⁸.
- » The NSW Critical Care Tertiary Referral Networks (Adults) Policy Directive defines the links between Local Health Districts (LHD) and tertiary referral hospitals, taking into account established functional clinical referral linkages. The policy aims to ensure that access to emergency care and/or surgical intervention for critically ill/injured patients is not delayed due to unavailability in the ICU.

³¹⁴ Agency for Clinical Innovation. "NSW Trauma Networks." Agency for Clinical Innovation. Agency for Clinical Innovation (ACI), November 20, 2020. Accessed February 20, 2023. https://aci.health.nsw.gov.au/networks/institute-of-trauma-and-injury-management/clinical/trauma_system/nsw_trauma_system/nsw_trauma_networks#:~:text=The%20NSW%20trauma%20system%20is,all%20injured%20patients%20across%20NSW.

³¹⁵ *ibid*

³¹⁶ *ibid*

³¹⁷ "PROTOCOL: T1 Prehospital Management of Major Trauma." Accessed February 9, 2023. https://aci.health.nsw.gov.au/__data/assets/pdf_file/0005/243779/ASNSW-Protocol-T1-Revised-July-2018.pdf

³¹⁸ "NSW Critical Care Tertiary Referral Networks and Transfer of Care." Government of New South Wales, Australia, March 28, 2018. Accessed February 20, 2023. https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2018_011.pdf

- » In collaboration with Regional Retrieval Services, the Aeromedical Control Centre (ACC) is responsible for the state-wide coordination of adult medical retrieval services for time-critical, critically ill or injured patients. The ACC is a point of contact for all severely ill or injured adult patients who require immediate medical attention.
- » Each LHD is responsible for ensuring that escalation protocols are in place to ensure that physicians can get timely clinical advice and/or support to speed the review, referral, and appropriate placement of critically ill or injured patients. This includes processes for professionals to follow when referring critically ill patients who are not in life-threatening situations when there are no appropriate beds available.

The NSW trauma system is coordinated by the NSW Institute of Trauma and Injury Management, which provides guidelines for the referral of patients with major trauma injuries.

Queensland

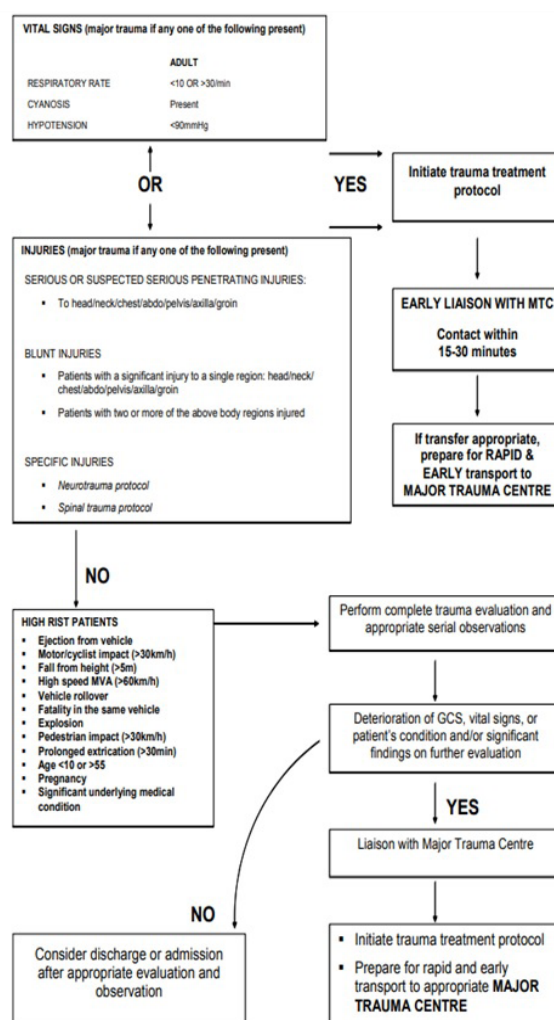
Similar to NSW, MTS receives referrals from across Queensland and liaisons with multiple services to coordinate and improve the management of trauma patients.

Summary of Protocols:

The figure below illustrates the Major Trauma Inter-hospital Transfer guidelines:

Commentary:

The Queensland Trauma Plan Project was initiated by the Queensland Ambulance Service (QAS)³¹⁹ under the authority of Queensland Emergency Medical System Advisory Committee (QEMSAC), with the assistance of the Motor Accident Insurance Commission. The Queensland Trauma Plan Project's findings encourage the development of a formalised trauma plan for Queensland.



319 "Trauma Data Scoping Project." Queensland Government, September 2008. Accessed February 20, 2023. https://www.pc.gov.au/_data/assets/pdf_file/0020/204338/sub121-data-access-attachment.pdf

Victoria

If a patient meets the major trauma transfer criteria, Adult Retrieval Victoria (ARV) and the Paediatric Infant Perinatal Emergency Retrieval (PIPER) must be notified. After initial notification of the trauma patient has been received, the retrieval service will make a coordination consultant with trauma expertise available for advice regarding clinical management and/or transfer. A multi-party teleconference between clinicians and facilities will be arranged as required.

Summary of Protocols:

Triage and transfer protocols provide clear medical and anatomical requirements, as well as how major trauma patients can be transferred through the trauma system. Major trauma requiring an inter-hospital transfer can be recognised by: (i) certain vital sign markers; (ii) the presence of a specific physiological or anatomical injury; (iii) deterioration associated with a high-risk mechanism of injury; or (iv) meeting the requirements of being a high-risk patient³²⁰.

WESTERN AUSTRALIA

The Western Australia Department of Health provides the guiding principles for major trauma with the aim of ensuring systematic and coordinated management of minor and major trauma patients in WA³²¹. The Western Australian state trauma service is made up of 6 streams³²²:

1. Major Trauma Services;
2. Metropolitan Trauma Services;
3. Urban Trauma Services;
4. Regional Trauma Services;
5. Rural Trauma Services; and
6. Remote Trauma Services.

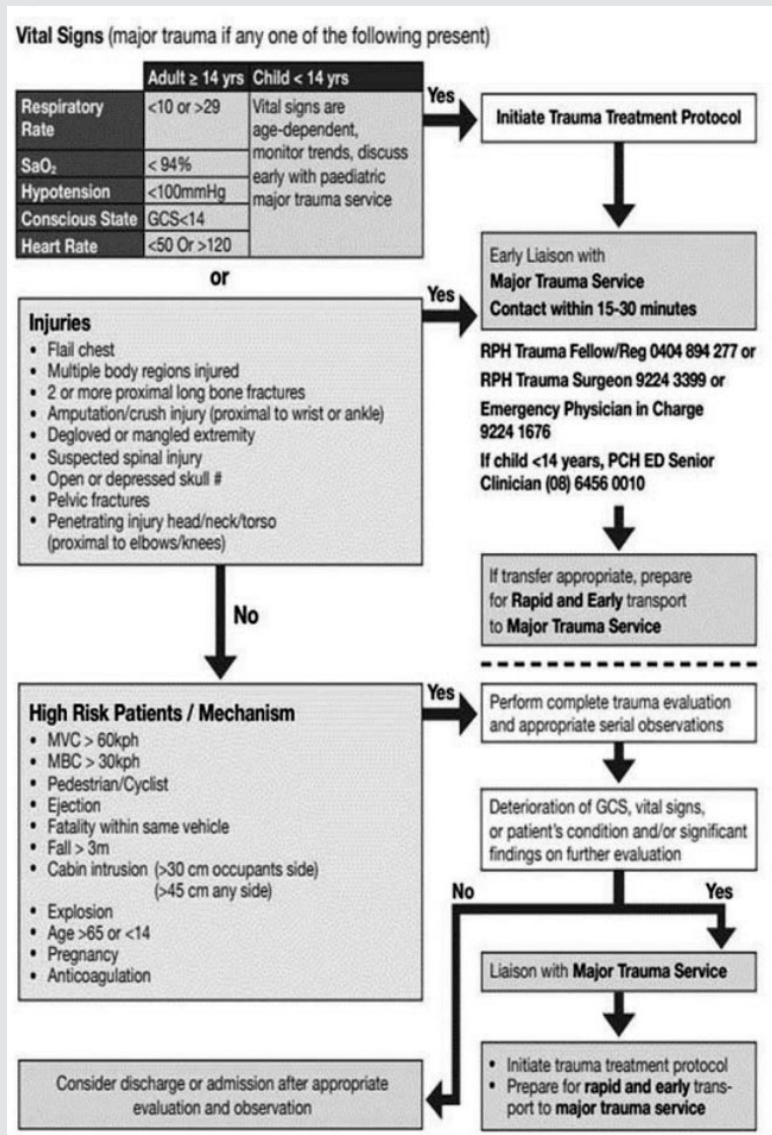
Summary of Protocols:

Guidelines and protocols are issued by the Department of Health, which provides procedures for major trauma inter-hospital transfer that must be followed depending on the vital signs and state of the patient.

320 "Inter- Hospital Transfer." Accessed February 20, 2023. <https://trauma.reach.vic.gov.au/guidelines/inter-hospital-transfer/key-messages>

321 "WA State Trauma System and Services." Department of Health, Government of Western Australia. Accessed February 20, 2023. https://ww2.health.wa.gov.au/Articles/U_Z/WA-State-trauma-system-and-services

322 "State trauma organisational structure: Western Australian State Trauma Service." Department of Health, Government of Western Australia. Accessed February 20, 2023. https://ww2.health.wa.gov.au/Articles/S_T/State-trauma-organisational-structure



Source: "Guiding Principles for Major Trauma inter hospital transfer." Government of Western Australia, July 31, 2013. Accessed February 20, 2023. <https://www2.health.wa.gov.au/~/media/HSPs/EMHS/Hospitals/RPH/Documents/Services/Trauma/major-trauma-guiding-principles.pdf>

South Australia

A triage method is used to determine the clinical urgency of a patient. Based on the results of the assessment, a patient may be transferred to MTS. The South Australian Trauma System provides retrieval and care to the regional and remote parts of South Australia as well as to the Northern Territory, parts of NSW and Western Australia. For example, Broken Hill Hospital,

located in far western NSW, maintains a clinical referral network with South Australia, as it is over 1,000 km from Sydney, yet only half that distance to Adelaide, South Australia^{323 324}.

Summary of Protocols:

There are no laws regulating the triage process. A physician-led triage system will determine whether a patient requires a referral to a more suitable unit or to MTS. Guidelines are issued by health departments to provide criteria for assessment of the patient's status.

Tasmania

Tasmania's two largest hospitals serve as MTS, receiving and stabilising serious trauma patients; smaller hospitals are bypassed where transit durations are not excessively long.

Patients from Tasmania may receive care from the Victorian Trauma service as some services, such as extensive burns treatment, are not provided in Tasmanian trauma centres. In such cases, interstate transport to Victorian hospitals is arranged³²⁵.

For Territorial Legislation, refer to annex 6a (Page 144)

BRAZIL

Summary of Mechanism to regulate referrals:

Brazil³²⁶ has developed organisational frameworks such as the regional regulatory centres, which coordinate patient referrals to specialised emergency centres and hospitals³²⁷. Under the SUS, Brazilians have direct access to emergency services and primary care. However, referrals are required for accessing specialist hospitals.

The SAMU is a free emergency transportation service that can be used by anyone that has suffered an accident or had a medical emergency³²⁸. In the SAMU, first aid is provided by first responders 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 provides both urgent and non-urgent medical care.

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- 323 "Trauma Services." Government of South Australia. Accessed February 20, 2023. <https://www.rah.sa.gov.au/health-professionals/clinical-services/critical-care-services/trauma-service>
- 324 Warren, Kirrily-Rae J.; Morrey, Chris; Oppy, Andrew; Pirpiris, Marinis; Balogh, Zsolt J. "The overview of the Australian trauma system." OTA International 2(S1):p e018, March 2019. Accessed February 20, 2023. https://journals.lww.com/otainternational/fulltext/2019/03011/the_overview_of_the_australian_trauma_system.6.aspx
- 325 Warren, Kirrily-Rae J.; Morrey, Chris; Oppy, Andrew; Pirpiris, Marinis; Balogh, Zsolt J. "The overview of the Australian trauma system." OTA International 2(S1):p e018, March 2019. Accessed February 20, 2023. https://journals.lww.com/otainternational/fulltext/2019/03011/the_overview_of_the_australian_trauma_system.6.aspx
- 326 "Instruction Manual of the Urgency and Emergency Care Network in The Unified Health System (SUS)." MINISTÉRIO DA SAÚDE, 2013. https://bvsms.saude.gov.br/bvs/publicacoes/manual_instrutivo_rede_atencao_urgencias.pdf
- 327 "International Health Care System Profiles: Brazil." The Commonwealth Fund, June 5, 2020. <https://www.commonwealthfund.org/international-health-policy-center/countries/brazil>
- 328 "Emergency mobile care service: About SAMU 192." Ministry of Health, Government of Brazil. Accessed February 7, 2023. https://www.gov.br/translate/goog/pt-br/assuntos/saude-de-a-a-z/s/samu-192?_x_tr_sl=pt&_x_tr_tl=en&_x_tr_hl=en&_x_tr_pto=sc

ENGLAND AND WALES

The NHS Act 2006 provides that integrated care boards have the duty of ensuring that medical services, hospital accommodation, nursing, ambulances, and other such services meet the reasonable requirements of the people for whom the boards have responsibility³²⁹. The relevant guidance with respect of referrals at Hospitals/Trauma Centres are as follows:

- » Patients suffering from major trauma are assessed on a scale known as the Injury Severity Score (ISS) that scores injuries from 1 to 75, the latter being the most serious. Patients who have an ISS>15 are defined as having suffered from major trauma.
- » It is often not possible to determine the ISS at the time of injury as it requires a full diagnostic assessment and often surgical intervention. To address this, a system of triage is used to identify patients most likely to have had major trauma.
- » The major trauma patient pathway is an emergency pathway with patients triaged through the local ambulance service or referred on by Trauma Units (TUs). Pre-hospital emergency services have developed major trauma decision protocols for use by crews to determine the most appropriate destination for injured patients. Those with potential major trauma injuries are taken directly to a Major Trauma Centre (MTC) where travel times allow, otherwise to the nearest TU for rapid stabilisation and transfer to the MTC where those injuries exceed the capability of a TU and are in line with local protocols³³⁰.

Summary of Protocols:

There are three types of MTCs – those that treat only adults, those that treat only children and those that can treat both adults and children. The service is designed to deliver high quality specialist care to patients of all ages starting from admission to the relevant MTC, with full assessment and diagnostics in the emergency department. This may be followed by operative treatment and an episode in the critical care unit and ward. Rehabilitation is required for a number of patients, and starts in the MTC and continue through specialist rehabilitation units or locally through a variety of commissioned providers defined in the network³³¹.

³²⁹ Section 21 of the "Health and Care Act 2022". Government of the United Kingdom, 2022. <https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/integrated-care-boards-functions>

³³⁰ "NHS Standard Contract for Major Trauma Service (All Ages)-Schedule 2." NHS England. Accessed January 24, 2023. <https://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf>

³³¹ "NHS Standard Contract for Major Trauma Service (All Ages)."<https://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf>

GERMANY

Incoming patients are subject to a first assessment with respect to the gravity of their health condition. According to the result of the triage assessment, they are either referred to the hospital's EMS unit (or to another hospital if specific care cannot be administered on site) or a specialised unit of the hospital more appropriate to handle the patient's condition.

Summary of Protocols:

There are no laws and regulations providing for any rules for the triage process. Guidelines are issued by professional medical or ethical associations in order to provide some guidance to the medical personnel carrying out triage assessments. However, on 16th December, 2021, via Order 1 BvR 1541/20³³², the German Federal Constitutional Court ruled that the German Legislature must regulate triage law to prohibit discrimination against patients on the basis of disability.

Commentary:

The question of the necessity for the legislator to create legal rules for the triage process rose in the context of the COVID-19 pandemic and the capacity issues faced by German hospitals due to the high number of patients requiring emergency and intensive care.

INDIA

According to the guidelines titled "Charter of Patient Rights" by the National Human Rights Commission, all patients have the right to proper referral and transfer³³³. However, at present, there exists no uniform national protocol with regard to such referrals and transfers. However, some states have released state-specific referral system guidelines. For example, Uttar Pradesh³³⁴ has a set of guidelines prescribed for healthcare facilities referrals, prepared by Department of Medical Health and Family Welfare, Government of Uttar Pradesh. Similar guidelines are also present in states such as Madhya Pradesh³³⁵, and Kerala³³⁶, to name a few. Karnataka has introduced an online system for referral of patients to tertiary healthcare facilities³³⁷. The status of implementation of the aforementioned state-level guidelines is unknown. However there exists no proof which regard to the systems to implement such guidelines.

332 "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

333 "Charter of Patients' Rights for adoption by NHRC." National Human Rights Commission. Accessed January 24, 2023. https://nhrc.nic.in/sites/default/files/charter_patient_rights_by_NHRC_2019.pdf

334 "Referral Guidelines for Health Facilities in Uttar Pradesh." Department of Health and Family Welfare, Government of Uttar Pradesh. Accessed February 1, 2023. http://dgmhup.gov.in/Documents/Referral_Guidelines.pdf

335 "Referral Guidelines For the State of Madhya Pradesh." Department of Public Health and Family Welfare, Government of Madhya Pradesh. Accessed February 1, 2023. <http://www.health.mp.gov.in/sites/default/files/2021-02/Referral%20Guidelines.pdf>

336 "Referral Guidelines for the common conditions for Institutions under DME & DHS in Kerala." Directorate of Health services, Kerala. Accessed February 1, 2023. <https://dhs.kerala.gov.in/wp-content/uploads/2020/06/reference.pdf>

337 "Karnataka govt introduces new online system for referral of patients to tertiary healthcare facilities." All India Radio News. Accessed February 1, 2023. <https://newsonair.gov.in/Main-News-Details.aspx?id=440094>

JAPAN

In Japan, each prefecture has established:

- » A table of criteria for classifying the status of patients;
- » A list of medical institutions that the emergency team should request for acceptance according to each classification.

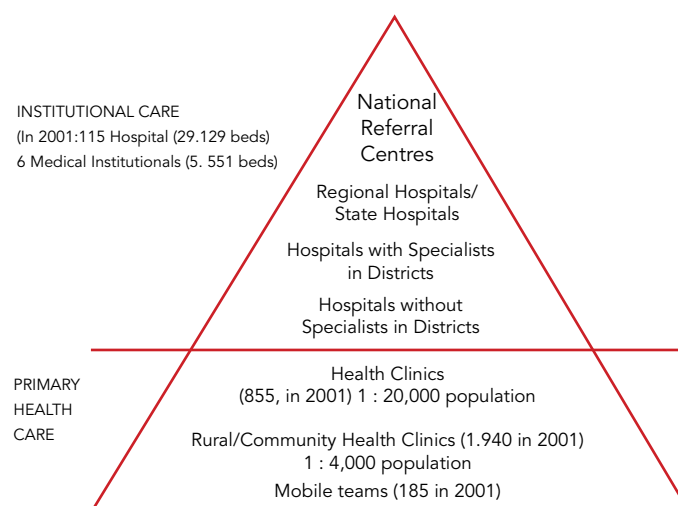
Each prefecture has established criteria for determining the order in which the request for acceptance should be made within the list.

Summary of Protocols:

Each EMS unit has a discretion in setting a protocol to prepare for the cases where it needs to handle more than one patient. There are local Protocol Councils³³⁸ at the municipal government level and most of the EMS units follow the guidelines issued by the Protocol Councils.

MALAYSIA

Malaysia has a national referral system which was implemented to ensure integrated health care services to the general population (see table below). It provides specialised care to augment the basic care services provided in health clinics. A key objective is to provide greater equity, accessibility and better utilisation of resources. Primary health care is therefore the thrust of the Malaysian health care system, supported by the secondary and tertiary medical care³³⁹.



Source: MOH, Malaysia

³³⁸ Nakao, Shunichiro et. al. "Epidemiological profile of emergency medical services in Japan: a population, based descriptive study in 2016." *Acute Med Surg*. 2020 Jan-Dec; 7(1): e485. Published online January 30 2020. Accessed February 27, 2023. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6992505/>

³³⁹ Merican MI, Y Rohaizat, and S Haniza. "Developing the Malaysian Health System to Meet the Challenges of the Future." *The Medical journal of Malaysia*, March 2004. https://www.e-mjm.org/2004/v59n1/Malaysian_Health_System.pdf

Person Management System Guidelines, Ministry of Health³⁴⁰

Internal:

- » All inpatient interdepartmental referrals shall be seen in the referring ward unless a special procedure is required where the individual will be moved to the point of care.
- » All referrals shall be made by the medical officer or specialist. Where a referral is made by the medical officer, it should be done after consultation with the specialist.
- » Doctors from the referring ward shall inform, by phone or email, the doctors in the discipline to where the individual is referred to.
- » All referrals shall be seen by the specialist. In circumstances, where the Medical Officer sees the case, the specialist shall be consulted.
- » All emergency referrals shall be seen immediately by the doctor and the time for the same shall be recorded.
- » Non-emergency referrals shall be seen as soon as possible.

External:

- » All emergency referrals shall be seen in the Emergency Department. The Emergency Department shall be informed prior to referral.
- » Emergency cases with prior consultation, approval and consent on the care plan shall be admitted directly to the ward concerned.
- » Pre-registration formalities may be done at the referring healthcare facility and such pre-registration shall be acknowledged and updated by the receiving healthcare facility.

Commentary:

The public health system in Malaysia has been structured to provide comprehensive health care, from primary to tertiary levels, to individuals in need in every region of the country. The network of referral hospitals ranges from small secondary care hospitals in rural districts to tertiary referral hospitals in large towns such as Putrajaya, the administrative capital of the country. The public teaching hospitals are also part of this referral system³⁴¹.

Designated specialty national and regional hospitals take referrals from around the country. For example, Hospital Selayang specialises in microsurgery and in kidney and liver conditions and Hospital Sungai Buluh provides trauma care and care for infectious diseases. Kuala Lumpur Hospital, the oldest and biggest hospital in Malaysia, has over 2000 beds and is a national referral centre for advanced tertiary care³⁴².

340 "Person Management System." Ministry of Health, Government of Malaysia, July 2006. Accessed February 20, 2023. <https://www.moh.gov.my/moh/resources/auto%20download%20images/589d72ec82adb.pdf>

341 Chiu-Wan Ng, Sarah L Barber, Luca Lorenzoni, and Paul Ong. "Case Study - Malaysia." Essay. In Price Setting and Price Regulation in Health Care, 175. World Health Organization and the Organisation for Economic Co-operation and Development, n.d. <https://apps.who.int/iris/bitstream/handle/10665/325547/9789241515924-eng.pdf>

342 "Malaysia Health System Review, Health Systems in Transition". World Health Organization Volume 3 (2013), Section 5.5. Pg 73-74. <https://apps.who.int/iris/handle/10665/206911>

PAKISTAN

There has been specific academic recognition within Pakistan that patient referral mechanisms, which are vital to the functioning of an effective emergency healthcare system, are not being implemented. For example, the Lady Reading Hospital is the major referral hospital for all districts of Khyber Pakhtunkhwa and is generally the first point of emergency care for all residents in and around Peshawar city. Due to low community awareness, many of those arriving at the emergency department are low-acuity non-urgent patients. Until recently, their arrival into the emergency department of the hospital was unregulated, causing great inefficiency with respect to prioritising those patients whose situation was most grave and required the immediate medical attention³⁴³. The lack of functional referral mechanisms therefore significantly decreases the effectiveness of the overall emergency healthcare system.

As yet, there does not appear to be a coordinated effort to rectify the referral management system at the different levels of the healthcare system across the country.

Summary of Protocols:

There is no coordinated referral system, and we understand that referrals between healthcare facilities and within regions happen on an ad hoc basis. However, the Rescue 1122 has also introduced referral ambulances³⁴⁴.

SOUTH AFRICA

South Africa, in 2020 introduced a policy for patient referrals³⁴⁵. Anyone experiencing a medical emergency can be taken to a hospital of their choice, whether private or government and the relevant trauma unit will assess whether there is an emergency or not. If there is no emergency they might either be given medication or referred to a doctor. In the case of an emergency, the patient will be admitted and any urgent treatment or procedures will be administered.

Commentary:

Generally, this system has been functioning well with the hospitals being able to manage the daily emergency cases they receive. During the COVID-19 pandemic though, hospitals did become overcrowded and strained and with the large influx of patients.

³⁴³ "Emergency health care in Pakistan: A look at the Lady Reading Hospital." International Committee of the Red Cross, July 20, 2018. <https://www.icrc.org/en/document/emergency-health-care-pakistan-lady-reading-hospital>

³⁴⁴ "Rescue 1122' Call To Action Is Within Seven Minutes, Says Spokesperson." UrduPoint, March 1, 2023. <https://www.urdupoint.com/en/pakistan/rescue-1122-call-to-action-is-within-seven-1651745.html>

³⁴⁵ "Referral Policy for South African Health Services and Referral Implementation Guidelines." Department of Health, South Africa. August 2020. Accessed March 16, 2023. <https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/National%20Referral%20Policy%20for%20SA%20Health%20Services%20and%20Implementation%20Guidelines%20Aug%202020.pdf>

UNITED STATES OF AMERICA

Federal: The EMTALA requires anyone coming to an emergency department at a hospital to be stabilised and treated, regardless of their insurance status or ability to pay. This prevents hospitals from transferring uninsured or Medicaid patients to public hospitals (i.e., “dumping”) without, at a minimum, providing a medical screening examination to ensure they were stable for transfer³⁴⁶. The EMTALA has expanded to cover patients seen anywhere on hospital property, including ambulances owned and operated by the hospital³⁴⁷.

State: Many states have legislation requiring hospitals to provide emergency care regardless of the patient’s ability to pay for such services. Similar to the EMTALA, other states require patients to be in stable condition before being transferred to another hospital.

Commentary:

With the exception of the “anti-dumping” legislation under the EMTALA, applicable mechanisms and legislation will apply on a state-by-state basis.

E. Specific Guidelines/Regulations to address Highway Trauma

AUSTRALIA

There are no specific guidelines/regulations to address Highway Trauma. States and territories use Clinical Practice Guidelines (CPGs), triage systems, and trauma systems whereby injured individuals are classified and treated depending on factors such as the type of blunt force, type of injury, and signs and symptoms of the injury.

BRAZIL

- » The transit of any nature on the terrestrial highways of the national territory, open to circulation, is governed by the Brazilian Traffic Code³⁴⁸.
- » SAMU Regulatory Ordinance n. 1.010 of 2012³⁴⁹ provides free transportation service from the crash site or medical emergency location to the emergency room.

³⁴⁶ The Emergency Medical Treatment and Labor Act.” Officer of Inspector General, 2001. Accessed February 21, 2023. <https://oig.hhs.gov/oei/reports/oei-09-98-00221.pdf>

³⁴⁷ “Department of Health and Human Services-Health Care Financing Administration.” Federal Register. Accessed February 21, 2023. <https://www.govinfo.gov/content/pkg/FR-2000-04-07/pdf/00-8215.pdf>

³⁴⁸ “Law No. 9.503.” Government of Brazil, September 23, 1997. Accessed February 21, 2023. https://www.gov.br/mj/pt-br/acao-a-informacao/atuacao-internacional/legislacao-traduzida/lei-no-9-503-de-23-de-setembro-de-1997-prf_eng-docx.pdf

³⁴⁹ “Ordinance No. 1.010.” Ministry of Health, Government of Brazil, May 21, 2012. Accessed on February 15, 2023. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt1010_21_05_2012.html

- » UPA Regulatory Ordinance ns. 1.601/11³⁵⁰, 2.820/11³⁵¹, 104/14³⁵² and 106/14³⁵³ provide a twenty-four hour unit for both immediate and non-urgent medical care.

ENGLAND AND WALES

The UK government has issued a “Highway Code”³⁵⁴ for assisting both crash victims and bystanders who may be present at the scene. The code advises such persons to firstly deal with ongoing sources of danger at the scene, for example, by switching off vehicles’ engines; secondly, calling the emergency services by dialling ‘999’ and providing the information requested; and lastly, following the basic first aid guidelines for safeguarding injured persons.

The National Ambulance Resilience Unit, that coordinates all NHS ambulance trusts, published the “Guidance for Ambulance Service response to Incidents on the Motorway Network”³⁵⁵. These guidelines outline best practices for ensuring a coordinated response by the emergency services and Highways England (an agency managing motorways in England). The guidelines outline information that must be gathered in an initial call from Highways England or via persons calling ‘999’, establishing access routes for responders, incident scene management, responder vehicle positioning and serious injury assessment.

GERMANY

There exist no specific guidelines/regulations to address Highway Trauma.

³⁵⁰ “Ordinance No. 1.601.” Ministry of Health, Government of Brazil, July 7, 2011. Accessed on February 15, 2023. https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2011/prt1601_07_07_2011_rep.html

³⁵¹ “Ordinance No. 2.820.” Ministry of Health, Government of Brazil, November 28, 2011. Accessed on February 15, 2023. https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2011/prt2820_28_11_2011.html

³⁵² “Ordinance No. 104” Ministry of Health, Government of Brazil, January 15, 2014. Accessed on February 15, 2023. https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2014/prt0104_15_01_2014.html

³⁵³ “Ordinance No. 106” Ministry of Health, Government of Brazil, January 17, 2014. Accessed on February 15, 2023. https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2014/prt0106_17_01_2014.html

³⁵⁴ “The Highway Code - Annex 7, First aid on the road - Guidance” . Department for Transport, October 1, 2015. <https://www.gov.uk/guidance/the-highway-code/annex-7-first-aid-on-the-road>

³⁵⁵ “Guidance for Ambulance Service response to Incidents on the Motorway Network (Including Smart Motorways).” NARU. National Ambulance Resilience Unit, November 2015. <https://naru.org.uk/wp-content/uploads/2015/12/NARU-MOTORWAY-INCIDENT-GUIDE-V1.0-11.2015-WEB-A.pdf>

INDIA

The federal government in India launched a scheme “Capacity Building for developing Trauma Care Facilities on National Highways,” aimed at ensuring that no trauma victim would have to be transported for more than 50 km to reach a trauma centre³⁵⁶. Main strategies of the scheme include providing basic life support ambulances at every 50 km along the Highways, with advanced life support ambulances at trauma care facilities for inter facility transfer. Trauma care was divided into different levels, with level IV trauma care being provided by appropriately equipped and manned mobile hospitals ambulances³⁵⁷. One hundred and sixteen trauma facilities were identified and funded under the scheme during the 11th five year plan (i.e. 2007-2012). 80 more trauma care facilities were identified and funded in the subsequent 12th five year plan (2012-2017)³⁵⁸.

Commentary: Though India’s federal government created a scheme to upgrade hospitals in the vicinity of highways to become trauma centres, given the lack of definition of trauma centres, their capabilities, their staffing, their interconnectivity etc. it is unclear as to the on-ground status of the effectiveness of such schemes.

JAPAN

No specific guidelines.

MALAYSIA

No specific guidelines.

PAKISTAN

No evidence of specific guidelines or regulations have been witnessed with regard to any level of highway trauma, with the exception of, for example, general provisions related to the role of the police in diverting and controlling traffic around the scene of an emergency (in the Punjab Emergency Act).

³⁵⁶ “Capacity building for developing Trauma Care Facilities in Govt. Hospitals on National Highways.” National Traumacare Programme, Government of India. Accessed January 23, 2023. [http://www.nisc.gov.in/PDF/Brief%20Trauma%20Programme-%2030.06.2016%20\(1\).pdf](http://www.nisc.gov.in/PDF/Brief%20Trauma%20Programme-%2030.06.2016%20(1).pdf)

³⁵⁷ “Specifications of Medical Equipments for ERS Ambulances under National Health Mission and Type of Ambulances.” National Health Mission. Accessed January 23, 2023. https://nhm.gov.in/images/pdf/programmes/ERS/Specification_of_Equipments_for_ERS_Ambulance.pdf

³⁵⁸ Setting Up of Trauma Centres.” Lok Sabha Unstarred Question answered by the Ministry of Health And Family Welfare, Government of India on March 19, 2021. <https://pqals.nic.in/annex/175/AU4070.pdf>

SOUTH AFRICA

There are no specific laws or guidelines in relation to highway trauma.

UNITED STATES OF AMERICA

Highway trauma is generally covered by the framework discussed in the previous section, which will generally apply on a state-by-state basis. 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 its Emergency Medical Services program³⁵⁹. 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.”

³⁵⁹ “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

IV. Recommendation: A “Right to Emergency Medical Care Act” for India

In July 2015, the former President of India, Dr APJ Abdul Kalam suffered a massive cardiac arrest while delivering a lecture at the Indian Institute of Management, Shillong. Rushed to Bethany Hospital, Dr Kalam, who was the Head of State from 2002 to 2007, succumbed to the heart attack. Hospital records revealed that the former President arrived in a “critical condition” where he was “almost dead.”³⁶⁰

More recently in June 2022, noted musician KK, too, succumbed to a massive cardiac arrest. The 53-year-old suffered a heart attack after performing a live show at Nazrul Manch, Kolkata. Various medical practitioners suggested that had immediate Cardiopulmonary Resuscitation (CPR) been provided to the singer—even by a lay person—and transferred to a cardiac care centre, this death could have been avoided.³⁶¹

In the years since these unfortunate events, more than one million patients across India have died as a result of medical emergencies. According to data from the National Crime Records Bureau of India, over a five year span between 2017 and 2021, 1,34,144 people died due to cardiac arrest alone³⁶².

³⁶⁰ “Former President APJ Abdul Kalam Passes Away In Shillong Following Massive Heart Attack.” *Businessworld*, July 27, 2015. <https://www.businessworld.in/article/Former-President-APJ-Abdul-Kalam-Passes-Away-In-Shillong-Following-Massive-Heart-Attack/27-07-2015-84108/>

³⁶¹ “Singer KK Could Have Been Saved If Timely CPR Was Given: Doctor Explains What Went Wrong.” *The Health Site*, June 6, 2022. <https://www.thehealthsite.com/news/%20singer-kk-could-have-been-saved-if-timely-cpr-was-given-doctor-explains-what-went-%20wrong-885079/>

³⁶² “Accidental Deaths and Suicides in India, 2021.” National Crime Records Bureau, Ministry of Home Affairs, Government of India, August, 2022. https://ncrb.gov.in/sites/default/files/ADSI-2021/ADSI_2021_FULL_REPORT.pdf

On the other end of the emergency medical care spectrum, trauma remains the number one killer of patients aged 1-44 in India. Road crashes form one of the biggest components of traumatic deaths. Over the five year span from 2017 to 2021, 7,36,129 people died as a result of motor vehicle crashes translating into nearly 403 people dying of road crashes everyday³⁶³. This is analogous to nearly 3 Boeing 737 aeroplanes crashing every day³⁶⁴ and represents a tremendous burden on the filial and socioeconomic fabric of the country. The astonishing gaps in emergency medical care in India, particularly trauma care, have a significant role to play in the preventable loss of life. Despite the Supreme Court of India in 1989 observing in the *Parmanand Katara v. Union of India* AIR 1989 SC 2039 that when “accidents” occur and victims are taken to hospitals or to a medical practitioner, they cannot be refused emergency medical treatment on the grounds of their ability to pay for the treatment. This was further reiterated by the Supreme Court in the *Paschim Banga Khet Mazdoor Samithi v. State of West Bengal*, 1996 (4) SCC 37.³⁶⁵ Although Article 21 of the Indian Constitution guarantees the Right to Life as a fundamental right, there is no explicit mention of a Right to emergency medical care.

Even though 30 years have passed since the Supreme Court identified a gap in the emergency medical care system, to date, this problem has not been fully addressed. It is still a well-known fact that trauma victims are often denied hospitalisation during their time of need. There are a multitude of reasons for this finding:

1. Lack of appropriate medical facilities for performing trauma resuscitation
2. Potential inability of a patient to pay, necessitating their need to go to a government hospital leading to potential delays in treatment of care and avoidable death
3. The higher the severity of trauma injury, the higher the chances of hospital denial

As per the 201st Report of the Law Commission of India, 50% of those killed in road crashes could have been saved had they received timely emergency medical care.

³⁶³ “Road Accidents in India, 2021.” Ministry of Road Transport and Highways, December 2022. https://morth.nic.in/sites/default/files/RA_2021_Compressed.pdf

³⁶⁴ “Technical Specs”. Boeing. Accessed January 24, 2023. <https://www.boeing.com/commercial/737ng/>

³⁶⁵ *Parmanand Katara v Union of India and Ors.* 1989 SCR (3) 997. <https://main.sci.gov.in/jonew/judis/7839.pdf>

A 2021 study by the All India Institute of Medical Sciences, New Delhi, found that while 91% of hospitals had ambulances, less than 35% of them had trained medical staff and paramedics to actually provide emergency medical care in life-and-death situations³⁶⁶. For any patient battling an emergency situation, time is of the essence. The “Golden Hour” of trauma care has been universally accepted as the most critical time in setting the trajectory of an emergency medical/trauma patient. Unfortunately, Indian citizens die every day, many whose deaths were preventable, due to a lack of a structured emergency response system at the pre-hospital and hospital levels. Several key factors can be attributed to these preventable deaths across India, including:

1. Lack of robust bystander training to activate the critical injury/illness chain of survival (see figure)
2. Lack of protections for those offering assistance to injured/critically ill patients, including a lack of a grievance redressal mechanism under the Good Samaritan Law
3. Lack of one designated universal access number for medical emergencies instead of multiple, differing numbers depending on the location
4. Lack of properly-equipped and properly-staffed emergency response vehicles depending on local geography/terrain
5. Lack of defined national standards for Emergency Medical Technicians (EMTs) and paramedics
6. Lack of designated/verified Emergency/Trauma Hospitals based on capabilities and based on local geography constraints
7. Lack of systems and authorised agencies to enable timely prehospital notifications, and transfer of patients to higher (or lower) levels of care based on severity/level of trauma/illness and based on pre-established protocols

³⁶⁶ “Emergency and Injury Care at District Hospitals in India, A Report of Current Status on Country Level Assessment.” All India Institute of Medical Sciences, New Delhi, and NITI Aayog, 2021. https://www.niti.gov.in/sites/default/files/2021-12/AIIMS_STUDY_2_0.pdf

8. Lack of a defined rehabilitation infrastructure to assist patients in returning to a healthy and productive lifestyle

The lack of these issues is further exacerbated by the lack of a lead agency that could serve as a governing body for how to address each of these points above as well as practice management guidelines. Such an agency may be created through the right to emergency medical care Act to act as a custodian to establish systems and protocols. Had the former President or the singer, KK, received CPR on site initiated by bystanders, followed by professional paramedics applying the lifesaving principles of Advanced Cardiac Life Support in a specialised ambulance with adequate resuscitation equipment while travelling to the receiving hospital that had been notified of their pending arrival and then promptly transferred their care to a trained emergency medical team, they may well be alive today.

Call to Action: The RIGHT to emergency medical care Act, with a special focus on trauma care

Pursuant to the fundamental right to preserve life established by Article 21 coupled with the significant impact of millions of lives lost due to preventable deaths in India from the data and cases described above, it is absolutely essential that a right to emergency medical care Act be established, with a particular focus on trauma care.

Such a right can be enshrined by way of an amendment to the Indian Constitution as in the case of the Right to Education Act, and called out along with essential components of the emergency medical care system, broadly defined as key components of the chain of survival below.

The right to emergency medical care Act may address components of the chain-of-survival at the Union and State levels.

At the Union-level, the following components may be addressed,



1. Bystander Care

Bystanders are often the first people who are witnesses to an emergency situation and with the maximum amount of time to assist the person requiring help. Therefore, within the Right to Bystander Care, three fundamental aspects need to be addressed. These include:



a. *Good Samaritan Law (GSL) for all medical emergencies*

Currently, the law relating to the protection of Good Samaritans is covered under section 134A of India's Motor Vehicles (Amendment) Act, 2019. In addition to incorporating a strong grievance redressal mechanism to give teeth to the GSL, the right to emergency care Act may expand the scope of GSL to all medical emergencies and trauma cases, and not just road crash trauma for it to enable lay rescuers to save more lives.



b. *Citizen training programs*

Bystanders are most often the first persons to come in contact with those that require help in an emergency situation. Given the large population and limited Emergency Medical Services, there is an urgent need for community capacity building. Training programs with a standardised curriculum and certifications need to be developed and ratified to train citizens in large numbers in the basic skills required for temporarily managing emergency medical situations. This aspect of the proposed Act may provide for rule-making by States in this direction.



2. Pre-hospital Infrastructure



a. *One Dedicated Universal Emergency Number*

A universal, easy-to-remember access number that would be available nationwide is absolutely fundamental to ensuring timely access to emergency medical care. While the Ministry of Home Affairs, under its Emergency Response Support System (ERSS) project, has proposed 112 as the single emergency response number for emergency assistance from Police, Fire and Rescue, Health and other services, there continue to exist multiple numbers to access emergency assistance. These include 108, 102, 1073, 1033, etc. Multiple numbers lead to confusion amongst the public as to which number to call, inevitably leading to a delay in activating the chain-of-survival.

It is therefore recommended that there should be nationwide availability of 112 as the single emergency phone number with subsequent triage by 112 operators for fire, police, medical emergency, disaster, etc. Emergency calls for help to 112 must automatically be accompanied by location-identifying information.



b. *Emergency Response Vehicles (ERVs)*

While the Automotive Industry Standard 125³⁶⁷ does provide guidance on ambulance design there is great variability in states across the country. The presence of nationally-standardised ERVs to rapidly transport injured or critically-ill patients to a receiving hospital are crucial to moving the patient through the chain of survival. These ERVs should be chosen by local agencies based on geography and terrain and Automotive

³⁶⁷ "AIS 125-Constructional and Functional Requirements for Road Ambulances (National Ambulance Code)" Ministry of Road Transport and Highways, Government of India, June 2013. http://www.nisc.gov.in/PDF/AIS_125.pdf

Industry Standard 125 may include any of the following: bicycle ambulances, motorised two-wheeler ambulances, standard van-type ambulances and air-ambulances.

It is imperative that these ERVs are equipped to meet one national standard, such as highlighted in Automotive Industry Standard 125, including proper lights and sirens, and proper equipment allowing the ambulance to be designated as either a Basic Life Support unit (BLS) or an Advanced Cardiac Life Support unit (ACLS). These ERVs need to be inspected and maintained on a regular schedule by designated state or local agencies.



c. Dedicated national pre-hospital emergency personnel training standards

After the universal access number has been dialled and the ERV arrives on the scene to meet the critically-ill or injured patient, care is assumed by a certified emergency medical professional. To ensure that patients receive the best possible medical assistance at the scene of injury and while in transit to the hospital, the presence of well-trained and certified emergency medical professionals is an absolute must. A select agency needs to establish a national standard curriculum and definitions for the designations of:

- Emergency Medical Responder (EMR)
- Emergency Medical Technician (EMT)
- Advanced Emergency Medical Technicians (AEMT)
- Paramedic³⁶⁸

For this to be possible on a pan-India basis, rigorous periodic training needs to be provided. To ensure holistic training, initial certifications and maintenance of certification will also require standardisation.

³⁶⁸ "The 3 Levels of EMT Certification:A Guide to the Various Levels of EMT Certification, Including Education, Training, and Testing Requirements ." United EMT. Accessed January 24, 2023. <https://www.unitekemt.com/blog/the-difference-between-emt-certification-levels/>



d. Communication mechanism

A robust communication mechanism is the backbone of emergency medical care. The emergency calls made to seek help trigger the chain of activities required to save the life of a patient. This includes the deployment of ERVs that help transport patients to the nearest appropriate medical facility. For this to happen in a timely and efficient manner, a robust communication mechanism is required which is capable of connecting the ERV to the calling centre as well as the various hospitals that are a part of the network and are receiving the patients.

An integrated EMS will allow for:

- Seamless interconnectivity between a centralised managed and/or governed by a central state/city/local agency to identify a sick/injured patient and under the guidance of medical providers, determine the ideal patient destination (closest medical facility vs closest trauma centre).
- Pre-hospital notification systems that will enable receiving hospitals and their teams time to prepare in advance of patient arrival allowing for maximal intervention, especially in life-threatening emergencies.



3. Hospital Infrastructure



a. Trauma Center Designation and Verification

A Statewide integrated or locally integrated EMS should have designated/verified Emergency/Trauma Hospitals based on location (City/Town/District/Mandal level) as

well as on capabilities. The different levels (i.e. Level I, II, III, IV or V) refer to the kinds of resources available in a trauma centre and the number of patients admitted yearly (see below). An integrated EMS will have several of these levels of trauma centres based on population requirements.

Level I Trauma Centers are a comprehensive regional resource, including tertiary care facilities central to the trauma system. A Level I Trauma Center is capable of providing total care for every aspect of injury – from prevention through rehabilitation. Its key elements include:

- 24-hour in-house coverage by general surgeons, and prompt availability of care in specialties such as orthopaedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology, internal medicine, plastic surgery, oral and maxillofacial, paediatric, and critical care.
- Referral resources for communities in nearby regions.
- Provides leadership in the prevention, and public education to surrounding communities.
- Provides continuing education for the trauma team members.
- Incorporates a comprehensive quality assessment program.
- Operates an organised teaching and research effort to help direct new innovations in trauma care.
- Program for substance abuse screening and patient intervention.
- Meets minimum requirement for annual volume of severely injured patients.

Level II Trauma Centers are able to initiate definitive care for all injured patients. Key elements include:

- 24-hour immediate coverage by general surgeons, as well as coverage by the specialties of orthopaedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology, and critical care.
- Tertiary care needs such as cardiac surgery, hemodialysis, and microvascular surgery may be referred to a Level I Trauma Center.

- Provides trauma prevention and continuing education programs for staff.
- Incorporates a comprehensive quality assessment program.

Level III Trauma Centers have demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care, and stabilisation of injured patients and emergency operations. Key elements include:

- 24-hour immediate coverage by emergency medicine physicians and the prompt availability of general surgeons and anesthesiologists.
- Incorporates a comprehensive quality assessment program.
- Has developed transfer agreements for patients requiring more comprehensive care at a Level I or Level II Trauma Center.
- Provides back-up care for rural and community hospitals.
- Offers continued education of the nursing and allied health personnel or the trauma team.
- Involved with prevention efforts and must have an active outreach program for its referring communities.

Level IV Trauma Centers have demonstrated an ability to provide Advanced Trauma Life Support (ATLS) prior to the transfer of patients to a higher level trauma centre. They provide evaluation, stabilisation, and diagnostic capabilities for injured patients. Key elements include:

- Basic emergency department facilities to implement ATLS protocols and 24-hour laboratory coverage. Available trauma nurse(s) and physicians available upon patient arrival.
- May provide surgery and critical-care services, if available.
- Has developed transfer agreements for patients requiring more comprehensive care at a Level I or Level II Trauma Center.
- Incorporates a comprehensive quality assessment program.
- Involved with prevention efforts and must have an active outreach program for its referring communities.

Level V Trauma Centers provide initial evaluation, stabilisation, and diagnostic capabilities and prepare patients for transfer to higher levels of care. Key elements include:

- Basic emergency department facilities to implement ATLS protocols.
- Trauma nurse(s) and physicians available upon patient arrival.
- After-hours activation protocols if the facility is not open 24 hours a day.
- May provide surgery and critical-care services, if available.
- Has developed transfer agreements for patients requiring more comprehensive care at Level I through III Trauma Centers.



b. Interconnectivity

Pre-established transfer protocols based on triage of the critically ill/injured patient is especially important for time-sensitive diseases such as severe trauma/stroke/MI/Cardio-pulmonary arrest. These transfer protocols will ensure that the right patient is brought to the right receiving hospital at the right time while also limiting the burden on lower-level facilities that may not have the resources to provide care for an injured or critically ill patient beyond initial stabilisation.



c. Refusals and transfers

It has oftentimes been witnessed that hospitals turn back patients, refusing to admit them. With families running from one hospital to another to ensure admittance for subsequent treatment, precious time is lost, at times proving to be fatal. This aspect of the law may prohibit such refusals by hospitals. Hospitals would be forbidden to turn back a patient without providing them with even basic care. The law should also establish stiff penalties for hospitals in violation of this provision. In order to ensure the seamless transfer of patients between hospitals, inter-hospital transfer agreements may be provisioned for as part of the law and the subordinate rules under it.



d. Training of Emergency Medical Care physicians

Healthcare providers taking care of injured or critically ill patients must be properly credentialed. Regular, rigorous, and specialised training is required for medical health professionals such as paramedics, emergency medical technicians, and others, as per the specific role they play within the entire emergency medical care system. This aspect of the law may mandate the different types of training for emergency medical physicians, trauma specialists, EMTs (classifications as noted in Section 2c above), etc. certifications. Initial certification as a prerequisite to obtaining a position as well as ongoing maintenance of certification (number of credits/mechanisms to be determined by the lead agency) are key elements of ensuring emergency medical providers in both prehospital and post-hospital phases are competent and up to date with their fund of knowledge and skills.



e. Rapid in-hospital triage

A triage system includes a basic structure in which all incoming patients are categorised into groups using a standard urgency rating scale or structure. This triaging helps rapidly identify patients who have suffered major trauma. Such classification through triaging helps determine treatment location and type on the basis of factors including the type of blunt force, type of injury, and signs and symptoms of the injury. Ensuring a timely triage of patients is extremely pertinent to making the most of the time following a health emergency to transport them to the exact facility equipped to assist them.



f. Care Pathways and Practice Management Guidelines (CP/PMGs)

Each designated receiving hospital should develop CP/PMGs to protocolize care of injured or critically ill patients in a standard fashion and based on best practices and current evidence. Examples of such CP/PMGs include Trauma Team Activation,

Trauma Transfers, when to place the Trauma Center on Bypass, Initial Assessment, and Resuscitation, How to order Blood, Management of specific injuries, etc. These CP/PMGs should be periodically updated by the hospital medical team to ensure they are current and up to date.



4. Rehabilitation of emergency and trauma patients

Trauma patients may take weeks, months, or even years to completely recover from the physical, emotional, and psychological impact of being a part of such a life-altering event. It is then paramount that they are provided with the required help and assistance. This aspect of the law may seek to provide access to rehabilitative care as a right to all patients requiring rehabilitation in order to optimise their ability to return to a healthy and productive lifestyle.



5. Funding mechanisms

This aspect of the law may enable the Union and State governments to develop schemes and policies to fund the right to emergency medical care. Among other essential responsibilities that this mechanism will fulfil, such a budget should also be utilised for training healthcare providers to impart emergency healthcare services in various capacities. Within the ambit of such training, drivers, police personnel and common citizens must also be included.

At the state level, the following component may be addressed,

Development of an integrated Emergency Medical System (EMS) at the State Level

The right to emergency medical care Act, with a particular focus on trauma care, may provide for States to develop a statewide emergency medical system with fourteen unique attributes:

1. Integration of Health Services
2. Performing EMS Research
3. Developing Statewide Legislation and Regulation
4. Developing and maintaining EMS Finance to determine the costs and benefits of EMS to the community as well as exploring opportunities for funding
5. Developing Human Resources
6. Medical Direction to guide best practices
7. Education Systems for the training of professionals (both prehospital and hospital)
8. Public Education: bystander training as described above
9. Injury Prevention and Awareness
10. Public Access
11. Robust Communication Systems to ensure timely decision-making
12. Standardisation of Clinical Care provided
13. Information Systems
14. Robust Evaluation and Transparent Process Improvement Processes

Annexure 1 (Chapter III)

Summary of Key Legislations/Case Laws with reference to emergency medical care:

1 a) Further details related to guaranteed/statutory rights to emergency medical care in England and Wales:

The NHS Constitution and the Handbook to the NHS Constitution are published by the Secretary of State under the terms of the Health Act 2009. The NHS Constitution states that the NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook, which further states:

- » For a maximum 4-hour wait in the A&E department of any NHS trust from arrival to admission, transfer or discharge;
- » That all ambulance trusts shall:
 - Respond to “Category 1” calls (calls requiring an immediate response to a life threatening condition, such as cardiac or respiratory arrest) in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes;
 - Respond to Category 2 calls (serious conditions, such as stroke or chest pain, which may require rapid assessment and/or urgent transport) in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes;
 - Respond to 90% of Category 3 calls (urgent problems, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting) in 120 minutes; and

- Respond to 90% of Category 4 calls (non-urgent problems) in 180 minutes³⁶⁹.

Case Law

» *Darnley v Croydon Health Services NHS Trust*³⁷⁰

Mr Darnley had gone to the Trust's A&E department after sustaining a head injury. Instead of being told that he would be examined by a triage nurse within 30 minutes, and that the triage nurse would decide how soon he needed to see a doctor, he was incorrectly informed by the receptionist that it would be four to five hours before he would be seen. As a result, Mr Darnley decided to return home after 19 minutes, without informing anyone and without being seen by a clinician as he did not want to wait for the duration confirmed by the receptionist. At home, he collapsed and was returned to hospital by ambulance. Although he underwent neurosurgery, he suffered permanent brain damage in the form of a left hemiplegia. He claimed damages from the trust, alleging that it had breached its duty of care to him when he first presented at A&E by failing to assess him for emergency triage and by failing to give him accurate information about how long he would have to wait before being seen by a clinician. The Supreme Court ruled that Mr Darnley was owed a duty of care and if a breach of that duty results in reasonably foreseeable harm, as had happened in this case, the hospital would be responsible.

» *Kent v Griffiths and Others*³⁷¹

The claimant was having an asthma attack. Her doctor attended her at home and called for an ambulance at 16:25. The ambulance, which was only 6 miles away, did not arrive until 17:05 during which time the claimant suffered respiratory arrest. Two phone calls had been made to enquire why the ambulance (which was operated by the London Ambulance Service NHS Trust) had not arrived and the operator confirmed that it was on its way. The Court of Appeal held that the ambulance service had a public law duty to provide an ambulance for the claimant, since it is not appropriate to regard the ambulance service and

³⁶⁹ "Handbook to the NHS Constitution." <https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england>

³⁷⁰ *Darnley v Croydon Health Services NHS Trust*. 2018 UKSC 50 <https://www.mind.org.uk/news-campaigns/legal-news/legal-newsletter-december-2018/darnley-v-croydon-health-services-nhs-trust-2018-uksc-50/>

³⁷¹ *Kent v Griffiths*. 2000, WLR 1158. <https://www.casemine.com/judgement/uk/5a8ff7b560d03e7f57eb1655>

its employees as volunteers whose only common law duty when responding to the 999 telephone call was not to add to the damage already suffered. In considering whether public policy grounds precluded the existence of a duty of care, the court held that the ambulance service should be regarded as part of the health service, where a duty of care to patients normally existed, rather than as providing services equivalent to those rendered by the police or the fire service when responding to a 999 telephone call. In this instance, the ambulance had been called for the claimant alone, and it was foreseeable that she would suffer further injuries if its arrival was delayed. The court further noted that resources had been available to provide an ambulance on which there were no alternative demands and there was no reason why it should not have been provided.

» *Barnett v Chelsea and Kensington Hospital Management Committee*³⁷²

The deceased drank tea, which had, unknown to him, been contaminated with arsenic. He attended the casualty department of a hospital complaining that he had been vomiting for three hours after drinking tea. The casualty doctor failed to examine him but sent a message that he should report to his own doctor. About five hours later, he died. On his widow's action for damages, it was held, (1) that the hospital authority owed a duty of care; (2) that the doctor was negligent in failing to examine and admit the deceased, and accordingly there had been a breach of that duty; but (3) that on the facts the deceased's condition was such that he must have died despite any medical attention which the hospital could have given, so that causation was not established and the claim failed.

1 b) Further details related to guaranteed/statutory rights to emergency medical care in India

Detailed below are the judicial precedents where emergency medical care has been interpreted as a part of Article 21 of the Constitution of India (Fundamental Right guaranteeing Protection of Life and Personal Liberty)³⁷³:

³⁷² *Barnett v Chelsea and Kensington Hospital Management Committee*. 1968, 2 WLR 422. https://www.iclr.co.uk/document/1961000242/casereport_75500/html

³⁷³ Article 21 of the Constitution of India provides as follows: "Protection of life and personal liberty: No person shall be deprived of his life or personal liberty except according to procedure established by law."

- » In *Pt. Parmanand Katara v. Union of India and Ors*³⁷⁴, the Supreme Court of India held that Article 21 of the Constitution cast an obligation on the State to preserve life. Thus a doctor at a government hospital is duty-bound to extend medical assistance to preserve life. Further, every doctor, whether at a government hospital or otherwise, had the absolute and paramount professional obligation to extend his services to preserve life. The Supreme Court clarified that no law or state action could intervene to avoid/delay the discharge of this obligation upon members of the medical profession.
- » In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal & Anr*³⁷⁵, the Supreme Court of India held that failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of the Right to Life under Article 21 of the Constitution. It was the State's constitutional obligation to provide adequate medical services to people and whatever was necessary for this purpose would be required to be done (which cannot be avoided on the grounds of financial constraints). In addition, the court issued further directions to ensure that proper medical facilities are available to deal with emergency cases, such as a centralised communication system to determine availability of beds in an emergency at state level hospitals. It was observed that all states should take necessary steps in light of the recommendations and directions given in the order.
- » In *Pravat Kumar Mukherjee v. Ruby General Hospital*,³⁷⁶ the issue before the National Consumer Disputes Redressal Commission, New Delhi, was whether the doctors in the hospital were deficient in the discharge of their duties by not continuing treatment of the deceased accident victim due to failure to deposit money for his treatment. The Commission held that emergency treatment was required to be given to the deceased who was brought in a seriously injured condition. It cited the *Parmanand Katara* case and held that there was deficiency in service under the Consumer Protection Act.

374 *Parmanand Katara v. Union of India and Ors.* 1989 CSR (3) 997. <https://main.sci.gov.in/jonew/judis/7839.pdf>

375 *Paschim Banga Khet Mazdoor Samity v. State Of West Bengal & Anr* (1996) 4 SCC 37. <https://indiankanoon.org/doc/1743022/>

376 *Pravat Kumar Mukherjee v. Ruby General Hospital & Ors.* Original Petition No. 90 of 2002. <https://indiankanoon.org/doc/173553/>

State Specific Legislations:

The Gujarat Government through Gujarat Emergency Medical Services Act, 2007³⁷⁷ recommends better facility and availability of emergency care services like ambulances, and the establishment of the Gujarat Emergency Medical Services Authority. The Act also directs that every base hospital should have an emergency department and must provide easy EMS access to every person in need of treatment without discrimination.

- » The Assam Public Health Act, 2010³⁷⁸ *inter alia* provides that the government in the Health and Family Welfare Department is to take appropriate legal steps to specifically address provision of trauma/emergency care. All hospitals or health establishments of the state, government or private including private nursing homes shall have to provide free health care services maintaining appropriate protocol of treatment for the first 24 hours to an emergency patient of any kind. Section 5 of the said Act also provides that every person shall have the right to *inter alia* appropriate health care and health care related functional equipment. The Act defines 'health care' to include emergency medical treatment, in any system of medicine.
- » Section 134 of the Motor Vehicles Act, 1988³⁷⁹ *inter alia* provides that when a person is injured due to an crash involving a motor vehicle, the driver of the motor vehicle or other person in charge shall, unless not practicable for reasons beyond his control, take all reasonable steps to secure medical attention for the injured person by conveying him to the nearest hospital/ medical practitioner. Section 187 of the Act provides that failure to comply with Section 134 is punishable with imprisonment that may extend to six months or with a fine of Rs. 5,000 or both. In the event of a second offence, the punishment is imprisonment that may extend to one year or a fine of Rs. 10,000 or both.

³⁷⁷ "Gujarat Emergency Medical Services Act, 2007." India Code. Government Of Gujarat, April 4, 2007. <https://www.indiacode.nic.in/bitstream/123456789/4462/1/emergencymedicalservices.pdf>

³⁷⁸ "The Assam Public Health Act, 2010." Government of Assam, May 7, 2010. Accessed February 23, 2023. https://www.indiacode.nic.in/bitstream/123456789/5607/1/the_assam_public_health_act%2c_2010._recognized.pdf

³⁷⁹ "Section 134 of The Motor Vehicles Act, 1988." pg. 101. Ministry of Law and Justice, Government of India, October 14, 1988. https://www.indiacode.nic.in/handle/123456789/1798?sam_handle=123456789/1362

Further, Section 134 also states that it shall be the duty of 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 desires otherwise.

1 c) Further details related to guaranteed/statutory rights to emergency medical care in Japan

A judgement of Kobe District Court on June 30, 1994 is considered as a typical precedent relating to this issue. In this case, when a patient who had been involved in a traffic crash late at night was transported by ambulance to a hospital, the hospital responded that they could not treat the patient due to the absence of the adequate doctors (a neurosurgeon and an orthopaedic surgeon). The doctors on duty that day were at home. The emergency rescue team then transported the patient to another emergency hospital in a neighbouring city 30 km away, where the patient was treated immediately. The patient died as a result of injuries sustained in the car crash. The patient's family claimed damages against the hospital, stating that the hospital's refusal to treat the patient violated the patient's legal interest in receiving proper medical care. In the judgement, the court firstly pointed out that the doctors are not immediately liable for damages to patients for refusing to provide medical treatment because the duty to respond is a duty to the government. The court said, however, that the duty to respond also has the aspect of protecting the interests of patients, and therefore a breach of this duty leads to a presumption of negligence by the doctor. Under this rationale, the court ordered the hospital to pay damages to the patient's family. Separate from the doctors' duty to respond, the legal schemes in relation to the Emergency Medical System were firstly established in 1963 through the Fire Service Act and evolved into the current form in 1977, while minor amendments have been continuously made. The Fire Service Act requires each prefecture to set and disclose standards for the transportation of injured and sick persons and the reception of them (Article 35-5 of the Fire Service Act).

In accordance with this provision, each prefecture must disclose their standards and it is understood that it is the obligation of municipal governments (i.e., prefecture, city, town or village) to establish an EMS. Under the Fire Service Act, an ambulance team member, when it is urgently necessary, may request a person who is near the scene where a person suffering an injury or contracting a disease is found, to cooperate with the ambulance services (Article 35-10, paragraph 1 of the Fire Service Act). In addition, under the Emergency Life-saving Technicians Act, there are 61,771 emergency life-saving technicians³⁸⁰ as of 2019, who are qualified to engage in the practice of emergency lifesaving. The majority of paramedics are employees of fire departments, including emergency rescue teams.

Other than these, there are no provisions prescribing the patients' rights in Japanese law. It should be also noted that Japan does not have a unified legislation on emergency care.³⁸¹

1 d) Further details related to guaranteed/statutory rights to emergency medical care in Malaysia

A recent study found that healthcare services in Malaysia are often inaccessible to migrant workers – although many of the barriers are beyond the control of the health sector. These include affordability and financial constraints, the need for legal documents like valid passports and work permits, language barriers, discrimination and xenophobia, physical inaccessibility, and employer-related barriers³⁸².

³⁸⁰ "Chapter 2: Health and Medical Services, Annual Health, Labour and Welfare Report 2021." Ministry of Health, Labour and Welfare, Government of Japan, 2021. <https://www.mhlw.go.jp/english/wp/wp-hw14/dl/02e.pdf>

³⁸¹ Note: Japan is divided into 47 prefectures. Under each prefecture, there are municipalities, consisting of either cities, towns or villages. One exception is Tokyo: Under the Tokyo metropolitan government (prefecture-level), there are 23 wards equivalent to cities. The emergency medical system in Tokyo, however, is operated only at the metropolitan level.

³⁸² "Breaking down the barriers: Understanding migrant workers' access to healthcare in Malaysia." PLoS One. 2019; 14(7): e0218669. Published online Jul 3 2019. Accessed February 21, 2023. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6608924/>

1 e) Further details related to guaranteed/statutory rights to emergency medical care in South Africa

S36 of the South African Constitution states:

"36. (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including — (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relation between the limitation and its purpose; and (e) less restrictive means to achieve the purpose."

Both private and public hospitals are under a peremptory obligation to provide treatment to persons experiencing a medical emergency³⁸³. However, in the instance of individuals not having medical health insurance, also colloquially known as medical aid, private hospitals will nevertheless stabilise such patients and thereafter, transfer them to public health hospitals.³⁸⁴ For example, if a person has been involved in a motor vehicle crash and requires emergency medical treatment, they may not be refused such treatment by a private institution on the basis that they do not have private health insurance.³⁸⁵ Further, a private ambulance is also under an obligation to transport a person in need of emergency medical treatment to the closest hospital, and the hospital needs to stabilise the person prior to requesting payment and then transferring the patient to an appropriate public facility, if they do not have private medical aid insurance.³⁸⁶

³⁸³ "Emergency Medical Services Regulations, 2017, National Health Act 61. of 2003." Minister of Health, October 26, 2017. <https://section27.org.za/wp-content/uploads/2018/02/EMS-Regulations-2017.pdf>

³⁸⁴ *ibid*

³⁸⁵ "Some Key Messages on National Health Insurance (NHI)." Accessed February 1, 2023. <https://www.health.gov.za/wp-content/uploads/2020/11/some-key-messages-on-nhi.pdf>

³⁸⁶ *Ibid*

At the Scene: Access to care (bystander response, system activation, bystander care)

AUSTRALIA

2a) Further details related to - At the Scene: Access to care (bystander response, system activation, bystander care) in New South Wales (NSW)

1) Volunteers

- a. NSW Ambulance conducts several clinical volunteer responder models across metropolitan, regional, rural, and remote NSW. One has to undertake a comprehensive process to become a NSW Ambulance volunteer, which involves a suitability assessment, health assessment, completion of a range of mandatory vaccinations, police checks, working with children checks, and referee checks.
- b. Chaplains from NSW Ambulance are part of a multidisciplinary support network that offers non-judgmental support to Ambulance personnel and their families, as well as support to bystanders in traumatic incidents. A Chaplaincy Team member can help with post-incident counselling and pastoral care 24 hours a day.

2) The Health Practitioner Regulation National Law 2009³⁸⁷ provides that unsatisfactory professional conduct of a medical practitioner includes refusing or failing, without reasonable cause, to attend (within a reasonable timeframe after being requested to do so) a person to provide medical services in the capacity of a medical practitioner, if the practitioner has reasonable cause to believe that the person requires urgent medical attention. However, the medical practitioner may not be held liable if they have taken all reasonable steps to ensure that another medical practitioner attends to the injured person within a reasonable timeframe (s139(c)).

³⁸⁷ "Health Practitioner Regulation National Law (NSW) No 86a of 2009." Government of New South Wales, Australia, as on November 11, 2023. Accessed February 24, 2023. <https://legislation.nsw.gov.au/view/html/inforce/current/act-2009-86a>

3) Guardianship Act, 1987³⁸⁸ provides that a health practitioner may carry out medical treatment on a patient without consent given, the medical practitioner carrying out or supervising the treatment considers it necessary as a matter of urgency. The nature of urgent medical treatment is provided as treatment to save the patient's life, prevent serious damage to the patient's health, prevent the patient from suffering, or continuing to suffer significant pain or distress (s37).

2b Further details related to - At the Scene: Access to care (bystander response, system activation, bystander care) in Queensland

Operational Volunteers

- a. Operational volunteers assist in the delivery of Queensland Ambulance Service (QAS) programs in areas determined by QAS operational needs, which are typically rural, remote, or isolated communities. These volunteers are also known as "honorary officers," a title derived from the Ambulance Service Act of 1991, which states that honorary Ambulance Operators (AOs) are volunteers who perform ambulance-related functions. The operational volunteer role includes the following:
 - ii. **Honorary AOs:** these are volunteers that received advanced first aid training and can respond to requests for help with initial first aid. In addition, they may be asked to provide community based first aid instruction.
 - iii. **First Responders:** these are volunteers trained in first aid, who are deployed in their own vehicles with equipment provided by the QAS to provide immediate EMS to patients within their local communities, while an ambulance is on its way. For instance, they could start CPR on a cardiac arrest patient.
 - iv. **Volunteer drivers:** these volunteers are typically available in areas where single-officer or hospital-based ambulance stations are required. They operate the ambulance vehicle in non-emergency conditions (no lights and sirens), enabling the QAS paramedic to concentrate on treating the patient while being transported to the hospital.

³⁸⁸ "Guardianship Act 1987 No 257." Government of New South Wales, Australia, as on March 27, 2021. Accessed February 24, 2023. <https://legislation.nsw.gov.au/view/html/inforce/current/act-1987-257>

2c Further details related to - At the Scene: Access to care (bystander response, system activation, bystander care) in South Australia

- a. The South Australia Ambulance Service (SAAS) is a Registered Training Organisation. The Ambulance Volunteer ATP ambulance service is divided into three levels. The AA, the AR, and the AO. The AA is the entry-level for all volunteers, in which volunteers are trained to support higher level officers in treating and transporting patients. The AR is the second level of volunteers, who may provide basic life support and utilise limited Clinical Practice Protocols. The AO is the third level of volunteers, who provide intermediate life support, utilising a wide range of Clinical Practice Protocols, including advanced skills and medication.
- b. All SAAS clinical staff receive an ATP after they have completed the stages of training. In terms of care and expertise, the ATP explicitly states their tasks and professional requirements.

2d Further details related to - At the Scene: Access to care (bystander response, system activation, bystander care) in Tasmania

- a. The Clinical Field Protocols for Volunteer Ambulance Officers, authorised by the Director of Ambulance Services, governs the work of volunteer AOs. Each volunteer, during training, completes a specific set of modules created by Ambulance Tasmania, and is responsible for ensuring that they are working within their approved scope of practice.

2e Further details related to - At the Scene: Access to care (bystander response, system activation, bystander care) in Victoria

1) Volunteers

- b. First responders support Ambulance Victoria to respond to emergencies in rural and remote Victoria, working alongside paramedics to deliver patient care.

- c. Community Emergency Response Teams (CERTs)³⁸⁹ are volunteer first responders who are deployed at the same time as an ambulance in response to an emergency call request in less populated and remote areas of the state. CERTs are qualified to provide advanced first aid services in their local community, and provide emergency treatment before an ambulance arrives. They operate in pairs on an “on-call” basis. They do not transport patients to hospitals, but do respond to emergencies in areas where there are few ambulances and no ambulance stations.
- d. Ambulance Community Officers (ACOs)³⁹⁰ are first responders who work part-time “on-call” at either a community or a paramedic division. They are qualified to provide advanced first aid in rural and remote areas, where the emergency caseload is minimal, the ambulance division is understaffed, or when the paramedic is not assigned to work with a second paramedic. ACOs are certified to assist skilled paramedics by performing early interventions and transporting patients to the hospital.

2f Further details related to - At the Scene: Access to care (bystander response, system activation, bystander care) in Australia

Territorial Legislation

Australian Capital Territory

1) Civil Law (Wrongs) Act 2002 ³⁹¹

- e. Provides protection from civil liability to Good Samaritans for an act done or omission made honestly and without recklessness in assisting, or giving advice about the assistance, to a person who is injured, at risk of being injured, or in need of emergency medical assistance.
- f. The protection under the Act also extends to medically qualified persons who, acting without expectation of payment or other consideration,

³⁸⁹ “Become a First Responder.” Ambulance Victoria. Accessed February 24, 2023. [https://www.ambulance.vic.gov.au/careers/become-a-first-responder/#:~:text=Community%20Emergency%20Response%20Teams%20\(CERTs\)%20are%20comprised%20of%20volunteer%20First,to%20a%20E2%80%9C000%E2%80%9D%20call](https://www.ambulance.vic.gov.au/careers/become-a-first-responder/#:~:text=Community%20Emergency%20Response%20Teams%20(CERTs)%20are%20comprised%20of%20volunteer%20First,to%20a%20E2%80%9C000%E2%80%9D%20call)

³⁹⁰ “Become a First Responder.” Ambulance Victoria. Accessed February 24, 2023. <https://www.ambulance.vic.gov.au/careers/become-a-first-responder/>

³⁹¹ “Civil Law (Wrongs) Act 2002.” Government of Australian Capital Territory, as on December 10, 2022. Accessed February 24, 2023. https://drive.google.com/file/d/1FzRCp-mhrq_PorxxdK7qg6XLbaYTHbL1/view?usp=sharing

advice by telephone or another form of telecommunication about the treatment of a person who is injured, at risk of being injured, or in need of emergency medical assistance.

- g. Standard of care: to avoid liability, the Good Samaritan must act honestly and without recklessness (s5(1)).

2) Guardianship and Management of Property Act states that urgent medical treatment to a patient may be provided without their consent. What constitutes urgent medical treatment has not been explicitly provided in the Act. Medical treatment is defined as a medical procedure or treatment, dental treatment, and a series of procedures or courses of treatment (s32N).

Pursuant to Section 5(4) of the Civil Law (Wrongs) Act 2002, a “medically qualified” person: is either (i) a medical doctor; (ii) has professional qualifications in a field of healthcare that is recognised under an Act; or (iii) works or has worked as a member of the ambulance service or in another paramedical capacity.

Northern Territory

1) Personal Injuries (Liabilities and Damages) Act 2003³⁹²

- h. Provides protection to Good Samaritans, with or without medical qualifications. Pursuant to the Act, Good Samaritans shall not be personally liable for an act or advice, provided in good faith and without recklessness, to an individual receiving emergency medical help.
- i. Standard of Care: the act must be in good faith and without recklessness (s8(1)).

2) Criminal Code Act 1983³⁹³ provides that any person who, being able to provide rescue, resuscitation, medical treatment, first aid, or succour of any kind of help to a person urgently in need of it and whose life may be

³⁹² “Personal Injuries (Liabilities and Damages) Act 2003.” Government of Northern Territory of Australia, as on January 1, 2023. Accessed February 24, 2023. https://drive.google.com/file/d/19FFKBuyM0jy_pdinBxl3F_6xGqU4Xs6H/view?usp=sharing

³⁹³ “Criminal Code Act, 1983.” Government of Northern Territory of Australia, as on May 1, 2013. Accessed February 24, 2023. <https://policehumanrightsresources.org/content/uploads/2016/07/Northern-Territory-Criminal-Code-Act-2013.pdf?x49585>

endangered if it is not provided, callously fails to do so, is guilty of an offence and is liable to imprisonment for seven years (§155).

2g Further details related to - At the Scene: Access to care (bystander response, system activation, bystander care) in Germany

Federal State Laws, e.g. the Bavarian Law on the Establishment and Operation of Integrated Control Centers (Integrierte Leitstellen-Gesetz – ILSG)³⁹⁴ state that emergency services can be reached via the free-of-charge telephone number 112 throughout Germany, at any time.

Federal State Law, e.g. sec. 3(2) of the Law on Rescue Service of Baden-Wuerttemberg³⁹⁵ - the time constraints for the arrival of the ambulance at the scene after receipt of an emergency call differs in the different federal states in Germany. For example, in Baden-Wuerttemberg and Rhineland-Palatinate, the ambulance needs to arrive at the scene within 15 minutes.

Federal State Laws, e.g. sec. 3.1.2 of the Accident Recording Guideline – Guidelines on the Tasks of the Police in Road Traffic Accidents of Hesse (Unfallaufnahme Richtlinien - Richtlinien über die Aufgaben der Polizei bei Straßenverkehrsunfällen Hessen) states that the police carry out necessary first aid measures when arriving at an emergency scene.

2h Further details related to - At the Scene: Access to care (bystander response, system activation, bystander care) in India

On 30 March 2016, the Supreme Court in *SaveLIFE Foundation v. Union of India*, (2016) 7 SCC 194, approved the Guidelines for Protection of Good Samaritans

³⁹⁴ "The Bavarian Law on the Establishment and Operation of Integrated Control Centers Act- ILSG) of July 25, 2002 (GVBl. p. 318) BayRS 215-6-1-I. <https://www.gesetze-bayern.de/Content/Document/BayILSG-1>

³⁹⁵ "The Law on Rescue Service of Baden-Wuerttemberg(Rettungsdienstgesetz - RDG) in Version of February 8, 2010. <http://www.landesrecht-bw.de/jportal/?quelle=jlink&query=RettDG+BW&psml=bsbawueprod.psml&max=true&aiz=true>

along with the SOP (with a slight modification) issued by the MoRTH, and issued directions under Article 32³⁹⁶ read with 142 of the Constitution,³⁹⁷ for compliance until such time that a substantive legislation dealing with these matters is passed and approved by the legislature/Parliament. It held that the Guidelines would have the force of law under Article 141 of the Constitution³⁹⁸, and by virtue of Article 144³⁹⁹, it would be the duty of all authorities- judicial and civil, to act in aid of the court by implementing them. It further ordered all Union Territories and state governments to comply with the said SOP Guidelines.

- » All public and private hospitals are required to implement the Guidelines immediately and appropriate action can be taken by concerned authorities in the event of non-compliance. Further, disciplinary, or departmental action can be initiated against public officials who coerce or intimidate bystanders or Good Samaritans to reveal names or personal details. Disciplinary actions can also be taken against doctors for lack of response during emergencies pertaining to road crashes.
- » On 3rd October 2021, MoRTH also introduced a scheme to reward Good Samaritans⁴⁰⁰ with a sum of INR 5,000 for saving the life of victim(s) of a fatal crash involving a motor vehicle. If more than one Good Samaritan saved the life of one victim of a road crash, then the amount of INR 5,000 shall be divided equally among each of them. Under the scheme, a separate bank account needs to be maintained by State Governments for the scheme's

³⁹⁶ Article 32 of the Constitution of India: "(1) The right to move the Supreme Court by appropriate proceedings for the enforcement of the rights conferred by this Part is guaranteed. (2) The Supreme Court shall have power to issue directions or orders or writs, including writs in the nature of habeas corpus, mandamus, prohibition, quo warrant and certiorari, whichever may be appropriate, for the enforcement of any of the rights conferred by this Part. (3) Without prejudice to the powers conferred on the Supreme Court by clauses (1) and (2), Parliament may by law empower any other court to exercise within the local limits of its jurisdiction all or any of the powers exercisable by the Supreme Court under clause (2). (4) The right guaranteed by this article shall not be suspended except as otherwise provided for by this Constitution."

³⁹⁷ Article 142 of the Constitution of India: "(1) The Supreme Court in the exercise of its jurisdiction may pass such decree or make such order as is necessary for doing complete justice in any cause or matter pending before it, and any decree so passed or order so made shall be enforceable throughout the territory of India in such manner as may be prescribed by or under any law made by Parliament and, until provision in that behalf is so made, in such manner as the President may by order prescribe.(2) Subject to the provisions of any law made in this behalf by the Parliament, the Supreme Court shall, as respects the whole of the territory of India, have all and every power to make any order for the purpose of securing the attendance of any person, the discovery or production of any documents, or the investigation or punishment of any contempt of itself."

³⁹⁸ Article 141 of the Constitution of India: "The law declared by the Supreme Court shall be binding on all courts within the territory of India."

³⁹⁹ Article 144 of the Constitution of India: "All authorities, civil and judicial, in the territory of India shall act in aid of the Supreme Court."

⁴⁰⁰ "Scheme for grant of Award to the Good Samaritan who has saved life of a victim of a fatal accident involving a motor vehicle by administering immediate assistance and rushing to Hospital/Trauma Care Centre within the Golden Hour of the accident to provide medical treatment." Ministry of Road Transport and Highways, October 3, 2021. Accessed February 15, 2023. https://morth.nic.in/sites/default/files/circulars_document/Scheme_for_grant_of_awards_to_Goods_Samaritan_0001.pdf

operation. The scheme also states that the reward will be accompanied with a "Certification of Appreciation" and there will be 10 National Level Awards for the "most worthy Good Samaritans," who will be awarded with INR 1,00,000 each.

Transfer from Scene to Facility: Protocols regarding ambulances and hospital care

3a - Further details regarding - Transfer from Scene to Facility: Protocols regarding ambulances and hospital care in Queensland

The Ambulance Service Act 1991 also provides the measures, without limitation, that may be taken by an authorised officer in order to protect individuals from danger or potential danger. Such measures include:

- i. To enter any premises, vehicle, or vessel;
- ii. To open any receptacle, using such force as is reasonably necessary;
- iii. To bring any apparatus or equipment onto the premises;
- iv. To remove from or otherwise deal with, any article or material in the area;
- v. To destroy (wholly or partially) or damage any premises, vehicle, vessel, or receptacle;
- vi. To cause the gas, electricity supply, motor, or any other source of energy to any premises, vehicle, vessel, or receptacle to be shut off or disconnected;
- vii. To request any person to take all reasonable measures to assist the authorised officer;
- viii. To administer such basic life support and advanced life support procedures as are consistent.

3b Further details regarding - Transfer from Scene to Facility: Protocols regarding ambulances and hospital care in Australia

Territorial Legislation

Australian Capital Territory

1) *Emergencies Act 2004*⁴⁰¹

Provides that in exercising its functions, the ambulance service may carry out the following:

- a. Provide medical treatment and pre-hospital or post-hospital patient care;
- b. Transport patients by ambulance; or
- c. Transport patients by medical rescue aircraft (s41(3)).

2. The Clinical Management Guidelines of the ACT Emergency Service Agency⁴⁰² provides guidelines for clinical management of patients, on-scene treatment, and the goal time limits within which a "time critical" or a trauma patient should be transferred to the hospital. A trauma patient is considered an actual or potential "time critical" patient. This requires a minimum scene time, treatment en route (wherever possible) and prompt transport to a designated Trauma Centre.

Northern Territory

The Clinical practice manual represents current clinical practices in the pre-hospital environment. It contains expert-reviewed evaluation and treatment material. Clinical Practice Guidelines (CPGs) cover a wide variety of clinical conditions and circumstances that paramedics face in the pre-hospital environment. Each CPG provides information about a typical clinical presentation in the case of a clinical condition, guidelines for clinical management, and diagnostic patterns associated with the relevant disorder. Also, Clinical Practice Procedures (CPPs) refer to particular clinical procedures that can be conducted as part of a patient's clinical management. Related CPPs often discuss the use of various items of equipment borne by SJANT ambulances⁴⁰³.

⁴⁰¹ "Emergencies Act 2004 (A2004-28): Republication No 35." The Parliamentary Counsel, Government of Australia, December 12, 2022. <https://www.legislation.act.gov.au/View/a/2004-28/current/html/2004-28.html>

⁴⁰² "Emergency Services Agency". Australian Capital Territory Government. Accessed February 1, 2023. <https://esa.act.gov.au>

⁴⁰³ "ST Johns Ambulance NT Clinical Practice Manual." Government of Australian Northern Territory. Accessed February 22, 2023. <https://www.stjohnnt.org.au/img/documents/clinical-manuals/cpmhvintro23june20136.pdf>

Commentary: The Senior Medical Advisor or Medical Director of St. John Ambulance Northern Territory (SJANT) may authorise an officer/officers of a specific class or category to perform paramedic duties at a level necessary to meet the requirements of a service provision agreement between SJANT and the Northern Territory Government. The Authority to Practice (ATP) entails that when providing ambulance services for SJANT, an authorised officer can take every reasonable measure to: (i) request any person to take all reasonable measures to assist the authorised officer; and (ii) administer such basic and advanced life support procedures as are compatible with the authorised officer's training, scope, and qualifications.

3c - Further details regarding - Transfer from Scene to Facility: Protocols regarding ambulances and hospital care in England and Wales

On 13 July 2017 NHS England announced a new set of performance targets for ambulance services, which saw standards applied to every 999 call for the first time. This move was made as a result of the findings of the Ambulance Response Programme, the largest study of ambulance services in the world⁴⁰⁴.

- » On 27 September 2018, the National Ambulance Commissioners Network (commissioned by the National Ambulance Improvement Programme) published a Commissioning Framework and a National Urgent and Emergency Ambulance Services specification to standardise the delivery of ambulance services⁴⁰⁵.
- » All ambulance services in England and Wales are measured by, and reported against, the Ambulance Quality Indicators⁴⁰⁶.

⁴⁰⁴ "Ambulance Response Programme Review." NHS England. Accessed February 22, 2023. <https://www.england.nhs.uk/wp-content/uploads/2018/10/ambulance-response-programme-review.pdf>

⁴⁰⁵ "Commissioning Framework: A Framework for the Commissioning of Ambulance Services ." NHS England Central Ambulance Team, September 27, 2018. <https://www.england.nhs.uk/wp-content/uploads/2018/09/commissioning-framework-and-national-urgent-and-emergency-ambulance-services-specification.pdf>

⁴⁰⁶ "Ambulance Quality Indicators." NHS choices. NHS. Accessed January 24, 2023. <https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/>

The National Urgent and Emergency Ambulance Services sets out a five-stage framework for ambulance services to follow which emphasises on early decision making⁴⁰⁷:

1. **Domain 1** “Before the 999 call”: public education and guidance – ambulance services should have strategies and plans in place to undertake public education and guidance regarding the appropriate use of the ambulance service.
2. **Domain 2** “Answer my call”: ensure calls are answered promptly and ambulance service is able to assess and triage calls via an accredited triage tool, provide clinical advice as soon as possible in the call process (either by a clinician or a clinical based system applied by a non-clinician);
3. **Domain 3** “Provide the Right Care”: the patient’s needs should be assessed to provide the most appropriate response in a timely manner. A telephonic or face-to-face patient triage will be documented on an Electronic Patient Report and the following immediate and necessary interventions will be undertaken:
 - a. **Heat and Treat**: incidents with no face-to-face response where calls are managed via the Clinical Support Desk resulting in no ambulance arriving at the scene;
 - b. **See and Treat**: calls which result in an emergency response arriving at the scene where following assessment no onward conveyance to the hospital is required;
 - c. **See and Convey**: calls which result in an emergency response arriving at the scene, followed by ambulance conveyance to a healthcare facility. Through the Ambulance Quality Indicators ambulance services are required to distinguish between conveyance to a type 1 (consultant led 24-hour services with full resuscitation facilities) or 2 (consultant led 24-hour services for single specialties) Emergency Department and conveyance to alternative service.

⁴⁰⁷ “Commissioning Framework: A Framework for the Commissioning of Ambulance Services.” NHS England. Accessed February 22, 2023. <https://www.england.nhs.uk/wp-content/uploads/2018/09/commissioning-framework-and-national-urgent-and-emergency-ambulance-services-specification.pdf>

4. Domain 4 “Respond to my Need(s)”: using an NHS Accredited triage system to undertake call prioritisation to establish the right response to every patient the first time every time and ensuring electronic care plans are up to date and made available to responders.

5. Domain 5 “Direct me to the right place”: work with local commissioners to enable direct referral of patients from dispatchers to a wide range of community based services and provide responders with immediate access to, and utilisation of, an easily navigable electronic directory of services, shared patient records and remote decision support in a mobile format to enable referral to services following telephone and face-to-face assessment.

The NHS Constitution and the Handbook to the NHS Constitution published by the Secretary of State under the terms of the Health Act 2009 (and updated for the 2017 targets) states that NHS commits to provide convenient, easy access to services within the following waiting times:

- » a maximum 4-hour wait in the accident and emergency department of any NHS trust from arrival to admission, transfer or discharge; and
- » all ambulance trusts shall:
 - respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes;
 - respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes;
 - respond to 90% of Category 3 calls in 120 minutes; and
 - respond to 90% of Category 4 calls in 180 minutes.

3d - Further details regarding - Transfer from Scene to Facility: Protocols regarding ambulances and hospital care in India

The Government of India has also launched and revised a course to train pre-hospital trauma technicians, with advisories issued to all states to implement

the said course curriculum for capacity building and training of para-medical personnel for ambulances.⁴⁰⁸

- » The National Ambulance Code⁴⁰⁹ provides for different types of ambulances based on the level of care they can provide, and lays down specifications of how the ambulances need to be equipped. Type A ambulances are first responders, and some flexibility is given to use a suitable vehicle for these as per the terrain. Type B ambulances are patient transport vehicles for those who are not expected to become emergency patients. Type C ambulances are basic life support ambulances while Type D ambulances are advanced life support ambulances for transport and treatment of emergency patients. The Code provides guidelines for the ideal condition that the medical devices in the ambulance need to be in. However, it does not appear to provide for any penalty in the event of non-compliance.
- » The National Ambulance Service (NAS) of the National Health Mission is the network of patient transport ambulances which can be called by dialling 108 by phone for critical care, trauma, crash victims etc. Implementation of NAS guidelines is mandatory for ambulances whose operational cost is supported by the National Health Mission⁴¹⁰. Specification for medical equipment to be carried by these ambulances is also stipulated⁴¹¹.
- » Several private organisations and NGOs have created ambulance networks to provide emergency care. For instance, the Apollo Hospital Group launched an EMS helpline in Hyderabad which was then scaled up into a 24x7 National Network of Emergency Services, including emergency rooms and ambulances to meet all medical and surgical emergencies.⁴¹² The Emergency Medicine and Research Institute launched the 108 EMS ambulance service in partnership with several states, with trained personnel to provide prehospital care during transport to appropriate hospital⁴¹³.

408 "Capacity building for developing Trauma Care Facilities in Govt. Hospitals on National Highways, Operational Guidelines." National Traumacare Programme, Government of India. Accessed January 23, 2023.

409 https://dghs.gov.in/WriteReadData/userfiles/file/Operational_Guidelines_Trauma.pdf and [http://www.nisc.gov.in/PDF/Brief%20Trauma%20Programme-%2030.06.2016%20\(1\).pdf](http://www.nisc.gov.in/PDF/Brief%20Trauma%20Programme-%2030.06.2016%20(1).pdf)

410 "AIS 125-Constructional and Functional Requirements for Road Ambulances (National Ambulance Code)" Ministry of Road Transport and Highways, Government of India, June 2013. http://www.nisc.gov.in/PDF/AIS_125.pdf

411 "ERS/ Patient Transport Service." National Health Mission. Accessed January 23, 2023. <https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1217&lid=189#:~:text=Dial%20102%20services%20essentially%20consist,benefit%20and%20are%20not%20excluded>

412 "Specifications of Medical Equipments for ERS Ambulances

413 "Specifications of Medical Equipments for ERS Ambulances under National Health Mission and Type of Ambulances." National Health Mission. Accessed January 23, 2023. https://nhm.gov.in/images/pdf/programmes/ERS/Specification_of_Equipments_for_ERS_Ambulance.pdf

4a - Further details regarding - At the Facility: Early advance care and decisive care (emergency room) in Australia

Territorial Legislation

Australian Capital Territory

In the ACT, emergency hospital services are provided at the Canberra Hospital (Woden) and Calvary Public Hospital (Bruce). The ACEM Policy on the Australasian Triage Scale⁴¹⁴ has been used since 1993 in ACT⁴¹⁵. The policy states that "All patients presenting to an Emergency Department should be triaged on arrival by a specifically trained and experienced registered nurse. The triage assessment and ATS code allocated must be recorded."

Northern Territory

A triage evaluation is undertaken⁴¹⁶, which takes no longer than two to five minutes, to maintain a combination of speed and thoroughness. The triage assessment requires a combination of the patient's presenting problem and general appearance and any applicable physiological findings. Vital signs are taken at triage if it's necessary to determine urgency or if time allows. Based on the triage category, the patient is immediately taken to the appropriate care area.

4b - Further details regarding - At the Facility: Early advance care and decisive care (emergency room) in England and Wales

The following A&E Quality Indicators set the standard for A&E care⁴¹⁷:

- » How many people leave the A&E before being seen for treatment;

⁴¹⁴ "Policy on The Australian Triage Scale." Australian College of Emergency Medicine. Accessed February 24, 2023. https://acem.org.au/getmedia/484b39f1-7c99-427b-b46e-005b0cd6ac64/Policy_on_the_Australasian_Triage_Scale

⁴¹⁵ "Emergency Department Performance Information: Performance Audit Report." ACT Auditor-General's Office, Government of Australian Capital Territory. https://www.audit.act.gov.au/__data/assets/pdf_file/0014/1205330/Report-6-2012-Emergency_Department_Performance_Information.pdf

⁴¹⁶ "Guidelines on the Implementation of the ATS in Emergency Departments." Australian College for Emergency Medicine. Accessed February 22, 2023. https://acem.org.au/getmedia/51dc74f7-9ff0-42ce-872a-0437f3db640a/G24_04_Guidelines_on_Implementation_of_ATS_Jul-16.aspx

⁴¹⁷ "A&E quality indicators." NHS Trust. Accessed February 22, 2023. <https://www.lnwh.nhs.uk/ae-quality-indicators/>

- » How many people come back to, or re-attend, A&E after having been seen;
- » The amount of time it takes the A&E team to perform an initial assessment on the patient;
- » The amount of time it takes the A&E team to treat the patient; and
- » The total amount of time the patient spends at A&E.

A&E departments in hospitals are required to report monthly on how they have performed against these indicators to NHS England. Some UK hospitals have clinical decision units designed for rapid patient assessment and treatment of emergencies with a view of avoiding unnecessary admission to hospital.

Commentary: The following principles of good practice should be considered to improve safety and flow at A&E⁴¹⁸:

- » A&E should be resourced to practise an advanced model of care where the focus is on safe and effective assessment, treatment and onward care. While it is essential to manage demand in A&E, this should not detract from building capacity to deal with the demand faced, rather than the demand that is hoped-for.
- » A&E crowding adversely affects every measure of quality and safety for patients of all ages, and for staff, and creates a 'negative spiral of inefficiency'. The main causes of A&E crowding include surges in demand and lack of access to beds in the hospital system due to poor patient flow and high hospital occupancy rates. These can result in the physical and functional capacity of the A&E (especially staffing and numbers of cubicles) and internal processes and responsiveness of other services being exceeded.

Performance against the 4-hour standard is a useful proxy measure of crowding.

- » There should be a joint plan with the ambulance service to manage ambulance handover safely, with dedicated A&E staff to take ambulance

418 "Transforming Urgent and Emergency Care Services in England." NHS - England, August 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf>

handovers and care for waiting patients. Suitable chairs should be available so that where appropriate, patients are not obliged to wait on ambulance trolleys.

- » Secure, audio-visually separate facilities and care should be provided for children in accordance with the recommendations of Royal College of Paediatrics and Child Health. Emergency medicine doctors should focus on those patients who require resuscitation, have undifferentiated conditions and musculoskeletal injuries. There should be clear clinical pathways for the prompt transfer of care from A&E to in-patient specialist teams, especially for high volume pathways including acute (internal) medicine, frailty and paediatrics.
- » Fast-track processes to bypass the main A&E patient streams are important for some patient subgroups with clearly differentiated conditions, such as hip fracture, bleeding in early pregnancy, stroke and ST-Elevation Myocardial Infarction (STEMI).

Emergency surgery⁴¹⁹:

- » Surgical treatment of acutely ill patients must take priority over planned, elective surgery when necessary. Adequate provision for urgent access to operating theatre time must be available such that it does not impact on elective operating for the efficient management of both patient pathways.
- » Emergency centres should consider dedicated surgical assessment units. These may be nurse led, supported by consultant led surgical teams. There should be care pathways for common conditions such as abdominal pain and abscesses.
- » A hospital offering emergency surgery should have a consultant of the day/many days model, where the surgical team has 24/7 access to dedicated and staffed emergency theatres and is free from all other commitments.
- » A surgeon (at ST3 grade or above or a Trust Doctor with MRCS and ATLS) should be available to see and treat acutely unwell A&E referrals at all times within 30 minutes and all routine referrals within 60 minutes. Resident doctors should be supported by consultants who are immediately available by phone and who can attend to provide senior support within

419 *ibid*

30 minutes of request. Surgery on high risk patients must be carried out by a consultant surgeon supported by a consultant anaesthetist.

- » All patients considered to be at high risk (>10% mortality) must be reviewed by a consultant in less than four hours (ideally within 60 minutes) if their management plan is undefined and they are not responding to treatment as expected.

All patients should be reviewed by a consultant within 14 hours of admission and then twice daily while on the surgical assessment unit and at least daily on inpatient wards until discharged.

4c - Further details regarding - At the Facility: Early advance care and decisive care (emergency room) in Germany

Hospitals can also qualify for the Staggered System of Emergency Care Structures if they operate very specific emergency care units (e.g. for severely injured patients, children and adolescents, a stroke unit, a unit for cardiac blood circulation disturbances and specific psychiatric units, among others).

Any hospital that does not reach at least one of the emergency levels and does not operate structures for the treatment of certain specific emergency cases will be considered not participating in the staggered system of emergency structures⁴¹⁹. Participating hospitals are entitled to obtain the payment of an additional amount for each inpatient hospital case. Non-participating hospitals are charged a certain amount for every inpatient emergency hospital case treated. The exact amounts are subject to negotiations between the national association of statutory health insurances and hospitals or hospital associations.

419 "Section 9: Law on the fees for fully and partially inpatient hospital services." Krankenhausentgeltgesetz – German Act on the Remuneration inpatient and day-care treatments in Hospitals, April 23, 2002. <https://www.gesetze-im-internet.de/khentgg/index.html> Section 9 para. 1a no. 5 KHEntgG (Krankenhausentgeltgesetz – German Act on the Remuneration inpatient and day-care treatments in Hospitals) – <https://www.gesetze-im-internet.de/khentgg/index.html>

4d Further details regarding - At the Facility: Early advance care and decisive care (emergency room) in India

- » Charter of Patients' Rights reiterates that hospitals, both government and private, are duty-bound to provide basic emergency medical care, and the injured persons have a right to such emergency medical care. Such care must be initiated without demanding payment of fees or advance and basic care should be provided to the patient irrespective of paying capacity. It is the duty of the hospital management to ensure provision of such emergency care through its doctors and staff, rendered promptly without compromising the quality and safety of the patients.

With regard to state specific legislations:

- » The Karnataka Good Samaritan and Medical Professional (Protection and Regulation during Emergency Situations) Act, 2016 stipulates that lack of response by a medical professional in an emergency situation shall be construed as "professional misconduct"⁴²¹ and is liable for disciplinary action as per Regulations 7 and 8 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.
- » The Government of Tamil Nadu has developed a Scheme of Emergency Accident Relief Centres (EARC) since 2002, through a public private partnership. There are 18 centres functioning under the EARC to provide trauma care to crash victims near the highways.⁴²²
- » Sections 41-42 of The Gujarat Emergency Medical Services Act, 2007 provide that every base hospital should have an emergency department and must provide easy access to Emergency Medical Services to every person in need of treatment without discrimination.⁴²³

⁴²¹ Regulation 20, The Karnataka Good Samaritan and Medical Professional (Protection and Regulation during Emergency Situations) Act, 2016

⁴²² "Scheme of Emergency Accident Relief Centres." Government of Tamil Nadu. <https://tnsta.gov.in/moremenu/emergency-accident-relief-centres.pdf>.

⁴²³ The Gujarat Emergency Medical Services Act, 2007

Commentary: The Report of the Working Group on Emergency Care in India⁴²⁴ highlights the following problems with respect to emergency care at healthcare facilities:

- » Non-availability of appropriate healthcare facilities within reasonable distances.
- » Mismatch of the healthcare facility capacity resulting in overcrowding at the limited number of available facilities.
- » Deficiencies in infrastructure at the existing facilities due to fund shortage or poor planning.
- » Inadequately equipped healthcare facilities due to lack of uniform national standards and guidelines regarding the same.
- » Sub-optimal quality care at the existing facilities due to inadequately skilled manpower.
- » Lack of standard operating procedures regarding on-arrival handling of a patient.
- » Lack of mechanisms ensuring accountability and monitoring towards optimal, timely care.

The Report makes the following recommendations:

- » Emergency Healthcare facilities should be present at every 50 kms along/ near the national and state highways to ensure definite care to a road crash victim during the Golden Hour.
- » To ensure the same, the existing public and private healthcare facilities near the highways should be audited, verified and designated with respect to the provision of trauma care facilities in accordance with the WHO "Guidelines for Essential Trauma Care."
- » Those facilities found deficient, should be upgraded in terms of manpower, equipment, skills, etc. in line with the WHO "Guidelines for Essential Trauma Care."

424 "Report of the Working Group on Emergency Care in India." Ministry of Road Transport and Highways. Accessed January 24, 2023. https://morth.nic.in/sites/default/files/group_on_Emergency_Care%20-3634804396.pdf

- » The government should reimburse the private facilities empanelled in the EMS network for providing emergency care to road crash victims. The funds for the same can be mobilised by imposing an EMS Cess on the road tax.
- » New facilities should be planned where there is no existing governmental or private facility.
- » Regional referral trauma centres should be established across the country supported by a heli-ambulance network to ensure speedy care to the severely injured.

4e - Further details regarding - At the Facility: Early advance care and decisive care (emergency room) in Malaysia

Malaysia: Issues and Challenges, published in the Journal of Paramedic Practice (July 2011), states that the EMS system in Malaysia comprises a mixture of⁴²⁵:

- a. Hospital model (i.e. training and management of EMS takes place at the hospital itself);
 - b. Private model (i.e. provided by private medical centres);
 - c. Jurisdiction based model (i.e. from a municipal level, linked to fire stations, etc.); and
 - d. Volunteer model (i.e. with NGOs like St John's Ambulance assisting with their vehicles, etc.).
- » EMS services range from basic transportation (i.e. 'scoop and run') to providing first aid or basic life support care with the presence of trained healthcare providers. Services are more limited in rural areas and in Borneo (Sabah and Sarawak), with some access to 'flying doctor services' via helicopters.
 - » EMS care is part of a wider network of integrated resources leading up to in-hospital care, rehabilitation, etc.

⁴²⁵ Chew, Sheng, Keng. "Prehospital care in Malaysia: issues and challenges." Journal of Paramedic Practice, 186, July 14, 2011. <https://ir.unimas.my/id/eprint/11713/1/JPP%20Prehospital%20Care%20Malaysia.pdf>

- » In terms of manpower, prehospital care is manned by the paramedics and a driver and occasionally a medical doctor. Staff training levels are inconsistent.
- » There is no standardised certification for prehospital care in Malaysia, with no national prehospital care training institute. While some universities have established EMS programs, the curriculum is not standardised.
- » Communication is based on a 'one nation, one number system,' (i.e. 991), but there remains a lack of coordination between different agencies.
- » There is no single coordinated patient recording system in Malaysia, but the Malaysian government is trying to change this with a standardised digital system.

Commentary: As per the Disaster Management and Emergency Medicine in Malaysia published in the *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health* (2011)⁴²⁶, Dr Rosidah Ibrahim, Head of Emergency and Trauma, Hospital Serdang, speaking about how the system is put into practice, discussed:

- » Critical cases or resuscitation cases (red zone) are about 10-15% of the total number of patients. All such cases are attended to immediately by a dedicated resuscitation team composed of a minimum of a resuscitation doctor, a nurse, and one assistant medical officer.
- » 20-30% of the total number of patients seen are semi-critical cases (yellow zone).
- » All cases are attended to within 30 minutes of arrival by a dedicated emergency department yellow zone team composed of a minimum of one ED doctor, one nurse, and one assistant medical officer. 45-70% of the total number of patients seen are non-critical cases (green zone). A minimum of two emergency department doctors are dedicated to run this area.

⁴²⁶ Lee, Sharon. "Disaster Management and Emergency Medicine in Malaysia." *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*, March 16, 2011. <https://escholarship.org/uc/item/9gv4h27b>

4f - Further details regarding - At the Facility: Early advance care and decisive care (emergency room) in South Africa

In *Soobramoney v Minister of Health*, the court defined a medical emergency⁴²⁷:

In *Soobramoney v Minister of Health*, the appellant was a diabetic who suffered from ischaemic heart disease and cerebrovascular disease. His kidneys failed in 1996 and his condition was diagnosed as irreversible. He did not qualify to be admitted to a dialysis program at a state hospital because of its limited resources (shortage of trained nursing staff and dialysis machines) and consequent policy of admitting patients who could be cured within a short period of time and eligible for a kidney transplant. The appellant, however, could neither be cured in a short period nor was he eligible for a transplant because of his heart condition. Consequently, the appellant applied to the High Court on the basis of his right in terms of s 27(3) of the Constitution (which provides that no-one may be refused emergency medical treatment). The application was dismissed.

On appeal, the Constitutional Court held that the right not to be refused emergency medical treatment meant that a person who suffers an immediate catastrophe which warrants immediate medical attention should not be denied emergency available medical treatment and should not be turned away from a hospital that is able to provide the required treatment. However, the appellant was said to not fall within this aforesaid scope because he suffered from chronic renal failure and required dialysis treatment two to three times a week to keep him alive. The Court held that the appellant's state of health did not constitute an emergency which called for immediate remedial treatment.

In more abstract terms, the Constitutional Court argued that section 27(3) thereof cannot be practically enshrined as an absolute right but is subject to the provisions of section 27(2), which states that the "state must take reasonable legislative and other measures, within its available resources, to

⁴²⁷ *Soobramoney v Minister of Health*, KwaZulu-Natal 1998 (1) SA 765 (CC) at 778. https://www.escri-net.org/sites/default/files/Soobramoney_Decision.pdf

achieve the progressive realisation of each of these rights”. Although section 27(2) is primarily referred to the rights in section 27(1), the Constitutional Court included section 27(3) in its ambit. It appears therefore that section 27(3), like many other rights, is not guaranteed or absolute and may need to be limited if necessary.

The problem arises when there are multiple versions of what an emergency medical situation is. A situation can arise where a patient is not given the adequate treatment as they do not meet that particular institution’s definition of “emergency” and do not fall within the scope of care provided at that institution. The legislations, guidelines, professional boards and regulations provide the framework into the practical running of access to Emergency Medical Services in South Africa.

5a - Further details regarding - Emergency Care Funding: state, insurance and privately-sourced funding in Australia

Territorial Legislation

Australian Capital Territory

Emergencies Act

1. The cost of providing emergency services is not covered by Medicare. The individual who receives ambulance service has a legal duty to pay the fee.
2. A fee determined by a service provided to a patient by an emergency service is payable by the patient even if the patient did not ask for, or consent to, the provision of the service (s201(2))⁴²⁸.

Northern Territory⁴²⁹

1. A callout charge and a per-kilometre fee are used to calculate the expense of an emergency ambulance.

⁴²⁸ “Emergencies Act 2004 (A2004-28): Republication No 35.” The Parliamentary Counsel, Government of Australia, December 12, 2022. <https://www.legislation.act.gov.au/View/a/2004-28/current/html/2004-28.html>

⁴²⁹ “St John Ambulance.” Government of Northern Territory, Australia. Accessed February 22, 2023. <https://nt.gov.au/wellbeing/hospitals-health-services/ambulance-services>

2. St. John Ambulance Northern Territory (SJANT) is supported by a combination of government grants, corporate and private donations, and usage fees.

5b - Further details regarding - Emergency Care Funding: state, insurance and privately-sourced funding in India

The Central Government Health Scheme (CGHS)⁴³⁰ has been introduced to provide healthcare facilities to federal government employees and their families. At the State level, the Employees' State Insurance Scheme was introduced to provide medical benefits to workers in the organised sector.

5c - Further details regarding - Emergency Care Funding: State, insurance and privately-sourced funding in Malaysia

Commentary:

As per the *Funding Challenges in the Malaysian Health Care System*, published by the Office of Health Economics in 2020⁴³¹,

- » The Malaysian government recognises that health care spending needs to be increased to around 6% of the GDP but increasing public spending will not be easy as the public-private divide, together with high dependence on out-of-pocket spending, needs to change. There is also the need for an overall strategic vision for national health financing implementation.
- » Specifically, the public sector should buy from private sector providers and vice versa; moves to national health financing need to be incremental and progressive; the new government financial protection schemes should lead to strategic purchasing of services for patients; and there is a need for private sector purchasers that are able to manage care for their policyholders and bargain effectively with hospitals and clinics.

⁴³⁰ "Central Government Health Scheme." Government of India. Accessed February 22, 2023. <https://cghs.gov.in/CghsGovIn/faces/ViewPage.xhtml>

⁴³¹ Banhawi, El, Hania. "Funding Challenges in the Malaysian Health Care System." Office of Health Economics, January 7, 2020. <https://www.ohe.org/news/funding-challenges-malaysian-health-care-system/>

5d - Further details regarding - Emergency Care Funding: State, insurance and privately-sourced funding in South Africa

During its introduction, it was announced that the National Health Insurance Bill was expected to be implemented over a period of 15 years in three phases. The first phase (which was implemented between 2012 and 2017) was focused on establishing the NHI Fund and key institutions, and moving central hospitals to the national sphere. Phase two (2017 – 2022) focused on ensuring the functionality of the NHI Fund to begin the process of the purchase of services and registration by the population. In addition, this phase involved the passing of the NHI Bill and amending various pieces of legislation. Phase three, (2022 – 2026), involves the compulsory prepayment and contracting of accredited private hospitals and specialist services as well as the finalisation of the Medical Schemes Amendment Act.⁴³²

The Fund will conclude legally binding contracts with health establishments which have been certified by the Office of Health Standards Compliance and any other prescribed health service providers to provide EMS as per section 39 (3)(b). The NHI will be funded through payroll taxes from employees and employers, an additional payment based on personal income tax, the reallocation of medical scheme tax credits to the fund and general taxes. Once implemented, medical schemes may only offer complimentary cover for services that will not be reimbursable by the Fund. In addition, the medical aid contributions of 16% of the population who are on medical aid will contribute towards the Fund by subsidising the cost of care for the rest of the population⁴³³.

According to the NHI Bill, services will be purchased from both public and private ambulance providers. Section 35(4)(a) of the NHI states that both public and private Emergency Medical Services will be paid on a capped base-based fee basis, with adjustments made for case severity where necessary. Private ambulances would be contracted individually by the NHI Fund, while provinces would provide public ambulance services.

⁴³² "When will the NHI be implemented?" News 24, South Africa, August 15, 2019. Accessed February 23, 2023. <https://www.news24.com/news24/explained-when-will-the-national-health-insurance-be-implemented-20190815>

⁴³³ "National Health Insurance Bill." Government of South Africa, as on July 26, 2019. Accessed February 17, 2023. https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf

6a - Further details regarding - Mechanism at the federal and state level to regulate referrals at Hospitals/Trauma Care Centres (including protocols established for such referrals) in Australia

Territorial Legislation

Australian Capital Territory

Processes vary depending on the initial patient location, the level of critical care required and the urgency of transfer. The Manual for Using Health Services in ACT states that local doctors may refer the patient to a specialist, if required. Usually, patients are not allowed to see specialists without a referral from a local doctor. The major hospitals with an emergency department are the Canberra Hospital and Calvary Public Hospital⁴³⁴.

Northern Territory

Processes vary depending on the initial patient location, the level of critical care required and the urgency of transfer. The NT Regional Health Services⁴³⁵ is responsible for:

Facilitating access to specialist and allied health treatment services in the community or through referrals.

Managing referrals and recalls and use of case-management/case coordination approaches to ensure access to a full range of specialist consultation and assessment services.

Commentary: Due to the small size of its hospitals, the Northern Territory is heavily reliant on interstate inter-hospital transfers, with no other option but referral and transfer to specialty facilities in Southern Australia. As a result, inter-hospital transfer is a critical service that allows those living in rural and distant locations to have equal access to high-quality health care.

434 "Using Health Services in the ACT." Government of Australian Capital Territory, February 2015. Accessed February 24, 2023. <https://health.act.gov.au/sites/default/files/2018-10/Using%20Health%20Services%20in%20the%20ACT%20.pdf>

435 "Service Plan 2021-22: NT Regional Health Services." Government of Northern Territory, Australia. Accessed February 24, 2023. https://health.nt.gov.au/__data/assets/pdf_file/0005/1043897/service-plan-2021-22-nt-regional-health-services.pdf

DEFINITIONS AND ABBREVIATIONS

DEFINED TERM	DEFINITION
A&E	Accident and Emergency
A&E Quality Indicators	Accident and Emergency Quality Indicators
AA	Ambulance Assist
ACC	Aeromedical Control Centre
ACOs	Ambulance Community Officers
ACT	Australian Capital Territory
AEC	Ambulatory Emergency care
AEDs	Automated External Defibrillators
AHS	Area Health Services
AMRS	Aeromedical and Medical Retrieval Service
AO	Ambulance Operator
AR	Ambulance Responder
ARV	Adult Retrieval Victoria
ATLS	Advanced Trauma Life Support
ATP	Authority to Practice
ATS	Australasian Triage Scale
CATS	Centralised Accidents and Trauma Services
CCG	Clinical Commissioning Groups
CCP	Critical Care Paramedics
CERTs	Community Emergency Response Teams

DEFINED TERM	DEFINITION
CP	Care Pathways
CPG	Clinical Practice Guidelines
CPP	Clinical Practice Procedures
CPR	Cardiopulmonary Resuscitation
CRG	Case Review Group
DHFWS	District Health and Family Welfare Samiti
EARC	Emergency Accident Relief Centres
ECC	Emergency Coordination Centre
ED	Emergency Department
EMA	Emergency Medical Assistant
EMRI	Emergency Management Research Institute
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labour Act
EMTS Policy	Emergency Medicine and Trauma Services Policy
ERSS	Emergency Response Support System
ESA	Emergency Service Agency
GB Emergency Act	Gilgit Baltistan Emergency Service Act 2012
GP	General Practitioner
ICESCR	International Covenant on Economic, Social, and Cultural Rights 1966
ICU	Intensive Care Unit

DEFINED TERM	DEFINITION
IGEM	Inspector-General for Emergency Management
ISS	Injury Severity Score
JSSK	Janani Shishu Suraksha Karyakram
KP Emergency Act	The Khyber Pakhtunkhwa Emergency Rescue Service Act, 2012
MECC	Medical Emergency Coordination Center
MHLW	Ministry of Health, Labour and Welfare
MOH	Ministry of Health of Malaysia
MoRTH	Ministry of Road Transport and Highways
MTC	Major Trauma Centre
MTS	Major Trauma Service
NHS	National Health Services
NHTSA	National Highway Traffic Safety Administration
NSW	New South Wales
NT	Northern Territory
PIPER	Paediatric Infant Perinatal Emergency Retrieval
PCI	Percutaneous Coronary Intervention
PMG	Practice Management Guidelines
Punjab Emergency Act	The Punjab Emergency Service Act 2006
QAS	Queensland Ambulance Service
QEMSAC	Queensland Emergency Medical System Advisory Committee

DEFINED TERM	DEFINITION
RCEM Guidance	The Royal College of Emergency Medicine
RTS	Regional Trauma Service
SA	South Australia
SAAS	South Australian Ambulance Service
SAMU	<i>Serviço de Atendimento Móvel de Urgência</i> (free emergency transportation service in Brazil)
SJA	St John Ambulance
SJANT	St John Ambulance Northern Territory
STCN	Statewide Trauma Clinical Network
SUS	<i>Sistema Único de Saúde</i> (Brazil's national health system that reaches universal health coverage within the country)
UDHR	The Universal Declaration of Human Rights
UPAs	<i>Unidade de Pronto Atendimento</i> (Emergency Care unit in Brazil)
VMTS	Victoria Metropolitan Trauma Services
VSTS	Victoria State Trauma System
WA	Western Australia
WA Health	Department of Health, Government of Western Australia
WHO	World Health Organisation



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