

Access to Emergency Medical Services in the Eastern Cape Hearing Report



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HEARING REPORT OF THE SOUTH AFRICAN HUMAN RIGHTS COMMISSION

INTO

ACCESS TO EMERGENCY MEDICAL SERVICES IN THE EASTERN CAPE

24 & 25 March 2015

In re:

South African Human Rights Commission

and

Eastern Cape Department of Health

First Respondent

Eastern Cape Provincial Planning and Treasury

Second Respondent

Eastern Cape Department of Roads and Public Works

Third Respondent

Provincial Government Fleet Management Service Trading Entity

Fourth Respondent

and Interested Stakeholders:

Public Service Accountability Monitor (PSAM)

Democratic Nursing Organisation of South Africa (DENOSA)

Eastern Cape Health Crisis Action Coalition (Coalition)

Ms Debbie Budlender

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Representatives of communities from Isilatsha; Nier; Lusikisiki; Xhora Mouth and Zithulele.

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Important notes

The specific documentary sources cited vary and include public documents; documents provided freely and openly to the SAHRC; and specific factual quotations or excerpts from communications to the SAHRC.

It should be noted that, where information was submitted to the SAHRC or otherwise made available to the SAHRC at a late stage after the dates of submission specified in communications with the relevant parties, such information may not be reflected in the report, or may not be reflected in its entirety.

A copy of the official hearing transcript and written submissions provided by the numerous respondents and stakeholders will also be available upon request.

List of acronyms and abbreviations

AEA	Ambulance Emergency Assistants
APP	Annual Performance Plan
BAA	Basic Ambulance Assistants
CCA	Critical Care Assistant
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CoGTA	Department of Cooperative Governance and Traditional Affairs
DSD	Department of Social Development
DoH	National Department of Health
DPME	Department of Performance Monitoring and Evaluation
ECDoH	Eastern Cape Department of Health
ECT	Emergency Care Technician
GIS	Geographic Information Systems
ICESCR	International Covenant on Economic, Social and Cultural Rights
IFT	Inter-Facility Transfer
MDGs	Millennium Development Goals
MOU	Maternity Obstetric Unit
MTSF	Medium Term Strategic Framework
NDP	National Development Plan
NHC	National Health Council
NHI	National Health Insurance
NPO	Non-Profit Organisation
NSDA	Negotiated Service Delivery Agreement
PHC	Primary Health Care
PPT	Planned Patient Transport
SDIP	Service Delivery Improvement Plan
StatsSA	Statistics South Africa
TAC	Treatment Action Campaign
UDHR	Universal Declaration of Human Rights

Foreword

The South African Human Rights Commission (SAHRC) dedicates its report on the SAHRC's Emergency Medical Services (EMS) Hearing to those who travelled long distances from across the Eastern Cape to contribute to the hearing. While the initial complaint the SAHRC received came from community members from the Xhora Mouth area, the SAHRC expanded the investigation and hearing to include Isilatsha, Nier, Lusikisiki and Zithulele in the Eastern Cape

With great dignity, representatives from these communities testified how the lack of access to EMS often had devastating consequences for their health and lives. They represented not just themselves, but many others living in South Africa's former Apartheid homelands. It was tragically evident how race, class, gender, disability, age and other factors intersect to reinforce Apartheid-era patterns of inequality and discrimination. Many expressed their disappointment that, twenty years into democracy, terrible suffering persisted.

Several village elders spoke of the fact that they had never seen an ambulance in their lives. People who phoned call centers shared how they were often treated disrespectfully. Some reported that they were disparagingly told to use their social grants to pay for transport. People complained that even when they called ambulances these often arrived too late or not at all. Community health workers spoke in anguish of women dying in childbirth after experiencing complications that they had not been trained to treat. People with disabilities were further disadvantaged. Often people on wheelchairs were not allowed to take their wheelchairs with them onto ambulances, leading to further indignities at the hospital. In the context of widespread unemployment, many shared that they paid an average of R800 to hire private transport to take family members to a hospital or clinic. The bad state of the roads also made it impossible for ambulances to reach many villages.

Human dignity, the inherent worth of all human beings, underpins all human rights. The SAHRC recognizes that South Africa's democratic Government, through the National Department of Health, has made significant advances in addressing the right to healthcare. However, in the hearing the SAHRC heard that the remnants of Apartheid's fragmented and under-developed health care system persists in the Eastern Cape, particularly in the former Transkei and Ciskei.

The SAHRC invited the Eastern Cape Departments of Health, Roads and Public Works and the Fleet Management Service Trading Entity to the hearings. Senior Government representatives made their presentations, listened to testimony and responded to questions from the SAHRC Panel. They were asked by the SAHRC to respond both at the hearing and later in writing.

The departments made important commitments including to increase the budget for Emergency Medical Services for more ambulances, including that these be designed to navigate rough terrain and well equipped; and to employ more staff including training for existing staff and ensuring that no-one will wait for an ambulance for longer than 4 hours. If no ambulance is available, the Department committed to hiring a private ambulance to make sure the patient is able to receive emergency medical treatment. The Departments also shared contact numbers for the District Managers, in the event that an ambulance is slow, or does not arrive.

Meaningful engagement and a human rights-based approach is essential to ensure that human rights are adequately addressed. This requires access to information through a transparent decision-making process and the recognition that all human beings are bearers of the human rights contained in South Africa's Constitution. Government has a constitutional responsibility to respect, protect and fulfil human rights. A failure to take sufficient account of specific needs of communities in overcoming institutional barriers of access will continue to

maintain the Apartheid spatial legacy. As the Eastern Cape hearing on EMS demonstrates, such failures reinforce the existing divisions of our society, perpetuating poverty and inequality.

Government institutions at all levels must remain accountable, especially to people who are poor. Dedicated, responsive measures are needed to ensure that the society based on dignity, equality, social justice and freedom envisaged in South Africa's Constitution becomes a lived reality.

We would like to thank community members, the Eastern Cape Coalition for Health and individual experts, who took the time and trouble to bring the urgent issues contained in this report, to the SAHRC Hearing.

Community members came to the SAHRC's hearing after trying many other avenues. Many expressed their sense of anguish and despondence. Importantly, they expressed their trust that the process initiated by the SAHRC will result in concrete changes that improve their access to EMS. The SAHRC looks forward to receiving responses from the relevant departments to this report's recommendations as well as the implementation of the commitments they have already made.



Pregs Govender

SAHRC Deputy Chair. Lead Commissioner on Health and EMS Hearing Chair

Executive Summary

The South African Human Rights Commission (“SAHRC” or “Commission”), as an institution established in terms of section 181 of the Constitution to support constitutional democracy, is specifically mandated to promote the protection, development and attainment of human rights, as well as to monitor and assess the observance of human rights in South Africa.

In 2007 the Commission hosted a Public Hearing on Access to Health Care Services,¹ which partly examined emergency transport and transportation costs. The Commission found that there appeared to be insufficient provision of emergency care, which impacted especially harshly on rural patients, and further noted that the cost of transport was “*a major prohibitive factor in accessing their health entitlements*”.² This enquiry further identified concerns over the inaccessibility of some areas due to the poor state of the roads; the lack of availability of ambulances; poor functioning of referral systems; and the fact that emergency personnel were often not adequately trained to deal with emergencies and life threatening situations.³

Despite concluding that “*access to health care services, especially for the poor, is severely constrained by expensive, inadequate or non-existent transport, by serious shortages with regard to emergency transport, and by long waiting times*”,⁴ which constraints were found to amount to a denial of the right to access health care, the same challenges are still widespread in the country today.

In March 2013 the Commission received a complaint relating to a lack of emergency medical services in the rural areas of the Eastern Cape, where its preliminary investigation revealed that the continuing denial of access to emergency medical services, particularly in rural areas, exacerbates existing vulnerabilities of some of the poorest communities and perpetuates the enduring inequality, while giving rise to substantial rights violations.

In order to delve deeper into the issues identified above and to gather more information, a decision was taken that the Commission would convene a Provincial Hearing into access to emergency medical services in the Eastern Cape to obtain a greater understanding of the challenges facing communities, government departments, and other relevant bodies, and to identify practical measures to address these challenges in future and promote the achievement of rights.

This Report draws from a number of written and oral submissions made by a community representatives, a variety of State respondents and other interested stakeholders, as well as from the current legal and regulatory framework and publically available planning and reporting documents and aims to provide insight into the complex and inter-related challenges in the delivery of and access to emergency medical services and healthcare in general in the Eastern Cape.

The investigation revealed that a number of gaps or uncertainties persist in the current legal framework governing the provision of emergency medical and planned patient transport services, which uncertainties impact directly on the ability to deliver an adequate and efficient service to communities. Further, the enquiry found that the Eastern Cape Department of Health (ECDoH) currently has an insufficient number of ambulances and qualified emergency service personnel; an even lower number of ambulances which are operational and able to respond to emergency situations; and severely inadequate numbers of Planned Patient Transport and Inter-Facility Transport vehicles to respond to the need. The prevalence of so-called “one-man crews” and the

¹ South African Human Rights Commission “Public Enquiry: Access to Health Care Services”, (2007) (as accessed at <http://www.sahrc.org.za/home/21/files/Health%20Report.pdf>).

² *Ibid* p. 42.

³ *Ibid*.

⁴ *Ibid*.

severe shortage of personnel trained at an advanced level of life support as well as reportedly poorly equipped ambulances were widely reported on.

The poor state of the road network, which is continually degrading as a result of insufficient funding allocated for the provision of maintenance and development also hampers the ability of the ECDoH to deliver emergency medical services, particularly in rural areas, which is further compounded by the fact that the majority of ambulances are unable to travel through the vast and difficult landscape (as they do not have 4x4 capabilities). These factors, it was found, often delay the response times of ambulances, or in many instances, completely prevents their response to emergency situations in rural areas. Consequently the impact is that people in need of timely medical assistance have no option but to resort to the use of public or private transport at personal expense, which costs range between R400 and R800 for a one-way trip. In a Province with high poverty levels and is the widest recipient of social assistance in the country, these unanticipated costs are devastating to families, and have long-term effects, depriving families of other daily essentials which are no longer affordable or compelling families to obtain loans at high interest rates, ultimately perpetuating the prevalence of poverty and inequality.

The Commission recognises that substantial investment has been made in improving the state of emergency medical services in the Province through increased budget allocations year on year. However, inconsistent planning and reporting mechanisms, combined with inaccurate data recording and information management negatively impact on the ability of the Department to adequately plan and effectively improve performance. Moreover, the Commission found that a vast number of policies in place did not adequately cater for groups with special needs, including pregnant women, the elderly, persons with disabilities, and persons suffering from chronic illness, which suffer disproportionately.

Overall, the Report highlights the fact that poverty remains an inherent barrier to accessing basic services, and that measures aimed at addressing the current difficulties cannot be taken by the Department of Health alone, but requires committed and in-depth cooperation and collaboration at both an inter-sectoral (i.e between departments) and inter-sphere level of government, with further partnership needed with both civil society and communities in order to create sustainable solutions and achieve equitable service delivery on the ground.

In light of these findings, the Commission has made a number of recommendations and calls for the on-going commitment of all parties.

Structure of the report

Section one of the Report provides the background and rationale behind the investigation and development of the Report into emergency medical services in the Eastern Cape. The aim is to explain the process and methodology utilised to generate critical information, as well as to explain the scope of the investigation.

Section two provides a legislative context to the right of access to health care services with particular focus on the right not to be denied access to emergency medical services in South Africa. The international legal framework is briefly considered while more emphasis is placed on the domestic legal framework as well as relevant case law.

Sections three to eleven of the report are divided into the themes identified during the investigation and Hearing process, and summarise the submissions received from the relevant stakeholders before providing a legal and policy analysis. Section twelve identifies additional gaps and challenges in the current formulation of policy, legislation and practice.

Section thirteen of the Report concludes with applicable recommendations aimed at addressing the existing gaps and challenges with a view of enhancing access to emergency medical services in the Eastern Cape in the future.

1. INTRODUCTION

The health care sector during the apartheid era was defined by a system based on racial segregation and inequality. After 1994 the country embraced the idea of Primary Health Care (PHC) based on the principle of equal access and further that access to healthcare services is a fundamental right. Despite the fact that access to healthcare, including emergency medical services is enshrined in the Constitution of the Republic of South Africa, 1996 (Constitution), inequalities and inefficiencies in access remain prominent.

The National Planning Commission identified 9 primary challenges that form the basis of the priorities set out in the National Development Plan (NDP). The inability of the public health care sector to meet current demand or sustain quality is one of the main challenges that were identified. In addition to this, the uneven and frequently poor quality of public service delivery, poorly located, inadequate and under-maintained infrastructure and the fact that spatial divides hobble inclusive development were also identified as some of the main challenges which need to be addressed.⁵

One of the main priorities of the NDP is tackling poverty, in which increasing health and nutrition along with public transport and infrastructure development have been indicated as key components. The challenges faced in rural areas in particular were included in the NDP in stating that “*over one-third of South Africa’s population live in the former “homelands”, and a large proportion of this group is economically marginalised. Policies are required to bring households in these areas into the mainstream economy.*”⁶

The country’s agenda for development was in line with the Millennium Development Goals (MDGs), which included the eradication of poverty, reduction of child mortality, improvement of maternal health and the combatting of HIV/AIDS, malaria and other diseases, which the NDP indicates will reduce the reliance and strain on the health care system.

The Ten Point Plan, released by the National Health Council (NHC) as part of the Medium Term Strategic Framework (MTSF) for the period 2009 to 2014, was aimed at assisting the country in meeting the MDGs and monitoring improvements in the health system. Some of the key priorities identified in the Ten Point Plan include improving quality of health services; improving human resource management; revitalising physical infrastructure; accelerating implementation of HIV and AIDS plan and reduction of mortality due to TB and associated diseases; and attaining better health for the population.

Budget allocations to health and social protection were increased in the current financial year (2015/16) with an aim of contributing towards better life expectancy and household income security, while the Eastern Cape Provincial Government has prioritised health, along with education and stated that “*the National Development Plan and the Department of Health’s Ten Point Plan, all affirm our policy intent of providing affordable, accessible and quality health care.*”⁷ Whilst the provincial health priorities are aligned to national priorities, including ensuring a comprehensive HIV/AIDS programme and increasing the number of skilled health professionals, the Eastern Cape Provincial Government has also prioritised infrastructure development of a number of hospitals as well as roads leading to hospitals and clinics. The priority of the health care sector in the

⁵ National Planning Commission “National Development Plan 2013: Our future – make it work, Executive Summary”, (2013) p 15 (as accessed at <http://www.gov.za/sites/www.gov.za/files/Executive%20Summary-NDP%202013%20-%20Our%20future%20-%20make%20it%20work.pdf>).

⁶ *Ibid* at p 37.

⁷ 2015/16 Eastern Cape Budget Vote, 6 March 2015 (as accessed at <http://www.gov.za/speeches/mec-sakhumzi-somyo-eastern-cape-201516-budget-vote-6-mar-2015-0000>).

Eastern Cape is evident in noting that it received the second highest budget allocation next to education in the 2015/16 Budget Vote.

As a result of the historical policies and development practices of the former Transkei and Ciskei regions during the apartheid era, the Eastern Cape Province inherited a severely underdeveloped and fragmented health system. Whilst many changes and improvements have been implemented, the province continues to experience significant challenges in health care, which are felt disproportionately by the large numbers of poor and vulnerable communities.

The Eastern Cape Province is the second largest province in South Africa, hosting the country's third largest population, estimated at 6.5 million people according to the 2011 national census.⁸ However, it is also one of the poorest provinces in the country and has the highest number of people vulnerable to poverty and deprivation, as well as one of the highest levels of unemployment.⁹ Despite levels of vulnerability having reportedly decreased by 5% between 2007 and 2011, poverty levels in the province remain high¹⁰ and a large number of individuals are reliant on the social welfare and public health system.

The extent to which access to emergency medical services is available has wide ranging implications on the overall health and well-being of persons, but apart from this it also has an impact on the quality of life and dignity of persons along with the potential to significantly impact on the eradication of poverty and inequality.

The 2015-2020 Strategic Plan of the South African Human Rights Commission (Commission)¹¹ sets a target to reflect on the human rights situation in the country 20 years into democracy and its existence, whereas the protection of human rights will be improved through the increased use of alternative dispute resolution or litigation. In considering the far reaching implications and the prevalence of substantial inequalities to access emergency medical services and health care in general in the province, together with the purpose of alternative dispute resolution mechanisms which are intended to deepen the understanding and on-going protection of human rights, the decision was taken to convene a public hearing relating to access to emergency medical services in the Eastern Cape.

1.1 Background

In 2007 the Commission hosted a Public Hearing on Access to Health Care Services,¹² which partly examined emergency transport and transportation costs. The Commission found that there appeared to be insufficient provision of emergency care, which impacted especially harshly on rural patients, and further noted that the cost of transport was "*a major prohibitive factor in accessing their health entitlements*".¹³ This enquiry further identified concerns over the inaccessibility of some areas due to the poor state of the roads; the lack of

⁸ Department of Economic, Development and Environmental Affairs "Eastern Cape Socio-Economic Review and Outlook" (2013), p 27(as accessed at <http://www.dedea.gov.za/research/Research/Eastern%20Cape%20Socio-Economic%20Review%20and%20Outlook%202013.pdf>).

⁹ *Ibid* p 31. The Fuzzy Index of Poverty (FIP) evaluates twelve indicators of well-being, namely employment, municipal services (such as refuse collection, access to water, access to toilet, and access to electricity for lighting, cooking, and heating), type of dwelling, education, income, household size, and access to means of communication such as cell phones, to identify average levels of deprivation and vulnerability to poverty.

¹⁰ Eastern Cape Department of Social Development "The People matter: The State of the Population in the Eastern Cape"(2010), p 125 (as accessed at <http://www.hsrc.ac.za/uploads/pageContent/558/ECapefullreport.pdf>).

¹¹ SAHRC "Strategic Plan for the fiscal years 2015 to 2020" (2015).

¹² South African Human Rights Commission "Public Enquiry: Access to Health Care Services", (2007) (as accessed at <http://www.sahrc.org.za/home/21/files/Health%20Report.pdf>).

¹³ *Ibid* p. 42.

availability of ambulances; poor functioning of referral systems; and the fact that emergency personnel were often not adequately trained to deal with emergencies and life threatening situations.¹⁴

Despite concluding that *"access to health care services, especially for the poor, is severely constrained by expensive, inadequate or non-existent transport, by serious shortages with regard to emergency transport, and by long waiting times"*,¹⁵ which constraints were found to amount to a denial of the right to access health care, the same challenges are still perverse in the country today.

Civil Society Organisations as well as media outlets have continued to report on the poor state of the public health care system in the Eastern Cape, and government officials have admitted to the existence of problems, noting allegations of the abuse of ambulances for personal reasons;¹⁶ shortage of the availability of ambulances;¹⁷ as well as the poorly equipped state of ambulances,¹⁸ amongst other things. In addition to this, the Portfolio Committee on Health tabled a report in Parliament for the 2013/14 financial year in October 2014 in which it found that *"[t]raining of Emergency Medical Services (EMS) personnel, improved response time and the shortage of emergency response vehicles remains a challenge"* and recommended that the Department of Health *"develop systems and measures to address challenges related to Emergency Medical Services."*¹⁹

On 12 March 2013, the Eastern Cape Provincial Office of the Commission received a complaint from a Non-Profit Organisation, Bulungula Incubator, relating to the lack of emergency medical services in the rural areas of the Eastern Cape in the former Transkei region, particularly in relation to the Xhora Mouth area under the O.R. Tambo District.

The complaint raised a number of allegations, including the fact that no ambulance service is available to the Xhora Mouth area, as well as other rural areas in the Province. The lack of medical transportation in the area meant that those in need of medical assistance would have to make use of public transportation at personal cost, and during times that public transportation is unavailable private transportation would need to be found, normally at an average cost of R700.00 per trip. Often faced with desperate situations, families may be forced to walk up to 30km to the nearest hospital, or to make use of wheelbarrows or donkey carts in order to acquire medical attention, whilst the delay caused in obtaining treatment often results in severe complications, permanent disability and loss of life.

During an investigation conducted by the Eastern Cape Provincial Office of the Commission, challenges relating to the number of ambulances as well as the number and availability of Planned Patient Transport Services (PPT); the response times of ambulances; the lack of essential equipment in ambulances; shortages and incompetence of ambulance staff; as well as the inability of ambulances to navigate through the terrain to reach rural communities as a result of the poor state of roads were identified.

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ News24 "Eastern Cape dept: Ambulance abuse concerning", 29 October 2013 (as accessed at <http://www.news24.com/SouthAfrica/News/Eastern-Cape-dept-Ambulance-abuse-concerning-20131029>).

¹⁷ Herald Live "Desperate ambulance shortage in province", 24 July 2014 (as accessed at <http://www.heraldlive.co.za/desperate-ambulance-shortage-province/>); SABC News "E Cape aims to improve health department amid challenges", 15 January 2014 (as accessed at <http://www.sabc.co.za/news/a/cb65c880429074149698fe56d5ffbd92/E-Cape-aims-to-improve-health-department-amid-challenges-20141501>).

¹⁸ SABC news "E Cape emergency workers put blame onto authorities", 14 January 2014 (as accessed at <http://www.sabc.co.za/news/a/fa259400428edae8b753ff56d5ffbd92/EundefinedCapeundefinedemergencyundefinedworkersundefinedputundefinedblameundefinedontoundefinedauthorities-20141401>).

¹⁹ Portfolio Committee on Health "The Budgetary Review and Recommendations Report of the Portfolio Committee on Health for the 2013/14 financial year", 22 October 2014 (as accessed at http://www.parliament.gov.za/live/commonrepository/Processed/20141103/592244_1.pdf).

In September 2013 the Eastern Cape Health Crisis Action Coalition (the Coalition) released a report entitled "*Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System*"²⁰ which painted a worrying picture on the state of the health care system in the Province in general. Amongst many other issues, the report highlighted the sporadic availability and in many instances, the complete unavailability of ambulances in the rural areas which has a direct impact on the quality of life of millions of people, with around 62% of the population residing in rural areas.²¹

The continuing denial of access to emergency medical services, particularly in rural areas, as well as the need to privately fund transportation in order to access medical services exacerbates existing vulnerabilities of some of the poorest communities and perpetuates the endurance of inequality. In order to delve deeper into the issues identified above and to gather more information, a decision was taken that the Commission would convene a Provincial Hearing into access to emergency medical services in the Eastern Cape in terms of section 9(1)(c) of the South African Human Rights Commission Act (SAHRC Act).²² The purpose of the Hearing was to obtain a greater understanding of the challenges facing communities, government departments, and other relevant bodies, and to identify practical measures to address these challenges in future and promote the achievement of rights.

1.2 Mandate of the Commission

The Commission is an institution established in terms of section 181 of the Constitution. The Commission and other institutions created under Chapter 9 of the Constitution are described as "*state institutions supporting constitutional democracy*".

In terms of section 184(1) of the Constitution, the Commission is specifically mandated to promote the protection, development and attainment of human rights, as well as to monitor and assess the observance of human rights in South Africa.

Section 184(2)(a) of the Constitution empowers the Commission to investigate and report on the observance of human rights in the country, whilst the mandate and responsibilities of the Commission are further extended through the SAHRC Act.²³ In addition to other powers, duties and functions, the SAHRC Act confers powers on the Commission to carry out investigations concerning the observance of human rights in South Africa. The aforementioned proceedings were convened under the provisions of section 15(1)(c) and 15(1)(d) of the SAHRC Act, which state:

"15. (1) Pursuant to the provisions of section 13(3) the Commission may, in order to enable it to exercise its powers and perform its functions-

...

(c) require any person by notice in writing under the hand of a member of the Commission, addressed and delivered by a member of its staff or a sheriff, in relation to an investigation, to appear before it at a time and place specified in such notice and to produce to it all articles or documents in the possession or custody or under the control of any such person and which may be necessary in connection with that

²⁰ Treatment Action Campaign and Section27 "*Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System*", (2013) (as accessed at <http://www.section27.org.za/wp-content/uploads/2013/09/SECTION27-report-redacted.pdf>).

²¹ *Ibid*, p 18.

²² 40 of 2013.

²³ 30 of 2014.

investigation: Provided that such notice must contain the reasons why such person's presence is needed and why any such article or document should be produced; and

(d) through a Commissioner, administer an oath to or take an affirmation from any person referred to in paragraph (c), or any person present at the place referred to in paragraph (c), irrespective of whether or, not such person has been required under the said paragraph (c) to appear before it, and question him or her under oath or affirmation in connection with any matter which may be necessary in connection with that investigation."

The Commission's Complaint's Handling Procedure further articulates the internal processes to be followed in carrying out its constitutional and statutory mandate. According to article 21, in resolving a complaint, the Commission is entitled, *inter alia*, to conduct hearings in the following instances:

- i. if a complaint cannot be resolved by way of conciliation, negotiation or mediation;
- ii. if a hearing will offer an appropriate solution regarding the complaint;
- iii. if it is in the public interest;
- iv. if the complaint cannot be fairly decided on the basis of documentary evidence or written statements submitted by the parties or any other person having information relevant to the complaint only; or
- v. if a party requesting a hearing supplies reasonable grounds.

1.3 Methodology

1.3.1 Procedure for investigation of complaint

Following receipt of the complaint in March 2013 the Provincial Office of the Commission conducted an on-site inspection along with interviews with community members in the Xhora Mouth area and established that there were problems relating to the availability of ambulances in the areas, and that those in need of medical care are often forced to resort to hiring private transportation as a result. The preliminary analysis established that the allegations appeared to constitute a violation of section 27(1) and (3) of the Constitution²⁴ relating to the right of access to health care and that no one should be denied emergency medical care.

The Commission engaged with the Eastern Cape Department of Health (ECDoH) on these issues by requesting a written submission in September 2013, and through a meeting held in December of the same year. During these engagements, the ECDoH made a number of concessions and confirmed the prevalence of challenges relating to emergency medical services in the province. Noting the systemic nature of the problem, the Provincial Office expanded the scope of the investigation to encompass all areas in the province. Surveys were distributed to District Directors of the ECDoH including Amathole; Chris Hani; O.R.Tambo; Alfred Nzo; Cacadu; Buffalo City; Nelson Mandela and Joe Gqabi Districts.

The Eastern Cape Health Crisis Action Coalition (EHCAC), as a representative of civil society dedicated to the fulfilment of the constitutional right of access to health care services in the Eastern Cape, was invited to make submissions on the state of emergency medical services in the province, and assisted the Commission in carrying out further on-site inspections in Administrative Areas within the O.R. Tambo District, including Mkhathazo; Nkenenkethe; Sundwana; Ngxakaxa; Qhatywa; and Nqabane, where interviews with traditional leaders and members of the communities were conducted. Written submissions were obtained from community

²⁴ Constitution of the Republic of South Africa, 1996.

members in Alfred Nzo; Buffalo City Metropolitan Municipality; Butterworth; Canzibe; Hamburg; Lusikisiki; Madwaleni; Mthatha; Tarkastad; Xhora Mouth; Zithulele and Jansenville.

In addition to the information obtained through interviews, surveys and direct responses received from the ECDoH, the Commission considered various official publications of the ECDoH and the Provincial Department of Planning and Treasury including planning and budgeting documents, as well as public statements of the ECDoH and media reports. Due to the failure by the ECDoH to respond to an earlier request for information, further correspondence was sent by means of a subpoena with a view of obtaining additional information on the extent of the problems identified, as well as plans to address these. Information and documentation relating to the size of the ambulance fleet and plans to increase the size; the state of ambulances and Planned Patient Transport (PPT) services; response times; and under-spending of the annual emergency medical services budget was requested.

After having considered all the information in the possession of the Commission, a number of inconsistencies were identified, and it became apparent that the level of emergency medical services required in the Province was not being met.

A variety of complaint resolution mechanisms are available to the Commission, however, given the widespread nature of the rights violations, particularly in the rural areas, the need for additional clarity on a number of issues, as well as the need to consult a wide range of stakeholders in order to formulate a deeper understanding of the challenges facing both communities as well as the Eastern Cape Department of Health, the Commission determined that the initiation of a Provincial Hearing was the most appropriate mechanism to address the matter. An open and transparent process of wide ranging consultations are often more conducive to information gathering and would allow the matter to be dealt with at a community level.

1.3.2 Terms of Reference for convening a Provincial Hearing

Although the complaint lodged with the Commission dealt with the denial of access to emergency medical services in the Xhora Mouth area, due to the pervasiveness of the rights violations as well as the severity thereof having a direct impact on the determining whether a person lives or dies, the scope of the Hearing was expanded to investigate and consider the challenges in preventing the effective delivery of EMS in the Eastern Cape generally, with particular focus on the impact on communities in rural areas. Additional challenges identified, including the provision of PPT services was also included in the scope due to its impact on the availability of ambulances for emergency medical situations.

The Commission aimed to include a wide range of Respondents and Stakeholders in order to attain a holistic view of the matter. In this regard, direct role players in the provision of EMS, individuals with expertise, as well as local and community based organisations were requested to make presentations or to provide written submissions to the Hearing Panel, whilst members of local communities were invited to attend and to make presentations.

The following Respondents were identified:

- Eastern Cape Department of Health;
- Eastern Cape Provincial Planning and Treasury;
- Eastern Cape Department of Roads and Public Works; and
- Provincial Government Fleet Management Service Trading Entity.

Other interested Stakeholders were further identified to provide additional information to the Hearing Panel and included:

- Public Service Accountability Monitor (PSAM);
- Democratic Nursing Organisation of South Africa (DENOSA);
- Eastern Cape Health Crisis Action Coalition (Coalition), as a group of organisations, individuals, healthcare professionals and community members;
- Ms Debbie Budlender as a budget expert;
- Dr. Jane Goudge: Director of the Centre for Health Policy, University of the Witwatersrand as a health expenditure expert;
- Representatives of communities from Isilatsha; Nier; Lusikisiki; Xhora Mouth and Zithulele.

It is noted that the outcome of the Hearing process may be applicable to and have an impact on a number of stakeholders and regions not included in the Hearing, but this does not prevent the Commission from building on the process and engaging further at a later stage.

1.3.3 Composition of the Hearing Panel

The Hearing Panel (Panel) was composed of the following:

- Deputy Chairperson, Commissioner Pregs Govender, responsible for the portfolio of basic services, access to health care, women's rights and access to information at the Commission: Chairperson;
- Commissioner Bokankatla Joseph Malatji, responsible for the portfolio of the persons with disabilities and older persons at the Commission: Panellist; and
- Dr Prinitha Pillay, Programme Manager, Rural Health Advocacy Project (RHAP): External Panellist.

The external panellist was identified and selected due to her expertise in the subject matter as a medical doctor and rural health expert. No objection to the participation of any of the Panellists was raised during the Hearing process.

1.3.4 Nature and Structure of the Proceedings

The Hearing process was inquisitorial as opposed to accusatorial in nature as the primary objective was to enlighten the Commission as to the causes of the violations currently being experienced by people in need of emergency medical services in the Eastern Cape. Respondents, including Ms Debbie Budlender; Dr Jane Goudge and the Eastern Cape Health Crisis Action Coalition were requested to provide written submissions, and the Coalition assisted in obtaining statements from communities in advance of the commencement of the Hearing.

Respondents were then invited to appear before the Panel to make presentations in an assigned time-slot, and the Panel was able to pose questions in order to acquire additional information or clarity on information arising from submissions. Before making submissions, Respondents were invited to take an oath or affirmation in the manner of their choosing.

Following the receipt of all presentations, the Panel posed additional questions in writing to several Respondents and requested that they provide written submissions in response thereto, and community members were invited to deliver any additional statements to the Panel after the close of the proceedings.

The scope of the Panel was to receive information, evidence and submissions from Respondents and other relevant and/or interested parties and to analyse material brought before the Panel. The objective was to gain a thorough and holistic understanding as to the challenges faced in the delivery of emergency medical services, and to identify practical measures that can be implemented to effectively end the rights violations and to make appropriate recommendations in this regard.

2. LEGAL AND POLICY FRAMEWORK

The right of access to health care is underpinned by a variety of international and national laws, but in most instances this right is limited by the availability of state resources and is subject to progressive realisation. Many domestic and international human rights instruments explicitly recognise the right to the highest attainable health and well-being, and it is widely accepted that the right to health care is intrinsically linked to a number of other rights, including, but not limited to the right to dignity and life. The fulfilment of the right to health may impede or foster the achievements of other rights, as explained by the Office of the High Commissioner for Human Rights below, and the guarantee and the achievement of the right to health is further reliant on the presence of a number of factors.

2.1 Overview of the Domestic Legal Framework

As it has already been mentioned, the right of every person not to be denied access to emergency medical services can be found in section 27(3) of the Constitution, and this guarantee is reaffirmed in the National Health Act²⁵ as well as the Eastern Cape Provincial Health Act²⁶. However, despite this express articulation of the right, the current domestic legal framework is focused more on illustrating responsible persons for the delivery of the right, as well as on the regulation of the emergency medical services industry without fully being able to give content and meaning to the right itself. This section will attempt to lay out the domestic legal framework, as well as the policy framework governing the delivery of EMS in the country, before going on to discuss the applicable case law relating to the right.

2.1.1 The Constitutional Framework²⁷

The Constitution, as the supreme law in South Africa, was founded with a view to heal the divisions of the past, establish a society based on democratic values, social justice and fundamental human rights and to improve the quality of life of all citizens.²⁸ Founded on the values of dignity, equality and freedom, the Constitution enshrines

²⁵ 61 of 2003.

²⁶ 10 of 1999.

²⁷ Constitution of the Republic of South Africa, 1996.

²⁸ Preamble of the Constitution of the Republic of South Africa, 1996.

the rights guaranteed to all persons in South Africa, and serves as an attestation to the commitment to achieving a quality of life for all.

These rights are found in Chapter 2, the Bill of Rights, and are binding on state organs as well as private persons,²⁹ and further oblige the state to "*respect, protect, promote and fulfil the rights in the Bill of Rights.*"³⁰

Section 27 of the Constitution provides the cornerstone of the applicable legal framework in guaranteeing every person the right to have access to healthcare services, including to emergency medical services. While the right to healthcare, set out in section 27(1)(a) is subjected to an internal limitation in requiring the state to take reasonable legislative and other measures "*within its available resources*"; section 27(3) categorically states that "*No one may be refused emergency medical treatment.*" Although it is yet to be determined by legislation or the courts, the layout of section 27, as well as the negative obligation created in section 27(3), implies that the latter provision is subject to a higher standard than progressive realisation based on the availability of resources.

Noting the interdependence of human rights, the right to equality, human dignity and the right to life are also of paramount importance. Our Constitution espouses that all persons must be treated equally and are entitled to live a life of dignity. The Constitutional Court has affirmed that "*The Constitution asserts dignity to contradict our past in which human dignity for black South Africans was routinely and cruelly denied. It asserts it to inform the future, to invest in our democracy respect for the intrinsic worth of all human beings.*"³¹ Furthermore, in quoting the United Nations Human Rights Committee, the Constitutional Court in *S v Makwanyane*³² reiterated that "*[t]he value of life is immeasurable for any human being, and the right to life...is the supreme human right*" and that organs of state have an obligation to protect it.³³ In emphasising the interconnectedness of rights, the Court went on to state that "*[t]he right to life, thus understood, incorporates the right to dignity. So the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.*"³⁴

2.1.2 The National Health Act³⁵

The National Health Act was established to provide a framework for a structured uniform health system while "*taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services*". The preamble of the National Health Act recognises the socio-economic injustices, imbalances and inequalities of the past along with the need to improve the quality of life of all citizens, while the objects of the National Health Act include the provision of the best possible health services "*that available resources can afford...in an equitable manner.*"³⁶

The definition of "health services" includes emergency medical treatment, although the Act does not propose a definition as to what emergency medical services encompasses. In line with section 27(3) of the Constitution, section 5 of the National Health Act articulates the fact that "*a health care provider, health worker or health*

²⁹ Section 8(1) and (2).

³⁰ Section 7(2).

³¹ *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* (CCT35/99) [2000] ZACC 8, at para 35.

³² *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3.

³³ At para 82, in quoting the United Nation Human Rights Committee in *Kindler's* case.

³⁴ *Ibid* at para 326.

³⁵ 61 of 2003.

³⁶ Section 2(2)(ii).

establishment may not refuse a person emergency medical treatment.” Again, unlike the other provisions in this Act relating to the provision of health care services in general, this section does not impose a limitation relating to the availability of resources.

The responsibility for the provision of emergency medical services, in terms of section 25(2)(m) falls on the head of the provincial department, along with the responsibility to plan, co-ordinate and monitor health services and the rendering of health services;³⁷ control the quality of all health services and facilities;³⁸ to consult with communities regarding health matters³⁹ and promote community participation in the planning, provision and evaluation of health services.⁴⁰ Public health establishments are further obliged to transfer patients to an appropriate public health establishment for necessary treatment if it is unable to provide such treatment itself, thus confirming the obligation to provide patient transport services.

The responsibility to develop norms and standards on health matters is allocated to the Director-General, while the National Health Council is tasked with the responsibility of advising the Minister of Health on policies, programmes and legislation, as well as the implementation thereof, relating to matters that will protect, promote, improve and maintain the health of the population.⁴¹

Section 90(1) of the National Health Act empowers the Minister to make regulations after consultation with the National Health Council on a variety of matters, including on emergency medical services.⁴² It is noted that draft regulations have been published for comment in 2014 which regulations are discussed in further detail below.

2.1.3 National Health Act: Draft Regulations for Emergency Medical Services⁴³

In accordance with the powers designated to the Minister in Section 90 of the National Health Act above, Emergency Medical Services Regulations (Draft Regulations) were approved by the Minister of Health and National Health Council in July 2014, and public comments on the Draft Regulations were invited. The content of the proposed regulations will be discussed briefly in this section to enable a complete analysis of both existing as well as draft legislation in order to properly assess the obligations and measures taken with regard to emergency medical services. However, in including the regulations in the legal framework, their draft (and therefore non-binding) nature must be borne in mind.

The main aim of the Draft Regulations is to regulate the licencing of emergency medical services in both the public and private health sectors, as well as to set mandatory standards relating to the staffing and equipment of ambulances and other emergency medical vehicles.

Several important definitions have been included in the Draft Regulations, including, amongst others:

“Ambulance” is defined as a *“vehicle licensed under the Road Traffic Act as such, designed or adapted for the treatment and conveyance of patients in an emergency care situation, marked as such, appropriately equipped, and staffed with a minimum of two emergency care providers”*;

³⁷ Section 25(2)(i).

³⁸ Section 25(2)(n).

³⁹ Section 25(2)(q).

⁴⁰ Section 25(2)(t).

⁴¹ Section 23(1).

⁴² Section 90(1)(m)

⁴³ Gazette 37869 Regulation Gazette 10239 Government Notice 585.

"Emergency Care" means the *"rescue, evaluation, treatment and care of an ill or injured person in an emergency care situation and the continuation of treatment and care during the transportation of such person to or between health establishment(s)"*

"Emergency Care Situation" means *"circumstances during which an ill or injured person or is for some other reason in mortal danger and in need of emergency care."*

"Emergency Medical Service" is defined as *"any private or state organisation which is dedicated, staffed & equipped to offer:*

- a) the pre-hospital medical treatment and the transport of the ill and/or injured, and where appropriate*
- b) the inter-health establishment referral of patients requiring medical treatment en-route,*
- c) pre-hospital emergency medical services for events,*
- d) the medical rescue of patients from a medical rescue situation."*

Further to this, the Draft Regulations also distinguish between two other types of emergency medical vehicles, namely "Medical Rescue Vehicle" and "Medical Response Vehicle". The former is defined as a vehicle to provide specialist rescue personnel and equipment to attend to a patient in a medical rescue situation. This definition also provides for the minimum level of staffing requirements in noting that a minimum of two emergency medical services personnel must be present and that both are required to have been trained at least in basic medical rescue. The latter, "Medical Response Vehicle", refers to a *"non-patient carrying vehicle"* which is used for the purpose of transporting specialist medical equipment and to respond to a patient in an emergency care situation. This definition only provides that the vehicle must be *"staffed with emergency medical services personnel"*.

In terms of Section 2, the Draft Regulations are applicable to public as well as private emergency medical services, which must be licenced in terms of the provisions set out in the Draft Regulations. Section 17 of the Draft Regulations also provide for the appointment of an emergency services manager obliged to ensure that the service is *"operated that provides quality care and does not compromise public, patient or personnel"*⁴⁴ and further ensures that *"no patient is ever refused care or transport by the emergency medical service on the patient's inability to pay for such treatment or transportation"*.⁴⁵ The Draft Regulations further prescribe that the person appointed as EMS manager must be qualified with a minimum level of intermediate life support.

Requirements in terms of staffing and equipment of ambulances and other emergency medical vehicles are also set out in Annexure A and B of the Draft Regulations, requiring a minimum of two persons to operate an ambulance or emergency rescue vehicle, where at least one of the persons must be qualified at an intermediate level or advanced level.⁴⁶ Medical response vehicles, on the other hand, need to be operated by a minimum of one person, qualified as a paramedic or medical practitioner.⁴⁷ All EMS personnel must be registered with the Health Professional Council of South Africa (HPCSA) and must possess the necessary public driving permits. The Draft Regulations go further to require that the "patient attendant" remain in the company of the patient at all times.⁴⁸

⁴⁴ Section 17(2)(b).

⁴⁵ Section 17(2)(e).

⁴⁶ Annexure A, Section 2(e).

⁴⁷ Annexure A, Section 2(d).

⁴⁸ Annexure A, Section 2.

With regard to equipment, a detailed list of equipment is provided in Annexure B of the Draft Regulations, while it is further prescribed that all emergency medical vehicles must be fitted with a two way radio and/or cellular communication system.⁴⁹

2.1.4 The Eastern Cape Province Health Act⁵⁰

The Eastern Cape Province Health Act (Provincial Act) was promulgated in order to structure health service delivery in the province; develop and implement health policy, norms and standards; define the provision and delivery of services; provide for rights and obligations and community participation, amongst other things.

In terms of the Provincial Act, "ambulance service" is defined as "*the provision of vehicles equipped for the purpose of providing emergency medical services as prescribed by regulation.*"⁵¹

Section 12 provides for the rights of health service users, subject, however, to provincial health resources, and specifically states their entitlement to "*emergency medical treatment for any life threatening condition through ambulance services and at any public or private health care establishment.*"⁵² In addition to this, section 26(1)(i) further obliges the MEC to "*Ensure the provision of emergency medical rescue ambulance services within each health district within the province.*"

Access to information about resources, services and any conditions are also guaranteed to health service users,⁵³ along with the right of community participation on the development and implementation of provincial health policy.⁵⁴ The MEC is further obligated to create viable mechanisms for community participation in the development and implementation of health policies and practices, and must further solicit such participation.⁵⁵

The provincial health policy must be directed towards, amongst other things, achieving equitable health care opportunities and the "*redress of past inequality in the provision of health services*";⁵⁶ ensuring that no person is denied access to services;⁵⁷ developing necessary skills and capacities to enable the effective delivery of health services;⁵⁸ and ensuring the cost effective use of resources.⁵⁹

In addition to this, the MEC is expected to ensure that proper monitoring and evaluation of the delivery of health care services takes place in order to assess progress in complying with the Constitution, national laws and provincial health policy.⁶⁰

2.1.5 Health Professions Act⁶¹

The purpose of the Health Professions Act is to regulate education, training and registration of health care professionals, and established the Health Professions Council of South Africa (HPCSA).⁶² The HPCSA was

⁴⁹ Annexure A, Section 3(b).

⁵⁰ 10 of 1999.

⁵¹ Section 1.

⁵² Section 12(b).

⁵³ Section 12(a).

⁵⁴ Section 12(d).

⁵⁵ Section 20.

⁵⁶ Section 7(b).

⁵⁷ Section 7(c), subject to the available financial and human resources.

⁵⁸ Section 7(d).

⁵⁹ Section 7(g).

⁶⁰ Section 11.

⁶¹ 56 of 1974.

established as a regulatory body over health professionals in the country, specifically dealing with “*aspects pertaining to registration, education and training, professional conduct and ethical behaviour, ensuring continuing professional development, and fostering compliance with healthcare standards.*”⁶³ All health professionals are required to be registered with the HPCSA in terms of section 17 of the Health Professions Act, and failure to register constitutes an offence.

Section 3 of the Health Professions Act empowers the HPCSA to “*ensure that persons registered in terms of this Act behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to act accordingly.*”

2.2 Overview of the Policy Framework

The policy framework relating to the right to emergency medical treatment in South Africa is not extensive. Throughout the Hearing process, the Commission requested a copy of the National Standards referred to by the Eastern Cape Department of Health but was not provided with the document. As a result, an extensive review of the policies governing this service could not be undertaken and is therefore limited to information included in or referred to in the various planning documents of the Department of Health, including the provincial Operational Plans, Annual Performance Plans, Five Year Strategic Plan, the revised Service Delivery Improvement Plan, as well as the Annual Reports of both the National and Provincial Department.

2.2.1 National Standards for Emergency Medical Services

According to the ECDoH, the ratio for the number of ambulances required for the population is set at 1 ambulance for every 10,000 persons, which ratio has been determined according to National Standards. Further to this, the ECDoH submitted that the required number of staff per ambulance has also been determined in accordance with National Standards at 10 persons for each ambulance, and a minimum of 2 persons per ambulance per shift.

As mentioned above, despite requesting a copy of the National Standards on three separate occasions, it is noted that the ECDoH failed to provide the Commission with a copy of these Standards and they could not be obtained through other research.

2.2.2 National Committee on Emergency Medical Services: Review

According to the National Department of Health Annual report 2013/14⁶⁴, a National Committee on Emergency Medical Services had been established for the purpose of coordinating emergency medical services throughout the country. According to the Annual Report, “[t]he National Emergency Medical Services Review Committee appointed by the Minister of Health, completed its review with a number of recommendations.” No additional information relating to the Committee or review undertaken could be found.

2.2.3 National Policy on Emergency Care on Education and Training

⁶² Section 2.

⁶³ <http://www.hpcsa.co.za/About>.

⁶⁴ p 46 (As accessed at http://www.gov.za/sites/www.gov.za/files/Department_of_Health_Annual_Report_2014.pdf.)

According to the 2014/15 Budget Speech by Deputy Minister of Health, Dr. Mathume Joe Phaahla, a national policy on National Emergency Care Education and Training was in the process of being developed in conjunction with the HPCSA. The National Department of Health Annual report 2013/14 reported that the policy, which aims to “*improve quality of care within the emergency care environment*”, was approved by the National Health Council. No further information could be found about the policy.

2.2.4 HPCSA National Patients’ Rights Charter⁶⁵

The HPCSA published a series of Guidelines for Good Practice in the Health Care Professions. In noting that practice as a health care professional is based on a relationship of mutual trust between practitioners and patients and in maintaining this relationship, health professionals are expected to comply with rules of conduct. The National Patients’ Rights Charter forms part of this series and explicitly notes in paragraph 2.3 that everyone has a right to, *inter alia*, receive timely emergency care at any health care facility that is open, regardless of one’s ability to pay;⁶⁶ provision for special needs in the case of newborn infants, children, pregnant women, the aged, persons with disabilities, patients in pain, persons living with HIV or AIDS patients;⁶⁷ and a positive disposition displayed by health care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance.⁶⁸

2.3 Overview of applicable case law

2.3.1 The right to emergency medical care

The only case in South Africa that has directly dealt with the right to emergency medical services is the case of *Soobramoney v Minister of Health, KwaZulu-Natal*⁶⁹ heard before the Constitutional Court. In this matter, the Applicant, a terminally ill patient, had been denied the use of the dialysis machines in the public hospital due to the limited resources of the state and its inability to provide access to the machines for every patient in need. Thus priority was given to those patients that were not terminally ill. The Applicant contended that his right to emergency medical treatment as encompassed in section 27(3) had been violated and sought an order for the court ordering the Department of Health to provide him access to the treatment in order to prolong his life.

Chaskalson P, in the main judgment, attempted to give meaning to the term “emergency medical services” in explaining that, although the term may be broadly interpreted to include on-going treatment of chronic illnesses for the purpose of prolonging life, that this was not the meaning it was intended to serve. Given the fact that the provision is couched in negative terms “[t]he purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention...should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment. What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm.”⁷⁰

⁶⁵ May 2008 (as accessed at http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_3_patients_rights_charter.pdf)

⁶⁶ Paragraph 2.3(a).

⁶⁷ Paragraph 2.3(c).

⁶⁸ Paragraph 2.3(g).

⁶⁹ 1998 (1) SA 765 (CC).

⁷⁰ Para 20.

In a concurring judgment, Madala J further explained the concept as one that "*envisages a dramatic, sudden situation or event which is of a passing nature in terms of time. There is some suddenness and at times even an element of unexpectedness in the concept.*"⁷¹

The Application in this case was turned down by the Court, but the judgment was useful in defining the concept "emergency medical services" and in providing a certain sense of clarity omitted by the existing legislation at the time. However, the Court fell short of providing additional meaning to the right in elaborating on the content of the entitlements or limitations. The Court did, however, reaffirm the need for the progressive realisation of the right to health care in noting that the unqualified need could not be met at present due to the limited resources of the state. Madala J stated that:

"The Constitution is forward-looking and guarantees to every citizen fundamental rights in such a manner that the ordinary person-in-the-street, who is aware of these guarantees, immediately claims them without further ado – and assumes that every right so guaranteed is available to him or her on demand. Some rights in the Constitution are the ideal and something to be strived for. They amount to a promise, in some cases, and an indication of what a democratic society aiming to salvage lost dignity, freedom and equality should embark upon...

*However, the guarantees of the Constitution are not absolute but may be limited in one way or another...In its language, the Constitution accepts that it cannot solve all of our society's woes overnight, but must go on trying to resolve these problems. One of the limiting factors to the attainment of the Constitution's guarantees is that of limited or scarce resources."*⁷²

However, in so noting, the Court had determined that the Applicant's case did not deal with emergency medical treatment, but rather with the right of access to health care services and the Court did not clarify whether the limitation provided for in section 27(2) requiring the state to take measures within its available resources was likewise applicable to section 27(3). It would appear, however, as noted in the sections above that the construction of section 27 as well as the negative wording of section 27(3) in particular would suggest that the right not to be denied access to emergency medical treatment is likely to be subject to a higher standard than progressive realisation based on the availability of resources.

In making its ruling, the Constitutional Court in the Soobramoney case referred to the decision by the Supreme Court of India in *Paschim Banga Khet Mazdoor Samity and others v State of West Bengal and another*⁷³ which held that "*Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. 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 his right to life.*"⁷⁴ Although this decision was taken on the basis of the right to life and not the right to health, it confirms the obligation of the State to ensure timely emergency medical services are provided to those in need.

2.3.2 Obligations of the State in designing reasonable measures to achieve the progressive realisation of socio-economic rights

⁷¹ Para 38.

⁷² Para 42-43.

⁷³ 1996 AIR SC 2426/ (1996) 4 SCC 37.

⁷⁴ Para 9.

In *Government of the Republic of South Africa v Grootboom*⁷⁵ the matter dealt with the realisation of the right to housing, but shed clarity on the State's obligations in taking reasonable legislative and other measures to achieve the progressive realisation of socio-economic rights. The Court held that the promulgation of legislation alone is not sufficient to discharge the State's obligations, but that such legislation must be supported by "appropriate, well-directed policies and programmes". In addition, the Court confirmed that the policies themselves must be reasonable, both in their conception as well as in the actual implementation thereof, providing that "an otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the state's obligations."⁷⁶

The Court further explained that the programme must be balanced and flexible, and must take into account the short, medium and long term needs, while emphasising the fact that a programme cannot remain static and must undergo continuous review.⁷⁷

In evaluating the reasonableness of a programme established by the State, the Court emphasised the fact that a programme that excludes a significant segment of society cannot be said to be reasonable.⁷⁸

"A society must seek to ensure that the basic necessities of life are provided to all if it is to be a society based on human dignity, freedom and equality. To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right. It may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realisation of the right. Furthermore, the Constitution requires that everyone must be treated with care and concern. If the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test."⁷⁹

Finally, in considering the overall appropriateness of measures taken by the State in fulfilling its obligations, the right to human dignity is of central significance.

"The proposition that rights are interrelated and are all equally important is not merely a theoretical postulate. The concept has immense human and practical significance in a society founded on human dignity, equality and freedom. It is fundamental to an evaluation of the reasonableness of state action that account be taken of the inherent dignity of human beings. The Constitution will be worth infinitely less than its paper if the reasonableness of state action...is determined without regard to the fundamental constitutional value of human dignity..."⁸⁰

2.4 Overview of the International Legal Framework

The international framework relating to the right to healthcare spans across a number of both international as well as regional instruments. The content of the right to health as laid out in the Universal Declaration of Human Rights,⁸¹ the International Covenant on Economic, Social and Cultural Rights (ICESCR),⁸² the Convention

⁷⁵ 2001 1 SA 46 (CC).

⁷⁶ Para 42.

⁷⁷ Para 43.

⁷⁸ Para 43.

⁷⁹ Para 44.

⁸⁰ Para 83.

⁸¹ Universal Declaration of Human Rights, 10 December 1948, adopted by General Assembly resolution 217 A (III).

⁸² International Covenant on Economic, Social and Cultural Rights, 16 December 1966, adopted by United Nations General Assembly resolution 2200A (XXI).

on the Elimination of All Forms of Discrimination against Women (CEDAW),⁸³ the Convention on the Rights of the Child (CRC)⁸⁴ and the African Charter on Human and Peoples Rights⁸⁵ will be explained, together with General Comment No. 14 of the Committee on Economic, Social and Cultural Rights⁸⁶ and a factsheet released by the Office for the High Commissioner of Human Rights which will further be used to explain the content and obligations of states in protecting and promoting the achievement of the right to health.

While the international instruments set out below do not explicitly mention the right to emergency medical care, this particular facet of the right to health is intrinsic, and is further expressly guaranteed in South Africa's Constitutional framework. This section therefore seeks to briefly lay out the current international legal framework, and to explain in more detail the content of the right to health.

2.4.1 Universal Declaration of Human Rights⁸⁷ (UDHR)

The Universal Declaration of Human Rights was the first comprehensive instrument encompassing the human rights of all persons. Article 25 of the UDHR guarantees that everyone has the right to "*a standard of living adequate for the health and well-being of himself and of his family, including...medical care...*"⁸⁸ and further states that "*Motherhood and childhood are entitled to special care and assistance*".⁸⁹

The UDHR provides for the right of every person to equal access to public service in his country⁹⁰ and further embodies the right to life.⁹¹

2.4.2 International Covenant on Economic, Social and Cultural Rights (ICESCR)⁹²

The Preamble of the ICESCR recognises that the rights encompassed derive from the inherent dignity of the human person and confirms the obligation of states to take steps toward the progressive realisation of rights to the maximum of available resources in Article 2(1).

The ICESCR further reiterates the right incorporated in the UDHR that every person is entitled to a standard of living adequate for the health and well-being of himself and his family, and to the continuous improvement of living conditions.⁹³ Article 12 of the ICESCR elaborates on the right by stating that everyone has the right to the "*enjoyment of the highest attainable standard of physical and mental health*"⁹⁴ and requires States Parties to take steps towards the full realisation of the right, including measures designed for the "*creation of conditions which would assure to all medical services and medical attention in the event of sickness*".⁹⁵

⁸³ Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, adopted by United Nations General Assembly resolution 34/180.

⁸⁴ Convention on the Rights of the Child, 20 November 1989, adopted by United Nations General Assembly resolution 44/25.

⁸⁵ African Charter on Human and Peoples Rights, 27 June 1981, CAB/LEG/67/3/Rev 5.

⁸⁶ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

⁸⁷ Universal Declaration of Human Rights, 10 December 1948, adopted by General Assembly resolution 217 A (III).

⁸⁸ Article 25(1).

⁸⁹ Article 25(2).

⁹⁰ Article 21(2).

⁹¹ Article 3.

⁹² International Covenant on Economic, Social and Cultural Rights, 16 December 1966, adopted by United Nations General Assembly resolution 2200A (XXI).

⁹³ Article 11(1).

⁹⁴ Article 12(1).

⁹⁵ Article 12(2)(d).

2.4.3 General Comment No.14: The Right to the Highest Attainable Standard of Health⁹⁶

The Committee on Economic, Social and Cultural Rights (CESCR) has recognised health as being a fundamental right that is indispensable for the exercise of other human rights.⁹⁷ Health is conducive to living a life of dignity, but yet for millions of people around the world this right remains what the CESCR describes as being a “*distant goal... especially for those living in poverty, this goal is becoming increasingly remote.*”⁹⁸

The CESCR emphasises the importance of equal opportunity to enjoy the highest attainable standard of health, and that a number of interrelated and essential elements composing the right include availability, accessibility, acceptability and quality. Availability requires there to be functioning health care facilities, goods, services and programmes which should be available in sufficient quality, whilst accessibility includes not only non-discrimination but also physical accessibility, noting that services and facilities should be within “*safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as...women, children...older persons, persons with disabilities and persons with HIV/AIDS...*” Accessibility further includes economic accessibility and stresses the importance that health care services should be affordable and that “[*e]quity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households...*”⁹⁹ The importance of developing appropriate measures to ensure that health policy or implementation thereof does not discriminate is emphasised in the General Comment, which further recognises the fact that resource allocation can lead to discrimination that may not be overt.¹⁰⁰

The CESCR interprets the right as imposing certain core obligations on States Parties including the integration of a gender perspective into health policies, plans and programmes; to ensure the equitable distribution of health-related goods and services and that health services are available to all, especially vulnerable groups.¹⁰¹

The General Comment further emphasises that public participation as an essential component in the formulation and implementation of national health strategies and plans of action. The CESCR explicitly states that processes for setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health must involve effective community action, and that “[*e]ffective provision of health services can only be assured if people's participation is secured by States.*”¹⁰²

2.4.4 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)¹⁰³

Article 12(2) explicitly requires that states take measures to ensure that appropriate services for women in connection with pregnancy, confinement and the post-natal period as well as adequate nutrition during pregnancy and lactation, whereas Article 14 explicitly recognises the particular problems faced by woman in rural areas.

⁹⁶ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4 (as accessed at http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf).

⁹⁷ Para 1.

⁹⁸ Para 5.

⁹⁹ Para 12.

¹⁰⁰ Para 19.

¹⁰¹ Para 20 and 43.

¹⁰² Para 54.

¹⁰³ Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, adopted by United Nations General Assembly resolution 34/180.

2.4.5 Convention on the Rights of the Child¹⁰⁴

Article 24(1) of the Convention on the Rights of the Child recognises the right of all children to the “*enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health*” and further obliges the state to ensure that no child is deprived of access to health care services. States are explicitly obliged to take measures to diminish infant and child mortality; ensure the provision of necessary medical assistance and health care to all children; and to ensure appropriate pre-natal and post-natal health care for mothers, amongst others.¹⁰⁵

The Convention further recognises that a “*mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.*”¹⁰⁶ The right of a child with disabilities to special care is further indicated and assistance provided by the state should be designed to “*ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development.*”¹⁰⁷

2.4.6 OHCHR Right to Health Factsheet¹⁰⁸

The Office of the High Commissioner of Human Rights (OHCHR) released a factsheet on the right to health, once again recognising that health is a fundamental part of our human rights and of our understanding of a life of dignity, and that a violation of the right to health may in turn impair the enjoyment of other rights.

*“It is easy to see interdependence of rights in the context of poverty. For people living in poverty, their health may be the only asset on which they can draw for the exercise of other economic and social rights, such as the right to work or the right to education. Physical health and mental health enable adults to work and children to learn, whereas ill health is a liability to the individuals themselves and to those who must care for them.”*¹⁰⁹

In explaining the obligation of non-discrimination, the OHCHR states that this implies that States must “*recognize and provide for the differences and specific needs of groups that generally face particular health challenges...The obligation to ensure non-discrimination requires specific health standards to be applied to particular population groups, such as women, children or persons with disabilities.*”¹¹⁰ The factsheet further suggests that States disaggregate their health laws and policies and tailor them to those most in need of assistance rather than passively allowing “seemingly neutral” laws and policies to benefit mainly the majority groups.¹¹¹

2.4.7 Millennium Development Goals (MDGs)

Of the 8 MDGs for 2015, 3 relate to health care which demonstrates the important role that health care plays in development. The health-related goals were the reduction of child mortality; the improvement of maternal

¹⁰⁴ Convention on the Rights of the Child, 20 November 1989, adopted by United Nations General Assembly resolution 44/25.

¹⁰⁵ Article 24(2).

¹⁰⁶ Article 23(1).

¹⁰⁷ Article 23(3).

¹⁰⁸ (as accessed at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>).

¹⁰⁹ P 6.

¹¹⁰ P 7.

¹¹¹ P 11.

health and the combatting of HIV/AIDS, Malaria and other diseases. The actions to be identified as part of the post-2015 agenda are expected to build on the 8 MDGs to promote sustainable development.

According to the 2013 MDGs Country Report for South Africa,¹¹² the State has put into place a number of initiatives aimed at combatting child mortality, including the Negotiated Service Delivery Agreement (NSDA) 2010–2024, the Strategic Plan for Maternal, Newborn, Child and Women’s Health, and the Campaign for Accelerated Reduction of Maternal and Child Mortality. According to the report, the level of infant and under-5 child mortality rates and mother-to-child transmission rates has significantly decreased as a result of these initiatives. According to research conducted in 2012, the Eastern Cape was estimated to have had the second highest level of perinatal mortality in the country, at approximately 37.7 deaths per 1000 deliveries.¹¹³

Complications related to pregnancy and childbirth are among the leading causes of mortality among women of reproductive age in many less developed countries, and improving maternal health has therefore been identified an important goal in the NSDA as well as in the NDP. According to Statistics South Africa (StatsSA), “*A key challenge in maternal mortality in South Africa is the absence of multi-sectoral planning for addressing socio-economic inequities necessary for the primary healthcare approach to be successful. The Fifth Report on the Confidential Enquiries into Maternal Deaths in South Africa reaffirms the fact that obstetric haemorrhage and hypertensive disorders are one of the main causes of maternal death.*”¹¹⁴ The Triennial Saving Mothers Report found that 40% of all maternal deaths have been classified as avoidable, and 81% of maternal deaths due to obstetric haemorrhage and 61% of maternal deaths due to hypertension are probably preventable.¹¹⁵

StatsSA recommended that the influence of contributory socio-economic factors on child and maternal mortality levels should be considered in designing initiatives aimed at reducing these rates, while other development factors, including the availability and efficiency of transportation systems should also be considered due to the fact that it severely impacts on access to clinics and referral hospitals.¹¹⁶

2.4.8 African Charter on Human and Peoples’ Rights¹¹⁷

The African Charter on Human and Peoples’ Rights (African Charter), also known as the Banjul Charter, was signed in 1981 as the first regional human rights instrument designed to promote and protect basic rights and freedoms on the African Continent. Similarly to the instruments referred to above, the African Charter recognises the right of all persons to enjoy the best attainable state of physical and mental health, obliging States Parties to “*take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.*”¹¹⁸

The African Charter goes on to express the inviolability of human beings, and that every person is entitled to respect for his right and the integrity of his person in Article 4, whereas Article 5 closely follows in recognising the right to the respect of the dignity inherent in a human being. In recognising the right to participate in

¹¹² Statistics South Africa “Millennium Development Goals, Country Report” (2013) (as accessed at http://www.statssa.gov.za/MDG/MDGR_2013.pdf).

¹¹³ Bamford, L “Maternal, newborn and child health”, (2013) p 61, SAHR 2012/13 (as accessed at [http://repository.up.ac.za/bitstream/handle/2263/21500/Bamford_Maternal\(2012\).pdf?sequence=1](http://repository.up.ac.za/bitstream/handle/2263/21500/Bamford_Maternal(2012).pdf?sequence=1)).

¹¹⁴ p 77.

¹¹⁵ National Department of Health: National Committee for Confidential Enquiry into Maternal Deaths “Saving Mothers 2011-2013: Sixth report on the Confidential Enquiries into Maternal Deaths in South Africa” (2013) (as accessed at <http://www.kznhealth.gov.za/mcwh/Maternal/Saving-Mothers-2011-2013-short-report.pdf>).

¹¹⁶ P 70 and 78.

¹¹⁷ 1981 (as accessed at <http://www.achpr.org/instruments/achpr/>).

¹¹⁸ Article 16.

government in Article 13, the obligation on states in “providing meaningful opportunities for individuals to be heard and to participate in the development decisions affecting their communities” was confirmed in the SERAC case¹¹⁹ before the African Court on Human and Peoples’ Rights.

3. ANALYSIS OF ACCESS TO EMERGENCY MEDICAL SERVICES AND PLANNED PATIENT TRANSPORT

The Emergency Medical Services (EMS) unit of the ECDoH is divided into two sub-programmes, namely emergency medical services and Planned Patient Transport (PPT). The two programmes have been defined by the Department as follows:

“Emergency Medical Services: Renders emergency medical services including ambulance services, special operations, communications and air ambulance services;

Planned Patient Transport: Renders planned patient transport including local outpatient transport (with the boundaries of a given town or local area) and intercity/town outpatient transport (into referral centres).”

According to the first submission received from the ECDoH in response to the allegations, ambulance services are divided into three types, namely community (or pre-hospital) ambulances which are used for responding to emergency medical situations; Maternity Obstetric Units (MOUs); and Inter-Facility Transfer (IFT) vehicles used to transfer patients being moved between facilities. The Department also submitted that an additional category of PPT vehicles also falls within the realm of EMS, where transportation is provided to people with appointments being referred to specialised care at specialised clinics in Regional and Tertiary care facilities.

The next portion of this Report is divided into the themes identified during the investigation. Within each theme the Report includes a summary of submissions received from the stakeholders identified in the Terms of Reference,¹²⁰ as well as a consideration of documents and reports provided to the Commission and those publically available. These sections will further provide an analysis of the submissions together with an analysis of the applicable legal and policy framework.

4. BUDGET AND PLANNING

4.1 Submissions

This section provides a summary of submissions received from the State respondents and interested stakeholders, while reference was also made to a number of planning and reporting documents from State entities. These documents include the Annual Performance Plans (APPs); the Operational Plan;¹²¹ Five Year Strategic Plan;¹²² and the revised Service Delivery Improvement Plan¹²³ of the ECDoH as well as the Provincial Treasury Estimates of Provincial Revenue and Expenditure (Provincial Treasury Estimates or budget books).

4.1.1 Budget Allocation and Utilisation

¹¹⁹ Social and Economic Rights Action Centre (SERAC) and Another v Nigeria (2001) AHRLR 60 at para 53.

¹²⁰ All community submissions were received between 13 and 20 March 2015.

¹²¹ 2014/15

¹²² 2012/13 – 2015/16

¹²³ 2014/15.

The EMS budget is controlled provincially and funding is available for EMS operations to be run in all districts. The Provincial Department of Planning and Treasury (Provincial Treasury) receives an equitable share and conditional grants from the National Treasury with an additional 2.5% of revenue generated by the province. However, the need outweighs the available resources. In allocating resources, the various provincial departments submit proposals in a bidding process that begins in June each year. The Provincial Treasury then assesses these proposals by considering a number of factors including, amongst others, the history of expenditure by a provincial department; the mandate of the department; and whether the proposal is in line with national and provincial priorities. The Provincial Treasury draws up a proposal on the allocation of resources, which is then tabled at the Cabinet Budget Committee and thereafter at the Provincial Executive Council to make a final determination in attempting to achieve an allocative efficiency, or the most efficient way of allocating resources according to the needs. In this regard, the Provincial Treasury explained that an EXCO outreach is in place, which allows the Cabinet Budget Committee to see and to determine the actual need on the ground. In order to ensure that resources are efficiently utilised, the departments make use of a Centralised Suppliers Database and are guided by the price index, which is consulted before the department awards tenders or contracts to the selected bidders. The departments then use allocated funds to pay suppliers for the services rendered.

Generally, around 82% of the budget in the Eastern Cape is allocated to the social sector, of which health receives 28.5%. Apart from the initial funding (Main Appropriation) allocated to departments, the Provincial Treasury may adjust the appropriation either upward or downward during the course of the year, where additional funding may be provided, or funding may be decreased in order to address burning cost pressures or underspending (Adjusted Appropriation). In addition to this, post-adjustment virements where funding is transferred from one financial account to another could also result in a change in the amount allocated.

4.1.1.1 History of budget allocation to EMS

The Eastern Cape State of the Province Address as well as the MEC Health Budget Vote has emphasised the need to strengthen the functioning and support of EMS, which has further been identified as a priority over a number of years in receiving the fourth highest allocation of budget for the ECDoH's programmes.

In reviewing the budget allocation to the EMS programme specifically, an upward trend can be identified, from an amount of R397,098 million allocated to the programme in 2006/07 to an initial allocation of R798,435 million in 2014/15, and most recently to R971,832 million for the current financial year (2015/16). In considering the adjusted allocations, an expert submission received from Debbie Budlender indicated that while there is a trend of an upward adjustment in most financial years, the 2012/13 year reflected a decreased adjustment by an amount of R18,481 million for the EMS sub-programme. The Provincial Treasury explained that the main allocation was adjusted downward to address in-year cost pressures due to underspending, and that the Department did underspend its budget for the financial year.

While the nominal values indicated above reflect an average positive growth, the real values adjusted for inflation (with the values in 2013 rands) indicate an average positive growth for the EMS programme, the real value demonstrated a real decrease in 2011/12 and 2014/15, as indicated in table 1 below. The submission further indicated that while the real value of the overall health budget showed minor positive growth, or negative growth over the years, the figures confirm the increasing share for EMS.

TABLE 1: TRENDS IN REAL VALUE OF EXPENDITURE FOR EMS (2013 R'000s)

	2011/12	2012/13	2013/14	2014/15
EMS sub-programme	707,717	638,276	795,687	734,657
% real change	15%	-10%	25%	-8%
PPT sub-programme	12,050	16,723	30,202	22,154
% real change	3%	39%	81%	-27%
Total EMS budget	719,767	654,999	825,889	756,810
% real change	14%	-9%	26%	-8%

On average, the EMS budget allocation has remained relatively constant in the last 10 years with a portion of between 4 – 5% of the total health budget for the Eastern Cape. However an incremental upward trend can likewise be identified here with a 4% allocation in 2006/07 to an estimated initial 4.9% in 2014/15, which portion was increased to 7% after the adjusted appropriation in November 2014 according to the Provincial Treasury.

The Provincial Treasury further submitted that in considering the increasing budget of the Department of Health for the province over the last decade, the EMS budget has in fact seen a 10% increase, while the overall health budget has seen a much smaller increase. In analysing the Provincial Treasury Estimates between 2012 and 2015, when comparing the initial allocation against the previous year's revised estimate, the EMS programme reflected an increase of 4.6% in 2012, 9,5% in 2013, 0,4% in 2014 and 10% in 2015, whereas the overall health budget reflected a decrease by 2.72% in 2011, followed by increases ranging between 1,3% and 3,8% between 2012 and 2015.

The low increase in 2014 of the allocation to the EMS programme of 0,4% is due to the fact that the PPT sub-programme reflects a decrease of 80,5% compared to the previous years revised estimate. However, the 2014 Provincial Treasury Estimates explains the "abnormal decrease" in the allocation of PPT as being due, in part, to a problem with "link codes in Compensation of Employees", which could suggest bureaucratic error in recording finances rather than a real decrease.

4.1.1.2 History of budget allocation to EMS sub-programmes

As indicated previously, the EMS programme is divided into two sub-programmes, namely EMS and PPT. The latter sub-programme has increased from approximately 1.9% of the total programme budget in 2010/11 to around 3.3% in 2013/14. The portion of the budget allocated to PPT was then decreased in the 2014/15 financial year to around 2.9% in the initial allocation, but was increased substantially to 9.3% of the total EMS programme budget after the adjusted allocation was made, increasing the amount allocated from R23,372 million to R83,362 million. The revised estimate for 2014/15 of R82,401 million therefore indicates an ongoing upward trend when considering the most recent allocation in 2015/16 to R83,295 million, an approximate 8.5% of the total EMS budget.

Despite the massive increase in the portion of the EMS budget allocated to PPT in 2014/15, followed by a slight decrease in 2015/16, the Mid-Term Estimates submitted by the Provincial Treasury indicate a further anticipated decrease in the estimated apportionment in the 2016/17 to 8.3% and an increase following in 2017/18 to 8.7% as indicated in Table 2 below.

TABLE 2: ALLOCATION TO SUB-PROGRAMMES: 2010/11 - 2017/18 (R'000s)

Sub-programme	2010/11	2011/12	2012/13	2013/14	2014/15		2015/16	2016/17	2017/18
					Main appropriation	Revised estimate			
EMS	526,935	633,797	603,708	784,898	775,063	800,821 (estimate)	888,537	906,819	947,810
PPT	9978	10,791	15,817	28,048	23,372	82,401	83,295	82,428	90,899
Total	536,913	644,588	619,525	812,946	798,435	883,222	971,832	989,247	1,038,709
<i>PPT as a %</i>	<i>1.9%</i>	<i>1.7%</i>	<i>2.6%</i>	<i>3.3%</i>	<i>2.9%</i>	<i>9.3%</i>	<i>8.5%</i>	<i>8.3%</i>	<i>8.7%</i>

The figures above represent the fact that the nominal value of the PPT allocation has increased by 88% overall since 2010/11 (while the increase in real terms would be less), with the largest increase being seen in the 2014/15 financial year.

4.1.1.3 *Division of total EMS budget allocation*

The annual budget allocation to the EMS programme is classified into portions allocated to compensation of employees; goods and services; transfers; and capital assets. The Annual Performance Plans (APPs) for the financial years 2012/13 to 2015/16 were analysed along with the Provincial Treasury Estimates for the same period.

In terms of compensation for employees, the initial allocation in 2012/13 was increased by 20,5% from the previous year's audited outcome, which increase is explained in the 2012/13 Provincial Treasury Estimates by the need to accommodate additional qualified personnel in the EMS programme. The reported figures reflect that the amount allocated to compensation of employees increased in 2013/14, but decreased in 2014/15. On the face of it this decrease appears to be inconsistent with one of the priorities identified in the 2014/15 APP which aimed to fill vacant operational posts, however the Provincial Treasury Estimates explains the apparent decrease as being attributable to the "once off payments of HR accruals from funding received in the 2013/14 financial year." According to the 2015/16 APP, employee compensation in 2014/15 was adjusted upward later in the year to R494,102 million. The substantial increase seen in the allocation for compensation of employees in the 2015/16 financial year is consistent with the submissions made by the ECDoH that it intends to increase its staff capacity.

Further to this, the 2014/15 Operational Plan indicated that an amount of R5,904 million would be made available for the EMS Training College under Programme 6 of the ECDoH (Health Sciences and Training), in line with the priorities set out in both the Operational Plan as well as the APP for 2014/15. However, the 2015/16 APP does not indicate a similar allocation for training under the EMS programme (Programme 3) or Programme 6.

In relation to capital assets, the 2012 Provincial Treasury Estimates further explained that the large decrease in the amount allocated to capital assets was due to the "department's last minute decision to lease ambulance fleet services rather than procuring its own fleet". However, the audited figures in the Annual Report reflect that amounts allocated for compensation for employees and for goods and services in 2012/13 were adjusted downward, with funds reallocated to the payment of capital assets in the total amount of R77,968.¹²⁴ This shift

¹²⁴ 2012/13 Annual Report.

is consistent with the increased initial allocation to capital assets in 2013/14 which is explained in the 2013/14 Provincial Treasury Estimates as “emanating from the department’s strategy decision to purchase ambulances and rescue vehicles.”¹²⁵ The ECDoH, however, clarified that the strategic decision to lease ambulances was not taken by the Department itself, but that a decision was taken by the Provincial Government to lease fleets for all departments.

This strategy shifted again in 2014/15 where the goods and services and the machinery and equipment portion of capital assets were projected to increase due to the “department’s strategic decision not to purchase ambulances and rescue vehicles but to lease them, and thus incur high finance lease expenditure.” According to the 2015/16 APP, the allocation to capital assets was adjusted upward to total R127,324, while the allocation for goods and services and transfers were adjusted downward.¹²⁶

According to the 2015/16 Provincial Treasury Estimates, due to the decision to lease ambulances from goods and services, this allocation has been increased by 36,3% in 2015/16 when compared to the revised estimate of the previous financial year in order to carry the cost of acquiring additional ambulances.

Table 3 below illustrates the classification of the main appropriation for each year.

TABLE 3: CLASSIFICATION OF INITIAL BUDGET ALLOCATIONS: 2012/13 – 2016/17 (R’000s)

Budget	Audited	Initial allocation				Estimate
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Compensation of employees	374,043	417,618	446,657	403,508	524,719	521,567
Goods and services	249,966	316,143	323,512	276,571	319,519	312,819
Interest and rent on land	116	-	-	-	-	-
Transfers	68	2,396	2,528	2,654	2,776	2,904
Capital assets	47,395	1,088	19,998	115,702	124,746	151,957
Total	644,588	737,245	792,695	798,435	971,832	989,247

4.1.1.4 Budget utilisation and history of under-spending

The ECDoH has continuously cited the impact of resource constraints on its ability to provide an efficient delivery of EMS in compliance with National Standards. However, an analysis of the budget utilisation has reflected a trend of under-spending of the allocated funds for EMS over the years, although significant underspending only occurred in one year.¹²⁷ The figures provided by the Provincial Treasury are indicated in Table 4 below.

TABLE 4: BUDGET EXPENDITURE ON ADJUSTED APPROPRIATION 2011-2015 (R’000s)

Budget	2011/ 2012	2012/ 2013	2013/ 2014	2014/2015 (estimate)
Adjusted Budget Allocation	649 984	667 394	812 946	890 940

¹²⁵ P 175.

¹²⁶ 2015/16 APP.

¹²⁷ It is acknowledged that exact expenditure of budget allocations year on year is largely unlikely, and therefore a slight over- or under-expenditure is generally expected and is reasonable.

Budget Expenditure	644 588	619 525	812 946	883 222
Underspent	5,396	47,869	0	7,718
<i>% of budget underspent</i>	<i>0.8%</i>	<i>7%</i>	<i>0%</i>	<i>0.9%</i>

The ECDoH 2012/13 Annual Report indicated that the under-spending of R47,87 million occurred as a result of the non-delivery of 130 ambulances from an order placed with the Department of Transport.

An expert submission was received from Debbie Budlender in analysing the adequacy of the budget for EMS in the Eastern Cape. This analysis was based on an assessment of the available budget books and audited outcomes of expenditure at the time and reflected a significantly greater level of under-spending when comparing the initial main allocation to the audited expenditure. Whilst the audited expenditure indicated by the Provincial Treasury and the expert submission were identical, the adjusted budget allocation figures differed.¹²⁸ Tables 5 – 7 below provide an overview of the expert submission and information reflected in the Provincial Treasury Estimates.

TABLE 5: BUDGET EXPENDITURE ON MAIN ALLOCATION 2011/12 (R'000s)

Budget	Main appropriation	Adjusted Appropriation	Audited expenditure	Amount of under-expenditure of adjusted appropriation	% of total under-expenditure on adjusted appropriation
EMS sub-programme	647,808	657,569	633,797	23,772	3,6%
PPT sub-programme	20,067	20,193	10,791	9,402	46,5%
Total	667,875	677,762	644,588	33,174	4,8%

TABLE 6: BUDGET EXPENDITURE ON MAIN ALLOCATION 2012/13 (R'000s)

Budget	Main appropriation	Adjusted Appropriation	Audited expenditure	Amount of under-expenditure of adjusted appropriation	% of total under-expenditure on adjusted appropriation
EMS sub-programme	716,889	698,408	603,708	94,700	13,5%
PPT sub-programme	20,356	25,756	15,817	9,939	38,5%
Total	737,245	724,164	619,525	104,639	14,4%

TABLE 7: BUDGET EXPENDITURE ON MAIN ALLOCATION 2013/14 (R'000s)

Budget	Main appropriation	Adjusted Appropriation	Audited expenditure	Amount of under-expenditure of adjusted	% of total under-expenditure on adjusted
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¹²⁸ While this discrepancy was not explained, it is possible that post-adjustment virements could be a source of the difference.

				appropriation	<i>appropriation</i>
EMS sub-programme	762,493	795,687	784,898	10,789	1,3%
PPT sub-programme	30,202	30,202	28,048	2,154	7,1%
Total	792,695	825,889	812 946	12,943	1,5%

The figures represented in the tables above indicate that the EMS programme budget was underspent in 2011, 2012 and 2013, with the largest under-expenditure occurring in 2012. Under-expenditure of the PPT sub-programme in the 3 years is significant with 46,5% in 2011 and 38,5% in 2012.

While the ECDoH admitted that the past has seen instances of under-spending, it provided assurances that this occurrence will no longer take place, submitting that most of the 2013/2014 budget had been spent and that by the end of the 2014/2015 financial year it was anticipated that 99% of the budget would have been spent. The audited outcome for the 2014/2015 financial year was not available at the date of drafting this report, however, the revised estimate provided by the Provincial Treasury anticipates an under-expenditure of 0,9%.

4.1.2 EMS Planning

The Annual Performance Plan (APP) produced by the ECDoH is issued each year and identifies the priorities, as well as targets set by the department for the next proceeding 3 years. Other planning documents considered include the Operational Plan,¹²⁹ Five Year Strategic Plan¹³⁰ and the revised Service Delivery Improvement Plan.¹³¹

The targets relating to the number of ambulances and response times will be discussed at a later stage in the report, while this section will illustrate the identification of priorities in the various planning documents.

4.1.2.1 *Identification of priorities*

As mentioned above, the APPs are released each year and set out the priorities that have been identified for the following 3 years. Ideally, as planning is conducted for 3 year periods, the priorities in each APP should correspond or overlap to a certain extent, unless situations have changed which calls for a review of existing priorities.

Table 8 below indicates the priorities identified by the APPs during this period. The Commission was unable to obtain a copy of the 2010/11 APP and is therefore unable to indicate the priorities of the EMS programme for this year.

TABLE 8: PRIORITIES OF THE EMS PROGRAMME

2008/09	<ul style="list-style-type: none"> • Ensure eradication of one-man crew province wide is maintained; and • Acquisition of at least 100 emergency vehicles per annum as required by the turn-around strategy
2009/10	<ul style="list-style-type: none"> • Eradication of one-man crew, province wide; and

¹²⁹ 2014/15

¹³⁰ 2012/13 – 2015/16

¹³¹ 2014/15.

	<ul style="list-style-type: none"> Acquisition of additional vehicles
2010/11	
2011/12	<ul style="list-style-type: none"> To provide a reliable and efficient EMS service by increasing the number of EMS vehicles for the communities of the Eastern Cape
2012/13	<ul style="list-style-type: none"> Placement of emergency services vehicles at strategic locations to improve response times
2013/14	<ul style="list-style-type: none"> To increase response times
2014/15	<ul style="list-style-type: none"> Build Management Capacity and employment of EMS Management teams; Improve call taking and dispatching ability by rolling out the computerised call-taking and dispatching system (CRM) to the Alfred Nzo and the Chris Hani EMS Centres; Increase the staff mix for ILS and ECT as well as Paramedics in the districts; Increase the EMS fleet to include dedicated fleet for inter hospital, XDR/MDR and maternity transfers; Improve data capturing and DHIS reporting by continuously developing staff in the field of information management, followed by monthly quality checks on the authenticity of data collected. Dedicated staff to be employed to perform these functions; Finalise the organogram for call centres in order to have dedicated staff employed within the EMS control rooms; All EMS vehicles fitted with satellite tracking systems, which will be linked to the call centres; Fill vacant operational posts in order to increase the number of rostered ambulances; Expand the training platform for Paramedics and the Mid-Level Emergency Care Practitioners (this priority will be implemented by Human Resources Development under Programme 6: Health Sciences and Training).
2015/16	<ul style="list-style-type: none"> Improve call taking and dispatching ability by rolling out the computerised call-taking and dispatching system (CRM) to the Alfred Nzo and the Chris Hani EMS Centres; Increase the EMS fleet to include dedicated fleet for inter hospital, XDR/MDR and maternity transfers

In addition to the priorities identified in the APPs, the departmental Five Year Strategic Plan for the period 2009/10 to 2014/15 identifies only one provincial priority, being the improvement of the health profile of the province through improving the health status of the population, while the Operational Plan for 2014/15 identified the same priorities as those indicated by the APP for this year.

Although the revised Service Delivery Improvement Plan (SDIP)¹³² does not indicate priorities as such, it does identify challenges as well as measures necessary to address them. In considering the revised SDIP, 3 key mechanisms to be implemented in order to address the challenges relating to poor response times of EMS were laid out, namely the roll out of CRM; improvement of the information management system as well as the proper

¹³² 2012/13 – 2014/15.

resources of EMS regional offices and EMS bases. Despite the fact that these measures were identified in 2012/13, they only appeared on the list of identified priorities in the APPs between 2014/15 and 2015/16.

4.1.3 Financial planning aimed at increasing access to Emergency Medical Services

In November 2014, the Provincial Treasury granted an adjusted allocation to the ECDoH for an additional R83.4 million; R62 million of which was allocated for leasing ambulances in order to increase the size of the current fleet, and R21.3 million was to fund the employment of additional staff, which, the Provincial Treasury advised, will continue gradually year on year until the total required number of staff have been appointed.

During its submission to the Panel, the ECDoH reiterated its intention to increase the number of staff members employed in the EMS programme to be commensurate to the number of ambulances required in terms of the National Standards, noting however that the acquisition of more staff is a long term goal. Along with this, the Department further attested to its intention to increase the level of training of current staff, which is discussed in more detail under the human resources section of the report.

In addition to this, the entity from which ambulances are leased, the Provincial Government Fleet Management Service Trading Entity, reflected a R90 million excess in earnings in 2014. Rather than returning this profit to the revenue fund, it was utilised to purchase additional ambulances for the ECDoH. Overall, the Provincial Treasury allocated an additional R173.5 million towards the improvement of the EMS function in the province. The Provincial Treasury further submitted that in its efforts to promote the improvement of EMS, the baseline budget for the ECDoH was not cut as a result of the National Treasury baseline cuts; that luxuries (including expenditure on consultants) were reduced; and that R500 million was allocated for social infrastructure projects in the province, which include access roads to clinics and schools.

4.1.4 Strategic decision to lease ambulances

The strategy of the Provincial Government with regard to the purchase or leasing of vehicles shifted on a number of occasions between 2011/12 to 2014/15. As discussed above, the allocation to capital assets was decreased in 2012/13 by the decision to lease ambulances, which amount was later increased in line with the decision taken in 2013/14 to purchase ambulances. This strategy was again shifted in 2014/15 by the decision not to purchase ambulances but to lease them from the Department of Transport.

According to the Provincial Treasury, a detailed cost analysis was undertaken before the decision was made that all departments would lease vehicles from an in-house Provincial Government Fleet Management Service Trading Entity (Trading Entity). The Commission requested an explanation on the cost analysis undertaken from the Trading Entity, however, this was not provided. The Trading Entity provided a detailed explanation on the cost to purchase ambulances and PPT vehicles which has been reflected in table 9 below.

TABLE 9: AMBULANCE PURCHASE COST

Type of vehicle	Main asset average price (including delivery)	Body/ conversion price	Standard vehicle accessories (Registration, number plates, fuel systems etc)	Additional accessories for ECDoH's account	Total purchase price
Pre-hospital unit 4x2	215,377.45	109,730.70	6,306.80	129,458.40 (2xstretcher)	460,873.35

Pre-hospital unit 4x4	248,559.31	109,730.70	6,306.80	129,458.40 (2xstretcher)	495,055.21
Pre-hospital unit standard	242,405.84	95,418.00	6,306.80	129,458.40 (2xstretcher)	473,589.04
MOU	465,622.86	150,000.00	6,306.80	69,932.16 (incubator)	730,336.82
				38,475.00 (1xstretcher)	
IFT	465,622.86	150,000.00	6,306.80	129,458.40 (2xstretcher)	751,388.06
PPT 16 seater	336,869.27	0	6,306.80	0	343,176.07
PPT 23 seater	485,657.09	0	16,794.80	0	502,451.89
PPT 35 seater	653,242.84	0	6,306.80	0	659,549.64

The leasing of ambulances is funded under the capital asset budget component, the cost of which has been set out below in table 10. According to the Trading Entity, the lease amount is calculated to include the capital amount for the purchase of the vehicle; interest at an amount of 10.2%; the period of the lease contract; residual values; insurance at 7.5% of the vehicle capital value; maintenance costs; E-fuel leasing and annual licence fees.

TABLE 10: MONTHLY LEASE CALCULATION

Type of vehicle	Lease period	Residual values	Average capital per category	Capital amount needed for the replacement of the vehicle	Amount for "self-insurance"	Overhead contribution	Tyre and maintenance CPK	Total fixed tuilisation per km/hour (excl fuel)	Total fixed monthly amount
Pre-hospital unit 4x2	40	30%	331,415	9,581.66	2,071.34	1,853.00	1.31	9,825	23,331.01
Pre-hospital unit 4x4	40	30%	364,597	10,404.67	2,278.73	1,853.00	1.09	8,175	22,711.40
Pre-hospital unit standard	40	30%	344,131	9,814.82	2,150.82	1,853.00	1.13	8,475	22,293.63
MOU	48	30%	621,930	14,969.01	3,887.06	1,853.00	1.52	11,400	32,109.07

IFT	48	30%	621,930	14,969.0 1	3,887.06	1,853.00	1.52	11,400	32,109.07
PPT 16 seater	48	38%	343,176	7,661.18	2,144.85	1,853.00	0.67	2,096.66	13,755.69
PPT 23 seater	48	40%	502,452	10,913.9 8	3,140.32	1,853.00	1.56	6,500.00	22,407.30
PPT 35 seater	48	43%	659,550	13,937.6 6	4,122.19	1,853.00	1.48	6,166.67	26,079.51

4.2 Analysis

4.2.1 Analysis of budget allocation

The recognition of the importance in health, and in EMS specifically, is apparent in the steady increase in the value of the budget allocated to the programmes over the past decade. The portion of budget allocated to EMS has increased gradually over time, from 4% in 2010/2011 to 4.8% in 2013/2014. Although the EMS share is slightly higher than the national average, a number of factors influence the relative need for EMS expenditure, including the geographical size of the province; terrain; and the availability of other transport options. Gauteng, the smallest province geographically as well as one of the most developed provinces in terms of infrastructure and transport, receives the smallest portion at 3.2% of the provincial health budget despite its large population size. The Northern Cape, on the other hand, being the largest province allocates a portion of 6.9% to EMS.¹³³ This analysis would indicate that geographical size and infrastructure are important considerations in the allocation of resources to EMS.

The urgent need to strengthen EMS in the province has further been recognised in the increased allocation to the programme during the adjusted appropriation in November last year, ending at approximately 7% of the total health budget for the province according to information provided by the Provincial Treasury. The current portion of the health budget for 2015/16 is around 5%.

An analysis of the planning documents and reports of the ECDoH would suggest that PPT, which forms part of the overall EMS function, was not perceived as a priority. The documents provided to the Commission reflect that the portion of the overall EMS budget allocated to this sub-programme grew only minimally between 2010/11 and 2013/14, with amounts allocated fluctuating and even decreasing in 2014/15, although the decrease may be due, in part, to manual error in financial recording. In considering the minimal allocations provided to this sub-programme together with the significant levels of under spending of PPT allocations between 2011 and 2012 and the lack of prioritisation of PPT services in the planning documents, this would suggest that the material importance of these services appears to have been neglected. This is particularly important in light of the challenges in obtaining access to transportation for individuals residing in the rural areas of the province. However, the increased investment in PPT since November 2014, which investment is foreseen to continually increase over the next three years, would indicate the subsequent recognition of the critical function of these services in providing an effective delivery of EMS in the province.

¹³³ Expert submission received from Debbie Budlender, 6 March 2015.

In terms of the allocation of funding according to economic classification, these appear to have been conducted in line with identified priorities, and any perceived inconsistencies have been explained in the relevant reporting documents. Allocation to compensation of employees has continuously increased year on year in line with the expressed intention to increase the number of staff in the EMS programme. The numerous changes of strategic decisions relating to the purchase or lease of ambulances is observed through the shifting of increased funding between the capital assets and goods and services allocations. This constant shifting may have negatively impacted the ability of the ECDoH to achieve full compliance with National Standards in relation to the number of ambulances required.

4.2.2 Analysis of under-expenditure

The figures provided by the ECDoH along with the Provincial Treasury as illustrated in table 4 above, would indicate that although under-expenditure of the budget in the EMS programme has occurred in the past, that the level of under-expenditure was not extensive. The year that reflected the highest level of under-expenditure at 7% in 2012/13 was explained as a result of the Department of Transport's failure to deliver vehicles ordered, whereas the other financial years between 2011/12 and 2014/15 demonstrated an under-expenditure of less than 1%.

However, the figures and analysis provided by Debbie Budlender considered together with the Provincial Treasury Estimates highlight a much larger extent of under-expenditure in the EMS programme overall. The proportion of under-expenditure in the PPT sub-programme is particularly concerning, given the small amount of funding already allocated to it. This trend indicates that the ECDoH may not have been fully utilising allocated resources, but the more recent trends do indicate a reduction in the under-expenditure of the programme.

The estimated expenditure for the 2014/15 financial year was estimated to reach 99%, however, at the time of drafting this report, the final audited figures were not available.

4.2.3 Analysis of planning, prioritisation and reporting

The adequate functioning of the health care system is largely dependent on good budgeting and rational expenditure, and the implementation of human rights therefore cannot be fully achieved without the commensurate budget. Consequentially, the design and implementation of a budget can either facilitate, or impede protection, promotion and fulfilment of human rights.

The Office of the High Commissioner for Human Rights (OHCHR) has indicated that rights can have budgetary implications, with national budgets having a significant and direct bearing on which human rights are realised and for whom.¹³⁴ The OHCHR emphasises how human rights standards can provide valuable guidance to policymakers and legislators when weighing competing demands on limited resources, and that a rights-based approach to budgeting can assist in ensuring, for example, that "*budget allocations are prioritized towards the most marginalized or discriminated against; provision is made for essential minimal levels for all rights; there is progressive improvement in human rights realization; and particular rights are not deliberately realized at the cost of others...*"¹³⁵ A proper assessment and consideration of the factors necessary for the achievement of rights is therefore important in ensuring that the policies and strategies designed for the provision of health care, including emergency medical care, are appropriate for all groups in society. The explanation by the CESCR

¹³⁴ OHCHR *frequently asked questions on a human rights-based approach to development cooperation* (2006), p 12 (as accessed at <http://www.ohchr.org/Documents/Publications/FAQen.pdf>).

¹³⁵ *Ibid.*

on the essential elements of an adequate healthcare system, including adequacy, accessibility, acceptability and quality should therefore be taken into account during the planning and budgeting process.

An analysis of the various planning documents and budget allocations by the ECDoH indicate a number of problems in terms of the overall planning performance by the Department. The APPs issued by the ECDoH between 2008 to 2015 reflect a constant shifting of priorities from year to year between the eradication of one-man crews, to the increasing of the number of EMS vehicles, placement of EMS vehicles at strategic locations, and finally to improving response times. Only the 2008/09 and 2009/10 years maintain consistent priorities, whilst the 2014/15 and 2015/16 financial years show some overlap with a number of priorities removed in the latter year. While it is reasonable that the Department may change its priorities from year to year, the constantly changing prioritisation could have impacted negatively on the ability of the ECDoH to give sufficient attention to any of the issues, resulting in the overall failure to significantly improve on the delivery of EMS over the years.

The inconsistencies in documents relating to the audited number of operational ambulances, relevant targets for the number of ambulances and response times will be highlighted in the sections to follow. While at first glance, the priorities identified by the Department do not appear to always correspond with the allocation of funding, a closer analysis of the Provincial Treasury Estimates indicates that funding allocations appear to be in line with the identification of priorities, although allocations are often shifted during the year. In analysing the 2015/16 priorities in relation to the budget allocated, these appear to be aligned with the amount allocated for compensation of employees having increased significantly, as well the amount allocated for capital assets.

5. AVAILABILITY AND ADEQUACY OF AMBULANCES

5.1 Submissions

As indicated in the introduction of the contextual analysis section above, the ECDoH explained that the ambulance services are divided into three types, pre-hospital, MOUs and IFT services, while a fourth service provided is that of Planned Patient Transport PPT.

Both PPT and IFT vehicles transport patients between health facilities; IFT vehicles do so in an emergency and PPT vehicles provide transport between health facilities for scheduled appointments. Further to this, while the ECDoH has indicated that it has a number of PPT vehicles available for the provision of transportation for scheduled appointments and/or referrals, these vehicles do not cater for transportation between communities and health care facilities and as a result residents of local communities are required to hire public or private transportation to reach the point of departure. This has a significant impact on low-income households and on persons with disabilities in particular, which will be explained further in later sections of the Report.

5.1.1 Number of ambulances

5.1.1.1 *National and Provincial Standards*

According to the National Standards as set out in the National Data Indicator Set (NDIS) released by the National Department of Health (DoH), the required number of ambulances is 1 ambulance for every 10,000 persons in the province. Reference to “ambulances” for the purpose of the National Standard includes emergency vehicles only (i.e pre-hospital, MOU and IFT) and excludes PPT vehicles.

As previously noted, the Commission has been unable to obtain a copy of the National Standards and reference to the exact wording is therefore not possible, and it appears from the submissions that the Standards do not purport to regulate the number of PPT vehicles required.

The appropriateness of the application of the National Standard of 1 ambulance for every 10,000 persons in the Eastern Cape was continually questioned throughout the Hearing process, mainly due to the geographical context of the Province with a number of villages located far apart, combined with the difficult terrain and the poor state of the road network and the resultant inability of ambulances to move as quickly as the case would be in urban or well developed areas. According to the ECDoH, the number of ambulances is only one indicator of the efficiency of an EMS system, and measures such as the local deployment of ambulances as well as the use of live tracking recently implemented will further add to the efficiency of the system. In noting this, the Department further contended that the relevance of the current Standard to the provincial context will only be measurable once the full target of ambulances and staff has been reached.

Noting the estimated population size of the Eastern Cape according to the 2011 census of around 6.56 million people, approximately 656 ambulances is required according to the National Standards in order for the ECDoH to be at an appropriate level.

5.1.1.2 Total Number of Ambulances

The first submission made by the ECDoH in September 2013 indicated that the fleet of ambulances at the time was 310, with an additional 100 ambulances undergoing conversion. It was therefore expected that by the end of the 2013 financial year the fleet would stand at 410 (0.63 to every 10,000 persons).

A submission received from the ECDoH in August 2014 confirmed that the total number of ambulances in its possession as at 31 July 2014 was 416, of which 55 were MOU vehicles and 8 were IFT vehicles.¹³⁶ The ECDoH further indicated that it had a total of 140 PPT vehicles in its possession in addition to the 416 ambulances. However, 157 ambulances were non-compliant¹³⁷ and therefore needed to be replaced.¹³⁸

The representations made by the ECDoH during the Hearing in March 2015 confirmed the total number of ambulances still stands at 416, and that the majority of previously non-compliant ambulances have since been replaced, while the remaining replacements were due to be received in the near future. The ECDoH then advised that the 157 replacement ambulances had in fact been divided amongst pre-hospital, MOU and IFT ambulances. In this regard, the Department explained that 70 of the replacement ambulances had been converted to be dedicated IFT ambulances, and a further 40 had been assigned as MOU ambulances in order to alleviate the pressure placed on pre-hospital ambulances. The ECDoH further submitted that as at the 23rd day of April 2015, in addition to the 416 ambulances, the number of PPT ambulances stood at 138 while the total number of ambulances with 4x4 capabilities was 58.

The above-mentioned submissions confirm that the size of the EMS fleet did not increase between July 2014 and March 2015. However, the submission made by the Provincial Treasury informed that the budget had been adjusted in November 2014 to allocate an additional R62 million for the leasing of ambulances, and on top of

¹³⁶ The IFT vehicles were located at in O.R Tambo (1), Amathole (5) and Nelson Mandela Bay (2).

¹³⁷ According to the ECDoH, a "non-compliant" vehicle usually refers to a vehicle which has exceeded the mileage or life span in years as stipulated in the Service Legal Agreement, but may still be in a roadworthy state and used in part of the day to day fleet.

¹³⁸ It must be noted that although the submission made before the Panel at the hearing stipulated that the 157 vehicles were not functional as they were in garages and were unable to assist with responding to emergencies, a later submission averred that the 157 vehicles were "non-compliant" in terms of the definition provided above, but were in fact operational.

this, that the R90 million in excess revenue received by the Trading Entity had been used to purchase additional ambulances for the ECDoH, bringing the total size of the fleet to 501.

In addition to this, a submission received from the Government Fleet Management Services Trading Entity (the Trading Entity) from which the vehicles are leased indicated that as at 31 March 2015, the ECDoH had a total number of 361 ambulances (including pre-hospital, MOU and IFT) or 497 vehicles in total (including PPT vehicles). According to the Trading Entity, this number increased to 446 ambulances or 583 if you include the number of PPT vehicles in the total as at 30 June 2015.

The breakdown of the numbers of vehicles according to the Trading Entity is reflected in table 11 below. While the number of MOU and IFT ambulances has increased between 31 March and 31 June 2015, the number of pre-hospital ambulances has in fact decreased slightly, and the number of pre-hospital ambulances with 4x4 and 4x2 capabilities has been drastically reduced.

TABLE 11: TOTAL NUMBER OF AMBULANCES ACCORDING TO THE GOVERNMENT FLEET MANAGEMENT SERVICES TRADING ENTITY

Type of vehicle	Number of ambulances leased as at 31 March 2015	Number of ambulances leased as at 30 June 2015
Pre-hospital 4x2	43	36
Pre-hospital 4x4	107	59
Pre-hospital standard	211	241
TOTAL PRE-HOSPITAL	361	336
MOU	0	40
IFT	0	70
TOTAL AMBULANCES	361	446
PPT	136	137
TOTAL VEHICLES LEASED	497	583

The Trading Entity further indicated that an additional 141 replacement ambulances with 4x4 capabilities are expected to be delivered to the ECDoH by December 2015.

Although the Trading Entity indicated that 361 ambulances were leased to the ECDoH as at 31 March 2015, the number of ambulances was confirmed by the ECDoH as being 416 as at 25 March and 23 April 2015, reflecting inconsistencies in the total number of ambulances reported between the ECDoH, the Provincial Treasury and the Trading Entity.

The ECDoH also submitted that it has procured the services of 3 helicopters that will be available to respond to emergencies, which have been placed at Port Elizabeth, East London and Mthatha. In terms of the policy established by the ECDoH, the service may be utilised by the logging of a call by the Medical Doctor to the helicopter desk, which is operated by a paramedic who conducts an assessment and dispatches the helicopter appropriately. The aeromedical services are only accessible for priority one calls but the ability to use these services is dependent on a number of factors, including amenable weather conditions and the existence of an appropriate landing area. The use of aeromedical services was available in previous years, with 2 helicopters being reported in the 2012/13 – 2014/15 revised Service Delivery Improvement Plan.

5.1.1.3 *Number of Operational Ambulances*

It is important to note that while the Department may have a number of ambulances and other EMS vehicles in its possession at any one time, not all of the vehicles will be operational. "Operational" or "rostered vehicles" refer to those vehicles which are currently being used to respond to emergency medical situations, while

vehicles which are non-operational may be so for a number of reasons, including limited staff capacity, maintenance and repairs.

In analysing the Department’s planning in terms of the number of ambulances, the APPs issued between 2012 and 2015 reflect a number of inconsistencies in the reported number of operational or rostered ambulances in the 2009/10 and 2010/11 financial years. In this respect, the 2012/13 APP indicates that the Provincial Department had 0.04 and 0.23 rostered ambulances per 10,000 persons (approximately 26 in 2009/10 and 151 in 2010/11). The 2013/14 APP on the other hand reports that the provincial department had 0.25 and 0.26 rostered ambulances per 10,000 persons (approximately 164 and 171 ambulances) rostered for the same years. The latter number is also reflected in the 2014/15 APP. In this respect, the numbers indicated in the 2013/14 APP will be taken as being correct, and it is therefore assumed that the ECDoH had a total number of 164 rostered ambulances in 2009, and 171 in 2010.

The number of rostered ambulances was increased slightly in 2011/12 with 0.27 rostered ambulances per 10 000 persons (or 178 ambulances)¹³⁹ and this number remained consistent in the following year according to the 2014/15 APP.¹⁴⁰ However, it must be noted that the 2013/14 APP indicates a slightly different ratio at 0.26 rostered ambulances per 10 000 persons (171 ambulances). In this instance the number of rostered ambulances as recorded in the 2014/15 planning documents will be taken to be correct.

The exact number of rostered ambulances in 2013 is unclear. The 2014/15 APP reflects an estimate that 0.28 ambulances per 10 000 people were rostered, however, this indicator has been removed from the 2015/16 APP and it is thus not possible to confirm the audited performance in this year. From the total 416 vehicles in the possession of the ECDoH, 0.34 ambulances per 10 000 (223 ambulances) were rostered in August 2014, however, only 180 were rostered at the time of the Hearing. Reasons provided for the low number of rostered ambulances include the fact that 157 ambulances were non-compliant with regulations and were in the process of being replaced, while a low number of staff further contributed to the shortage of rostered ambulances. The total number of ambulances as well as the number of rostered ambulances per district as at March 2015 can be seen on table 12 below.

TABLE 12: NUMBER OF AMBULANCES PER DISTRICT V POPULATION

District	Population	Required number of ambulances as per national standard	Total number of ambulances	Rostered ambulances	% of required number rostered
Alfred Nzo	801,344	80	70	24	30%
Amathole	892,637	89	45	22	25%
Buffalo City Metro	755,200	76	32	18	24%
Cacadu	450,584	45	53	31	69%

¹³⁹ 2013/14 APP

¹⁴⁰ 2014/15 Operational Plan and 2014/15 APP

Chris Hani	795,461	76	66	27	36%
Joe Gqabi	349,768	35	35	18	51%
NMMM	1,152,115	115	40	12	10%
OR Tambo	1,364,943	136	75	28	21%
TOTAL	6,562,048	656	416	180	27%

A later submission made to the Commission in April 2015 has revealed that a total number of 200 vehicles are now operational, as indicated in Table 13 below. The number of rostered PPT ambulances was not provided to the Commission. It must be noted that despite the fact that the ECDoH converted 70 vehicles to be dedicated IFT ambulances (the delivery of which had been confirmed as at 23 April 2015), only 3 were operational at the time of drafting this report. As indicated by the table below, only 48% of the total ambulances available were rostered at the time of drafting this report (accounting for only 30% of the target).

TABLE 13: NUMBER OF AMBULANCES ROSTERED/OPERATIONAL AT 23 APRIL 2015

Type of Ambulance	Number of Rostered
Pre-Hospital Ambulance	153 (19 of which are 4x4)
Inter-Facility Transfer Ambulance	3
MOU Ambulance	44
TOTAL	200 (inclusive of 4x4)

5.1.1.4 *Target number of ambulances*

The APPs issued in 2012, 2013, 2014, and 2015 were analysed in order to identify the targets for the number of ambulances. The 2013/14 APP shows an overall decrease in the targets for the next 3 years when compared to the APP in the previous year. In terms of the targets set in the 2013/14 APP, the target number of ambulances is estimated to increase slightly for the year 2014/15 from 0.28 ambulances per 10,000 persons to 0.30, but then was expected to decrease again to 0.29 for the year 2015/16.

The 2014/15 APP reports new targets with a significant increase between 2014/15 to 2015/16 from 0.50 to 0.85 ambulances per 10,000 people and the Operational Plan for 2014/15 is consistent with the target of 0.50 ambulances per 10 000 people for the year 2014/15. The 2014/15 APP further indicates that no increase is anticipated for the 2016/17 financial year with the target remaining at 0.85 ambulances (which is approximately 555 ambulances in total).

The latest APP for 2015/16 does not provide an indication on number of ambulances, and although the ECDoH has repeated its commitment to increasing the number of ambulances in anticipation of the National Standard, the target rate at which the Provincial Department aims to reach the target in terms of the National Standard cannot be established. The ECDoH indicated that, whilst the Department may not necessarily increase the size

of the fleet as a result of limited resources, it intends to ensure that the full current fleet of 416 vehicles becomes operational.

The variation of targets is indicated on table 14 below.

TABLE 14: ECDoH EMS AMBULANCE COVERAGE: TARGETS 2012 – 2016 (per 10,000 persons)

APP	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
2012/13	0.36	0.44	0.50			
2013/14		0.28	0.30	0.29		
2014/15			0.50	0.85	0.85	
2015/16				No target indicated	No target indicated	No target indicated

The Provincial Treasury Estimates of Provincial Revenue and Expenditure provide for service delivery measures, which include targets for operational ambulances. The targets indicated in the Provincial Treasury Estimates differ substantially from those contained in the various planning documents of the ECDoH and did not indicate a projected increase in the target number of operational ambulances between 2013/14 and 2016/17, as indicated in table 15 below. As with the ECDoH planning documents, this indicator has been removed for 2015/16.

TABLE 15: PROVINCIAL TREASURY EMS AMBULANCE COVERAGE: TARGETS 2012 - 2016

Provincial Treasury Estimates	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
2012/13	100 ambulances	100 ambulances	100 ambulances			
2013/14		0.36	0.36	0.36		
2014/15			0.36	0.36	0.36	
2015/16				No target indicated	No target indicated	No target indicated

5.1.2 Equipment of Ambulances

The ECDoH advised the Commission that the minimum standards for the equipment of ambulances are taken from the HPCSA guidelines, and the minimum standards have been further set out in Annexure B of the Draft Regulations referred to earlier in the report. Due to the extensive list, the full requirements will not be listed.

Numerous members of local communities shared their experiences with the Commission through both written¹⁴¹ as well as oral submissions, which experiences illustrated the frequent occurrence of poorly equipped ambulances in responding to emergency medical situations. Communities shared accounts of instances where an ambulance would arrive, but necessary and life-saving equipment was not available in the ambulance. One community member, in describing an event where an ambulance arrived to assist a family member explained that *“the ambulance was bare inside. There was no equipment at all.”* A lack of oxygen and regulators in particular has been identified as a recurring problem.

A further statement received from a medical officer at the Canzibe Hospital reiterated the contentions raised that ambulances are frequently missing critical pieces of equipment, including instances where MOU

¹⁴¹ Written submissions were received between 13 – 20 March 2015.

ambulances have arrived without having incubators to transport small babies, and that hospitals would at times need to provide this equipment on loan to enable the patients to be transported.

The ECDoH, however, provided its assurance that all rostered ambulances comply with the minimum standards and are checked before each shift commencement.

5.1.3 Availability of Planned Patient Transport

Accessing health care is difficult even in non-emergency situations, often forcing people in need of treatment to walk several hours and catch public transport before reaching a clinic or hospital, only to find long queues and waiting times ahead. The intermittent and oftentimes unpredictable access to PPT services causes gross inconvenience to patients, financially, emotionally and physically. With long queues and waiting hours at most public health care facilities, PPT services are often scheduled to depart in the early hours of the morning, sometimes as early as 03:00 am. People hopeful of using the services in order to access treatment often arrive at the place of departure the night before. Despite the effort taken to be there, the vehicle often simply does not arrive, leaving patients stranded, resulting in appointments being missed, and ultimately, increasing the burden to return another day. The delay of treatment inevitably increases the risk of complications and bestows an even heavier burden on existing public health care services.

Although planned patient transport services form part of the ECDoH's EMS programme, many residents, Community Health Care Workers and NPOs have raised concerns that these services are unreliable and are often not available at all in certain areas.

"...hospital staff told me the bus didn't work. They advised me that I could only go for my surgery if I had money to pay for private transport. I was unemployed and did not have any income...the bus only took me to Mthatha over six weeks later. I was in horrible pain throughout the long wait." - Submission received from a resident in Lusikisiki¹⁴²

A vast number of men, women and children are reliant on social grants, and if patients are referred from one health facility to another for treatment, the frequent unavailability of these services means they often need to hire private transportation at costs ranging between R400 and R800 per one-way trip in order to access the medical services they need. The Commission received numerous statements and heard testimony from a number of residents about the hardships faced in frequently having to miss visits to hospitals and the pain and deterioration of their health as a result.

In addition to this, private transportation is often unable or unwilling to transport very ill persons or persons with disabilities, particularly those in wheelchairs. PPT ambulances that are available have even been reported to have refused to transport patients that are "too sick", and further that they refuse to allow family members to travel with the patients. Once again, this has a severe impact on persons with disabilities particularly, as they are often required to leave their wheelchairs behind and are delivered to a different facility with no one to assist them. The particular challenges facing vulnerable groups are discussed in more detail at a later stage in the report.

The lack of PPT services not only impacts on patients being able to access the treatment in arriving at the health care facility, but also impacts on the ability of them to return home. The lack of transport home taken together with the frequent unavailability of public transport in certain periods often leaves people stranded. Accounts of many of the most vulnerable persons – women, the elderly, disabled for example – were given of

¹⁴² Submission has been dated 12 March 2015.

having to sleep outside or on a chair at an outpatient facility over night with no provision for food, water, or blankets. Employees of local NPOs often provide shelter overnight for those with nowhere else to go.

5.1.4 Resource Management

The number of ambulance and staff members available to respond to emergency calls are not the only important factors in ensuring the efficiency of emergency medical services, but the management of existing resources also plays an important role, even more so when resources are already insufficient to cater for existing needs.

The unavailability and low numbers of inter-facility and planned patient transfer vehicles place an additional strain on the already critically under-resourced EMS system, resulting in a situation where pre-hospital ambulances are often not available to respond to emergency calls due to the fact that they are accommodating the PPT or IFT programmes. Access to planned patient transport services are further hindered by the fact that PPT ambulances are only able to transport persons who are able to sit in a chair and a patient with a broken leg for instance will need to hire private transportation or wait to be transported in a pre-hospital ambulance, again diverting pre-hospital ambulances away from emergency cases.

As discussed above, the Department has increased the proportion of inter-facility transport and MOU ambulances to alleviate the strain and to ensure that ambulances dedicated to providing pre-hospital care will not be delayed by inter-facility transfers. The number of PPT vehicles has, however, not been increased. In a submission made by the Public Service Accountability Monitor (PSAM), it was emphasised that the continual shortage of specialised ambulances can only lead to the collapse and unmet health targets and outcomes for the Province, and therefore whatever efforts are put in place to cater for the specialised functions can only be as good as the current efforts and planning in place as well.

In calling for an ambulance, call centre agents are often unable to advise the caller of the estimated time of arrival of the ambulance, only being able to advise that one has been dispatched. The inability of call centres to be able to communicate directly with ambulances negatively impacts on the ability of call centres to manage the allocation and utilisation of resources.

In efforts to improve the management of resources and enhance the delivery of EMS across the province, the Department has fitted all ambulances with tracking devices, which are linked to call centres to enable operators to monitor the location of all ambulances, and is further able to indicate whether the ambulance is static or in motion. However, it must be noted that this is not a new initiative launched by the ECDoH, as the 2010/11 Annual Report illustrated the fact that dispatch and tracking devices had been installed in vehicles¹⁴³ and confirmed in its revised Service Delivery Improvement Plan (SDIP)¹⁴⁴ that 100% of ambulances had been fitted with advanced tracking systems by the end of the 2011/12 financial year. This performance indicator does not appear in the latter Annual Reports. The ECDoH has also reported plans to expand this system to enable the call centre operators to communicate directly with ambulance personnel in the near future, although no timelines for this have been indicated.

A further factor hindering the effective management of resources in the EMS programme is the fact that call centre posts are currently unfunded and permanent operators cannot be appointed to perform this critical function in the system. Consequentially, in order to operate the call centres, other permanent and contract employees within the EMS department are being utilised for this purpose, and are therefore only available to perform their main functions to a limited extent. The already low numbers of employees are therefore under

¹⁴³ P 164.

¹⁴⁴ 2012/13 – 2014/15 revised.

considerable pressure to perform additional functions. Both the ECDoH as well as the Provincial Treasury are aware of this challenge and a request for additional funding has since been submitted to the Provincial Treasury.

In addition to the challenges identified during the Hearing process, the ECDoH indicated that it experiences a number of other challenges, including the receipt of a high number of hoax calls, non-emergency calls, as well as delayed treatment which may lead to complications, all placing additional and undue strain on existing ambulance services. The Department advised that in order to address this, it will be embarking on education campaigns aimed at encouraging people to seek treatment earlier on, and to only request the services of an ambulance in a medical emergency.

5.2 Analysis

5.2.1 Interpretation and application of the National Standards

In responding to concerns relating to the appropriateness of the application of the National Standards in the context of the Eastern Cape due to factors such as the peculiar and vast landscape and the location of hospitals in relation to communities, the ECDoH submitted, as indicated above, that the relevance of the current standard to the provincial context can only be measurable once the full target of ambulances and staff has been reached. While it is accepted that the number of ambulances is only one factor contributing to the effectiveness of an emergency medical service programme, an assessment taking into consideration all relevant factors including the landscape and speed at which ambulances are able to travel; distance between communities and hospitals; as well as the prevalence of indicators such as crime; poverty and disease would enable the Department to determine the potential efficiency of the programme if it were operating at full capacity.

The context in which the National Standards are applied may have a significant impact on the extent to which the efficient delivery of emergency medical services can be achieved and it is not clear whether the context is currently taken into account in applying National Standards. Factors including, but not limited to the geographical size of a province; level of development; distance between ambulance bases and communities; economic situations (including the proportion of the population that has access to private health care); and the availability of public or other transportation are important in determining the appropriateness of the National Standard in specific provincial contexts.

Whilst a National Standard is applied for implementation by various provinces, the efficiency of EMS programmes across provinces will inevitably vary due to the vast number of influential factors, and as a result, a "one-size fits all" approach to the provision of EMS poses particular risk by potentially creating a service delivery model that is not appropriate for the context in which it is being applied.

Further, the manner in which the National Standard is interpreted is crucial in analysing the appropriateness of the application of the Standard in the context of a particular province and in further measuring the performance of provincial departments.

As mentioned previously, a copy of the National Standards has not been provided to the Commission and as a result, reference of the exact terms cannot be made in this analysis. In considering the submissions received by the ECDoH together with the various Departmental planning documents, it would appear that two different interpretations of the National Standards have been used. In acknowledging the fact that 656 ambulances are required in line with the National Standards, the ECDoH submitted that the current number stands at 416 (0.63 to every 10,000 persons), and that in line with the 2014/15 APP the ECDoH aims to acquire a total of 555 (0.85

per 10,000 persons) ambulances by the end of the 2015/16 financial year. However, in analysing the APPs, the target refers to “operational ambulance coverage” per 10,000 persons in the population, and not to the total number of ambulances. In noting that, as at April 2014, a total of 200 ambulances were operational, the current performance of the ECDoH is actually 0.30 per 10,000 people, and not 0.63 as submitted.

As the Commission is not in a position to consider the wording of the National Standards in order to determine the correct interpretation, an inference has been drawn that the Standard of 1 ambulance per 10,000 people is intended to refer to the number of operational ambulances, and not to the overall fleet size. If the latter interpretation were to be applied, there would be no way to determine the adequate ratio of operational vehicles, and thus no adequate standard against which provincial health departments could be held accountable. The fact that the number of operational ambulances are referred to in the planning and reporting documents further informs this conclusion.

The National Standard refers to emergency vehicles only, including pre-hospital; MOU and IFT ambulances. However, no information was provided to the Commission that would indicate that the National Standard distinguishes between the 3 kinds of ambulances, and without additional clarity and specificity on the proportionate allocation of each type of ambulance required, it would be difficult to ensure a uniform approach on a national basis. Furthermore, this potential lack of clarity in the Standard may result in a situation where an unreasonable division of vehicles across the 3 emergency purposes may be applied, impacting on the overall effectiveness of the programme.

Finally, in considering the fact that PPT vehicles are not included in the National Standard of 1 ambulance for every 10,000 persons, a further gap in the current framework can be identified in that no Standard relating to the required number of PPT vehicles is available, and no guidelines for provincial departments or measures of accountability are therefore in place.

5.2.2 Analysis of targets and distribution of operational ambulances

Although the size of the ambulance fleet has been increased from 310 in 2013 to 416 in 2015, the numbers of EMS practitioners have not been proportionately increased and the number of operational ambulances has in fact been reduced during this period. While 110 of the replacement ambulances have been converted into MOU and IFT ambulances will no doubt alleviate some of the pressure placed on responding to emergency cases, without a commensurate increase in the staffing profile of the EMS programme, a large number of ambulances will remain unutilised and the communities may not see a significant impact in the immediate short term from the increase in the overall size of the fleet.

In terms of the submissions received, the operational fleet decreased from 223 in August 2014 to 180 in March 2015, a reduction of 43 vehicles over a 7-month period. Operational ambulances then increased to 200 by April 2015. Despite having converted 70 vehicles to become dedicated IFT ambulances with a view of alleviating the strain placed on pre-hospital ambulances, only 3 IFT ambulances were rostered at the time of drafting this report to serve the entire population in excess of 6 million. No reasons have been provided by the ECDoH for the low number of rostered IFT ambulances, but this number is wholly inadequate and would not be able to sufficiently alleviate the strain as intended or be able to provide a noticeable improvement in the efficiency of inter-facility transfers.

In addition to this, only 153 pre-hospital ambulances and 40 MOU ambulances were rostered in April 2015. Given the high number of home births in the province as a result of insufficient availability of transportation, continuing risks of birth defects or complications relating to home births, mother-to-child transmission of HIV/AIDS and infant mortality cannot be adequately mitigated.

No indication of the number of rostered PPT vehicles was provided by the ECDoH despite its submission that the Department had a total number of 138 PPT vehicles in its fleet and as such, an analysis on the adequacy of operationalised PPT vehicles cannot be conducted.

Wide recognition has been given by the ECDoH throughout the process of the difficulties experienced in the ability of ambulances to navigate the roads. Despite this recognition and the explicit intention of the ECDoH to acquire more ambulances with 4x4 capabilities, the number of ambulances with these capabilities has in fact decreased to 48 according to the ECDoH and 59 according to the Trading Entity, with only 19 of have been rostered. In considering the fact that around 62% of the population in the Eastern Cape reside in rural areas, priority should be placed on rostering all available 4x4 ambulances in order to mitigate the delay in responding to emergencies in these areas as much as possible.

In terms of the allocation of rostered ambulances, the ECDoH provided a breakdown per district as at March 2015, which has been reflected in table 12. While the Nelson Mandela Metropolitan Municipality hosts the second biggest population in the province, it has the smallest number of operational ambulances. Only 12 ambulances are available to serve a population in excess of 1 million – 10% of the required number. The OR Tambo district, which has the biggest population of approximately 1,3 million persons has a total number of 28 ambulances, 21% of the number required by National Standards while the highest number of operational ambulances, being 31 available in Cacadu, serves the second smallest population in the province of 450,000 persons – 69% of the required number. The overall analysis of the allocation of rostered ambulances to the various districts appears somewhat irrational and although the ECDoH has not provided an indication as to how the allocation is applied, the numbers of EMS practitioners available in the particular districts, population density, as well as the levels of infrastructure are likely to be important factors.

5.2.3 Analysis of the adequacy of resource management

The inadequacy of the number of rostered ambulances has been discussed above and is therefore not addressed in this section other than to reiterate the importance of the effective utilisation of all available resources, especially under circumstances where the existing resources are already inadequate to cater for existing needs.

The installation of tracking devices in all ambulances which have been linked to call centres will improve the resource management of ambulance services, allowing call centres to review the progress being made and enabling agents to provide callers with an estimated time of arrival.

The ability of dispatch centres to communicate directly with ambulances is a crucial component of an efficient emergency medical service as it will allow an ambulance to be re-routed according to priority situations, or to dispatch an ambulance that is already in a particular area to respond to more than one call if circumstances allow. The essential nature of this function has been recognised in the mandatory installation of such a system in terms of the Draft Regulations. The implementation of this component has the potential to contribute to a more effective management of resources within the programme and to ensure responses are prioritised according to the level of an emergency. Patients in critical condition can be responded to faster and callers can be advised of the estimated time of arrival and any potential delays in responding, while EMS practitioners can be provided with necessary assistance when the need arises.

While the ECDoH has indicated its intention to proceed with the installation of a communication system in all its ambulances, no timelines or detailed plans were provided to the Commission, nor has the project been referred to in the most recent planning documents. Consequentially the anticipated implementation of this component cannot be ascertained.

In raising additional challenges that hamper the effective utilisation of available resources, the ECDoH indicated that it receives a high number of non-emergency calls, and that communities will be advised that an ambulance should only be called in emergency situations. The ECDoH did not provide further details as to what it constitutes as a “non-emergency” situation and the Commission is not in possession of the ECDoH policy relating to the dispatching of emergency medical services.

The current legal framework does not provide a definition of this concept, but the Draft Regulations define it as being “*circumstances during which an ill or injured person or is for some other reason in mortal danger and in need of emergency care.*” The definition of an emergency medical situation provided by the Constitutional Court explained that the term relates to an event of a sudden or unexpected, but passing nature. However, in considering this interpretation, the facts that were before the Court must be borne in mind. A situation where a person suffering from a chronic or terminal illness gradually declines to the point where an individual requires medical treatment on an immediate or timely basis would not justify a denial of access to emergency medical services on the grounds that such situation was not of a sudden and passing nature and therefore does not constitute an emergency. In this regard, the submission from one community member which will be described in greater detail under the response times section of the report, indicated that the call centre refused to dispatch ambulances for terminally ill patients, noting that they are only dispatched for patients that have been injured raises concerns over the adequacy of training and the application of the policy for dispatching of ambulances by call centre agents.

Finally, the contention that the delay in seeking treatment may lead to health complications which will inevitably increase the strain placed on emergency medical services cannot be disputed. However, while the intention of the ECDoH to embark on education campaigns aimed at discouraging communities from delaying in seeking treatment is welcomed, the averment that resource management can be further enhanced through this initiative alone fails to take into account the wider impediments encountered by communities in accessing health care in general. While the value of educating communities on the importance of obtaining treatment early and regularly is important, the ECDoH must ensure that policies and programmes are considered holistically in order to ensure measures designed to address problems are appropriate and reasonable.

6. RESPONSE TIMES

6.1 Submissions

6.1.1 National targets for response times

National Standards have been set by the Department of Health for the speed at which emergency medical services are expected to respond to calls, which standards are divided between urban and rural areas.

These standards require that all critical or priority one (P 1) calls should be responded to and have an ambulance on the scene within 15 minutes of placing a call in urban areas, and within 40 minutes in rural areas, whilst all priority calls should be responded to within 60 minutes. In order to comply with these national standards, the provincial departments are required to achieve a rate of 80% of the anticipated timeframes for urban and rural set out above, and 100% of all priority calls within 60 minutes.

6.1.2 Current response times

Submissions received from the Eastern Cape Health Crisis Action Coalition (ECHCAC), along with the shared experiences of people obtained during community consultations have illustrated the frequent unavailability and unreliability of ambulances. In some instances, residents are told by call centre agents that an ambulance

cannot be dispatched because an ambulance is unavailable as it is responding to another call, is being repaired, there are no staff to drive the ambulance, the ambulance is unable to travel on the roads in rural areas, or is unavailable for another reason. In many cases, this is done without the agent conducting an assessment to determine the severity of the case (by conducting a medical triage¹⁴⁵). In other instances, however, a call centre agent reports that an ambulance has been dispatched, but frequent testimonies and submissions attest to the fact that it often arrives several hours and in extreme instances, even days later, while on other occasions it does not arrive at all. Included in these was the description of an event where an ambulance was called to respond to a critically ill child. In this instance, a call was made at around 09:00 am and call centre agents advised that the ambulance was on its way but had gone to fill up with petrol. The child passed away in the late afternoon, and the ambulance only arrived at around 14:00 the following day, 29 hours after being called. Community members explained that a response time of 10 or even 14 hours is a common occurrence and not an exceptional case.

Local communities and health care professionals have informed the Commission that they often resort to extreme measures in order to obtain the services of an ambulance, including requesting a member of the South African Police Service (SAPS) to call the call centres; calling the call centres several times at regular intervals; and in some cases even reporting the matter to the local media or contacting the District Manager directly.

In his submission to the Commission, a man from Isilatsha Village described that the call centre refused to dispatch an ambulance for his terminally ill sister on a Friday evening, giving the reason that ambulances are not available on the weekend, and further insisted that ambulances are not dispatched for terminally ill patients, only for patients that have been injured and stabbed. The caller placed calls regularly and was told the same thing repeatedly. Only after the matter was reported by a local media outlet was an ambulance dispatched on the Monday. In response to this, the ECDoH provided assurances that there is no policy that ambulances are not dispatched on weekends, and that ambulance services are in fact available 24 hours a day, 7 days a week.

The lack of trust in the system was clearly highlighted and can be illustrated by this expression received by an employee at a home for the elderly in Jansenville who stated that *"We face great difficulty in accessing ambulance services. In a true medical emergency, we cannot rely on them at all...We therefore no longer call them in most cases of a life-threatening emergency. We rather call private ambulances."*

The response times between 2008 and 2014 were assessed using the APPs of the ECDoH between 2012/13 and 2015/16. As displayed by Table 16 below, the response times reported by the Department vary considerably from year to year, reflecting a large increase in the portion of urban priority calls responded to within the timeframe in 2012/13 to 81.9%, before dropping to 41% the following year. A similar trend can be seen with rural priority calls with the highest reported response rate at 81% in 2011/12, falling to 65.5% in 2012/13 and to 56% in 2013/14. The rate of response to all priority calls within 60 minutes has reportedly gradually increased from 26.7% in 2009/10 to 72.2% in 2012/13. The 2013/14 APP reflected a drop to an estimated 70% of priority calls responded to within 60 minutes.

The current average of response times is reflected as being 47.5% of priority one calls in urban areas responded to within the 15 minutes and an overall average of 68.8% of calls responded to within 60 minutes. The actual achievement of the National Standard for rural areas was not provided to the Commission, however, the 2015/16 APP indicated an estimated 59.3% and the ECDoH advised that the average time taken to respond to priority one calls in rural areas is 57 minutes.

¹⁴⁵ "Triage" is the process of determining the priority of patients' treatments based on the severity of their condition. This rations patient treatment efficiently when resources are insufficient for all to be treated immediately.

TABLE 16: RESPONSE TIMES 2008/09 – 2014/15

Performance Indicator	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Percentage of PI calls within 15 minutes in urban areas	47.8%	66.9%	52.6%	59.44%	81.9%	41%	47.5%
Percentage of PI calls within 40 minutes in rural areas	54.7%	68.9%	68.3%	81%	65.5%	56%	59.3% (estimate)
Percentage of all PI calls within 60 minutes	76%	26.7%	34.8%	41.9%	72.2%	70% (estimate)	68.8%

The ECDoH 2012/13 Annual Report indicates that “*response times that are herein reported significantly overestimate the true response times as a result of the poor quality of data.*”⁴⁶ Therefore, as a result of potential human error in the manual recording of data as well as the functioning of the data capturing system, it is not clear to what extent the above figures reported by the department are accurate.

6.1.3 Target Response Times

The APPs of the ECDoH between 2012/13 and 2015/16 were again referred to when assessing the trend of response time targets set over the period. In the APPs, we can identify a decrease in targets set in the 2013/14 financial year, which is then followed by an increase in 2014/15. What is notable is that the 2013/2014 APP sets a target of 65% for compliance with urban and rural priority call targets, which target was not anticipated to increase in the three year period at all, whilst the target for compliance with responding to all priority calls within 60 minutes was set to increase between 2 and 3 percent over the 3 year period.

Despite having increased the size of the ambulance fleet and staff complement last year, the newest targets set in the 2015/16 APP have again been decreased substantially when compared to the previous year’s targets. The targets for responding to urban and rural priority calls are identical, with an anticipated increase of 2 percent every year, whilst the target for responding to all priority calls within 60 minutes cannot be established due to the fact that this performance indicator has been removed. The latest APP, however, reflects a new indicator referring to the inter-facility transfer rate, which it anticipates will be achieved at a 30%, 35% and 40% rate between 2015 and 2017, whilst the national target for this indicator is 70%. It is therefore not anticipated by the ECDoH that it will be in a position to comply with national targets by the year 2017, however the Department submitted that its investment in the EMS programme was increased in 2014, and that it expects to begin to see a gradual increase in the performance going forward. Please see table 17 below.

TABLE 17: TARGET RESPONSE TIMES 2012/13 – 2017/18

Performance Indicator	Annual Performance Plan	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Percentage of PI calls within	APP 2012/13	65%	67.5%	70%			

15 minutes in urban areas	APP 2013/14		65%	65%	65%		
	APP 2014/15			65%	80%	85%	
	APP 2015/16				66%	68%	70%
Percentage of PI calls within 40 minutes in rural areas	APP 2012/13	60%	65%	70%			
	APP 2013/14		65%	65%	65%		
	APP 2014/15			65%	75%	80%	
	APP 2015/16				66%	68%	70%
Percentage of all PI calls within 60 minutes	APP 2012/13	75%	75%	80%			
	APP 2013/14		55%	58%	60%		
	APP 2014/15			70%	75%	80%	
	APP 2015/16				Not indicated	Not indicated	Not indicated
EMS inter-facility transfer rate	APP 2015/16				30%	35%	40%

The figures as set out above correspond with those reflected in the 2014/15 Operational Plan, however, the targets illustrated in the revised Service Delivery Improvement Plan¹⁴⁷ are inconsistent. The first inconsistency relates to the fact that the standard for responding to priority calls in rural areas is stated as being 45 minutes (compared to the 40 minute standard in the APPs and Operational Plan), however, the ECDoH clarified that the National Standard is in fact 40 minutes, and the 45 minute standard included in the SDIP is an error. Other inconsistencies relating to the targets set have been indicated in Table 18 below.

TABLE 18: INCONSISTENT REPORTING OF TARGETS IN ECDoH PLANNING DOCUMENTS

Performance Indicator	2012/13		2013/14		2014/15	
	APP 2012/13	SDIP 2012/13-2014/15	APP 2012/13	SDIP 2012/13-2014/15	APP 2012/13	SDIP 2012/13-2014/15
Percentage of PI calls within 15 minutes in urban areas	65%	60%	67.5%	70%	70%	80%
Percentage of PI calls within 40 minutes in rural area	60%	60%	65%	70%	70%	80%

¹⁴⁷ 2012/13-2014/15.

In addition to these inconsistencies, the service delivery measures provided for in the Provincial Treasury Estimates of Provincial Revenue and Expenditure also indicate targets for response times which are inconsistent to those provided for in the ECDoH planning documents. For easy comparison, the same table as the one above has been used, with the top figures in black representing the targets set in the ECDoH APPs and Operational Plan; and the bottom figures in red representing the targets indicated in the Provincial Treasury Estimates of Provincial Revenue and Expenditure in table 19 below. The targets in the 2012 planning documents of the ECDoH and Provincial Treasury are consistent, as well as the targets set in the 2015 planning documents, with the exception of the new indicator relating to IFT rates, while the indicator for the response time of all priority one calls within 60 minutes has been removed in the Provincial Treasury Estimates.

Targets set in terms of the remaining indicators vary, and the targets set for the number of priority one calls in rural areas responded to within 40 minutes are particularly notable, with the target rates differing of between 16-30% between the two departments in 2013/14. The target rate of IFT transfers also vary significantly between the two departments.

TABLE 19: INCONSISTENCIES IN TARGET RESPONSE TIMES 2012/13 – 2017/18

Performance Indicator	Annual Performance Plan	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Percentage of PI calls within 15 minutes in urban areas	2012/13	65% 65%	67.5% 67.5%	70% 70%			
	2013/14		65% 60%	65% 60%	65% 60%		
	2014/15			65% 60%	80% 75%	85% 75%	
	2015/16				66% 66%	68% 68%	70% 70%
Percentage of PI calls within 40 minutes in rural areas	2012/13	60% 60%	65% 65%	70% 70%			
	2013/14		65% 81%	65% 81%	65% 95%		
	2014/15			65% 81%	75% 95%	80% 95%	
	2015/16				66% 66%	68% 68%	70% 70%
Percentage of all PI calls within 60 minutes	2012/13	75%	75%	80%			
	2013/14		55% 75%	58% 75%	60% 75%		
	2014/15			70% 75%	75% 75%	80% 75%	
	2015/16				Not indicated	Not indicated	Not indicated
EMS inter-facility transfer rate	2015/16				30% 70%	35% 75%	40% 80%

6.1.4 Measures implemented to improve response times

During the Hearing, the Superintendent General of the ECDoH, Dr. Thobile Mbengashe, emphasised that the Department remains committed to achieving the targets set out above for responding to calls. In addition to the plans to increase the size of the ambulance fleet (including the proportion of operational ambulances) and numbers of employees, together with the tracking of ambulances, the Department has implemented a policy through the distribution of a formal circular to all Districts in 2014 to ensure that all calls are responded to within a maximum period of 4 hours. In terms of the circular, if a call has not been responded to within 2 hours it will be escalated to the Director of Ambulance Services, and in the event that the call has still not been responded to, it will be further escalated to the Chief Director of Ambulance Services to handle the matter appropriately. The Superintendent General further committed that if the Department does not have an ambulance available to respond to a call within the 4 hour period, a private ambulance will be hired to ensure that every person receives treatment and a formal instruction on this has reportedly been communicated to all health facilities during 2014. The ECDoH advised that in terms of this communication, private ambulances may be procured to respond to an emergency after approval has been granted by the General Manager of Clinical Support and will be funded through the EMS goods and services budget allocation. In ensuring that communities are able to utilise this process, the direct telephone numbers of the District Managers in OR Tambo; Alfred Nzo; Buffalo City and Amathole were provided to members of communities and civil society organisations present at the Hearing.

In assuring the commitment of the ECDoH and in response to the desperate calls from members of local communities, the Superintendent General stated that:

"It is totally unacceptable for somebody to call for an ambulance for the whole day and the ambulance does not arrive. I can feel the pain of the communities when their loved ones were sick and needed an ambulance which was not there...nobody should not have an ambulance within four hours." – Eastern Cape Department of Health Superintendent General, Dr Thobile Mbengashe.

6.2 Analysis

6.2.1 Analysis of response times and planning

While indicators such as the number of operational ambulances or personnel in the EMS programme are important in monitoring the performance of the programme, the measurement of the response time is a crucial. An assessment of the actual performance of the Department heavily relies on the evaluation of past and current performance in respect of its ability to respond timeously, which is then needed to inform the evaluation of the effectiveness of current policies and strategies, and to develop appropriate mechanisms to address continuing challenges. The method of calculating response times is therefore vital in conducting a thorough analysis and in undertaking subsequent planning. However, the current system in place is unable to produce reliable data and an accurate evaluation of the level at which the Department is able to perform cannot therefore be undertaken.

Despite the crucial nature of response times in measuring the performance of the Department, the questionable accuracy of the data makes a proper assessment impossible. In terms of the data presented, the performance of the ECDoH is far below the anticipated National Standards and ratings vary considerably from year to year. The improvement of data capturing and information management capacities was indicated as a priority in 2012/13 as contained in the revised Service Delivery Improvement Plan, and was again reflected as a priority in the 2014/15 APP, however the planning documents and submissions do not indicate that a formal strategy has been adopted with a view of addressing this.

Apart from problems arising from the inaccurate recording of data, a number of other factors also have the potential to influence an accurate performance assessment based on response times. Although the performance indicator does not define "response time", this generally refers to the time taken from the initial dispatch of an ambulance to the time at which the ambulance arrives on the scene. The time between the receipt of the call and the actual dispatch is not included in this response time, which can potentially skew the reported data. Instances in which an ambulance cannot be dispatched at all due to resource or other constraints not related to the assessment of the situation, or the failure to answer emergency calls are also not reported. The result is that the data may not accurately reflect the true response times and the ability of the Department to respond timeously.

In attempting to conduct an analysis of the response times, the recorded figures were compared with the number of operational ambulances reported by the ECDoH in the same years in order to determine whether any correlation could be found between the two indicators. The findings illustrate that an increase in the number of operational ambulances when compared to the previous financial year did not always result in an improvement in the response times, and often shows an increase in response times. Further, large fluctuations in the response times (up or down) can be seen in instances where the number of ambulances remained constant over two financial years, or when the number of ambulances increased only minimally. As a result, no indication that the number of operational ambulances effects the response times could be determined with the current data.

Additionally, the target response times were compared with priorities identified by the ECDoH in the same years, which analysis similarly found that the two indicators are not always aligned. For example, the 2013/14 APP depicted that the increase in response times was a priority, however the target response times for the next three years did not indicate any anticipation of improvement of the response times in urban and rural areas, which target remained at 65% consistently. However, while many of the financial years under consideration did not indicate a priority to improve response times despite setting increasing targets, this increase may have been informed by the anticipated prioritisation of other factors such as a priority to increase the fleet size or staff complement. Despite the expectation of a significant increase in the size of the fleet and number of EMS practitioners to be employed in the next few years, the latest target response times set by the ECDoH reflect a small increase of 2% per year.

An assessment of the planning documents revealed inconsistencies in the target response times set for the period 2012 – 2014. In this regard the contextual analysis pointed out the discrepancies in the APPs when compared with the Service Delivery Improvement Plan. These discrepancies in the different planning documents illustrate problems in the alignment of various policies appear to exist and which ultimately have an important impact on the ability of the ECDoH to effectively deliver on its targets

Lastly, the newest indicator which aims to measure the delivery of IFT services anticipates an increase of 5% per year, which is in line with the Department's expressed intention to increase the number of IFT ambulances. However, while this may be an important indicator in assessing the ability of the Department to deliver a reliable service, it falls short of being an appropriate assessment tool due to the fact that it fails to indicate a timeframe in terms of which such services should be delivered. As a result, the transfer of a patient to a different facility weeks after the request had been placed will still be able to be recorded as having been successfully delivered, and the reliability and adequacy in terms of the period of time taken cannot therefore be measured.

6.2.2 Analysis of measures aimed at improving response times

While the Super-Intendant General of the ECDoH emphasised the implementation of the new policy in stating that the Department is committed to ensuring that all persons receive an ambulance within 4 hours, the successful compliance with this policy cannot be assessed unless an appropriate performance indicator is included in the planning and reporting documents of the Department. The potential escalation to District Managers of non-response or slow response times of emergency medical services may serve as an effective control against instances of unacceptable delay or denial of access to emergency medical care. Whilst the assurance provided by the ECDoH is admirable, its success is dependent on the extent to which communities have access to the relevant information that would allow them to utilise the measures set out in terms of the policy. Moreover, without critical allocation to redress pre-existing imbalances, it may be difficult for the ECDoH to meet the set Norms and Standards.

The decision taken to lease private ambulances when the need arises may provide much needed relief and assistance in responding to emergency situations in the short term. However, this option also has the potential to drain the already strained financial resources of the Department, and planning for the EMS system should therefore adequately take this into account and ensure that too much reliance is not placed on the procurement of private ambulance services in the longer term.

Additional measures relating to the increase of the fleet size and staff profile as well as the installation of tracking devices in ambulances have been discussed other sections and will not be repeated in this section.

7. ACCESSIBILITY

7.1 Submissions

"Phone an ambulance? My dear, phoning an ambulance doesn't even cross my mind. In my seven years at Pilani Clinic I have never ever seen an ambulance at this clinic." - Assistant nurse at Pilani clinic ¹⁴⁸

The accessibility of EMS in rural areas in particular presents significant challenges to the ECDoH as well as to the communities in need of such services. Apart from the wide majority of submissions detailing the general unreliability of ambulance services in their areas, several statements were received from people claiming to have never seen an ambulance in their areas.

"I am grateful to hear that there is something called an ambulance that the government has issued out; we have never even heard of an ambulance." - Community member, Xhora Mouth

A wide array of factors affect the accessibility to emergency medical services, including, but not limited to the state of road networks; the type of ambulances utilised in responding to emergencies; and difficulties experienced in locating areas and addresses of those in need of assistance. This portion of the report illustrates the impact of these factors on the ability of large portions of the Eastern Cape population to access emergency medical services, as well as the measures that have been identified and implemented in view of addressing these challenges.

7.1.1 State of the road network and the impact on the delivery of emergency medical services

¹⁴⁸ Treatment Action Campaign and Section27 "Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System", (2013), p 16 (as accessed at <http://www.section27.org.za/wp-content/uploads/2013/09/SECTION27-report-redacted.pdf>).

The extreme disparities between urban and rural areas in the Eastern Cape were highlighted throughout the Hearing process, and the ECDoH indicated that the state of the road network, particularly in rural areas, has a severe impact on its ability to efficiently deliver emergency medical services. As a result of the apartheid homeland legacy of the Eastern Cape, the province has the lowest per capita investment in infrastructure in the country. A submission received from the Eastern Cape Department of Roads and Public Works demonstrated the extent of difficulties being experienced in the province.

With the current constraints being placed on the national fiscus, funding allocated to the Department of Roads and Public Works from both the National and Provincial Treasury remain wholly inadequate to provide for the needs and keep up with maintenance requirements on existing road networks. All in all the total capital backlog stands at around R55.5 billion,¹⁴⁹ together with an additional maintenance backlog of around R25 billion.

The Provincial Department of Roads and Public Works estimates that it should ideally be spending an amount of R3.2 billion per year on maintenance, but that the current funding level is only around R1 billion (31% of the required funding). Although a further R3.4 billion per annum on capital infrastructure is needed, the Provincial Department of Roads and Public Works is only allocated R0.7 billion (20.5%). However, the funding shortfall is not unique to the Eastern Cape, but is a national issue. It is estimated that on average provincial road networks receive around 30% of funding required, whilst municipalities receive close to 13%.

The inability of the Provincial Department of Roads and Public Works to keep up to date with road maintenance leads to a gradual decay of road surfaces, continually pushing the cost of repair higher. The current cost to re-gravel a road, depending on varying factors, is an average of R500,000 per kilometre, and normally requires materials to be brought in from far distances, whereas the cost of upgrading a road to a class 2 surfaced road can vary between R10 million and R20 million per kilometre. Another problem identified by the Provincial Department of Roads and Public Works that causes a tremendous disruption to the daily lives of communities in the province is the high number of low-level causeways and undersized bridges and culverts, which become flooded when it rains and also need to be replaced.

The quality of roads to local clinics is also not conducive to provide adequate access to health care needs in general. The roads, which are often inaccessible to vehicles transporting medical supplies and equipment in dry conditions are made even more inaccessible during wet weather conditions as the vehicles are unable to travel through mud. Greatly needed supplies are therefore often not delivered and large numbers of people cannot obtain the medication they need and will have to travel to the nearest hospital for treatment. This trip often comes at a huge cost, not only in financial terms, but also in terms of time and health, and the elderly; sick; pregnant women and persons with disabilities find this especially difficult. The particular difficulties faced by vulnerable groups will be elaborated on further in this section.

The state of roads in the province has deteriorated significantly since 1996, when the percentage of poor and very poor surfaced provincial roads was around 10%, to what is now just under 35%, while the figure for the gravel road network serving a vast extent of the rural areas is even more alarming with close to 40% of provincial and 80% of municipal roads in a poor or very poor state. Overall, the Eastern Cape has the worst gravel road network in the country. A high percentage of road networks in the former Transkei and Ciskei areas fall under the municipal network, which municipalities often do not have the capacity to maintain. In addressing this, the Department is in a process of rationalising the road networks between municipalities and provinces, where a number of municipal roads will be taken over by the Provincial Department. This will result in an increase in the funding of the Provincial Department, and an anticipated improvement in the state of the roads network.

¹⁴⁹ This includes an estimated cost of R18 billion for over 1,000 km of gravel roads carrying high to very high traffic volumes that should ideally be immediately upgraded to surface roads.

In addition to several projects underway within the province, a Road Forum has been established in every municipality which will allow citizens to engage with the Provincial Department of Roads and Public Works, which engagements will then feed into the planning and prioritisation of the maintenance and development of roads.

The deterioration of the road network nationally is having a severe drain on the economy and on the socio-economic circumstances of people in the country; however, the historical downward trend is unlikely to manifestly change in the near future, unless the economic position of the country as a whole improves. Greater detail on the projects being undertaken by the Eastern Cape Department of Roads and Public Works in conjunction with the ECDoH will be discussed in the co-operative governance section of the report.

7.1.2 Type of ambulances

As a result of the low level of infrastructure and deteriorating conditions of existing road networks, the inability of the ECDoH to effectively deliver adequate emergency medical services to rural areas has further been consistently explained by the averment that ambulances are unable to navigate through the difficult and mountainous terrain in order to reach those in need of assistance. The resultant impact on people living in these rural communities is that a vast number of people do not receive treatment in time, or even at all as ambulances that do respond often take an exceptionally long period of time. For people who are unable to wait, or in instances where ambulances are not dispatched to the village where the sick or injured person is located, public or private transportation at personal cost is a last resort.

While private transportation may be available in the rural areas, this is not always the case. Families, friends and neighbours regularly need to assist sick or injured persons to travel to a local clinic, or main road before any form of transportation can be accessed. A number of community members shared memories on how loved-ones were carried on blankets or transported with a wheel barrow or donkey cart before they could find transport.

According to the ECDoH, the majority of ambulances in its possession are Quantum vehicles that are unable to travel into large portions of rural areas due to the bad state of the roads. In August 2014, the ECDoH advised that at the time it had a total number of 72 ambulances with 4x4 capabilities. A more recent submission received by the ECDoH on 23 April 2015, however, claimed that the Department has a total number of 48 ambulances with 4x4 capabilities, of which only 19 of these pre-hospital 4x4 ambulances were operational. However, according to a submission received from the Government Fleet Management Services Trading Entity, the number of ambulances with 4x4 capabilities leased to the ECDoH as at 31 March 2015 was 107, with an additional 43 ambulances having 4x2 capabilities. This number has been drastically reduced as indicated earlier in the report to 59 4x4 ambulances and 36 4x2 ambulances as at 30 June 2015.

In its plans to progressively increase the size of the fleet over the next few years, the ECDoH highlighted the fact that the procurement of additional 4x4 ambulances which will be more capable of navigating the rural and mountainous terrain will be prioritised, and gradually existing ambulances will be replaced with new ones that have 4x4 capabilities. In line with this, the Trading Entity has submitted that the delivery of 141 replacement ambulances with 4x4 capabilities is expected by December 2015. No further submissions were made relating to the prioritisation of the rostering of ambulances with 4x4 capabilities.

7.1.3 Challenges in Locating Communities

The ECDoH alluded to the difficulties faced in accessing communities that do not have formal addresses, resulting in the fact that ambulances often get lost en route to respond to an emergency call.

Submissions received explained how ambulances must first stop at a local police station to obtain directions, or that people are instructed by call centre agents to wait in the street until an ambulance arrives. If the sick or injured person cannot be carried to the road side, a family member, loved-one or neighbour must often wait for the ambulance and then direct them to the address where assistance is needed. The need to wait on the street for an ambulance often occurs during the evenings or early hours of the morning, and without any indication given on the estimated time the ambulance is expected to arrive, people may be left waiting for hours.

Community members have suggested that the call centre agents do not know all of the areas well due to the fact that they are located far from many villages, and are therefore unable to properly direct the ambulance. Submissions relating to the location of call centres will be discussed in more detail at a later stage.

Whilst the ECDoH admitted that the need for a person to wait in the street or at a local landmark is not an ideal solution, it attested to the fact that this is not a problem that is facing the Eastern Cape alone and that a long term solution must come from inter-departmental collaboration at a national level.

7.1.4 Accessibility of public and private transportation

As alluded to above, in the event that an ambulance is not available to transport a patient, they may be forced to rely on public or private transportation in order to receive treatment. Public transport is not always available, especially during evenings and weekends, and procuring private transportation services results in an enormous financial burden and it may be difficult to find at all. The cost of hiring a private vehicle varies, but on average can cost around R400 during the day and up to R800 after-hours to transport the person to the hospital, and the same amount to again return the person home.

In addition to the initial challenge in finding transportation, drivers of public or private vehicles are often unwilling to transport persons who are disabled, critically sick or injured for concern that the person may pass away in transit or cause damage to the vehicle.

7.1.5 Specific challenges faced by vulnerable groups

Rural communities feel the effect of an inadequate EMS system disproportionately, and vulnerable groups such as the elderly, pregnant women, persons with physical and mental disabilities and chronically ill persons face even more obstacles in accessing health care services in general. The peculiar geographical landscape of the province creates difficulties for access, which are compounded by the far distances of clinics and hospitals and the unreliability of ambulances.

The Commission received a written statement from a person detailing the difficulties she experiences in accessing treatment for her mentally-ill son who can become violent suddenly and requires immediate medical assistance when this happens. Even during periods when he is not violent, she has been denied access to an ambulance service, being told that ambulances do not transport mentally ill patients and that the South African Police Service (SAPS) must do this. In times when a member of the SAPS is unable or unwilling to assist her in transporting her son, he is unable to access medical treatment at all.

The absence of adequate patient transport facilities means that injured persons and persons with disabilities often do not undergo physiotherapy or rehabilitation therapy, which could considerably improve their conditions. The total inability to attend or difficulties in attending regular sessions may lead to a permanent impediment or further deterioration of their health which, in the long term, places additional strain on family members and fundamentally impacts on a person's self-esteem and feelings of dignity.

"My doctor recommended that I go for physiotherapy once every month. It was also recommended that disabled people in the village form a sports group, which we did. We were supposed to play netball, this

was meant to further intensify our physiotherapy sessions. I cannot attend these events or my physiotherapy sessions because I do not have money to spend on taxis or hired vehicles. I have never been to a physiotherapy session...the taxis prefer not to take me because I am in a wheelchair. They say taking me slows them down and is too much of a physical task...

If transport were available, I would be attending physiotherapy regularly and my condition would stabilise and I would have a better life."

Private vehicles frequently refuse or are unable to transport persons in wheelchairs, and community members have repeatedly stated that they are told by employees operating the ambulances that their wheelchairs cannot be transported and must be left behind. The ECDoH confirms that all its ambulances are able to transport wheelchairs, but that residents are encouraged to leave them behind in order to protect them against the potential loss at hospitals. The difficulty of this policy was made clear when members of a group for people with disabilities testified at the Hearing that patients who use wheelchairs are taken to health care facilities, that family members are not permitted to travel with them and that they are left stranded at the hospital without a wheelchair or person to assist them.

One statement described a situation where an elderly patient living at an older persons' facility suffered from gangrene in his ankle and was transported to hospital for immediate surgery, arriving at the hospital at around 17:00. Several hours later, the Manager of the home received a desperate call from the elderly patient telling of how he had been abandoned in the hallway in his wheelchair. The food that had been sent with him had been lost on the journey to the hospital along with his luggage. He was not given food or medication for his diabetes. The Manager contacted the hospital and hospital staff confirmed the patient had been checked in but did not know his whereabouts. Two days later, after searching the hospital, the man was found on a mattress on the floor and was in tears. The gangrene had spread through his leg, which had to be amputated.

In a statement submitted to the Commission, one elderly resident described the process she endures when treatment is not available at the local clinic and she has to travel to the nearest hospital as no planned patient transport is available.

"In order to get there, we take a taxi to Tafalahashe Viillage, then take a ferry to cross the river, then take a second taxi to the hospital...we received treatment at 17h00. There was no transport available to take us back home, so we slept on chairs in the outpatient department at the hospital. We had no food or blankets and we could not bathe. The next day...we took transport home. We left Zithulele Hospital at 09h00. We arrived at Tafalahashe Viillage and then waited until 20h00 for a taxi to bring us home. While we were waiting, three drunken men passed by us and said "Zifuna ntoni exi zinto ngelixesha", literally meaning "What do these things want at this time of night?" This frightened us...travelling like we have done makes us vulnerable to crime." – Anonymous, Xhora Mouth

The above statement illustrates how already long and difficult journeys are even more strenuous for elderly persons, women, children, sick and the disabled, and that these groups are particularly at risk of crime. Community representatives submitted statements explaining that people often forego medical care because of the monetary and physical cost of accessing it, which often causes their health to deteriorate and increases the dependency placed on relatives.

The ECDoH provided its assurances that it has taken note of the specific challenges faced by vulnerable groups and that it will continue to improve in terms of service delivery to these groups.

7.2 Analysis

7.2.1 Analysis of challenges hindering access and measures to address

The Commission's 2007 Report¹⁵⁰ highlighted the fact that despite the guarantee of section 27(3) that no one may be denied emergency medical treatment, the shortcomings of existing ambulance services was found to impact especially harshly on rural patients, while the apparent lack of alternative arrangements was also highlighted.¹⁵¹ An analysis of the submissions illustrates how these shortcomings are still prevalent in the Eastern Cape.

The submissions outlined in the contextual analysis above have shed light on the extreme difficulties facing both the provincial government on its ability to deliver services, and on the ability of communities to access these services. One of the main hindrances appears to be the poor state of the road network, the solution to which will take a long time. The Provincial Department of Roads and Public Works in collaboration with the ECDoH are in the process of carrying out projects to upgrade access roads to a number of health care facilities which, when completed, will have a positive impact on transportation and access to health. However, the lengthy process required to undertake these projects means that communities will not experience an immediate impact. Realistically, funding available is insufficient to meet current demands and difficult decisions need to be made in the allocation to projects. The prioritisation of roads to NHI sites and schools is reasonable given the competing demands, and decisions have been informed through the initiation of public consultation processes, which enables local communities to participate in the planning and development of their own areas.

In considering the types of vehicles used for the delivery of EMS in the province, the ECDoH admitted that while a number of ambulances did in fact have 4x4 capabilities, the majority did not and were therefore unable to travel into many hard-to-reach areas. This particular barricade impacts a large number of people with an estimated 62% of the population residing in rural areas. The impediments created by the poor state of the roads were indicated in the 2007 Report of the Commission,¹⁵² but despite the fact that the impediments created by the poor state of roads have not only recently come to light, it does not appear that the ECDoH gave sufficient attention to this factor in drafting its policies and plans, and in purchasing equipment for the delivery of emergency medical services.

In compounding this problem, although inconsistencies in the number of ambulances reported by the 3 departments have been identified, it is clear that the number of 4x4 ambulances has in fact decreased over the last year. Not only did the number of 4x4 ambulances in the possession of the ECDoH decrease, but only a small portion has been operationalised. The already limited availability of the type of vehicle required to access a large portion of the province is therefore even more strained, however, the Department did not provide reasons for the decision to roster the low number of 4x4 ambulances. Information provided by the Trading Entity has indicated that the ECDoH intends to substantially increase the portion of ambulances with 4x4 capabilities with an additional 141 replacement vehicles expected to be delivered by December 2015, which clearly reflects an intention to address the current accessibility challenges in the province. However, the extent to which the increased number of ambulances with 4x4 capabilities will impact on the ability of the Department to deliver emergency medical services will be dependent on a larger portion of these vehicles being operationalised.

¹⁵⁰ South African Human Rights Commission "Public Enquiry: Access to Health Care Services", (2007) (as accessed at <http://www.sahrc.org.za/home/21/files/Health%20Report.pdf>).

¹⁵¹ P 42.

¹⁵² P 42.

The difficulties experienced by EMS practitioners in finding the location of the sick or injured persons also appears to have been an issue which has been on the radar of numerous departments and institutions for some time. From the submissions received it does not appear that the ECDoH has a formal policy in place designed to address this particular issue and the interim solutions appear to be applied sporadically. In some instances local SAPS stations are requested by EMS practitioners to provide directions upon arrival in the area and in other instances individuals are instructed to wait on the street for the arrival of the ambulance. While these measures may provide a short term solution, neither one is appropriate. The need for ambulances to first stop at a local police station to request directions further delays the receipt of treatment in situations where time is of the essence. The expectation of individuals to wait in the street is further unreasonable and does not adequately consider the risks associated. Not only are individuals unaware of the estimated time of arrival for ambulances and often end up waiting for hours, but this exposes individuals to crime and other health risks resulting from prolonged exposure to the elements. In considering the age demographics of the province, children, women and elderly persons are more likely to be those expected to wait. Family members having to wait on the street also potentially leaves the person in need of emergency care at home, alone.

7.2.2 Analysis of specific challenges facing vulnerable groups

A number of submissions referred to the fact that patients that are transported to hospitals for emergency medical treatment or as part of planned patient transport services are delivered to facilities without being provided with any assistance. In addition to this, a loved-one is not allowed to accompany the patient in the ambulance on the way to the hospital, and patients that are unable to walk due to injury or disability are therefore often stranded. Experiences were also shared with the Panel that explained how patients in need of care were often required to wait in chairs in the waiting area due to the lack of available beds and did not receive assistance for excessively long periods of time. While the latter issue falls outside of the scope of the current investigation, the poor treatment of patients requiring medical attention is of great concern. While the severe strain placed on limited EMS resources is noted, the provision of emergency medical services should incorporate more than immediate response and transportation, but EMS personnel have a corresponding duty to ensure that the transferral of patients to hospitals is carried out in a proper manner that is conducive to the respect for the dignity and human rights of persons.

The multiple challenges in accessing emergency medical services in the province as a whole have been enumerated in the context above. In addition to the challenges experienced by all patients in need of emergency medical services, there are a number of challenges in accessing care that are faced particularly by members of vulnerable groups.

The infrequency or complete unavailability of patient transport services force people to undertake journeys across long distances and harsh landscapes to receive treatment. This reality presents difficulties in accessing health care for all persons in need, but for vulnerable groups it is often dangerous and unfeasible. Those who are physically unable to travel consequentially do not only face challenges in accessing treatment, but experience an absolute exclusion.

7.2.2.1 *Persons with disabilities*

Persons with disabilities face unique challenges in acquiring transportation, both public or privately procured transport, as well as ambulances. The ECDoH has confirmed that its policy advises persons in need of wheelchairs to leave them behind. While recognising the security concerns that have prompted the formulation of this policy, it fails to take into account the consequences that may arise. Where a wheelchair is not available

at public health care institutions, or where no one is available to assist the person upon arrival, not having one's own wheelchair can have debilitating effects on the dignity of persons who have been stranded. The security concerns faced at health care facilities cannot be resolved through the expectation of persons to forfeit the transportation of equipment necessary to ensure their mobility.

Access to emergency medical care for persons with disabilities is often severely limited and the inability to access regular medication or rehabilitation treatment has long term consequences. Persons with disabilities may also face additional impediments to health, which include difficulties in accessing water pipes or sanitation facilities in some areas. The harsh landscape often prevents their ability to travel, and at times their movement is limited to a small area around their home.

The Commission's 2007 Report demonstrated the barriers facing persons with mental disability, including the limited number of specialist institutions, which are often difficult to access due to the far distances. While this falls outside of the scope of the current investigation, the long distances to health care facilities and difficulties in accessing transport, especially in emergencies, were highlighted as additional barriers.

7.2.2.2 Women and children

Women and children are also vulnerable. A large portion of the submissions received referred to pregnancy complications or births that were conducted at home, sometimes with the assistance of Community Health Care Workers, sometimes with only family or friends to assist when an ambulance failed to arrive. Many of these situations result in the death of the mother or child, transmission of HIV/AIDS to the child, or birth defects as a result of a difficult birth. Maternal deaths are often largely preventable, which is one of the reasons the reduction of maternal mortality was identified as one of the Millennium Development Goals. Some submissions further spoke of the fact that some health facilities are not able to provide essential services such as caesarean sections due to the fact that a doctor is not always available. This gives rise to the need for women to be transferred to a different facility, which delays the receipt of treatment. The unreliable IFT service causes a further, sometimes incredibly long delay, which can have severe consequences for the health of the mother and child. The reduction of child mortality was further identified as an MDG, as well as the reduction of new infections of HIV/AIDS, and mother-to-child transmission is preventable where proper assistance is given during the birth.

7.2.2.3 Older persons

The Commission's 2007 Report found that older persons face challenges including long waiting times, client overloads, understaffed facilities, shortage of medicines, and unavailability of assistive devices. While these issues were not specifically addressed in the current investigation, waiting times, medicine shortages and understaffed facilities were identified as continuing barriers to access. The submissions illustrated the situations endured by many older persons in accessing regular treatment. With increasing life expectancy and advancing age, many will need closer monitoring of existing conditions and there is an increasing risk of debilitating complications with higher risk of death.

The shortage and recent stock outs of medication at local clinics means that patients need to travel to the nearest hospital. The long distance, difficult landscape, and long waiting times once a person arrives at the facility has a significant impact on older persons. The frequent need to wait for transport, often overnight, aggravates the situation even more and therefore the decision to access treatment under these circumstances or the decision to forego treatment both have adverse effects on the health of older persons.

7.2.2.4 *Chronic illness including HIV/AIDS*

Persons on chronic medication, too, face barriers in accessing treatment due to medicine shortages at local clinics, which necessitates the need to travel to the nearest hospital. The increased cost for transportation decreases the amount of money available for other necessities, including food. The ability to obtain an adequate amount of nutrition on a regular basis is reduced, and the health of the person declines further as a result. The declining health can reduce the lifespan of a person, give rise to complications, and further adds additional burden onto the public health care system.

Vulnerable groups therefore experience a range of additional impediments in accessing health care and the current policy conception does not appear to have given sufficient consideration to the needs of different groups, specifically vulnerable groups in society, which may give rise not only to the violation of the right to healthcare, but to the right to be treated with dignity and may lead to the inadvertent perpetuation of discrimination.

8. HUMAN RESOURCES

8.1 Submissions

8.1.1 Staffing of Ambulances

According to the ECDoH, the EMS programme works on a 4 shift system, which requires 2 staff members per vehicle per shift, and requires a total number of 10 persons per ambulance to accommodate for shift changes in accordance with National Standards. In order to comply with National Standards in relation to the current number of ambulances in the Department's possession (416), the number of staff required is 4,160. However, in aiming to comply with the standard of one ambulance for every 10,000 persons, the Department would need a staff complement of 6,560 to operate the 656 ambulances needed overall. While the Department submitted that staff allocated to PPT services are drawn from the total staff compliment, in considering that PPT vehicles have not been included in the calculation of ambulances in compliance with the National Standards, the total number of staff required would therefore exceed 6,560.

According to the Eastern Cape Department of Planning and Treasury Estimates of Provincial Revenue and Expenditure for 2013/14, the number of personnel employed within the EMS programme was not anticipated to increase with the number of staff estimated to remain at 1,819 between 2013/14 and 2015/16. The Estimates for 2014/15 provide a similar indication with numbers expected to remain at 1,824 between 2014/15 and 2016/17. In fact, in the latter Estimates, the number of staff was expected to decrease from 2,084 as at 31 March 2014 to 1,824 as at 31 March 2015.

In August 2014, the ECDoH reported that it had a total of 2,135 staff members for the 416 vehicles in its possession at the time, and that an additional 534 posts had been advertised which, when filled, would equal a total number of 2,669. Despite the intended increase in the number of employees, submissions made by the ECDoH during the Hearing in March 2015 informed that the EMS staff profile was now 2048, approximately 5 persons per ambulance which is less than the number originally in the employ of the ECDoH during the preceding year.

In addition to this, the ECDoH indicated that an additional 120 advanced and intermediate, as well as 720 basic level practitioners have been appointed which will be added, bringing the total number to 2,888. The ECDoH is currently sitting at around 69% of staff required to operate the current number of ambulances (416), and around one third of the overall target required by National Standards (excluding the number of staff required to

operate PPT vehicles). The Department submitted that the achievement of this target is a long term plan which may not be reached within a five year period and the Provincial Treasury, as discussed earlier, has provided that additional funding will continue to be made available as a gradual process until the ultimate target has been reached. Table 20 illustrates the number of personnel employed under the EMS programme as at 31 March each year according to the 2015/16 Eastern Cape Department of Planning and Treasury Estimates of Provincial Revenue and Expenditure.

TABLE 20: PERSONNEL EMPLOYED IN EMERGENCY MEDICAL SERVICES PROGRAMME AS AT 31 MARCH 2012/13 – 2017/18

	2011/12	2012/13	2013/14	2014/15	Projected		
					2015/16	2016/17	2017/18
EMS personnel	1,845	2,003	2,084	2,224	2,624	2,624	3,424

The figures above demonstrate an incremental increase in the number of EMS personnel employed between the 2011/12 and 2014/15 financial years, with an anticipated increase in 2015/16 followed by no anticipated increase in 2016/17. The projected number of staff as at 31 March 2018 illustrates an estimated increase of 800 staff members.

Apart from practitioners required to operate the ambulances and respond to emergency calls, the EMS Directorate was almost completely vacant in 2014, with only one post filled. All posts within the Directorate have since been filled to comprise a full team of 7, along with the appointment of 28 station managers and 188 shift leaders which the Department expects will strengthen the overall EMS function of the ECDoH.

As alluded to in the sections above, no dedicated staff are currently employed to operate the call centres due to the fact that no funding is available to fill the posts, and contract as well as permanent staff are used to perform this task until funding is made available. While the need to address this situation was identified as a priority in 2014/15, the posts remain vacant and the ECDoH has requested additional funds be made available from the Provincial Treasury for this purpose.

In light of allegations raised relating to the lack of legislative compliance of ambulance practitioners, specifically relating to non-compliance with registration with the HPCSA and possession of a valid Public Drivers Permit, the ECDoH submitted that measures are taken to ensure compliance with statutory requirements, and that any practitioner in violation of such requirements are removed from the system until such compliance has been resumed.

8.1.2 Competencies and training of staff

Concerns around the competencies of EMS practitioners responding to emergency calls have been raised by NPOs, health care practitioners as well as community members relating to the apparent inability to perform basic tasks as well as to the attitudes displayed towards patients.

Three basic levels of practitioners are recognised and regulated by the Health Professions Council of South Africa (HPCSA), namely Basic Ambulance Assistants (BAA) which are able to drive an ambulance and to provide basic assistance to patients; Ambulance Emergency Assistants (AEA) which are at an intermediate level and are able to provide basic treatment en-route to the hospital; and finally advanced life support practitioners able to provide assistance to critically injured persons as well as resuscitation. The latter category is divided into Critical

Care Assistant (CCA); Emergency Care Technician (ECT); National Diploma EMC; and paramedics with a Bachelors Degree EMC /HSc.

The majority of EMS practitioners employed by the ECDoH are only qualified at a basic level of life support. The Basic Ambulance Assistants course is a 5 week long course on average and equips the practitioner with knowledge on basic life support. BAA level practitioners are therefore often unable to provide adequate support to patients in a critical condition and many accounts of practitioners being unable to render assistance, or afraid to assist patients in serious cases were shared during the Hearing process.

A submission received from a doctor revealed that the perceived limited medical knowledge of ambulance responders effects the decisions to transport patients to specialised facilities, which at times can impact on the quality of healthcare received.

"...we were often concerned that patients would not survive during transit. We would therefore choose not to transport patients even though they ideally should have been treated at another facility."

In August 2014, of the 2,135 practitioners at the time 1527 were BAA's, whereas only 589¹⁵³ were qualified to provide intermediate and advanced life support. While the number of advanced level practitioners increased slightly from 38 to 47 by March 2015, the number of both basic and intermediate levels dropped, with 1502 basic level practitioners and 499 intermediate level practitioners. The additional 720 BAA level and 120 intermediate and advanced level staff were due to commence duties with the EMS Department at the time of the Hearing. The SDIP¹⁵⁴ set the target of training 108 Critical Care Assistants and 90 Emergency Care Technologists between 2012/13 and 2014/15 but the Annual Report for 2012/13 confirmed that only 17 candidates attended and successfully completed the Paramedics course in 2012, and that a further 18 would enrol for the next year.

The Eastern Cape Department of Planning and Treasury Estimates of Provincial Revenue and Expenditure for the years 2013/14 to 2015/16 provide an indication of the level of funding allocated for payments on training for the EMS programme. While the 2013/14 Estimates provide for a decrease in funding allocated when compared to the previous year's revised estimate, both the 2014/15 and 2015/16 Estimates provide for an increase. The 2015/16 Estimates in particular have allocated an increase of 4.6% for training, as indicated in table 21 below.

TABLE 21: ANTICIPATED PAYMENTS ON TRAINING IN THE EMS PROGRAMME

	2014/15	2015/16	2016/17	2017/18
Anticipated expenditure on training	1,052 (revised estimate)	1,100 (4.6% increase)	1,100	1,155

In recognition that the number of basic level practitioners far exceeds intermediate and advanced, the Department aims to up-skill at least 50% of practitioners to the level of intermediate life support, while it continues to head hunt for advanced life support paramedics and emergency care technicians. No timeframe was indicated for achieving this target, and no further information is provided in the planning documents of the ECDoH on the target of increasing the level of staff. The ECDoH indicated that a proposal would be submitted to the Provincial Treasury as part of a mid-year budget bid process whereby an adjusted allocation may be provided for the training of additional staff.

¹⁵³ 551 were qualified to provide intermediate life support, while 38 were qualified to provide advanced life support to patients during emergencies.

¹⁵⁴ 2012/13 – 2014/15

Noting that a large proportion of calls responded to by ambulance services were classified as priority three (P III) calls and not critical, two challenges were identified. Firstly, the ECDoH has engaged with the Eastern Cape Ambulance College to provide all call centre agents with a specialised course entitled "Emergency Medical Dispatchers (EMD) course", which will enable agents to prioritise calls more effectively and dispatch ambulances immediately to priority cases. The second issue highlighted from this observation is that the call centre receives a large number of calls for assistance in non-emergency cases, which increases the strain on the system. In addressing this, the ECDoH plans to hold community engagements in order to ensure that communities only call ambulances in emergencies, which engagement is anticipated to be done through radio health talks.

8.1.3 The role of Community Health Care Workers and Non-Profit Organisations

The shortage of emergency medical services, including planned patient transport, and the difficulties experienced by people in accessing basic as well as emergency health care means that both health NPOs and Community Health Care Workers play a crucial role in their communities.

Many communities are heavily reliant on NPOs, which places a significant amount of strain on both the financial and human resource burden of these NPOs with already limited resources. These NPOs are often required to finance private transportation, or to attend to sick and injured persons when no alternative treatment is immediately available. One NPO explained that although it was established to conduct projects in health and education, it essentially acts as an emergency medical and planned patient transport service. Drivers in this particular NPO spend around 4 to 5 hours each day providing transport to patients in need of treatment, and receive calls to respond to emergency medical situations almost daily. While NPOs are able to provide the much-needed transport in emergencies, staff members are not medically trained and cannot provide critical life-saving assistance if this is required.

Despite receiving only a modest stipend, Community Health Care Workers, too, regularly pay for the private transportation of patients to health care facilities from their own pockets. In addition to this, Community Health Care Workers are often faced with situations where they are expected to provide medical assistance to patients suffering from an illness, or injury, and frequently to assist in mothers giving birth despite the fact that they are not adequately trained or equipped to do this. *"Trying to assist people in need of medical care when I have no formal training is difficult and stressful, The community should not have to rely on Village Health Workers to deliver babies and should not have to use private transport to take women who are about to give birth to hospital."*

Apart from this, Community Health Care Workers raised concern over the increasing drive to regulate the profession in terms of age restrictions and formal qualifications, which would exclude many currently filling these roles, resulting in even fewer persons to supplement the current gap in emergency and general health care services.

Communities also place additional reliance on individuals with medical training, including former midwives and retired nurses. In a statement received by the Commission, one woman describes her role in providing assistance to those in need of medical assistance *"Because people know that I used to work as a nurse, they began to come to me with their medical needs...I have begun to purchase more and more medicine and supplies, I now purchase between R300 and R400 of basic supplies bi-monthly...I worry that the burden of attending to medical emergencies will increasingly fall on me."*

8.1.4 Staff attitudes and accountability

Many submissions spoke of caring and dedicated medical staff and the difficulties they experience in trying to assist patients in emergency medical situations in the absence of an EMS response. Nurses at understaffed local clinics are often forced to provide treatment they are able to and wait after hours with patients until an ambulance arrives, while they often pay for private transportation for patients from their own pockets.

However, throughout the proceedings and submissions received from a wide-range of stakeholders, issues were continuously raised on the callous and insolent attitudes displayed by some call centre agents and some EMS practitioners. Call centre agents were accused of being unsympathetic and unhelpful in attending to calls for help, and allegations were further raised that calls are often not answered or are answered but that only a radio can be heard playing in the background, leaving those in need of assistance with no other option but to search for private transportation, or turn to other community members and NPOs for help.

Disdain for welfare beneficiaries was highlighted in numerous submissions. One person from Nier Village described an incident where she called for an ambulance to respond to an emergency situation involving an elderly patient. The call centre agent reportedly asked the woman whether the person in need of assistance receives an old age grant. In responding that she does, the woman told the Panel that the reply was that "*there are many things that you are asking from the government, there are many services that you receive from the government, you can also do something for yourself and hire a car and take that person to hospital.*" In a later narrative, another woman from Xhora Mouth described a similar situation, explaining that "*this money is for food. You just break down and cry when people say such things.*"

Responding to testimony from communities relating to the lack of respect and responsiveness from call centre operators, the ECDoH has confirmed that calls will be monitored, and that any staff members found to have caused or have had the potential to cause harm to the communities are being dealt with through the instigation of appropriate disciplinary mechanisms. Attitudes and performance of staff members throughout the Department are also monitored through complaints received lodged with a 24 hour call centre on 0800 032 364.

8.2 Analysis

An adequate number of qualified health care professionals is a crucial element in the efficient functioning of a health care service. The shortage of qualified EMS personnel constitutes a significant restraint on the ability to provide an appropriate level of emergency medical care to those in need, and while many personnel have displayed poor attitudes and levels of care, others have displayed a huge amount of dedication and compassion. Large workloads overburden the current health practitioners, and a frequent lack of adequate equipment places unnecessary and significant strain on the ability of health practitioners to perform their functions, while Community Health Care Workers, NPOs and former health practitioners provide an invaluable contribution to the delivery of health care services to people in need.

8.2.1 Recruitment and retention of staff

While the number of staff required to operate the target number of ambulances is 6,560, the EMS programme presumably requires a range of other personnel to perform other tasks. It is not clear whether the figures presented above reflect only the number of personnel employed to operate ambulances, or include all staff members.

The current level of staff at an estimated 2,988 still falls short of the requirement of 4,160 needed to comply with National Standards of 10 practitioners per ambulance, and the lack of funding to fill call centre posts, currently being operated by existing practitioners, further reduces the number of practitioners available to

respond to emergency situations. The low numbers of practitioners often gives rise to the fact that ambulances can only be staffed by a single person who is required to drive the ambulance, meaning that on-going medical attention cannot be given to the patient whilst in transit. Due to the distances of many rural villages, as well as the harsh terrain, the lack of treatment can continue for an extended period of time. The eradication of "one-man crews" was identified as a priority by the ECDoH in the APPs for 2009/10 and 2010/11, whereafter no mention is made of this intention. In fact, from 2011/12 to 2013/14, none of the strategic priorities identified by the ECDoH related to human resources. Although the APP for 2014/15 clearly identifies the need to appoint more practitioners and to increase the skill sets of existing practitioners to intermediate and advanced levels as a priority, the most recent APP for 2015/16 has again removed any mention of human resource related targets.

The ECDoH consistently submitted its intention to increase the number of EMS practitioners, but the rate at which this increase is anticipated has not been indicated in submissions or in the relevant planning documents. The only submission relating to the rate of increase noted that the expansion of the EMS staffing profile is a long-term goal, which may not be achieved fully in the next 5 year period. The intention, however, is clearly indicated by the fact that the budget available for compensation of employees has increased significantly for the current financial year.

The shortage of qualified health practitioners, including EMS practitioners, is not unique to the Eastern Cape and the need to emphasise the training and recruitment of qualified staff has been highlighted by the National Department of Health and specifically identified in the National Development Plan. Unfortunately there is no immediate solution for this particular challenge as the conduction of training, especially to reach the level of advanced life support practitioner takes several years. In considering the number of EMS personnel submitted by the ECDoH, it would appear that the number of advanced practitioners did grow slightly, but that the number of intermediate practitioners decreased between August 2014 and March 2015, which could indicate problems relating to staff retention in the Department. The Commission's 2007 Report found that discrepancies between the salaries in the public and private sector contribute to low staff retention in the public sector, but also found that non-financial incentives are an important aspect of staff-retention strategies.

A study conducted in 2011 on the retention strategy of Paramedics in South Africa¹⁵⁵ found that it is not only public-private competition that impacts on the retention of skills, but also competition from international recruiters. The findings of the survey indicated that despite being passionate about their job, a large majority of paramedics who took part in the survey indicated high levels of job dissatisfaction. Factors that were found to be influential in this included concerns related to remuneration and benefits, motivation and support from management, personal development and career advancement, increased exposure to crime, long working hours, and paramedics working by themselves in ambulances. In fact the availability of further training initiatives was emphasised as a particularly important factor in encouraging retention, while improving working conditions is also an important factor.

The importance of aligning the increase of the fleet size with the corresponding increase in the staffing profile has been enumerated above. However, despite the fact that the relative increase in staff (in particular reference to the 720 new BAA employees as well as the 120 advanced and intermediate employees recently employed) this has not resulted in a significant increase in the number of operational ambulances. The further plans of the ECDoH indicated in the 2014/15 APP to increase the size of the fleet on an appreciable scale will be ineffectual in enhancing the delivery of EMS in the province if the same intent is not applied in the training and recruiting of practitioners to operate the ambulances and eliminate the prevalence of "one-man crews".

¹⁵⁵ Binks "Retention Strategy of Paramedics in South Africa" (2011), Graduate School of Business Leadership, University of South Africa (as accessed at <http://uir.unisa.ac.za/bitstream/handle/10500/4445/2011%20MBA3%20Research%20Report%20FM%20Binks%20Chapters%201%20to%204.pdf>)

Call centre posts have remained un-funded for a number of years despite the fact that resolving this issue was identified as a priority. While the ECDoH advised that a proposal for funding has been submitted, it is not clear whether any previous proposals were submitted in the past and concern can be raised around the period of time taken to permanently address this issue.

The stretched and inadequate resources of the EMS programme result in an enduring reliance placed on NPOs and Community Health Care Workers to fill the gap. While some of the issues giving rise to this reliance such as the low number of staff and pre-hospital ambulances will take time to be sufficiently addressed, other issues can be addressed to alleviate the burden placed on NPOs and Community Health Care Workers in the short to medium term. The role that NPOs play in delivering patient transport services can, for example, be replaced by ensuring that PPT vehicles are operationalised. This will be expanded on in the recommendation section of the report.

The emphasis on increasing the number of Community Health Care Workers has been made in the National Development Plan; however, the level of training received is not appropriate for the current services they are unofficially expected to provide. Assistance to pregnant mothers experiencing complications or giving birth, for example, should be dealt with at health care facilities and by appropriately qualified medical practitioners and although Community Health Care Workers should not be encouraged to perform these kinds of services, the current reality is that there is often no other option. The challenges in accessing emergency medical care are largely those which cannot be immediately resolved, and in the interim Community Health Care Workers will continue to bear an unimaginable burden of providing assistance without sufficient training or equipment.

It is not clear how much of the burden placed on the critically low-resourced public health care system is alleviated by these former mid-wives, retired nurses, Community Health Care Workers and organisations, however, given the submissions received by the Commission, their contribution to the everyday lives of people in local communities cannot be overestimated.

8.2.2 Training

The importance of acquiring highly qualified EMS personnel is illustrated in the essential role that these practitioners play in providing critical and life-saving assistance to persons in an emergency. In addition to this, a highly qualified EMS team is also able to reduce the burden placed on emergency care units at health care facilities by providing much needed care to patients at the scene of the incident, or en route to the hospital. Basic level assistants are at times unable to provide necessary treatment to persons who may not otherwise need to be transferred to hospital, placing additional strain on trauma clinics. A high level of medical knowledge also enables EMS practitioners to predetermine the destinations for patients to hospitals specialising in certain types of illness or injury, thus ensuring the patient receives the appropriate treatment while reducing the burden on inter-facility transfers.

The plans to up-skill currently employed BAA staff members to at least an intermediate level is a favourable strategy and may contribute to the recruitment and retention of staff, but timelines for the implementation of this have again not been articulated. The effectiveness and ability of this strategy to enhance the EMS system is reliant on the timeframes set by the ECDoH, as well as on the allocation of sufficient budget required to fulfil its commitment and the ECDoH has indicated that the funding will be sourced during the mid-year bidding process with the Provincial Treasury.

8.2.3 Accountability and attitudes of staff

The contemptuous attitudes seemingly often displayed towards some of the most vulnerable persons in society raised serious concerns with not only the training and accountability of staff, but also about the attitudes persistently underlying the public sector service delivery in the country. Similarly, the indifference sometimes shown towards patients and their loved ones by both EMS practitioners as well as other health care practitioners at local clinics and hospitals, again raise serious cause for concern.

The ECDoH submitted that in addressing staff performance and attitudes it has appointed call centre managers and shift leaders to monitor call centre agents to ensure that calls are answered and emergency medical support is dispatched to those in need. This measure together with the intention to record all calls have the potential to greatly assist in addressing the current problems and in ensuring accountability. The ECDoH has, however, not provided timelines for the implementation of this system and it is therefore not possible to anticipate how soon this problem will be adequately addressed.

The appointment of supervisory staff is a reasonable solution, but apart from the intention to offer additional training to call centre staff to assist in the assessment and prioritisation of emergency calls, no indication has been provided that the ECDoH intends to ensure that members of staff undergo training relating to attitudes and behaviour displayed towards patients and other community members. The existence of a complaints hotline is another measure that bears value, however, the effectiveness of this mechanism is again dependent on the extent to which people have access to information to enable them to utilise it.

9. CALL CENTRES AND DISPATCH CENTRES

9.1 Submissions

9.1.1 Location of Call Centres and Dispatch Centres

During the initial investigation, residents of the Xhora Mouth area raised concern that ambulances were kept at bases that were located far away from communities, and that ambulances were therefore unable to respond quickly when needed. Members of other neighbouring communities shared similar sentiments and called for ambulances to be decentralised and brought closer to local villages.

According to the ECDoH in a submission received by the Commission in August 2014, EMS vehicles were previously run from central Medical Emergency Transport and Rescue Organisation (METRO) bases in each district but following a decentralisation process they have since been relocated closer to communities and placed at hospitals.

However, this policy is impacted by security concerns in certain areas and the ECDoH stated that it is not always possible to run ambulances from bases located close to the communities, and in some instances ambulances are stored at other bases, which it conceded was "*counter-productive to the principle of location within the community to reduce the response times and enhance efficiency of delivery of service*". The ECDoH indicated further that plans were being made to keep ambulances at primary health care facilities once the necessary security arrangements had been made. A new EMS base has since been established at Ngcwanguba, and the "department of infrastructure" is in the process of including EMS bases, whether through renovating existing bases or building new ones, within all Departmental plans going forward.

MOU vehicles are kept at all facilities where deliveries are conducted in order to ensure an efficient and rapid transfer of mothers and babies in need of special care, while inter-facility transfer vehicles were allocated at all tertiary hospitals at the time of making the first submission in September 2013. The ECDoH further indicated that plans were under-way to expand this to all Regional and District hospitals within the province. In its

submission in April 2015, however, only 3 IFT ambulances were operational, the exact location of which were not provided.

Allegations were raised during the Hearing process that call centres, too, are located far from communities and that agents are not familiar with many of the rural villages and are therefore unable to accurately direct ambulances to the scene of an emergency. The ECDoH advised that there are 10 call centres located throughout the province, and it does not intend to further decentralise the locations. The call centres are currently located in Port Elizabeth, Mthatha, Queenstown, Cradock; Aliwal North; Mount Ayliff, Humansdorp; Grahamstown; Graaf Reinet and East London. The Department suggested that issues with ambulances getting lost en route to an emergency, which has been dealt with in more detail above, are not attributable to the location of call centres, but rather to a deeper problem of development facing the country as a whole.

9.1.2 Monitoring of calls and dispatching of ambulances

One of the key problems identified throughout the Hearing process was that calls placed through the call centre are often not answered. The ECDoH has identified that this problem occurred mainly at the East London Call Centre, and in response a new manager has been deployed to this centre to monitor staff, whilst disciplinary measures are also taken in instances where negligence has been identified.

In response to testimony received from communities relating to a lack of responsiveness and respect shown by call centre operators, the ECDoH plans to implement a system whereby all calls will be tracked and recorded in order to ensure efficiency and accountability in responding to emergencies. In addition to this, the ECDoH is awaiting approval for the installation of a system of computerised call-taking and dispatching system (CRM) to increase the efficiency of the system. This project has been identified as a priority in the Departmental Operational Plan for 2014/15 as well as the APPs for 2014/15 and 2015/16. The Department contemplates the finalisation of the CRM system to the Alfred Nzo and the Chris Hani EMS Centres by the end of the 2015/2016 financial year. No indication of the anticipated timelines for implementation of the CRM system at other centres has been indicated, nor has the timeframe for the implementation of the system to record all calls been provided.

9.2 Analysis

Despite requests from community members that call centres be relocated in vicinities closer to them, and allegations that the location of the call centres is the reason that staff members do not know the areas well and are unable to direct ambulances appropriately, the ECDoH has expressed that there is no intention of decentralising the 10 call centres spread throughout the province. The location of the call centres themselves will not impact on the ability of the ECDoH to deliver emergency medical services and the difficulty in directing ambulances can be addressed through other mechanisms, as will be discussed in the recommendations section.

The installation of a computerised call-taking and dispatch system ("CRM") has been emphasised by the ECDoH as an important measure designed to increase the efficiency of the system, and will further ensure that all calls are answered and responded to. The installation of this system in Chris Hani and Alfred Nzo has been indicated as a priority for a number of years, but no reasons have been provided by the ECDoH on the delay of completing the project. The planning documents of the ECDoH have also not indicated the expected timeline for the installation of the system across all call centres and as a result this system may not be implemented at all centres in the near future.

10. CO-OPERATIVE GOVERNANCE

10.1 Submissions

10.1.1 Inter-departmental programmes aimed at improving access to medical services

Noting the impact of numerous factors on the delivery health care, including the poor state of roads and the location, accessibility and equipment of local clinics, the ECDoH has advised that going forward it intends to work closely with other departments to ensure that all factors are considered and addressed collectively.

According to the Provincial Treasury, in order to ensure synergy and effective service delivery, it is imperative to ensure inter-sphere as well as inter-sector collaboration and cooperation, but that while this approach has been stressed in various forums with departments, very little has been achieved in this area. Moreover, the Provincial Treasury advised that a resolution has been taken at the recent infrastructure MTEC hearings with departments that all departments need to use a "zero gate" concept in their infrastructure delivery and also make use of Geographic Information Systems (GIS) as a means of enhancing cooperation and synergy in service delivery.

Several programmes have been implemented by the Provincial Department of Roads and Public Works which will have a positive impact on the delivery of healthcare services in the province. Firstly, the Roads-to-Hospitals Programme was established several years ago and aims to build all-weather surface roads to every rural hospital with 100 or more beds. The project, which has been prioritised in the province, has seen the completion of Phase 1 of Siphethu and Mlamli Hospitals, with work on Siphethu, Isilimela and Canzibe Hospital roads underway. The Department is also busy working on the roads to Madwaleni Hospital, as well as on the upgrade of the road connecting Coffee Bay to Zithulele Hospital.

A major 3 year Rural Roads Intervention Plan is due to commence shortly, which aims to tackle high priority projects and to increase the technical capacity of the Municipal and Provincial Departments of Roads and Public Works. A number of roads have been identified through a number of stakeholder engagements, with priorities being given to roads leading to National Health Insurance ("NHI") sites and scholar transport roads. Thereafter, roads to emerging farms and tourist attractions will be developed.

With respect to the timelines of the projects, the process is a lengthy one with each phase (approximately consisting of between 10 to 15 kilometres of road) typically taking between two to three years to complete.

10.1.2 Monitoring and Evaluation

In order to ensure that resources are used efficiently, an expenditure evaluation procedure takes place where Provincial Treasury officials conduct on-site visits and calculates whether the expenditure provided a value-for money result. This means that, for example, when a tender is awarded for the construction of clinics, officials from the Provincial Treasury will visit the site along with officials from the ECDoH to evaluate whether value has been received. Thereafter a report is drawn up and submitted to the Executive Council, which may hold specific departments or individuals accountable for instances of, amongst others, wasteful expenditure and incompleteness of the project according to timeframes established.

In addition to this, the Provincial Treasury Estimates of Provincial Revenue and Expenditure provide for service delivery measures for each programme within a department. While the service delivery measures of the Provincial Treasury generally correspond with the performance indicators identified by the ECDoH, the Provincial Treasury has included a number of additional measures not included in the planning and reporting documents of the ECDoH which have changed between 2011/12 and 2015/16 including the number of operational PPT

ambulances; the target number of Maternal Obstetric Units; and the percentage of calls from obstetric services responded to in urban areas within 30 minutes and in rural areas within 60 minutes.

Although the Provincial Treasury undertakes a review of the first and second draft of the APP of the ECDoH and provides comments on anomalies identified, these are not always rectified before the APP goes to print the final APP. Going forward, the Provincial Treasury has undertaken to cooperate with OTP in ensuring that performance indicators are not only consistent and smart but also reliable and reasonable to the strategic imperatives of the Department. It has further been decided that where indicators are contested, the Accountant-General and the Department of Performance Monitoring and Evaluation (DPME) should be invited to provide clarity and guidance. The Provincial Treasury further expects that the rigorous implementation of these measures will assist to address the inconsistencies in the performance indicators of the health sector.

10.2 Analysis

Many issues cannot be dealt with in isolation and require inter-departmental cooperation to identify and implement appropriate solutions. The ECDoH has collaborated with other departments in addressing the challenges enumerated in this report, including the Eastern Cape Provincial Treasury, the Eastern Cape Department of Roads and Public Works and the Department of Transport through the Provincial Government Fleet Management Service Trading Entity.

Both the provincial departments of Roads and Public Works and Treasury have expressed their commitment to continue to work closely with the ECDoH to enhance the delivery of EMS in the province. Through this collaboration, the Provincial Treasury has ensured that additional funds have been, and will continue to be made available to the EMS programme.

However, discrepancies identified in the number of ambulances which have been procured for the ECDoH as well as the performance indicators identified between submissions by the ECDoH and the Provincial Treasury may suggest that information sharing between the various departments is currently inadequate. Additionally, the monitoring and evaluation procedures undertaken by the Provincial Treasury has the potential to ensure the reasonable and accountable expenditure of allocated resources, but this potential is dependent on the measures taken by the Exco in holding individuals and departments accountable when necessary. The extent to which expenditure is monitored is not clear, and there was no indication of whether an evaluation of specific purchases in relation to capital assets (ie equipment and ambulances) in the EMS programme are undertaken in order to ensure that purchases are appropriate and in line with priorities.

11. SOCIAL IMPACT

11.1 Socio-economic context of the Eastern Cape

According to research done by the Eastern Cape Department of Social Development ("Provincial DSD")¹⁵⁶ *"The health profile of the province follows a pattern of poverty that is rooted in historical socioeconomic deprivation...a predominance of diseases of poverty, and major inequalities amongst sub-sections of the population, remain major challenges in the health profile of the province."*¹⁵⁷

¹⁵⁶ Research and Population Unit: Eastern Cape Department of Social Development "The People Matter: The State of the Population in the Eastern Cape", (2010) as accessed at <http://www.hsrc.ac.za/uploads/pageContent/558/ECapefullreport.pdf>.

¹⁵⁷ *Ibid* at p 110.

In addition to the high level of poverty in the Eastern Cape, the province also experiences a high rate of “outmigration” as a result of the economic vulnerabilities of the province, with large numbers of individuals of working ages leaving the province in search of employment opportunities elsewhere. The Provincial DSD further confirms that because of the migratory patterns, the Eastern Cape has one of the largest dependency burdens, carrying a larger proportion of children and older persons than individuals of working age.¹⁵⁸

The social welfare system is designed to assist the poor, vulnerable and marginalised persons in society, aiming to combat the high levels of poverty and inequality in the country. In the context of the Eastern Cape, around 58.5% of all households receive at least one grant, while 40.3% of individuals were grant beneficiaries in 2013¹⁵⁹ making the Eastern Cape the widest recipient of social assistance in the country.¹⁶⁰ Apart from the number of individuals receiving grants, Statistics SA found that 37.4% of households were reliant on grants as the main or only source of income.¹⁶¹

11.2 Submissions

11.2.1 Impact of the lack of emergency medical services on the eradication of poverty and inequality

While mention has been made in earlier sections of the report of the reliance placed on private transportation in accessing treatment due to the inaccessibility of adequate emergency medical services provided by the state, it is crucial to take cognisance of the social impact of this.

11.2.1.1 Impact on the overall health and well-being of persons

The shortage of emergency medical services, including planned patient transport, has an appreciable impact on the overall health and well-being of people in the province. In submitting a written statement to the Commission, an Occupational Therapist from Zithulele Hospital described the impact on people suffering from epilepsy, cerebral palsy, and strokes.

While disorders such as epilepsy can be effectively treated, uncontrolled or prolonged seizures can cause permanent neurological damage and children are at particular risk. In the event that no emergency service is available, a person suffering from an epileptic fit will often be left until the seizure has ended as family and community members are unable to move them to find private transportation. This, in turn, can have severely debilitating effects for the person.

The statement goes on to explain that cerebral palsy, which is often brought on by labour delays and complications; head trauma; and uncontrolled epilepsy, is a common condition seen amongst children in the province. Although this condition is often preventable, it leaves a person completely dependent on his or her caregiver for the remainder of their life. While caring for a young child is easier, the difficulties in caring for a person increases with age. The inability to carry an individual to a place where public or private transport can

¹⁵⁸ Department of Economic, Development and Environmental Affairs “Eastern Cape Socio-Economic Review and Outlook” (2013), p 150 (as accessed at <http://www.dedea.gov.za/research/Research/Eastern%20Cape%20Socio-Economic%20Review%20and%20Outlook%202013.pdf>).

¹⁵⁹ Statistics South Africa “General Household Survey” (2013), p 31 (as accessed at <http://www.statssa.gov.za/publications/P0318/P03182013.pdf>).

¹⁶⁰ M. Hamann and V. Tuinder “Introducing the Eastern Cape: A quick guide to its history, diversity and future challenges”, (2012), Stockholm Resilience Centre (SRC), p 28 (as accessed at <http://www.sapecs.org/wp-content/uploads/2013/11/Eastern-Cape-Background-Report.pdf>).

¹⁶¹ Statistics South Africa “General Household Survey” (2013), p 56 (as accessed at <http://www.statssa.gov.za/publications/P0318/P03182013.pdf>).

be accessed, and the lack of services provided by the ECDoH results in the fact that a patient will no longer be able to receive medical and therapeutic treatment at all.

A submission received from an anonymous medical officer further stressed the impact of the unavailability and delay of patient transport as contributing to the high rate of perinatal death in the province and the fact that a large number of babies are born with disabilities as a result of birth complications, which disabilities they allege could be prevented if emergency medical services were more frequently available. The delayed response to calls to assist mothers in labour may also negatively impact on the aim to reduce the rate of mother-to-child transmission with persons infected HIV and AIDS.

11.2.1.2 Economic impact

The cost to privately transport a loved one to a health care facility in the event of an emergency can vary greatly depending on a number of factors, including the distance to the nearest hospital and time at which the need arises. While trips during the day may already cost as much as R400 per one way trip, this is inflated to an amount ranging between R600 and R800 at night, an expense that is simply not affordable to many.

The out of pocket expenditure on transportation in medical emergencies, or in otherwise accessing health care in general has severe implications for low-income households. An expert opinion submitted by Dr Jane Goudge indicated that the direct cost burden of out of pocket expenditure is considered to place a "catastrophic burden" on households spending 10% of more on healthcare. As a result of often unanticipated expenditure on private transportation, other necessities including food, clothing and education suffer directly as a result, with many families having to incur additional debt.

In a statement submitted by members of the Xhora Mouth community, the adverse effects of the cost of private transport in emergency situations was described as follows:

"In short, our health emergencies are financially devastating. They drive us deeper into poverty and make it even harder for us to climb out. We face not only the health issue requiring the emergency care, but also the hunger and debt that accompanies a medical emergency. The financial consequences cripple families and indeed whole communities."

Submissions received by communities attested to the fact that the time, physical effort and financial cost make the trip difficult, especially for the sick, elderly, disabled, children and pregnant women, as well as impoverished families that cannot afford the costs associated with treatment. These circumstances give rise to the simple reality that many people forego treatment as a result. In a written statement received by the Commission, one woman describes the difficulties she faces in receiving regular treatment for her epilepsy:

"Depending on the state of my health, I have to go to the hospital on average twice a month. A lot of the times I become so sick that I am unable to go to the hospital on public or even hired transportation and as a consequence I do not go to hospital...Both my husband and I are unemployed and our disability grants are our only source of income...these costs are therefore terrible for me. I have to borrow money to cover them and sacrifice on other essential items such as food. When I borrow, my only option is loan sharks...The lack of ambulance services in my area places my health and life in danger and has pushed me into debt and deeper poverty."

Another submission from an elderly woman suffering from chronic arthritis further depicts the struggle to obtain treatment with the lack of transportation:

"I regularly skip visits to the hospital because of my arthritis. However, I am in even greater pain when I do not have medication. This pain renders me unable to do anything in the house...We do not have a

clinic nearby and there is no patient transport available in the area. As a result, I cannot take my medication regularly. Therefore, my health is deteriorating and my home is a place of agony and strife. As my health becomes worse, I am increasingly at risk of being in need of emergency medical treatment. If this happens, the financial burden will be crushing."

The expert submission further examined numerous statements received by communities, and established that in a large number of cases, individuals were spending an average of 40 – 50% of the monthly income in order to access treatment. While in some cases this expenditure was not anticipated and only occurred once, for numerous individuals with recurring difficulties, this situation can arise several times a year. In conclusion, Dr Goudge submitted that out of pocket expenditure at such catastrophic level "*perpetuates and exacerbates chronic poverty, leads to increased morbidity and death as well as undermines the intended effects of the provision of free public health care services to poor people...*"

11.3 Analysis

The adverse health impacts enumerated earlier in the report illustrate that an inaccessible or unreliable emergency medical service has both immediate implications for the health of a person, but can also have permanent and long term consequences. An emergency medical situation requires an immediate or timely response, the failure of which can result in permanent damage, including mental and physical disabilities or impairments, the on-going pain and suffering of a person, and often the eventual loss of life. In many instances calling for emergency medical attention, these effects are manageable, if not completely preventable.

Further impacts on the overall general health and well-being of persons is apparent in the fact that difficulties in obtaining regular treatment from health care facilities frequently leads to the intermittent receipt, or to the discontinuation treatment altogether. The impact of limited or impeded access to treatment, including emergency medical treatment, further impacts on the ability of a person to work and to learn, to travel freely and has a substantial impact on quality of life. The right to human dignity, which is at the heart of the constitutional dispensation, is severely impacted by the continued restraints to medical care experienced on a daily basis.

"Over the years, I have witnessed many people die as a result of the unavailability of ambulances. It's as if we are second-class citizens who are unworthy of government's protection and respect." – Community member, Xhora mouth

As described above, over half of the households in the Eastern Cape receive at least one social grant, while around 37.4% are reliant on the grant received as the main or only source of income needed to survive. The financial burden imposed on families with no choice but to resort to the hiring private transportation can have a devastating impact on the socio-economic welfare of persons. In situations where financial stability is already distressing, these expenses often exceed half of the monthly household income. Other essentials including food, clothing and even schooling are sacrificed, and money for transportation to enable a person to travel to and from work may become insufficient. The occurrence of an event requiring emergency medical services can therefore have long-term consequences that far exceed the immediate provision of treatment.

The socio-economic implications are felt even more harshly by persons requiring ongoing medical treatment, including disabled, chronically ill persons and the elderly. When treatment or medication is not available at a local clinic, the ongoing necessity to fund private transportation on a regular basis is financially and often emotionally insurmountable. In some instances, even local clinics are located far from communities and require exceptional time and cost to access. Persons in these categories often require additional nutrition which is likely to become unaffordable, resulting in a continuous decline of health.

Desperate circumstances lead to the acquisition of unaffordable loans, usually from loan sharks in which the interest rates are exceptionally high. The repayment of these loans in turn continues to reduce the monthly income of families and the unintended and often unapparent consequence is that the social welfare system which is designed to uplift people out of poverty is ineffectual and the cycle of poverty therefore continues unabated.

As a result, the challenges experienced in accessing emergency medical care and the adequate provision of transport in circumstances provided for under the EMS programme not only has a grave impact on the immediate health of patients, but gives rise to a number of far reaching socio-economic consequences, including the endurance of poverty and inequality and the deterioration of health.

12. CHALLENGES AND GAPS IDENTIFIED IN LEGISLATION, POLICIES AND PRACTICE

12.1 Gaps identified in the current legal and policy framework

The Commission's 2007 Report found that there was a lack of clarity on what the constitutional and legislative guarantee that no one may be denied access to emergency medical services meant in the context of people being denied access to basic health care. The Report went on to state that "*Unless there are transparent policies to guide services that will and will not be provided, unequal distribution, consisting of a perverse form of rationing and an unequal access to and fulfilment of human rights will result by default, or by omission...*"¹⁶²

This lack of clarity remains in the current situation today and the implementation of EMS policies and practices in their current form has undeniably resulted in the provision of unequal access to both emergency medical services as well as basic health care.

Apart from the National Health Act, which obliges provincial governments to provide emergency medical services, there is no national legal framework currently in operation that regulates the provision of such services, although the Draft Regulations on Emergency Medical Services were established to fulfil this function. The Draft Regulations attempt to regulate both private as well as public emergency medical services and provides for the minimum number of EMS personnel required to staff medical rescue and medical response vehicles, while it also provides for the level of training these personnel are required to have. The equipment and features of ambulances are further prescribed, including emergency lights, sirens and a communication system to allow personnel to communicate with dispatch centres, the latter feature being one that is currently not available in the ambulances of the ECDoH. The number of ambulances required is not regulated as this is done in accordance with the National Standards, as are the target response times.

The National Health Act obliges public health establishments to transfer patients to other health facilities where they are unable to provide the necessary treatments, confirming the obligation to provide an inter-facility and planned patient transportation service. However, the existing legal framework, including provincial and national policy does not attempt to regulate the provision of these services, although they form part of the EMS programme of the provincial Department of Health. The scope of obligations in the planned patient transport function in particular is therefore not clear.

As already discussed in more detail earlier in the report, the current conception of the National Standards lack sufficient clarity in a number of respects, including whether the prescribed number of ambulances refers to fleet size or operational ambulances; whether the Standards distinguish between the 3 types of ambulances and provides guidelines for the proportion of each to be determined by the provincial department; and finally

¹⁶² P 56.

whether the number of PPT ambulances is prescribed in terms of the National Standards. Without clarity in these respects, the Standard cannot adequately hold provinces to account, while the apportionment of ambulances to the various emergency functions is left to the discretion of the province which may result in an inequitable division.

This clarification is crucial given the wide ranging effect differential interpretations can have on the ability to deliver, as well as on the adequate planning undertaken by a provincial department in aiming to comply with the National Standards.

12.2 Challenges relating to information management, planning and policy development

A number of challenges have been identified in the fields of information management as well as planning and policy development. The inaccuracies resulting from the manual recording of data of response times makes it impossible for the Department to conduct a proper analysis on its level of performance, which in turn will render the establishment of new targets for the proceeding years arbitrary. The development of other policies is likely to be impacted as well, as the Department will be unable to determine whether the current strategies from a holistic perspective are effective in raising the level of delivery.

In analysing the submissions and planning documents of the ECDoH it appears that no formal strategies have been identified to address the challenges in information management, which is a crucial tool in the ability of the Department to design appropriate strategies.

The second gap that can be identified in this regard is the apparent lack of cohesion applied in the policy and planning process. As elaborated upon in the preceding sections of this report, a comparison between the various planning documents highlighted a number of inconsistent or contradictory targets and priorities.

12.3 Lack of a human rights and gender-based approach to policy development

The adoption of a human-rights and gender based approach to policy development and implementation is an important tool. This approach takes a holistic stance by considering the contents of human rights, with special attention placed on the rights and needs of vulnerable groups, while additional emphasis is placed in ensuring that services are accessible to all. The Constitutional Court in *Government of the Republic of South Africa v Grootboom* defined the obligation placed on organs of state in designing and implementing policies. A policy that is reasonable in theory alone is not sufficient to discharge this obligation, and it must endeavour to ensure that the implementation of the policy is able to respond to the particular groups or segments in society whose needs are most desperate and most in peril.¹⁶³ The right to dignity is central in the consideration of the reasonableness of measures taken to promote the achievement of rights.

General Comment 14 of the CESCR¹⁶⁴ explained that factors necessary for the promotion of the right to health care in general include availability, accessibility, acceptability and quality. As elaborated on in the legal framework, accessibility includes the principle of non-discrimination, physical as well as economic accessibility, and explains that in fulfilling this right, States are required to take measures to ensure that health services are available and accessible to all, especially vulnerable groups, and further encourages the adoption of a gender perspective into the development of health policies, plans and programmes.

¹⁶³ Para 44.

¹⁶⁴ E/C.12/2000/4

The distinction between policy design and implementation must also be noted. While a policy, on the face of it, may appear to be adequate and non-discriminatory, the manner in which a policy is implemented can have far-reaching and often unintended consequences. However, this does not mean that design and implementation should be perceived as being two separate aspects, but rather should be viewed comprehensively and the consideration of the manner in which a policy is to be implemented during the design process is therefore important in order to identify practical constraints, highlight unintended consequences, and assess sustainability amongst other things. Additional consideration should also be given to the integration between policy sectors or government departments, as well as the appropriate correlations between different policies within the same department.

Although the policy in delivering emergency medical services and patient transport does not overtly discriminate, these services are not always accessible. Persons residing in rural areas and vulnerable groups specifically face a number of impediments in accessing this service in both physical as well as financial terms. The adoption of a human rights and gender-based approach would enable the ECDoH to take cognisance of the various challenges impacting on different groups in order to develop appropriate measures to accommodate these challenges, and can facilitate the construction of policies that incorporate a holistic perspective to development and service delivery.

12.4 Insufficient community engagement

The National Health Act requires provincial governments to consult with communities regarding health matters and to further promote community participation in the planning, provision and evaluation of health services. Similarly, the Eastern Cape Province Health Act reiterates the right of communities to participate in the development and implementation of health policies and practices, and the ECDoH is explicitly obliged to solicit such participation.

The submissions received from the various stakeholders during the Hearing process reflected a strong indication that sufficient community engagement and consultation had not been undertaken by the ECDoH in developing its policies and plans for emergency medical services. Contentions raised by community members suggest that consultation does not take place, including a situation where a site had been allocated for the development of a clinic a number of years ago but that no clinic has been built to date, nor has the community been able to receive feedback on the project. The second indication which points to a lack of consultation is that the Department did not appear to have been adequately aware of the challenges facing vulnerable groups. This is evident in the fact that policy design as well as the implementation thereof by the Department does not provide for the unique challenges facing these groups. The submissions further indicated a lack of awareness of the longer term financial consequences of the need to procure private transportation at high rates, nor did it appear to be aware of the fact that difficulties in accessing planned patient transport leads to a widespread discontinuation of treatment. Further, at no point during the investigation and Hearing processes did the ECDoH indicate that community consultations are in fact conducted.

Community participation is not only a statutory obligation that should be fulfilled on paper, but it is an essential tool in the adoption of a human rights and gender based approach referred to above as it allows people to participate in the development of policies and mechanisms that will affect their lives. The African Court on Human and Peoples' Rights has further emphasised the importance of "*providing meaningful opportunities for individuals to be heard and to participate in the development decisions affecting their communities*".¹⁶⁵

¹⁶⁵ Social and Economic Rights Action Centre (SERAC) and Another v Nigeria (2001) AHRLR 60 at para 53.

The National Policy Framework on Public Participation has defined public participation as being an “*open, accountable process through which individuals and groups within selected communities can exchange views and influence decision-making. It is further defined as a democratic process of engaging people, deciding, planning, and playing an active part in the development and operation of services that affect their lives.*”¹⁶⁶

Apart from being a legal requirement, the creation of mechanisms to allow communities to participate in the development of policies and plans, as well as in the manner in which these will be implemented have several advantages. Firstly, conducting meaningful engagements with communities allows for the sharing of information between communities and organs of state. This information is able to inform the policy development process, which ensures that policies adopted are more relevant to the local needs and conditions. Holistic policies that have been developed having a deeper understanding of the underlying challenges and needs on the ground are more likely to lead to a higher quality of service delivery, and can promote the achievement of sustainable solutions and fulfilment of rights.

This process also provides communities with a better understanding of the processes and policies undertaken by organs of state and has the potential to empower local communities to influence policy that will inevitably affect the quality of their lives. Recognition and investment in the intrinsic value of people has been defined as one of the core principles of public participation, while finally, access to information promotes good governance through the empowerment of communities to hold government bodies accountable.

13. RECOMMENDATIONS

In terms of the South African Human Rights Commission Act, the Commission is entitled to:

*"make recommendations to organs of state at all levels of government where it considers such action advisable for the adoption of progressive measures for the promotion of fundamental rights within the framework of the law and the Constitution."*¹⁶⁷

In light of all available evidence, the Commission has drafted appropriate recommendations with a view of enhancing the delivery of and access to emergency medical services in line with constitutional obligations. The Commission strongly encourages that the recommendations be taken seriously and calls for the on-going commitment by all Parties.

Accordingly, the Commission makes the following recommendations:

13.1 Legislative and policy framework

Although the Draft Regulations have been developed with a view of regulating the delivery of emergency medical services and will add value in filling the gaps relating to standard equipment and staffing of ambulances and clarify the responsibilities of private ambulance services, a review of the Draft Regulations as well as existing national policies is needed with an aim of addressing the current gaps in the framework.

As mentioned earlier in the report, the lack of a conclusive understanding of the content of the right of access to emergency medical services may result in the unequal distribution of services and fulfilment of human rights. The current definition of an “emergency care situation” as provided for in the Draft Regulations merely provides

¹⁶⁶ Department: Provincial and Local Government “National policy framework on public participation” (2007) p 15 (as accessed at [http://www.capetown.gov.za/en/PublicParticipation/Documents/DPLG_Public_Participation_Policy_Final_5_July\(2\).pdf](http://www.capetown.gov.za/en/PublicParticipation/Documents/DPLG_Public_Participation_Policy_Final_5_July(2).pdf)).

¹⁶⁷ Section 13(1)(a).

for a situation in which “*an ill or injured person or is for some or other reason in mortal danger and in need of emergency care*”. A clear and transparent policy and/or definition is required to clarify obligations and entitlements, and to define what services will and will not be provided. Special care must be taken in drafting the relevant policy and/or definition to ensure that no persons are excluded from accessing health care services. In this regard, instances in which persons require timely medical assistance (for the treatment or cure of an existing illness or injury, or for the treatment of the symptoms in the case of terminally ill patients) which do not mortally endanger a person, but may nevertheless be required for the recognition and respect of a persons rights, including the right to dignity, must be adequately provided for.

In this respect the Commission makes the following recommendations:

- i. The National Department of Health (DoH) is required to conduct a review of the National Standards applicable for the number of ambulances and to provide clarity on the interpretation relating to total fleet size, operational ambulances and type of ambulances required.
- ii. The DoH is further required to establish National Standards relating to the number of MOU, PPT and IFT vehicles required, which Standards should allow for flexibility depending on the context in which they will be implemented.
- iii. The DoH should reconsider the determination of National Standards for the number of ambulances in taking relevant contextual factors into account including, but not limited to, geographical size of the province; the level of development; distance between ambulance bases and communities; economic situations (including the proportion of the population that has access to private health care); and the availability of public or other means of transportation. It is further recommended that these National Standards be made publically available to contribute to a system of transparency and accountability for service delivery.
- iv. The ECDoH to assess whether the ambulance to population ratio and response times laid out in the National Standards are appropriate to the context of the Eastern Cape, taking into account factors including, but not limited to, the relative geographical size of the province; distances between EMS bases and communities; level of infrastructure and additional time anticipated to travel to communities due to the poor state of the road network; and the anticipated quality of service delivery if the Department were acting at full capacity.
- v. Following the above assessment, the ECDoH is required to formulate a clear policy relating to the applicable number of ambulances to population ratio. This policy is required to, *inter alia*, develop a clear criteria for the determination of the appropriate number of vehicles (including pre-hospital, MOU, PPT and IFT); the determination of the location of ambulances per district; as well as the type of vehicle (i.e quantum, 4x4 etc).
- vi. It is further recommended that all policies developed by the ECDoH relating to the delivery of emergency medical services be made publically available to contribute to a system of transparency and accountability for service delivery. These include, but are not limited to policies relating to the determination of appropriate numbers, types and locations of vehicles; timelines for the procurement of vehicles and the delivery of services; and recourse available in the event that service delivery is not adequate, amongst others.
- vii. The DoH should reconsider the definition of “emergency care situation” as provided for in the Draft Regulations to ensure that persons who are not “*in mortal danger*” but require urgent or timely medical treatment are not excluded from accessing such services. This should include the provision of services to, amongst others, terminally ill persons in line with the protection of and respect for the fundamental right to health care and dignity.

13.2 Ambulances

Following from the lack of clarity relating to the interpretation of the National Standards in relation to the number of ambulances, the submissions have illustrated a discrepant application of the National Standards by the ECDoH in application of, planning for and reporting on the level of compliance. Furthermore, the negative effects of the significant inadequacy of the current ambulance fleet are further intensified by the relatively small number of operational vehicles. Without the operationalisation of all the vehicles currently in the ECDoH's fleet, the acquisition of further vehicles will not significantly improve service delivery and appropriate steps therefore need to be taken to ensure that all ambulances currently in its possession become fully operationalised as soon as it is reasonably possible, and to develop appropriate strategies to achieve full compliance with the National Standards.

In this respect the Commission makes the following recommendations:

- i. The ECDoH to ensure that the implementation and measurement of compliance with National Standards is applied consistently in all planning and reporting documents.
- ii. ECDoH to take appropriate steps to ensure that all ambulances currently in its possession become fully operationalised as soon as it is reasonably possible. The measures taken should prioritise the operationalisation of ambulances with 4x4 capabilities and of IFT and PPT vehicles.
- iii. The ECDoH is required to conduct an evaluation on the appropriate number of pre-hospital, MOU, PPT and IFT vehicles required in terms of the anticipated need in the province, and include the anticipated target number for each in the planning documents along with the timelines for the procurement thereof.
- iv. The ECDoH must ensure that the proportion of pre-hospital, MOU, PPT and IFT vehicles, as well as the location of these ambulances are determined in accordance with the relevant factors including, but not limited to the population demographics and the anticipated level of need, level of infrastructure, peculiar geographical landscapes, economic factors and transportation systems available in each district. The location of ambulances/vehicles with 4x4 capabilities should also be determined after having taken the relevant factors into account, where priority of the location of such vehicles should be given to hard-to-reach areas.
- v. The purchase and allocation per district of the type of vehicle to be used (namely Quantum; 4x2; 4x4 etc) should be informed by the geographical and infrastructural context and a clear policy should be established in this regard.
- vi. The ECDoH to ensure that all ambulances are fully equipped according to the National Standards as a matter of priority and is further required to conduct inspections on the equipment of ambulances prior to the commencement of every shift, which inspections should be recorded and regularly audited. The ECDoH must take timeous and appropriate action to resolve any instances of non-compliance.

13.3 Patient Transport

The heavy reliance placed on pre-hospital ambulances for the transfer of patients between health facilities, or to specialised facilities for appointments hinders the capacity of pre-hospital ambulances to respond to emergency medical situations, and the large proportion of people who simply forgo regular and necessary medical treatment as a direct result of the difficulties faced in obtaining it is a serious cause for concern. The lack of the provision of frequent and accessible planned patient transport has severe adverse consequences on the overall health and well-being of patients, which inevitably increases the burden placed on the already over-burdened public health and emergency medical service system and impacts on quality of life.

In this respect the Commission makes the following recommendations:

- i. In the allocation and distribution of operational PPT and IFT ambulances in various districts or at various health facilities, the ECDoH must take the anticipated extent of needs into account to ensure that a sufficient number of vehicles are available to perform this function. The allocation of PPT vehicles, as well as the schedules for services should be adequately communicated to health care personnel and communities.
- ii. The ECDoH must review its policies and practices in providing planned patient transportation services to communities, taking into account the implications of the practical implementation of these policies to ensure that needs can be appropriately accommodated. In reviewing the design and implementation of the applicable policies, particular emphasis should be given to the specific needs of vulnerable groups.
- iii. In reviewing the policy referred to above, the ECDoH should ensure that planned patient transport services are available to groups which are otherwise unable to access public or private transportation services, particularly for persons with mental and physical disabilities.
- iv. The ECDoH to monitor the delivery of patient transport services according to a predetermined schedule which should be recorded and regularly audited, and ensure that appropriate action is taken against individuals responsible for a failure to comply. The performance relating to the delivery of PPT as well as IFT services should be reported in the Annual Report.
- v. The ECDoH to ensure that all planning and reporting documents clearly distinguish between IFT and PPT vehicles, and that the rostering of such ambulances form part of the Annual reporting process.
- vi. The ECDoH should ensure that patient transport is available to transport patients back to communities after receiving treatment, particularly in the evenings when persons are exposed to particular risk of crime and violence.

13.4 Response times

Due to the nature of emergency medical situations, response time is crucial in ensuring that patients receive treatment timeously and it is one of the most important factors in minimising the possibility of permanent damage or loss of life. While response time in many instances will not necessarily impact on the patient outcome, it may be crucial for ensuring survival in critical cases.

In this respect the Commission makes the following recommendations:

- i. The ECDoH to ensure that all performance indicators relating to response times are calculated in a manner which takes into account all relevant factors, and that the method of calculation should be clearly explained in planning and reporting documents.
- ii. All instances where an ambulance is not dispatched should be recorded by the ECDoH along with reasons, which data should be audited on a regular basis. The number of instances where ambulances cannot be dispatched for reasons not relating to the assessment of the level of emergency should be reported on annually in the reporting documents of the Department along with the relevant performance indicators for response time.
- iii. The ECDoH is required to ensure that the time between the receipt of an emergency call and the time of actual dispatch is recorded, audited on a regular basis, and reported on annually in the reporting documents of the Department along with the relevant performance indicators for response time.
- iv. The performance indicator relating to inter-facility transfers should be reviewed by the ECDoH to provide for an appropriate timeframe in which transfers should occur.

- v. The ECDoH to develop methods to ensure the accuracy of data and improve on the information management capacity, which measures should be clearly indicated in the relevant planning documents. Regular audits should be undertaken to determine the effectiveness and accuracy of data management.
- vi. In order to enhance the accuracy of data management and accountability of staff, the ECDoH should take steps to ensure that all calls placed to call centres and dispatch centres be automatically recorded. Plans to implement this measure should be reported on annually in the reporting documents of the Department, which reporting should include appropriate timelines.
- vii. Departmental documents and communications by the ECDoH to personnel and communities should clarify what the targets for response times are (i.e 15 minutes in urban areas and 40 minutes in rural areas for all priority calls) and should explicitly include information relating to the recourse available in the event that an ambulance does not arrive. This information must be widely distributed to communities in order to enhance a system of transparency and accountability in the delivery of services.
- viii. The newly established policy that all persons should receive an ambulance within 4 hours must be communicated to all personnel and communities by the ECDoH to ensure that this measure can be effectively applied to reduce the response times. In communicating this policy, it must be clearly explained that the target response times remain 15 and 40 minutes, but that 4 hours should be the maximum amount of time taken to respond to an emergency situation and should the ECDoH be unable to respond itself, private services must be procured in line with this policy.
- ix. The ECDoH to ensure that all personnel are aware of the policy and procedures to be followed for the procurement of private ambulance services should all ambulances of the ECDoH be unavailable to respond.
- x. The number of instances in which the response is escalated in terms of the policy as well as the number of instances in which private ambulance services are procured should be reported on on annually in the reporting documents of the Department.

13.5 Human Resources

The shortage of competent and qualified health personnel is a challenge facing the health sector in the country as a whole, and understaffed health programmes contribute to the inadequate delivery health care. The shortage of qualified EMS practitioners, particularly those at an intermediate and advance level are further exacerbated by fierce competition for resources between the public and private sector.

Priorities and goals aimed at increasing the number of qualified EMS personnel must be accompanied by appropriate plans and strategies that not only attempt to attract people to enter into these professions, but that also provide for appropriate retention strategies.

Further to this, poor service delivery and staff attitudes have been identified as an on-going problem in the public healthcare system, although the problem is not limited to the health sector but is widely recognised as a larger problem underlying public service delivery in general. While factors such as low job satisfaction may contribute to this, a lack of appropriate training and supervision may also be high contributing factors. A lack of dignity and respect often displayed results from a negative perception and stigma of welfare beneficiaries and inhibits the promotion of social cohesion and undermines the culture of the respect for the human rights and dignity inherent in all human beings.

In this respect the Commission makes the following recommendations:

- i. The ECDoH in collaboration with the DoH should review recruitment strategies aimed at attracting new EMS practitioners in the province, and particularly in the rural areas. Recruitment policies should be

- developed in line with other departmental strategies, including plans relating to the expansion of the size of the EMS fleet.
- ii. ECDoH human resources planning should prioritise the funding and employment of call centre staff, and the ECDoH must ensure that the level of training should be commensurate with the triage responsibilities.
 - iii. ECDoH human resources planning should further prioritise the training and recruitment of EMS staff with intermediate or advanced life support training.
 - iv. The ECDoH should emphasise retention strategies that address factors such as safety and security, educational and career development, the eradication of "one-man crews" and other non-financial incentives.
 - v. In rostering EMS personnel, the ECDoH must take steps to eradicate the practice of "one-man crews" and should ensure, to the extent possible in the immediate future, that at least one member of each crew has intermediate or advanced life support training.
 - vi. The ECDoH must take measures to address problems relating to poor attitudes and service delivery of personnel including, but not limited to, the conducting of sensitivity and human rights training for all EMS personnel and the imposition of appropriate sanctions and/or disciplinary measures in appropriate situations.
 - vii. The ECDoH in collaboration with the DoH must develop plans for the recruitment and training of additional Community Health Care Workers in line with the National Development Plan. Although the role of Community Health Care Workers does not include the provision of emergency medical services, the current inadequacy of the delivery of such services results in the *de facto* reliance on them. While their objective role and functions should not necessarily change, Community Health Care Workers should be more closely linked to the EMS system to empower them to call for an ambulance when needed.

13.6 Accessibility of Emergency Medical Services

The underdevelopment of the former Transkei and Ciskei areas is still apparent in the Eastern Cape today with few quality road networks connecting rural areas in particular to health and other facilities, and limited available funds constrained by slow economic growth in the country means that further development of road networks in these areas is a long term goal. The ability of the provincial Department of Roads and Public Works to promote access to basic services, including health care services for rural communities is, however, dependent on the resources made available to it. In this regard, the respective budget allocation at a national as well as provincial level should give particular attention to infrastructure projects in rural areas with a view of enhancing the achievement of equality and the protection of the rights for vulnerable and marginalised groups in particular. Information around the prioritisation of infrastructure projects should further be made widely available.

In this respect the Commission makes the following recommendations:

- i. The ECDoH should prioritise the procurement of ambulances with the ability to navigate difficult terrain, and ensure that all ambulances with 4x4 capabilities are made fully operational. The proportion of ambulances with 4x4 capabilities the ECDoH intends to procure as well as appropriate timelines should be indicated in the relevant planning documents of the ECDoH.
- ii. The ECDoH to develop a formal policy to address the difficulties in locating communities in the short term, and develop appropriate policies and strategies to address this challenge in the medium and long term in collaboration with other government departments. Specific consideration should be given to the potential consequences of the implementation of the policy on communities, and the Department should ensure that measures should not disproportionately burden or endanger communities.

- iii. The ECDoH must revise its policy on the provision of ambulance services to persons in wheelchairs to ensure that persons are able to travel with their wheelchairs, and must ensure that a friend or family member be allowed to accompany elderly persons; persons with disabilities and other persons with similar needs, to hospital.
- iv. The ECDoH should ensure that appropriate policies are in place to provide for the transfer and delivery of patients to hospitals in a manner which is conducive to a respect for the dignity and human rights of persons. In this regard, both EMS personnel and hospital staff should be trained on the procedure to be followed when patients are transferred to hospitals to ensure that patients are not left stranded without assistance. In considering this policy, provision should be made for the allowance of an additional person to accompany the patient in the ambulance, provided that the number of persons allowed per ambulance in terms of regulation is not exceeded.
- v. The DoH is required to conduct an evaluation on the dispatching of emergency medical services on a national basis to ensure that the definition of "emergency medical care" encompasses all situations which require immediate or timely medical care.
- vi. Whilst awaiting the outcome of the above mentioned evaluation by the DoH, the ECDoH must review its policy relating to the dispatch of emergency medical services and ensure that the definition of "emergency medical care" encompasses all situations which require immediate or timely medical care. Call centre agents should be adequately trained on the correct interpretation and application of the policy.
- vii. In noting the challenges experienced in accessing basic services as a result of infrastructural challenges, particularly in rural areas, it is recommended that the National Treasury consider these factors when allocating the national budget in order to ensure that respective allocations to provinces and departments are commensurate with the provision of basic services, including health care services, to the poorer and vulnerable communities in the country. Information on the prioritisation of infrastructure projects should further be made accessible to the public.

13.7 Planning and policy development

Inconsistent or inadequate planning can negatively impact on the ability to achieve targets and implement priorities, and all targets, priorities and budgetary allocations should be aligned to ensure that a clear purpose with appropriate resources has been identified and is capable of being achieved. However, while the various planning and reporting documents are designed for the guidance of and implementation by the Department, they are also intended to provide access to information in promoting a transparent process. In order to achieve this purpose, these documents should contain a sufficient amount of detail to provide a thorough understanding of the current challenges, priorities and measures implemented to address these challenges.

Policies should not be designed from the perspective of a "one size fits all" solution, and must be adapted to apply to the specific circumstances or context in which they will be implemented. The strategies employed in the conducting of an EMS programme in one province or district may, therefore, not be appropriate for application in another province or district and the theoretical adequacy of a programme is further insufficient to ensure a fair and equitable implementation in practice.

Distinct health programmes are managed separately by teams specialising in the delivery of the particular services falling within their scope. Although the division of programmes and tasks is necessary and inevitable, recognition must be given to the reality that these programmes are often inter-related and cannot be conducted in isolation. What is further important is that external factors such as socio-economic, transportation, education and development may have a significant impact on the effectiveness of health-related policies and programmes. The adoption of a human-rights and gender based approach to policy development and implementation enables

government bodies to develop a deeper understanding of the specific challenges facing communities, and allows them to develop policies holistically with a view of creating sustainable solutions.

In this respect the Commission makes the following recommendations:

- i. The ECDoH must ensure that all planning and reporting documents are aligned, and reflect priorities, targets and correlating budget allocations. The ECDoH must further ensure that targets and performance related data provided to other departments are consistent with those contained in ECDoH planning and reporting documents.
- ii. The ECDoH must ensure that reporting on performance indicators should remain consistent to ensure that adequate monitoring and evaluation takes place and that achievements and challenges can clearly be identified.
- iii. The ECDoH is required to review all performance indicators to ensure that all relevant factors in the efficient delivery of EMS are adequately monitored and reported on, and that sufficient information relating to the level of achievement is provided. The information should be provided in a manner which is easily accessible and understandable to communities to ensure that the process is transparent.
- iv. The ECDoH must ensure that appropriate timelines are included in all strategies and solutions identified to address relevant challenges. Plans to address challenges identified in this report, as well as any additional challenges that may arise, should include short, medium and long term solutions.
- v. The ECDoH should adopt a human rights and gender-based approach policy development and planning and ensure that solutions do not disproportionately place the burden on communities. Specific consideration should be given to the needs of vulnerable or marginalised groups.

13.8 Community engagement

Community engagement is an important tool in promoting accountability and transparency, and provides the opportunity for government departments to ensure that policy design and implementation are relevant and sufficient to promote the achievement of rights and fulfilment of obligations in an equitable manner. The legal framework creates the obligation for the ECDoH to conduct community engagements and to solicit participation in the planning and implementation of the relevant health related plans, policies, and programmes.

The ECDoH has indicated that community engagement and education is necessary to address a number of issues relating to the number of hoax and non-emergency calls received, and to encourage people not to delay in seeking treatment in order to avoid further health complications at a later stage. While the intention is to conduct such awareness campaigns through the conducting of radio health talks, it is recommended that this strategy been broadened to include other mechanisms for engagement that will also allow community members to voice concerns and seek information.

In this respect the Commission makes the following recommendations:

- i. The ECDoH, in consultation with local Districts and Municipalities, must establish appropriate mechanisms to encourage and solicit community participation relating to the design and implementation of health-related policies, plans and programmes. Consultation processes should be designed to ensure that the view points from all groups in society are solicited, with specific emphasis on vulnerable and marginalised groups.
- ii. The ECDoH is required to develop effective strategies to widely disseminate information to communities on health-related matters, with specific consideration to the use of an appropriate language and mechanisms of dissemination. The dissemination of information should specifically include, but should

not be limited to general information relating to policies and available recourse for poor delivery. Timelines relative to the implementation of strategies should further be included.

- iii. The ECDoH is specifically required to ensure that communities are informed on the policy and procedure to be followed in the event that an ambulance does not arrive. Reporting guidelines, including the details relating to the complaints hotline, should be widely disseminated and the ECDoH should consider alternative methods for its complaints procedure, including the provision of complaints boxes and forms at local clinics and hospitals.

13.9 Inter-governmental coordination

Inter-governmental and inter-departmental coordination is of paramount importance in ensuring that policies and programmes are aligned across all sectors and levels of government and adequately aim to address challenges in a collaborative and sustainable manner. The delivery of an efficient emergency medical service (and the resultant outcomes on overall health) is impacted by a wide range of factors which require collaboration between departments in developing appropriate solutions. Insufficient coordination between departments, on the other hand, may result in the formation of inappropriate plans and policies and give rise to policy gaps and unintended consequences. In this way, the health outcomes of the population in the province are a responsibility of more than just the ECDoH.

While the full extent of inter-departmental collaboration was not examined in detail during the Hearing process, further coordination with other departments may help to address the prevailing challenges identified in this report. In addition to this, discrepancies identified in information received by departments may indicate a challenge in relation to the sharing of information, which in turn may affect the proper alignment of plans and programmes across various sectors.

In this respect the Commission makes the following recommendations:

- i. ECDoH should, with the assistance of the Department of Cooperative Governance and Traditional Affairs ("CoGTA"), collaborate with other relevant departments in finding appropriate solutions to the challenges identified, and such solutions should address the short, medium and long terms. Challenges to be addressed through collaboration should include, but not be limited to, issues relating to the locating of patients in need of an ambulance, additional financial burden placed on families, the stigma against welfare beneficiaries, and sufficient monitoring of planning and performance.
- ii. The ECDoH should work with the Department of Human Settlements and the Department of Transport together with other appropriate departments in order to develop appropriate and sustainable solutions to address the challenge identified in locating communities, which solution should address the short, medium and long terms.
- iii. The ECDoH should work with the Department of Transport in order to address the challenge identified in accessing transportation to ensure that community members are able to access health care services.
- iv. The Provincial Treasury should conduct monitoring and evaluation exercises in relation to the expenditure of the ECDoH in its EMS programme, which should include an evaluation on whether planning and expenditure is in line with priorities identified.

13.10 General

- i. It is recommended that the ECDoH provide the Commission with a detailed plan outlining the measures it intends to take to enhance the delivery of emergency medical services in the Eastern Cape with a period of 6 months from the date of the launch of this Report. This plan should include measures to

address all, but not be limited to, the challenges raised in this report and must indicate applicable timelines for the implementation thereof, as well as providing additional information relating to the progress made to date.

The Commission is considering hosting a National Hearing on Health and issues that have been identified in this Report may be dealt with in more detail during this process.

14. CONCLUSION

In the past, people residing in rural areas of the Eastern Cape were routinely denied adequate services including health care, and the democratisation of South Africa and promulgation of the Constitution guaranteed access to a better life for all, based on freedom, equality and human dignity. Despite the embodiment of explicit recognition of the right of all persons not to be denied access to healthcare in a number of legal instruments, access to these services remain inadequate and inequitable and a significant number of rights violations continue to be experienced.

Despite having identified a number of issues in the Commission's 2007 Health Report including challenges relating to the provision of emergency medical services and the adequacy of transportation systems on the ability of persons to access health care services, particularly the poor and those residing in rural areas, there appears to be a significant lack of progress in addressing these issues. This report has illustrated a number of challenges experienced by the Eastern Cape Department of Health which have contributed to its failure to adequately fulfil the right that no person may be denied access to emergency medical services and to access to health care services in general, which failure further contributes to the perpetuation of a number of other social problems.

The importance of immediate or timely medical assistance in an emergency situation is undisputable in the recognition that a denial or delay of treatment may potentially have a profound and devastating effect on the health and resultant quality of life of persons. While the number of ambulances required in terms of National Standards is 1 ambulance to every 10,000 persons, the uncertainties surrounding the correct interpretation of the Standards creates difficulties in calculating the current level of compliance in the Eastern Cape. However, regardless of these uncertainties, the current fleet size of the Eastern Cape Department of Health is below the required level and is not sufficient to meet the needs. The problems stemming from the already under-resourced fleet size are further compounded by an equally under-resourced staff profile, a shortage of highly qualified EMS personnel, low numbers of ambulances that are currently operational, and a majority of the current fleet unable to navigate the difficult terrain to respond to emergencies in large parts of the province, particularly in rural areas. These factors significantly curtail the speed at which the ECDoH is able to respond to emergency calls and to ultimately uphold the rights of persons requiring immediate or timely medical assistance.

Other difficulties in responding to emergency medical situations include issues relating to resource management and response prioritisation according to the level of emergency. The frequent inability of ambulances to locate communities, as well as the prevalence of "one-man crews" in ambulances contributes further to the delay in providing immediate or timely treatment to patients.

The insufficient level of patient transport services increases the strain on ambulances dedicated to respond to emergencies, and the frequent unavailability and unreliability of services force patients in need to seek public or private transportation in order to receive treatment. The current level of patient transfer services often results in additional barriers for vulnerable persons and the need to navigate difficult and treacherous landscapes, far distances between villages and health care facilities, combined with out of pocket expenses for transportation

regularly results in the discontinuation of treatment altogether. This has long-term effects on the overall health and well-being of persons, may lead to health-related complications, and inevitably increase the burden on an already overworked public health care system.

While the immediate and long term implications on a person's health are easily recognised, the in-depth investigation into the lack of access to emergency medical and patient transport services has demonstrated the perverse and incessant impact on the economic stability of families and on the eventual eradication of poverty and inequality. The high costs involved in obtaining private transportation services place an incredible financial burden on families, often with devastating effects. Daily necessities such as food, clothing and education are sacrificed, while the reliance on already unaffordable loans at high interest rates drive families deeper into poverty.

While further problems were illustrated relating to the disrespectful and callous attitudes seemingly often portrayed towards patients and community members, the compassion and dedication displayed by many health care practitioners, Community Health Care Workers and Non-Profit Organisations in going beyond the call of duty and playing an indispensable role in contributing to the health and dignity of people is commendable.

Shortages of medical supplies, equipment and staff; inappropriate policy design and implementation; insufficient consultation and provision of access to information; unreliable information management systems; and poorly managed and resourced call centres have further contributed to a severely constrained EMS programme and an unequal provision of services.

Although a number of achievements have been made in the Eastern Cape relating to access to healthcare over the last 20 years, many of the same challenges in impeded access persist. An under-resourced and ineffective emergency medical service not only impacts on the immediate and long-term health of persons, but contributes to a deepening cycle of poverty and deprivation, and to the preclusion of the achievement of equality and human dignity inherent in all human beings. The advent of democracy came along with the promise of a better life and healing the divisions of the past, yet for many people this promise remains unfulfilled.

While the measures taken to address the situation are notable, a number of these are long-term challenges and require the sustained commitment of government departments and civil society alike. The Preamble of the Constitution reflects the importance of the values of social justice and fundamental rights, but this guarantee is only as strong as the measures taken to promote its achievement. The Commission hopes that special recognition of the recommendations included in the report will be taken and calls for the on-going recognition of and commitment to the achievement of equality and for the transformation of rights into reality so that all people can live in dignity in the full realisation of their rights.

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