

Emergency Medical Services in the Eastern Cape 2005 – 2015: Planning, Budgeting and Delivery

Thokozile Mtsolongo

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Introduction

Chapter 2 of the Constitution of South Africa protects and promotes the progressive realisation of socio-economic rights within available resources. These rights include the right to have access to adequate housing (section 26), the right to have access to healthcare services, sufficient food and water and social security (section 27) and the right to basic and further education (section 29). The attainment of these socio-economic rights is subject to the state taking reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights. Yet the framing of the right to emergency medical treatment in Section 27(3) of the Constitution, is different from that of other socioeconomic rights in sections 27(1). Section 27(3) states as “no one may be refused medical treatment”. In *Soobramoney v Minister of Health, KwaZulu Natal* the Constitutional Court held that the purpose of the section 27(3) right is to ensure that treatment be given in an emergency and is not frustrated by bureaucracy or other reasons such as unavailability of resources.

Even though the attainment of the right to emergency medical treatment¹ is not subject to bureaucracy or other reasons such as unavailability of resources, the actual provisioning of the right requires in particular sound planning and adequate budget and human resources provisioning and efficient management. The analysis of the budgets available to the Eastern Cape Department of Health (ECDoH) as well as its strategic planning documents will be used to understand both the measures that have been taken to realise requisite outcomes of Emergency Medical Services (EMS) in the Eastern Cape.

This report seeks to evaluate the EMS of the province with particular emphasis on:

1. Institutional arrangements for EMS provisioning in the Eastern Cape
2. Giving a background to the provisioning of transport for health in South Africa
3. Scrutinizing the planning and budget allocations provided to the Emergency Medical Services (EMS) programme
4. Scrutinizing the provision and allocation of ambulances
5. Scrutinizing the human resource provisioning for the EMS

¹ While the scope of this study is limited to pre-hospital care, emergency medical treatment envisioned in 27(3) of the Constitution does not distinguish between pre-hospital emergency care and emergency care that continues within the health care facility.

Institutional Arrangements for EMS provision in the Eastern Cape

The Eastern Cape Department of Health is divided into 8 administrative programmes, of which Programme 3 is Emergency Medical Services whose purpose is to provide an equitable, efficient, effective, professional and sustainable service of “pre-hospital emergency medical services including inter-hospital transfers and planned patient transport”². The programme consists of two sub-programmes, that is, the emergency medical services (EMS) as well as the planned patient transport (PPT). The EMS as a sub-programme is responsible for rendering emergency medical services including ambulance services, special operations, communications and air ambulances.³ The Planned Patient Transport deals with the planned patient transport including local outpatient transport (within the boundaries of a given town or local area).⁴

The policy mandate of the EMS programme is derived from a number of documents but primarily section 27(3) of the Constitution⁵, Schedule 5 of the Constitution which provides for ambulance services as functional areas of exclusive provincial legislative competence. Additionally, section 5 of the National Health Act⁶ states that “a health care provider, health worker or health establishment may not refuse a person emergency medical treatment” as already protected within section 27 of the Constitution. However, the meaning and thus enforceability of what constitutes emergency medical treatment has for a long time remained largely undefined or has been defined vaguely at best.⁷ The promulgation of the National Emergency Medical Services Regulations⁸ has assisted in providing some clarity, wherein an ambulance is defined as “an appropriately equipped vehicle which is waterborne, airborne, or land-based and designed or adapted for the purpose of providing emergency care and the transportation of patients and licensed under the National Road Traffic Act (Act No.93 of 1996) as an ambulance”.⁹ The definition given in the Eastern Cape Provincial Health Act, ambulance services are described as the “provision of vehicles equipped for the purpose of providing emergency medical services as prescribed by regulation”.¹⁰

The provisioning of ambulance services consists of multiple components and involves multiple role players and complex intergovernmental relations^{11, 12, 13}. For example, policies

² Estimates of Provincial Revenue and Expenditure (EPRE) – 2015/2016 Financial Year, p.130.

³ Ibid.

⁴ Ibid.

⁵ The Constitution of the Republic of South Africa, Act 108 of 1996.

⁶ National Health Act, Act No. 61 of 2003

⁷ Marius Pieterse. 2010. Legislative and executive translation of the right to have access to health care services. *Law Democracy & Development* (14): 1-25

⁸ National Health Act, 2003, Act No.61 of 2003 – Emergency Medical Services Regulations, 24 July 2014.

⁹ Ibid, p. 4, 8 May 2015.

¹⁰ Act No.10 of 1999,p.2.

¹¹ Wendy Hall, Daniel Radebe and Jaine Roberts. 2006. *Transport Policy for Health Services in the Public Health Sector: Lessons the Learned from a Study of Impact on Health Services of a Public-Private Partnership for Transport in the Eastern Cape*. Health Systems Trust

¹² Wendy Hall, Dawie du Plessis, and David McCoy. 2002 *Transport for Health Care Delivery South African Health Review*. p.353-372

¹³ Wendy Hall, *Transport for Health Services in a decentralised district health system in South Africa – Challenges and possible solutions*.

for the management of the government motor fleet are centrally determined and controlled by the National Department of Transport,¹⁴ while the provincial health departments are held financially accountable “for the costs of transport used for delivery of health services”¹⁵ in terms of the Public Finance Management Act (PFMA). Provincial health departments also rely on the provincial departments of transport, for the repair, maintenance, supply of new and replacement of vehicles.¹⁶ Hall explains further that the relationship that exists between the national and provincial departments of transport, health and provincial treasuries as well as the private health sector is a rather complex one and prone to inefficiencies culminating in weakened services.

EMS Planning

Perusal of ECDOH strategic planning documents and annual reports in the period of analysis shows that there has been a lack of consistency of indicators for measuring progress. As a result of this, it has been difficult to keep up with progress made in achieving the stated goals and objectives of the EMS programme over the years. The strategic objective of ‘response times’ is the only one that has been kept constant over time. Significantly the strategic planning process for EMS has consistently failed to foreground the implications imposed by section 27 (3) of the Constitution.

Although there has been a recognition of the importance of the role of the EMS programme in health services delivery, this has still not translated into the steady and desired provision or even at times planned for targets of EMS within the province. With the increased fiscal resources to the EMS programme over time, there is not enough evidence to show that even in the face of these increases that the EMS programme would function at its optimum. The planning for these services that has taken place in the study period is reflective of this. The planning of the Department has to give some important indicative details of how the allocated funds will be spent, and not merely stating what sub-programmes and line items the funds will go towards. A clear and actionable mapping of the planning made needs to chart the direction of progress over time of the EMS programme.

As mentioned already, the availability and the use of financial resources plays a central part of the planning for EMS. Where funds are not adequate or are limited to execute the ideal measure of EMS services in the province, this too should form part of the planning to ensure as far as possible that reaching the ideal levels or standards of EMS provisioning in the province are ‘within reach’. This implies for planning beyond what the budget allows for. The display of such commitment would show the progressive actualisation of the constitutional provision of section 27(3). Essentially, a call upon the state to break out of the parameters and confines of their budget allocations in ways that would improve the services of this programme, while at the same time adhering to the legal budget frameworks.

¹⁴ Ibid

¹⁵ Ibid.

¹⁶ Ibid.

EMS Budget

What is observed in the summary below is that over the study period the budget allocation, final appropriation and actual expenditure to the EMS programme have been on an upward trajectory (Figure 1). In fact the final appropriation for EMS as a ratio of the final Eastern Cape Department of Health budget increased from 3.5% of the total budget in 2005/6 to 4.9% in 2013/14 suggesting the increased value attached to the EMS programme as shown in the line graph.

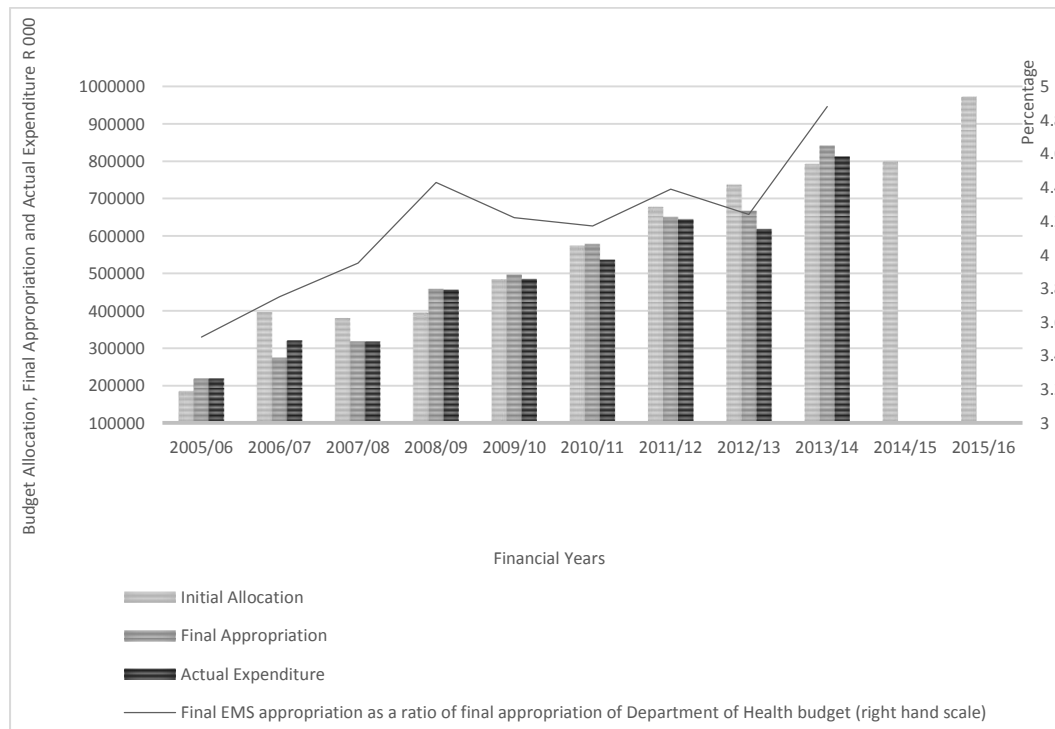


Figure 1: EMS Budget Allocation, Final Appropriation and Actual Expenditure 2005/6-2015

While the EMS programme has regularly failed to spend the budget appropriated to it, with exception of the 2005/6, 2006/7 and 2007/8 financial years, the lack of fiscal resources has been cited as a reason for lack of progress in achieving the national norms of 1 ambulance per 10 000 people and the recruitment of adequate staff to ensure for the provision of a quality, effective and efficient EMS (Interview with an official in the Eastern Cape Department of Health). The relatively small proportion of the budget allocated to EMS, of between 3.5% and 5% of the department's total departmental budget, provides scope for significant increase of the EMS proportion while having unimportant effects on other departmental programmes.

Increases in the nominal allocations have also been noted between financial years from 2010/11 right through to the 2015/16. Another significant increase in allocation to note is that which took place in the between the 2014/15 financial year to the 2015/16 financial year. The 2015/16 financial year being the current year of the time of producing this research report, it will therefore not be possible to evaluate what the increases in budget were able to achieve.

While overall real allocation of the EMS programme (Figure 2 below) has increased over the study period, it experienced noticeable declines in two consecutive financial years (2007/08 and 2008/09, as well as later in 2014/15). It has been argued in time past how these declines were linked to the Department’s inability to spend their funds on the one hand, while on the other hand their budgets would be overspent.

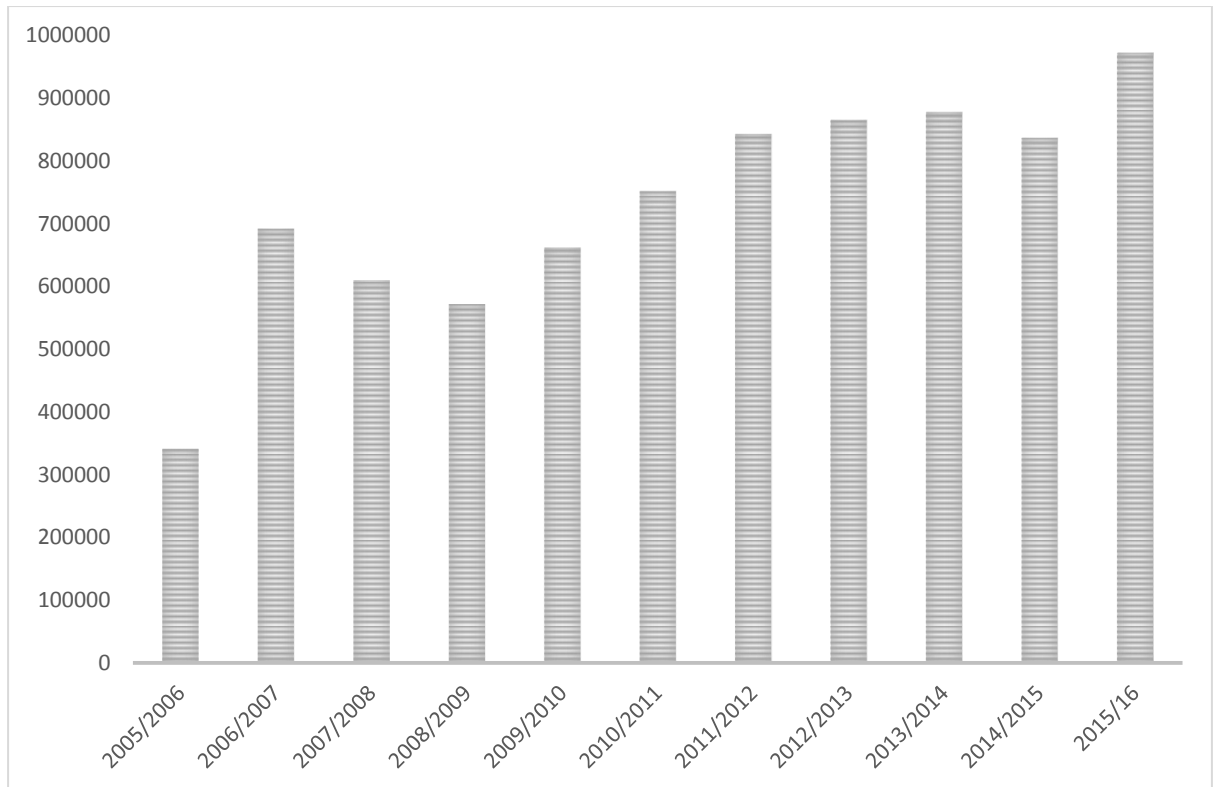


Figure 2: Real Allocations to EMS

Ambulance Fleet Numbers in the Eastern Cape

The procurement of additional vehicles regularly receives prominent space in the budget speeches of the Member of the Executive Council (MEC) of the Eastern Cape Department of Health¹⁷ as well as widespread media coverage. However, there is a lack of coherency of numbers of EMS vehicles available at any given time, and how the optimal fleet size needed in the province will be achieved. In addition, in spite of the prominence afforded to procurement of new ambulances, it is patently clear that these announcements do not change the situation on the ground. That is, the announcements of increases in numbers of ambulances year on year seldom amounts to changes in the actual operational size of the fleet available as well what is needed in the province at any given time.

The ratio of rostered ambulances in the two strategic planning periods of 2004/5-2008/9 and 2009/10-2013/14 have remained constant at 0.3 ambulances for every 10 000 people against the national norm of 1 ambulance per 10 000 people (Figure 4). This is surprising given that the shortage of ambulances, high mileage, high maintenance costs, reduced roadworthiness

¹⁷ Eastern Cape Department of Health. Budget and Policy Speech 2015/16. Bhisho: Eastern Cape Department of Health; 2015.

have consistently been flagged as areas of concern for being unable to meet the national norm. Consequently, the available vehicles have on average been travelling increasingly longer distances per annum, for example the distance travelled by each available ambulance increased from 109587 km per ambulance in 2007/8 to 190829km in 2009/10.¹⁸ Again as in the strategic planning analysis above, this data illustrates a poor prioritisation of this important component of EMS and an inevitable assurance of unnecessary loss of lives.

A report by the South African Human Rights Commission (SAHRC)¹⁹ tells of many communities who have lost hope of receiving the services of EMS and have lived with the fear of the consequences felt by them as a result of this lack of prioritisation of their fundamental right to life.²⁰

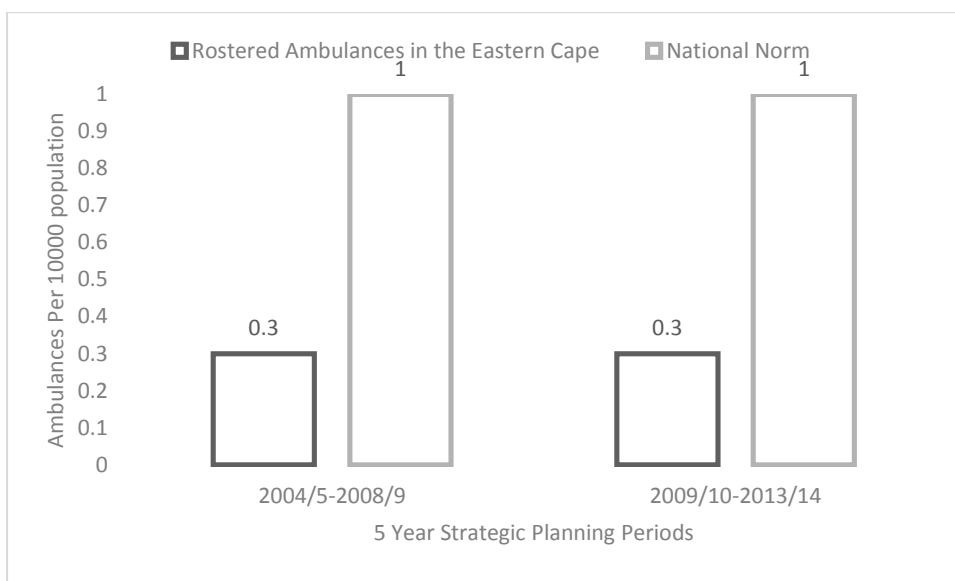


Figure 3: Ratio of Rostered Ambulances per 10 000 people in the two 5 year strategic planning periods 2004/5-2008/9 shows that the ratio of rostered ambulances per 10000 of population remained unchanged in the two periods.

Human Resources for EMS in the Eastern Cape

The general availability of adequate numbers of staff needed in the operation of the EMS programme has also been a matter of concern and not only limited to the staff required to operate ambulances.

Within the actual operations of ambulance services the department has long cited a history of challenges with shortages of a range of categories of EMS required in the operation of ambulance services. Challenges cited have ranged from lack of skills in the staff recruited to

¹⁸ Eastern Cape Department of Health. Annual Report 2009/2010. Bhisho: Eastern Cape Department of Health; 2010.

¹⁹ South African Human Rights Commission. Access to Emergency Medical Services in the Eastern Cape in the Eastern Cape Hearing Report. South African Human Rights Commission; 2015.

²⁰ Republic of South Africa. 1996. Constitution of the Republic of South Africa, 1996 Pretoria: Government Printer.

insufficient funding to recruit the requisite numbers of staff. Of most concern are the extent of the challenges that have arisen over the years related to the human resource component of EMS, in particular core staff required within the ambulance services that have had a direct consequence on the operations of these ambulances.

This shortage of ambulance related workers alone has been identified as a constraint to the efficient functioning of the EMS in the province. In general there are three categories of pre-hospital emergency care practitioners in South Africa, namely, basic life support (BLS), intermediate life support (ILS), and advanced life support (ALS). According to Booley and Welzel (2015)²¹, the vast majority of practitioners in South Africa only have BLS and ILS training. Thus, at a national scale, South Africa faces an acute shortage of ALS personnel, which is exacerbated by relative lack of work-life desirability of the Eastern Cape when compared to other provinces such as Gauteng and the Western Cape. For example in 2013 the Eastern Cape province only had 51 ALS out of 2 305 in South Africa, which amounts to a ratio of 1: 129 411 patients, compared to the South African ratio of 1: 21 258.²²

According to the Emergency Medical Services Regulations an ambulance should have a minimum of two personnel who have to be registered with the Health Professional Council of South Africa (HPCSA). Based on the nature of the service being offered these personnel will be in possession of a qualification/licence of BLS, ILS or ALS.²³ The licences will include “an appropriate valid driver’s licence” for the driver of the ambulance, and an additional “valid professional driving permit” (PDP) where the vehicle is for the purposes of carrying patients.²⁴ The ambulance vehicle used, in compliance with the road traffic act, will also be configured in such a way as to aid the function of carrying patients. The exact fittings of what these ambulances are supposed to look like are elaborated upon in greater detail within the regulations.²⁵

Data from document analysis as well as interviews conducted show that the bulk of the operations of the ambulance system have depended on the BLS qualified personnel. There are currently only four institutions in South Africa accredited by the Health Professions Council of South Africa (HPCSA) to provide ALS training: the Durban University of Technology, the Cape Peninsula University of Technology, University of Johannesburg and starting in 2014 the Nelson Mandela Metropolitan University. In response to capacity constraints in the training of ALS, the Eastern Cape Department of Health has entered into an agreement with the Durban University of Technology to guarantee a steady supply inflow of this category of staff.²⁶ The Nelson Mandela Metropolitan University has also committed to address shortage of ALS trained EMS staff in the Eastern Cape.²⁷ While the staff vacancy rate has largely

²¹ Booley MR, Welzel T. A cross-sectional analysis of the short-term outcomes of patients receiving prehospital treatment for symptomatic hypoglycaemia in Cape Town, *Afr J Emerg Med* 2015; 5(4):159–164.

²² Nelson Mandela Metropolitan University. 2013. New paramedic degree for NMMU. <http://news.nmmu.ac.za/News/New-paramedic-degree-for-NMMU> accessed 20 November 2015

²³ National Health Act, 2003 (ACT No.61 OF 2003), p.26.

²⁴ *Ibid* at p.27.

²⁵ *Ibid* at p.27 – 28.

²⁶ Eastern Cape Department of Health. Annual Report 2011/12. Bhisho: Eastern Cape Department of Health; 2012.

²⁷ Nelson Mandela Metropolitan University. 2013. New paramedic degree for NMMU. <http://news.nmmu.ac.za/News/New-paramedic-degree-for-NMMU> accessed 20 November 2015

declined since 2010/11²⁸ this has been largely achieved through a reduction in total establishment rather than new employment.

Analysis of the number of posts, the number of posts filled and the vacancy rates in the EMS programme over the study period (shown in Figure 4 below) reveals an inconsistency in the total number of posts in the EMS programme – with the total number of posts spiking in 2009/10 (7941 posts), 2011/12 (6828 posts) and 2014/15 (3067 posts) and concomitant increases in vacancy rates of those years of 75.4%, 73% and 38.6% respectively. These increases and subsequent drops are not explained.

Financial Years	Number of posts	Number of posts filled	Vacancy Rate
2005/06 ²⁹	2231	1135	49.1
2006/07 ³⁰	2231		
2007/08 ³¹	2186	1956	10.5
2008/09	No data	No data	No data
2009/10 ³²	7941	1955	75.4
2010/11 ³³	2157	1955	9.4
2011/12 ³⁴	6828	1845	73
2012/13 ³⁵	1884	1828	3
2013/14 ³⁶	1938	1837	5.2
2014/15 ³⁷	3067	1884	38.6

Figure 4: Vacancy rates of EMS Programme - 2005/06 to 2014/15

Improving Response Times as the key provincial priority

Response time is the most widely cited performance indicator in planning and management of EMS systems in South Africa and in fact in many EMS systems across the world.³⁸ While

²⁸ Eastern Cape Department of Health. Annual Report 2010/11. Bhisho: Eastern Cape Department of Health; 2011.

²⁹ Eastern Cape Department of Health Annual Report 2005/06, p.282.

³⁰ Eastern Cape Department of Health Annual Report 2006/07, p.291. Full details of post filled and those posts that were vacant were not provided.

³¹ Eastern Cape Department of Health Annual Report 2007/08, p.326.

³² Department of Health Annual Report 2009/10, p.428.

³³ Eastern Cape Department of Health Annual Report 2010/11, p.363.

³⁴ Department of Health Annual Report 2011/12, p.319.

³⁵ Eastern Cape Department of Health Annual Report 2012/13, p.265.

³⁶ Department of Health Annual Report 2013/14, p.222.

³⁷ Eastern Cape Department of Health Annual Report 2014/15, p.189.

³⁸ Stein, C, Wallis, L and Adetunji, O. *The Effect of the Emergency Medical Services Vehicle Location and Response Strategy on Response Time*. South African Journal of Industrial Engineering. August 2015. Vol 26 (2) pp 26 – 40.

the elements of EMS response to a report of an incident are well understood, there is often dissonance on what exactly constitutes the response time. The time from when an emergency call is first received to the time when a patient receives medical attention has long been viewed by various sections of society as “perhaps the most important graded component of the EMS system”.³⁹ Viewed that way response time would encapsulate the times from the dispatch of an emergency vehicle to the administration of definitive care⁴⁰. This view thus supports the shift from traditional ambulance services staffed by attendants who had little or no medical training and whose functions was to only load a patient into an ambulance and rush them to the nearest emergency facility to the contemporary approaches that include ambulances staffed by emergency medical technicians (EMTs), clinicians⁴¹ and those staffed by highly qualified paramedics who are able to provide some degree of medical care.⁴²

South African literature defines the response time as the time taken for the vehicle to reach the incident node, from beginning of the dispatch process⁴³, illustrated in Figure 5 below. It typically excludes the scene time i.e. the time spent at the incident node, the transport time i.e. the time taken to travel between the incident node and the receiving hospital and the hospital time i.e. the time taken to hand the patient over at the receiving hospital and prepare the vehicle to attend to the next incident. The dispatch time i.e. the time taken for the dispatch process to be completed is also a critical component in consideration.⁴⁴

³⁹ Blackwell, TH and Kaufman, JS. *Response Time Effectiveness: Comparison of Response Time and Survival in an Urban Emergency Medical Services System*, p. 288 – 289. Clinical Practice April 2002, Volume 9, Number

⁴⁰ Jonathan D. Mayer *Emergency Medical Service: Delays, Response Time and Survival* Author(s): Source: Medical Care, Vol. 17, No. 8 (Aug., 1979), pp. 818-827

⁴¹ Black, JJM and Davies, GD. International EMS Systems: United Kingdom. Resuscitation 64 (2005) 21 – 29.

⁴² Jonathan D. Mayer *Emergency Medical Service: Delays, Response Time and Survival* Author(s): Source: Medical Care, Vol. 17, No. 8 (Aug., 1979), pp. 818-827.

⁴³ C. Stein, L. Wallis & O. Adetunji, *The effect of emergency medical services vehicle location and response strategy on response times*. South African Journal of Industrial Engineering August 2015 Vol 26(2) pp 26-40

⁴⁴ *ibid*

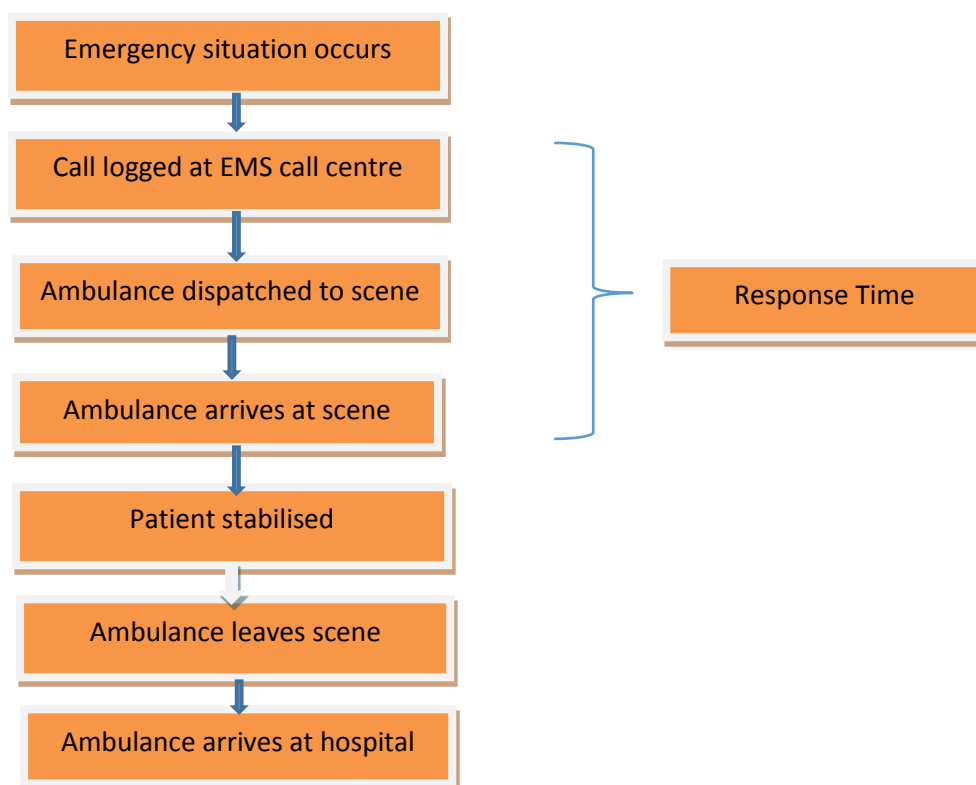


Figure 5: Response time

In itself ‘response times’ carries a lot of responsibility and makes an assumption of the availability of fundamentals and a system whose parts come together to function in a seamless and integrated manner so that the best possible care is administered to patients. A study recently carried out in the Western Cape mapped out a basic “sequence of events” that should ideally take place when trying to respond within the ‘golden hour’, which is described as the first hour immediately after the injury has occurred,⁴⁵ in particular when responding to rural settings. In the reference study the ‘golden hour’ was used to refer to the critical point in any trauma scenario where the patient is in urgent need of care - essentially, the chances of morbidity or mortality are critical. Many writers have debated whether the reduction of response times will lead to the decreasing of morbidity rates and whether that in itself will lead to better chances of survival of patients in need. It has been argued that the understanding of this is a far more complex matter than generally understood.⁴⁶

Response times cannot be viewed in isolation or planned for in isolation. They have to be viewed with a background of the area within which the services will be delivered. The Eastern Cape landscape for example has been viewed as largely rural in nature, with indeed a bulk of the population of the province residing in non-urban areas. This characteristic in itself should be one of the first key considerations when planning on the pre-hospital services that will be rendered in the Eastern Cape. The condition of the vehicles to be used to respond to

⁴⁵ Ibid at p.2.

⁴⁶ Blackwell, TH and Kaufman, JS. Response Time Effectiveness: Comparison of Response Time and Survival in an Urban Emergency Medical Services System, p. 288 – 289. Clinical Practice April 2002, Volume 9, Number 4.

emergencies, as well as the distances that will be travelled by these vehicles also play a critical part of the delivery of this service. However, what does not come out clearly in the discussions of the department within its recent strategic plan is the full scope of the response times considered.

A 2010 study in rural Eastern Cape reported that the distances travelled by ambulances were long, and on average the majority of the response times were 4 hours instead of the 1 hour 45 minutes that appear in planning documents.⁴⁷ As indicated in an earlier discussion, the poor response times form part of the systemic problems manifesting in the provision of EMS services in the Eastern Cape. In fact the planned response times have yet been reported in the period under review.⁴⁸ Priority 1 (P1) calls, that is, high acuity situations requiring immediate response such as traffic injuries, and drowning, must be responded to within 15 minutes in an urban setting; and within 40 minutes in a rural setting. Data from the Eastern Cape Department of Health indicates that in general the response times improved between 2004/5 and the 2013/14 measured in terms of percentage of P1 urban response time under 15 minutes and percentage of P1 rural response time under 15 minutes (Figure 6), although the veracity of these data has come under scrutiny from the department itself.⁴⁹

In the South African context emergency services have regularly come under fire. The importance of operating in an integrated manner when it comes to pre-hospital EMS services within public EMS systems have degraded in the face of “reduced ambulance fleets, breakdown and non-replacement of equipment, the shortage of consumable stock, the migration of highly qualified and experienced staff, and the choice of private EMS companies to serve selected patients.”⁵⁰ The inability of the emergency medical services to respond timeously has implications on the ability of both pre-hospital emergency response practitioners and in-hospital medical practitioners’ to perform procedures that would save life, and or allow for substantial or full recovery. The Eastern Cape Department of Health has claimed that its inability to meet the target times is due to particularly (1) poor condition of roads (2) high volume of hoax calls, and (3) lack of funding.⁵¹ In relation to the shortage of ambulances, Stein et al⁵² indicate that the addition of emergency vehicles alone is insufficient to bring about the magnitude required to meet targets for response time and suggest that in addition ambulances should be close to areas of demand, a practice that the Eastern Cape Department of Health has already adopted (Interview with Eastern Cape Department of Health official).

⁴⁷ Meents, E and Boyles, T. *Emergency Medical Services – poor response time in the rural Eastern Cape*. South African Medical Journal, December 2010, Vol.100, No.12,

⁴⁸ Province of the Eastern Cape Health 5 Year Strategic Plan 2015/16 – 2019/20, p.66. In fact the department has stated this as the only strategic objective for the programme of EMS, and the only indicator discussed.

⁴⁹ Eastern Cape Department of Health. Annual Report 2010/11. Bhisho: Eastern Cape Department of Health; 2011

⁵⁰ Boden, J. Integrating pre-hospital emergency medical services with hospital emergency units. 2003 ESSA July/August.

⁵¹ Eastern Cape Department of Health. Annual Report 2010/11. Bhisho: Eastern Cape Department of Health; 2011.

⁵² Stein C; Wallis L; Adetunji O. Meeting national response time targets for priority 1 incidents in an urban emergency medical services system in South Africa: More ambulances won't help. SAMJ 2015; 105(10): 840-844.

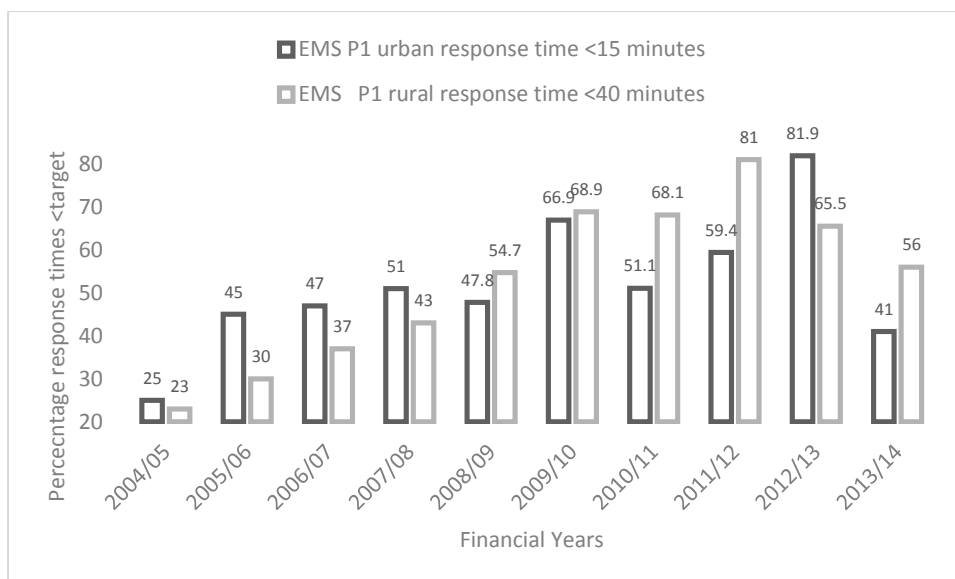


Figure 6: P1 Emergency response times from 2004/05 to 2013/14 illustrates the percentage P1 urban response time <15 minutes and percentage P1 rural response time <40 minutes from 2004/5 financial year to the 2013/14 financial year as recorded by the EMS in the Eastern Cape Department of Health.

Conclusion

While it is noted that the Eastern Cape Department of Health has made some progress in the provision of EMS services to the people of the Eastern Cape, there still remain serious planning, funding and implementation challenges that have resulted in the failure of the department to meet its objectives, and more seriously providing the state of emergency care services as prescribed in the Constitution.

As discussed in detail earlier in the report, the department has faced challenges with providing consistent indicators for planning purposes and thereby making it difficult to track the progress it has achieved over the years. Insufficient resources allocated to the running of EMS as well ultimately the efficient use of these limited resources has created further setbacks to services delivered most acutely felt by those residing in rural areas of the province. The Eastern Cape Department of Health must institute measures to ensure that the planning, budgeting and delivery of EMS in the province conforms to the EMS legal framework.

A number of reasons have been proffered by the Eastern Cape Department of Health to explain the failure to meet the national norms and targets that have been set have been limited in resolving the standing challenges. These reasons include matters that require urgent attention such as (1) poor condition of roads, (2) high volume of hoax calls and (3) lack of funding to acquire sufficient numbers of ambulances. However, these cannot be indefinitely relied upon as a concrete reason to deny access to emergency medical treatment.

The different components discussed within the research pointed to the insufficient interrogation and engagement by the ECDoH of the implications of the provision within section 27 (3) of the Constitution. These implications encompass the entirety of what is and would be involved in the efficient delivery of the services of EMS in the Eastern Cape Province. If these were accepted to be reasons for the current state of emergency medical services in the Province, they would be exemplary of forms of constructive refusal to provide

the necessary emergency medical treatment as well as reliance on bureaucratic requirements or other formalities, rendering these invalid in terms of the Constitutional Court interpretation of the Section 27(3) of the Constitution.