Review article

Governing access to emergency care in Africa

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ABSTRACT

Emergency care not only has the potential to address a large portion of death and disability in low- and middle-income countries, it is also essential to achieving the current Universal Health Coverage agenda and fulfilling the universal human right to the highest attainable standard of health. One of six health system building blocks, governance is often neglected but nonetheless essential for guaranteeing access and strengthening emergency care systems in Africa. In this paper, we highlight key components of governance that are necessary to guaranteeing access to emergency care, describe current examples of emergency care accessibility laws and regulation in various African countries, and suggest priorities for measuring and evaluating the impact of legal guarantees for access to emergency care in Africa.

African relevance

- Access to emergency care in Africa is currently limited
- Good health system governance is essential to guaranteeing access to emergency care
- This article reviews considerations for governing emergency care accessibility via examples of African governance mechanisms

Introduction

Emergency care is the provision of care for conditions that require rapid intervention to avoid death or permanent disability [1]. The time-dependent nature of emergency conditions makes unrestricted accessibility a critical prerequisite of a functional Emergency Care System (ECS). Even if healthcare facilities with dedicated emergency units—adequately equipped and staffed with trained personnel—are available in sufficient quantities for the population, the system will fail if acutely ill or injured people are unable to access the ECS promptly. For the individual, the consequences are avoidable death or permanent disability; for society, the consequences include lost productivity, increased spending on care, and poor population health. Previously identified barriers to emergency care access include distance, financial costs, and perceived (lack of) quality and acceptability of available services, among others [2–4].

Health system governance, one of the six WHO health system building blocks, is a means to ensure coordination of efforts between the many actors and stakeholders within the health system to maximize system effectiveness. Broadly, governance comprises "*the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals.*" [5] Governance incorporates a strategic policy framework with effective oversight, coalition building, regulation, attention to system-design, and accountability [6]. As such, achieving universal access to quality emergency care is inseparable from strong governance. Yet, to date, there has been little published in the academic literature related to governance of the ECS.

In this paper, we (i) highlight the key components of the ECS that are critical to guaranteeing access to emergency care, (ii) describe current examples of African governance mechanisms to enforce accessibility of emergency care, and (iii) suggest priorities for measuring and strengthening emergency care governance to improve accessibility to emergency care in Africa. To this aim, we begin by introducing the importance of accessibility and its key components, discuss the role of governance in the health system building blocks, and then describe contemporary examples of governance mechanisms being used in Africa to ensure access to emergency care. Finally, we suggest methods for evaluating governance of emergency care systems and potential metrics for tracking progress toward universal access to emergency care.

Accessibility and the emergency care system

Accessibility of health care is a complex concept involving an individual or population's ability to seek, reach and utilize health care services, with five dimensions: approachability, acceptability,

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availability & accommodation, affordability and appropriateness [7]. The time-dependent nature of emergency conditions makes accessibility all the more important. Problems with accessing emergency care, whether via systematic barriers or lack of available emergency services, lead to delays in care and worse outcomes. The "three delays model," adopted from its original use by emergency obstetric programs to reduce maternal mortality, points to delays in deciding to seek care, delays in identifying and reaching a facility, and delays in receiving adequate and appropriate care [8]. It is a useful model for considering issues with accessing emergency care that may be improved with proper governance mechanisms among other health systems interventions.

There have been significant strides in developing emergency care in Africa during the 21st century, yet accessibility remains limited to a small proportion of the population. Ouma and colleague estimated that 71% of people in Africa live within 2 h of a hospital that potentially provides emergency services [9]. However, this method likely overestimates the geographic accessibility of emergency care, since the true availability of emergency services in many of these hospitals is limited, ineffective or frankly non-existent [10]. Additionally, this calculation neglects other dimensions of accessibility such as affordability, acceptability, and appropriateness.

Accessibility is not only critical for optimizing the ECS's performance with regard to averting death and disability, but also for ensuring basic human rights. The United Nations Office of the High Commissioner for Human Rights' *General Comment N° 14* frames the "Right to Health" in terms of availability, accessibility, acceptability and quality (AAAQ). It further elaborates accessibility in terms of non-discrimination and economic affordability [11]. The rights-based approach to emergency care stresses the AAAQ framework as a means for developing ECSs that fulfill a government's core responsibilities—no matter the country's income level—to its people. Issues of access feature prominently when mapped across health system building blocks, including laws guaranteeing access to emergency care, bystander protection ("Good Samaritan") laws, regulatory mandates for initial screening and stabilization before requesting payment, and financing mechanisms to fund facilities that provide emergency care to people who otherwise cannot pay [12]. Table 1 highlights key governance components found in the World Health Organization (WHO) ECS Framework. As economic development and reallocation of resources allows for the progressive realization of a more comprehensive emergency care system, other components such as a toll-free universal emergency number and ambulances can be legislated and regulated though various governance mechanisms.

Through the Universal Health Coverage (UHC) agenda, multilateral organizations such as the WHO, academic institutions, funders, and many national governments are strategizing methods to enhance coverage and improve the health of the entire population. UHC focuses on equity in access to health, protection against financial risk, and quality of health services [6]. As it relates to the ECS, UHC will require non-discriminatory and timely access to emergency care without regard to ability to pay. While significant strides are needed in building blocks such as human resources, essential medical products and technology and information, none will be as foundational as issues of governance and financing.

The role of governance

Governance encompasses a broad range of activities beyond the scope traditionally defined by national and regional governments. The United Nations Development Programme defines governance as "the exercise of political, economic and administrative authority" in the management of public affairs at all levels, and note that it allows citizens to collectively voice interests, mediate differences and claim legal rights through a variety of institutions and complex mechanisms [13]. Applied to health, good governance yields effective delivery of health services to meet the needs of the population and fundamentally relies on the setting of standards, incentives to motivate or deter certain actions, information to clearly define outcomes and performance, and a system of accountability [14].

Health governance brings together a large number of societal actors (e.g. governments, civil societies, non-governmental organizations, corporations, medical practitioners, and citizens). Through these groupings, governance allows for responsible and equitable allocation of resources to maximize the benefits to the population; done poorly, laws and policies can waste resources and harm marginalized populations. The quality of governance has been linked to health system performance, although this effect is limited when inequities are prominent within the system [15,16].

Current governance of emergency care access in Africa

There are a variety of legal and regulatory instruments that are used in governing health systems, including international treaties, constitutional and statutory law, regulations, guidelines, protocols and informal practice patterns. Laws and regulations are two of the most concrete mechanisms for communicating strategic plans, setting incentives, and enforcing governing directives.

The literature has not discussed key components of laws that lead to effective implementation of universal access to emergency care. However, drawing from the WHO ECS Framework and published laws, certain commonalities and best practices emerge. The variability of global legal systems (i.e. common law, civil law, statutory law, religious law or a combination) is an important consideration before applying these, though [17]. In general, policymakers may wonder what components are essential to a comprehensive law that guarantees access to emergency care. In order to truly guarantee access to emergency care without regard to ability to pay, such laws must (1) apply to all persons - citizens and all others, including vulnerable populations and minorities - who are, or believe they are, experiencing a health emergency, (2) protect against demands for payment prior to assessment that may delay life-saving care, and (3) mandate emergency evaluation and stabilization in all qualifying facilities. These laws should also (4) dictate penalties for violations and (5) establish regulatory bodies with the

Table 1
Example governance components for emergency care accessibility.

Laws	Laws guaranteeing access to emergency care for all people without regard to ability to pay
	Legal protections for bystanders providing care to acutely ill or injured persons (Good Samaritans)
Regulations	Mandate for initial emergency screening and stabilization prior to request for payment
	Creation of a universal access phone number (e.g. 112, 911) to activate the prehospital ECS
	Establishment of a national and sub-national regulatory agency with sufficient authority to monitor and enforce laws and regulations that protect access to emergency care.
	Establishment of emergency referral networks and transfer protocols
	Financing of facilities that serve geographically- or resource-limited populations
	Creation of a system for monitoring and evaluating access regularly
	Development of a system for reporting discriminatory practices and violations of emergency care access laws

Source: WHO ECS Framework (annex) [38].

authority to enforce the law. These components were derived from a rights-based framework for emergency care cross-referenced with the WHO Emergency Care System Framework [12]. To our knowledge, no one country has achieved all components in full, but we review several examples of governance mechanisms to fulfill key portions in a variety of African countries below.

International treaties

International treaties are multinational agreements that carry legal obligations for member states that ratify them. There are several that deal with right to health issues and therefore obligate signatories to uphold certain principles or policies with regard to health. Every country in the world had signed at least one of these treaties as of 2008 [18]. Eight international treaties, ratified by 48 to 196 member states each, guarantee access to emergency and essential surgical care and anesthesia, which overlaps the ECS [19]. While the legal obligations are well-codified for the signatories of these treaties, international mechanisms for accountability are often lacking [20]. That said, international human rights law has successfully been used at the level of national courts to improve access to essential medications in 59 court rulings as of 2006 [21]. On this basis, countries in Africa that have ratified one of these treaties might already have a legal obligation to guarantee access to emergency care even without passing domestic laws, although enforcement and accountability will often depend on claims and lawsuits in the country's judicial system. Treaties also signal a public commitment that may be more easily followed by national laws and regulations that further codify the governance directive related to emergency care access.

Constitutional law

A nation's constitution is its most fundamental law, establishing its conception and organizational structure as well as the extent of its sovereign power and the methods through which it exercises power. With respect to health systems, constitutional laws are a powerful mandate to respect, protect and promote the right to the highest attainable standard of health [22]. For example, the incorporation of a right to access essential medications into the national constitution has been shown to have an effect - via favorable court rulings - on national implementation [21].

At least seven African countries - Egypt, Kenya, Somalia, South Africa, South Sudan, Sudan, and Zimbabwe - have constitutional guarantees of access to emergency care [23–28]. For example, Article 27.3 of the *Constitution of South Africa* states, "*No one may be refused emergency medical treatment,*" while Article 18 of the *Constitution of the Arab Republic of Egypt* declares, "*Denying any form of medical treatment to any human in emergency or life-threatening situations is a crime.*" [23,25] These constitutional provisions clearly articulate a person's right to access emergency care but provide scant guidance on what constitutes a health emergency or emergency medical treatment, do not clearly define the party responsible for delivering emergency care or the regulation and enforcement of the constitutional guarantee, and do not describe the penalties for failing to comply with this law. However, the presence of a constitutional guarantee for emergency care accessibility is an important first step to facilitate further legislation, regulation and enforcement via lawmaking bodies, courts, and regulatory ministries.

Statutory law

In contrast to constitutional law, statutory laws (also known as *acts* or *legislation*) are more detailed and specific. Elected or appointed legislators (parliamentarians) perform an important role in drafting and passing statutory laws, and then judges, executives and their ministries must interpret and enact them [29]. To date, there has been no formal review of statutory laws that are applicable to emergency care access in

Africa, but we present some examples here.

In the *2003 Health Act of South Africa*, a statement mirroring that expressed in the Constitution re-enforces the right to access emergency care. In addition to this clause, the act also contains language that places emergency care under the purview of the Ministry of Health (article 90.m) and delegates, or decentralizes, much of the regulatory responsibility to the provincial level (article 25.m) [30]. The act does not clearly define health emergencies, delineate the scope and extent of emergency medical treatment, or specify the enforcement and penalties for violations. In light of this failure to provide sufficient guidance on issues such as the definition of a medical emergency, the judicial courts and regulatory bodies were forced to clarify. In the case of Soobramoney vs. Minister of Health, Kwazulu-Natal (1997), the courts interpreted the Constitution in the case of a man that sued for routine dialysis to be covered in a government hospital on the basis that his chronic renal failure would result in death if not addressed with haemodialysis. The courts ruled that a medical emergency is "*the dramatic, sudden situation or event, which is of a passing nature in terms of time. There is some suddenness and at times an element of unexpectedness in the concept of Emergency Medical Treatment.*" [31] Based on this justification, the courts denied the claim by Soobramoney but provided the first definition of a medical emergency—albeit controversial—that would obligate facilities and healthcare providers to care for a person under the Constitutional right [32].

The South African Council for Medical Schemes, the health insurance regulatory body, defines medical emergencies as part of the prescribed minimum benefits covered by insurance: "*An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation AND if the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.*" [33] This definition, although only applicable to medical schemes (e.g. insurance), enhances access to emergency care by improving affordability and financial coverage.

In Kenya, the *2017 Health Act* established the right to emergency care in clear language that also mirrors its constitution. In the act, a medical emergency is defined as "*an acute situation of injury or illness that poses an immediate risk to life or health of a person or has potential for deterioration in the health of a person or if not managed timely would lead to adverse consequences in the well-being.*" The law goes on to define the scope of services that is included in the guaranteed emergency care provision, including prehospital care, stabilization, and referral to another facility based on capacity and needs (article 7.2). Specific provisions of the law indicate that the mandate extends to both public and private sector healthcare providers (article 12.2b). A financial penalty is set for institutions that are convicted of failing to comply with the mandate to provide emergency medical treatment (article 7.3). Finally, the law delegates responsibility for emergency care regulation and policymaking to the MoH, requests the creation of a dedicated funding source for emergency medical treatments, and obligates the MoH to develop policies, training and standards for the provision of emergency healthcare [34].

Regulations

Regulations, protocols, guidelines and other policies are less permanent and enforceable when compared to constitutional or statutory laws, but they nevertheless play an important role in governing access to emergency care by clearly outlining the strategic direction, creating incentives and sanctions, directing intelligence gathering, and formalizing a system of accountability. Often passed by the MoH or other executive office, these rules are detailed and prescriptive when done properly. For example, the MoH of Ghana created its "Policy and guidelines for hospital accident and emergency services in Ghana," in 2011. In it, the government (1) offers guidance regarding the physical structure, staffing and stocking of functional emergency units, (2)

defines health emergencies, (3) mandates a triage-based screening for emergencies, (4) prohibits facilities for requesting payment within the first 48 h of hospitalization for an emergency, and (5) proposes avenues for financing the ECS [35]. This type of policy allows for granular details.

South Africa's *Emergency Medical Services Regulations* detail how prehospital care services should be provided, including establishing a licensing process for all services, laying out norms and standards for services, establishing the powers of EMS personnel, and providing penalties in the event of contravention [36].

Strategic plans that dictate the government's intention to develop emergency care are becoming more commonplace throughout Africa. For example, Rwanda released the MoH Emergency Medical Services Strategic Plan (2018–2024) that uses a current system assessment to develop a roadmap for improving emergency care—including a specific objective to improve the "equity and geographic accessibility of [emergency medical services]" across the country [37]. The plan focuses primarily on improving available services rather than protecting accessibility for vulnerable populations but does later discuss sustainable financing which would improve the affordability (economic accessibility) of emergency care. Policy documents like this one set priorities and dictate the processes that will be followed to enhance access to emergency care. They are particularly useful for building consensus among stakeholders and may initiate the processes to subsequently pass enforceable legislation and regulation.

Administrative structures

No two countries have the same administrative structures for health governance, and there is no consensus or evidence-based guidance for the optimal structure of health ministries to facilitate emergency care systems. However, preliminary reports from the WHO Emergency Care System Assessment (ECSA)—a survey-based and consensus-oriented tool that both assesses a country's emergency care system and sets priorities for improvements—suggest that the designation of a specific agency within the government would ensure better coordination of emergency care, as reported in *Disease Control Priorities* [38]. This suggests that many of the countries that have voluntarily completed WHO ECSA believe that there are currently inadequate administrative structures or agencies to implement and oversee emergency care. In several of the example statutes and regulations above (e.g. South Africa, Kenya), this authority is designated to the ministries of health, which have subsequently created dedicated units for the oversight of the emergency care system. While it logically follows that a dedicated agency with purview over emergency care would allow for more coordinated governance (including functions such as oversight, coalition building, and accountability) and improved system efficiencies, to date there has not been adequate study of these functions. Further research is needed to quantify the effect of such administrative structures on the delivery of emergency care and its cost-effectiveness.

Measuring progress and setting priorities

Given the complexity of processes such as legislation and regulation, health system governance initiatives are often slower than changes to other health system building blocks that require less formal processes. That said, governance is iterative and requires regular measurement and evaluation to assess progress and refine interventions to achieve the desired improvements to the health system.

In order to understand gaps in health system governance and identify areas for improvement, a framework has been proposed for assessment, which includes ten principles of good governance with a focus on policy and operations at the national and sub-national level [39]. This framework is designed to find targeted areas for improvement via qualitative and value-driven (rather than normative) assessment of available information. In Box 1, we have applied these

principles to governing accessibility of emergency care. Notably, governments prospectively creating administrative structures can also use this framework to ensure best practices are followed a priori.

The principle of effectiveness and efficiency is of particular interest to agencies wishing to measure the impact of laws and regulations on the accessibility of care. At the most fundamental level, accessibility to emergency care can be measured by the presence or absence of laws and regulations governing access to care with explicit provisions that define what constitutes emergency care, specify the right to stabilising care regardless of ability to pay, and extend these provisions to the entire population including vulnerable populations. In countries with health insurance schemes that explicitly provide coverage for emergency care, the percentage of the population with insurance may also serve as a surrogate measure for access.

While the presence of laws and regulations that guarantee access is important, this may not reflect the reality experienced when the population attempts to access care. Additional metrics for assessing barriers to access may include emergency health outcomes indicators stratified by different socio-economic and minority statuses, quantifying catastrophic health expenditures from seeking emergency care, or determining rates of patients being turned away due to inability to pay (either extrapolating from pre-hospital data of ambulances turned away or personal patient experiences). The collection of these types of metrics in particular requires a robust data collection and reporting infrastructure, which may be challenging to gather in low resource settings without investing in data systems.

Conclusion

Improving access to emergency care in Africa requires careful consideration of governance mechanisms. Legislation is needed to establish a legal guarantee of access to emergency care regardless of ability to pay. Constitutional and statutory laws, regulations, and other governance mechanisms show the potential impact of legislative guarantees of access to emergency care in Africa, but further research is needed to answer questions of impact and effectiveness of such legislation. For example, what are the costs (and cost-effectiveness) of such laws? What are the key components of legislation that are essential to guarantee access to emergency care? Which modifications of key components are acceptable for varying resource and cultural contexts? Which indicators most feasibly and accurately measure accessibility? Finally, what are the barriers to implementing such laws in Africa and worldwide? Academic partners of governments will play an important role in monitoring, evaluating and reporting on advances in governing access to emergency care, which in turn will assist policymakers in drafting the most impactful legislation for their countries.

Author's contributions

Authors contributed as follow to the conception or design of the work; the acquisition, analysis, or interpretation of data for work; and drafting the work or revising it critically for important intellectual content: TB contributed 50%; HB 30%; and LW 20%. All authors approved the version to be published and agreed to be accountable for all aspects of the work.

Declaration of competing interest

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Box 1

Ten principles of good governance [39] applied to ECS accessibility.

1. *Strategic vision*. Leaders have a long-term perspective on developing the ECS according to best-practices and the fulfillment of human rights.
2. *Participation* & *consensus orientation*. The governance process is inclusive of diverse voices from the population and major actors within the ECS in order to achieve consensus for priority-setting and the acceptability of ECS developments.
3. *Rule of law*. Legal frameworks are fair, impartial and readily enforced to protect the population's ability to access emergency care.
4. *Transparency*. Information on emergency care policies is readily available to the community and other actors to understand and monitor changes in the ECS.
5. *Responsiveness*. Emergency care policies and regulations are created to serve and respond to the needs of the many stakeholders.
6. *Equity* & *inclusiveness*. All people, regardless of gender, income, religious affiliation, immigration status or sexual orientation should be able to participate in the ECS and receive care for a perceived emergency.
7. *Effectiveness and efficiency*. Policies and processes created through ECS governance should create measurable improvements in accessibility to emergency care and related emergency health outcomes in the population.
8. *Accountability*. Policymakers, healthcare facilities, and healthcare providers must be held accountable via enforceable mechanisms to ensure that universal access to emergency care is protected and promoted.
9. *Intelligence* & *information*. Data on the state of accessibility to emergency care and health outcomes should be reliably collected and used to inform policy decisions and system improvement efforts.
10. *Ethics*. Policy decisions should consider ethical principles such as autonomy, nonmaleficence, beneficence and justice in patient care and research related to accessing emergency care.

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