EMERGENCY MEDICAL SERVICES IN THE EASTERN CAPE
Mothers giving birth at home; babies developing disabilities due to difficult unsupervised births; diabetics unable to reach treatment; old women crossing rivers and spending most of their pensions to get to the clinic; a 10-year-old boy dying of pneumonia because his mother could no longer carry him to hospital; a young woman dying in pain after a 10-day wait for an ambulance. Countless tragedies occurring every day across the Eastern Cape and stemming from one cause: an emergency medical services system that has failed.

On 25 and 26 March 2015, the South African Human Rights Commission held a public hearing on emergency medical services (EMS) in the Eastern Cape. The hearing followed a complaint made to the commission in March, 2013 by the community of Xhora Mouth, an investigation by the commission into the state of EMS in the province, and ongoing advocacy by the Eastern Cape Health Crisis Action Coalition (ECHCAC).

The EMS hearing was quite unlike the normal consultation processes attended by government officials and community members. It was preceded by mass meetings in Xhora Mouth, Isilatsha Village, Nier Village, and Lusikisiki in which attendees spoke about EMS problems in their areas and elected representatives to attend the hearing. The hearing itself had the feel of a truth and reconciliation commission, with old women, young men, chiefs and grief-stricken family members standing up and talking publicly about the tragedies they have witnessed when an ambulance fails to arrive or arrives hours after it was called. Government officials from the Department of Health, Provincial Treasury and Planning and Roads presented their plans and answered questions. There was nowhere to hide.

The commission published a report on the hearing in October, 2015. In the report, the commission made findings and recommendations for the improvement of the EMS system in the Eastern Cape. A summary of key findings and recommendations can be found from page 9. The commission's report is detailed. It found that although a number of important achievements have been made in the Eastern Cape relating to access to health care over the last 20 years, many of the same challenges in impeded access persist. The commission recommended a number of steps for the Eastern Cape Department of Health to take to meet its obligation to realise the rights of everyone in the Eastern Cape not to be refused emergency medical treatment and to access to health care services.

The coalition supports the findings and recommendations of the commission and is committed to monitoring their implementation. We cannot allow the department to continue to fail in its obligations to health care service users in their hour of most desperate need and the EMS hearing and report are a step in the right direction. Read the full report from the commission here: www.section27.org.za/SAHRCreport
The ECHCAC is a coalition of organisations and individuals primarily from the Eastern Cape dedicated to fixing the health care system and ensuring the realisation of the constitutional right to health in the province.

**The Eastern Cape Health Crisis Action Coalition includes:**

- Association of Concerned Specialists of the PE Hospital Complex
- Black Sash
- Budget Expenditure Monitoring Forum
- Counsel for the Advancement of the South African Constitution
- Democracy from Below
- Democratic Nursing Organisation of South Africa
- Hospersa
- Igazi Foundation
- Jubilee
- Junior Doctors Association of South Africa
- Keiskamma Trust
- People’s Health Movement
- People Living with Cancer
- Professional Association of Clinical Associates in South Africa
- Public Service Accountability Monitor
- Restless Development South Africa
- Rural Doctors Association of South Africa (RuDASA)
- Rural Health Advocacy Project
- Rural Rehabilitation South Africa
- SECTION27
- Sonke Gender Justice
- South African Medical Association
- Treatment Action Campaign
- TB/HIV Care Association
- World Aids Campaign
- World Vision South Africa
Why the focus on Emergency Medical Services?

The Coalition has, since its inception, maintained a focus on EMS. There are a number of reasons for this focus:

+ First, the right not to be refused emergency medical treatment is laid out in section 27(3) of the Constitution and is not subject to progressive realisation or resource limitations. The Eastern Cape Department of Health is obliged constitutionally to prioritise emergency medical treatment in its planning and budgeting. Tokozile Mtsolongo’s contribution at page 41 describes the worrying historical and current state of planning and budgeting for EMS in the Eastern Cape.

+ Second, it is clear from the evidence that the coalition has gathered that people across the province are being denied their right not to be refused emergency medical treatment every day. The problem is wide ranging; occurs across the province; results in the loss of life, in ongoing sickness and sometimes disability, in the violation of the dignity of the elderly, the disabled, mothers, babies, children, and men; and in the violation of the right to equality of Eastern Cape residents who are denied the rights accorded to people in other parts of the country and people who have the resources to rely on private health care services. The stories of some of the people who gave evidence to the commission and at the hearing can be found throughout this report on light red pages.

+ Finally, the coalition has focussed on emergency medical services and planned patient transport because the failure of these service impacts disproportionately on the most vulnerable. People with disabilities have a particularly difficult time accessing health care services and this is made worse when transport is not available (in emergencies but also for planned appointments), especially in rural areas where many people walk long distances to clinics and hospitals. Shannon Morgan’s contribution at page 38 contains some harrowing examples of the tragedies experiences by people with disabilities in the province when they are unable to access emergency care. While there is a stated emphasis in the Eastern Cape on providing access to health care services to pregnant women and children to reduce the high maternal and infant mortality rates, countless people have told the coalition about children being born at home when the ambulance that was called failed to arrive or arrived many hours late. Too many of the women forced to give birth at home have complications and we have been told of a number children who have died after or during home births where an ambulance never arrived. Poor people incur catastrophic expenditure hiring private transport in emergencies. Dr. Jane Goudge speaks about the impact of this expenditure at page 36.

While the Department of Health attempts to move toward a less hospicentric model of health care, where health problems are prevented through early intervention, emergency medical services will always be required and will remain a fundamental component of any functional health system.
WHAT SHOULD AN EMS SYSTEM LOOK LIKE?

The World Health Organisation has endorsed the importance of EMS and the need and priority for development of EMS systems worldwide but there is no international standard for EMS systems. In fact, EMS systems differ greatly around the world depending on context. Important elements of the context influencing EMS systems include the level of national development, geography, and social and health system priorities and capabilities.

What is generally accepted internationally is that a well-organised EMS system that is appropriate to its context can minimise poor health outcomes, mortality and morbidity.

An effective EMS system cannot be based on standards lifted wholesale from an entirely different context. In order to be efficient and effective, an EMS system must be conceived with consideration given to the context in which it will operate. Only then will it be capable of facilitating emergency medical treatment in anything resembling an efficient and effective manner to the society that it is meant to serve.
A basic EMS system in the Eastern Cape should have at least the following components:

+ Ambulances need to be close to the people they serve. Proximity to the community served is vital for the provision of an adequate basic ambulance service, particularly where roads are bad. The standard of 1 ambulance per 10 000 people is a rough standard that is in no way related to the South African or the Eastern Cape context. A better standard may be to base the number of ambulances on the number of health care facilities because the placement of health facilities has already been considered in the context of the distribution of the population in South Africa.

+ Two people, both of whom have at least basic life support training (but preferably one of whom has a higher level of training), should staff each ambulance that is operational. Under no circumstance should any ambulance ever be staffed by a single person, as it turns an ambulance, which is meant to provide transport and treatment, into a simple non-medical means of transport.

+ Each ambulance needs to be equipped with the equipment required in the scope of practice of basic life support professionals. This is a basic and relatively inexpensive list of equipment.

+ The call centres currently used to dispatch ambulances should serve two additional functions:
  - Call centre operators should be trained to assess the degree of the emergency to enable them more properly to determine the prioritisation of calls. This process is referred to as “triage” and is a basic practice used around the world in various forms. This will prevent ambulances being dispatched to non-emergencies, which leaves the vehicles unavailable to respond to emergencies.
  - Call centre operators should be trained to provide verbal advice to telephone callers seeking medical assistance to enable them to provide care while waiting for the ambulance.

+ Target response times should be developed, publicised and reported on.
FINDINGS AND RECOMMENDATIONS

EMS IN THE EASTERN CAPE

UNIT 254

EMERGENCY SERVICE
FINDINGS AND 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.”

As a state institution supporting constitutional democracy and mandated to promote the protection, development and attainment of human rights, the commission’s recommendations are aimed at ensuring that the ECDoH complies with its constitutional obligations and the rights of the people of the province.

The commission made numerous recommendations on each aspect of the EMS system. The recommendations can be summarised broadly as follows:

1. There is a need for clarity by the ECDoH on what standards it intends to comply with, what targets it sets to move towards compliance with standards, and how it measures its level of compliance. Particular problems in this regard have arisen in the planning and budgeting for the number of ambulances needed; the type and distribution of those ambulances and the factors considered in deciding on the type and distribution; the equipping of ambulances; and response times.

2. The ECDoH is obliged to plan in a way that aims at improvement of the EMS system.

3. The ECDoH does not report in a way that is transparent, consistent, or allows itself or others to monitor progress. Reporting needs to be in line with targets set and consistent across years.

4. Human resources for EMS is a huge problem and, as it stands, human resources constraints limit the ability of the ECDoH to use the vehicles that it has for EMS. The ECDoH needs to prioritise the employment, training and retention of staff, particularly intermediate and advanced life support staff, to ensure that each ambulance is staffed by at least two people, one of whom should have more than basic training.

5. In deciding on the distribution of resources, including the rostering of vehicles and the location of vehicles in different districts, the ECDoH needs to take account of the needs of different communities, particularly people in vulnerable groups and rural areas. This is a matter of prioritisation and resource management.

6. The ECDoH should communicate better with its staff and with patients about its plans and priorities, procedures and mechanisms that are available within the system to improve EMS.
My nephew died after waiting for hours for an ambulance. This incident still haunts me to this day. I remember it as if it were yesterday.

I received a phone call from my sister who lives in Ngqamakhwe Village at about 19h00 on an evening in October, 2012. She was scared and panicking. She asked me to phone for an ambulance as my nephew, her son, had had a severe seizure and had a fever and was vomiting. She had phoned for an ambulance and had been waiting for an hour. I immediately called the ambulance dispatch operator and I was told that the ambulance was out responding to another case. I called repeatedly, desperately, for a few hours to no avail.

At 23h00 – five hours after my sister’s initial call – I called again and was told that the ambulance had been dispatched to the scene. It arrived soon after that and collected him. My sister called me a few minutes later, however, to inform me that her son had passed on before the ambulance reached the hospital. It is unacceptable that the ambulance took five hours to arrive.
1. Legal framework

**Key findings**

- The national standards for ambulance services (which were never provided to the commission) purportedly lay out an ambulance to population ratio of 1:10,000 but it is not clear whether this ratio includes the total number of vehicles in the department’s fleet or the number of vehicles that are operational or rostered. In addition, it is not clear whether all vehicles (pre-hospital, IFT, MOU and PPT) are included in the ratio.
- It is not clear that the context of a district or province is taken into account when deciding on the application of national standards. Factors including, but not limited to, 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 transportation are important in determining the appropriateness of the national standards in specific provincial contexts. Before applying national standards, a consideration of their appropriateness for the province should be undertaken.

**Recommendations**

1. 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.
2. The DoH is further required to establish National Standards relating to the number of Maternity Obstetric Units (MOUs), Planned Patient Transport (PPT) and Interfacility Transfer (IFT) vehicles required, which standards should allow for flexibility depending on the context in which they will be implemented.
3. The National Department of Health 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 transportation. It is further recommended that these national standards be made publicly available to contribute to a system of transparency and accountability for service delivery.
4. The Eastern Cape Department of Health (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.
5. 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.).
6. It is further recommended that all policies developed by the ECDoH relating to the delivery of emergency medical services be made publicly 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.
2. Ambulances

Key findings

- There is no clarity on the meaning and application of the national standards, which (among other factors) leads to discrepant application of, planning for and reporting on compliance with the ambulance to population ratios purportedly in the national standards.
- The ECDoH’s long-term vision for its EMS fleet is unclear given the fluctuating targets given in its planning documents.
- The ECDoH has been inconsistent in its reporting on the number of vehicles in its EMS fleet, the type of vehicles, and how many and which vehicles are operational and rostered, making assessment of its adequacy difficult.
- The total fleet size of the ECDoH at present (416 vehicles) is inadequate to provide for the EMS needs of the people of the province.
- Only 200 ambulances are currently rostered, for a population of 6.56 million people spread over a large and mostly rural area. Without the rostering of the vehicles currently in the ECDoH’s fleet, the acquisition of further vehicles will not improve service delivery.
- There appears to be no prioritisation of the operationalisation and rostering of ambulances with 4x4 capabilities, with the result that only 19 of such vehicles are currently rostered.
- Only 40 MOU vehicles are currently rostered.
- There is a disparity between the experiences of health care service users and reports from the ECDoH concerning the equipping of ambulances. Many people who called an ambulance report it arriving without, sometimes basic, equipment. The ECDoH claims that ambulances are checked before being dispatched and are properly equipped in line with HPCSA requirements.

Recommendations

1. The ECDoH to ensure that the implementation and measurement of compliance with national standards is applied consistently in all planning and reporting documents.
2. The ECDoH to take appropriate steps to ensure that all ambulances currently in its possession become fully operational 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.
3. 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.
4. 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.
5. 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.
6. 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.
I suffer from epileptic fits and I depend on St Elizabeth Hospital for my treatment. Depending on the state of my health, I have to go to hospital on average twice a month. A lot of the time 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.

Sometimes the fits are mild and they pass without the need for medical interventions. When I have severe fits, I must see a doctor urgently. This happens sporadically. There have been months when it has happened three times. In the past, my children have called the ambulance from St Elizabeth Hospital, which is the closest hospital. However, the ambulance has never arrived when they have done this. Therefore, they go to my neighbour, who has a car. He charges R400 if he takes me during the day and R450 if he takes me in the night.

Both my husband and I are unemployed and our disability grants are our only source of income. These grants amount to R1200 for each of us. The knock-on effect of these costs are therefore terrible for me. I have had to borrow money to pay and sacrifice on other essential items such as food. When I borrow, my only option is loan sharks that charge very high interest rates.

I have never seen an ambulance in my village. My children and I have called for ambulances on many occasions but they have never arrived.

The lack of ambulance services in my area places my health and life in danger and has pushed me into debt and deeper poverty.
Villagers wait for a mobile clinic to arrive.
PEOPLE’S STORIES

SINDISWA NGCANGA, A 56 YEAR OLD UNEMPLOYED WOMAN LIVING IN ISILATSHA VILLAGE

In October of 2014, my daughter, who was pregnant at the time, went into labour. I called for an ambulance at around 20h00. The operator at the call centre told me that an ambulance would be dispatched once one came back from a call out. I kept phoning the call centre for an update and was repeatedly told that an ambulance would come but my daughter would have to wait until an ambulance was available.

I gave up hope after midnight.

I did not want my daughter to have to give birth at home because I am not trained to deliver a baby and I wouldn’t know how to deal with any problems that arose. We knew we had to get to hospital so we decided to hire private transport to get to Komga Hospital. We knew that the driver did not have a drivers license but we were desperate. The trip cost R300.

Fortunately we got to Komga Hospital in time for my grandson to be born.

After the birth, we learned that the geyser at the hospital was not working so there was no warm water to bathe my grandson and my daughter. I went all the way back to Isilatsha Village to fetch warm water to bathe the child. I arrived back at the hospital around 8h00 the next day. Neither of them had bathed and we used the water that I brought in a flask to bathe each of them.

No one should have to go through this to give birth.
3. Interfacility transfers and planned patient transport

**Key findings**

- 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.
- The lack 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.
- The lack of a planned patient transport system which transports patients from communities to health care facilities creates severe impediments for access to health care in general, especially for vulnerable groups. Disabled persons in particular face absolute barriers to access as public and private transportation services regularly refuse to provide transportation services, either because they are unable or unwilling to do so.
- The ECDoH does not report on PPT in detail in its reporting and planning documents and, where it does, it frequently conflates IFT and PPT.

**Recommendations**

1. 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 ambulances 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
ANONYMOUS, A TREATMENT ACTION CAMPAIGN (TAC) MEMBER LIVING IN TARKASTAD

Because of my membership of the Treatment Action Campaign, I spend time with a lot of people in my community in need of health care services and witness the difficulties that they experience in accessing them. I have also experienced difficulties in accessing health care services myself.

The most significant health service failing that I have experienced relates to ambulance services. On two occasions in 2012, I called an ambulance for the victim of a stabbing and had difficulty in getting the ambulance to respond.

In mid-2012, a member of my community was stabbed near to my house. I called the ambulance service only to be told that the ambulance was not available as it was in Queenstown. I then called the police who responded and when they saw the state of the stabbing victim, they called the ambulance and it was dispatched. Calling the police for assistance is also not consistently effective. At the end of 2012, a woman was stabbed at night just outside the TAC branch office. I was at the office and came outside to see this woman in the street. I called the ambulance service and was told that no ambulance was available and that I should hire a car or a taxi to take the person to the hospital. It is not easy to get hold of a private car at night in Tarkastad under normal circumstances — it is even more difficult in an emergency medical situation because the taxi drivers are reluctant to take a person with a medical emergency to hospital because of the risk that the person may die or make a mess in the taxi.

I walked a few kilometres to Matjie Venter Hospital and saw an ambulance parked in the yard. I asked the person at the reception desk at the hospital why this ambulance could not be sent to collect a patient and I was told that there was no driver.

I then went to the police station to ask the police to call the ambulance. The police officer told me that there was nothing they could do if there is no ambulance driver. When I arrived back to the TAC office, I discovered that the woman had been taken to the hospital by a man in a private car. She was bleeding a lot and it was obviously clear to this man that she needed help. Fortunately, he was there and able to help her. Without him, we do not know what would have happened. Because of the lack of an available ambulance, we had to wait a number of hours before getting to the hospital to get the medical attention she needed.
PEOPLE'S STORIES

SCOTT LEE-JONES, A COMMUNITY SERVICE DOCTOR AT MADWALENI HOSPITAL FROM JANUARY 2013 TO DECEMBER 2013

Madwaleni Hospital is a district hospital in the Madwaleni–Xhora area of the Mbashe sub-district of the Amathole district. During my time at Madwaleni hospital, I experienced first hand some of the problems in the EMS system.

Personal public transport (PPT) refers to the system of transporting patients between health facilities in non-emergency situations. For example, if a patient had an appointment at Nelson Mandela Academic Hospital, he or she would take PPT to the appointment. The PPT services at Madwaleni Hospital were frustratingly unreliable, which had negative consequences for patient care and health. The inadequacies of PPT services also affected ambulance services because ambulance services took extra strain when they were used to compensate for poor PPT services.

The PPT bus was scheduled to leave at 3 am every morning in order for patients to secure a place in the queues at the hospital in Mthatha. This was the only way to allow for the patients to be seen on the same day. However, in my time at Madwaleni Hospital, there were many mornings in which the PPT bus simply did not arrive. This would leave 10 to 15 patients without transport. The patients would then miss appointments and need to be personally rebooked by clinical staff. This would delay access to services for weeks and often months. It could also lead to poorer health outcomes due to delays in receiving treatment. This, in turn, could lead to an increased demand for ambulance services in the future.

Moreover, even if the PPT operated as planned, it was still unable to serve the needs of an important group of patients. Often, we had to use ambulances to transport patients who were not in emergency medical situations because the PPT could or would not transport them for a variety of reasons. For example, a person with a broken femur or other fracture is not necessarily an emergency case and would not need to be transported in an ambulance if the PPT services were improved. However, because PPT services are only able to transport patients who can sit in a chair, a patient with a broken femur would need to be transported in an ambulance. This particular example, the lack of facilities to accommodate patients who cannot sit in a chair, means that a range of non-emergency stretcher cases must be transported by ambulance even though they are not in fact...
emergencies. In these cases, we had to book the ambulance a day in advance. Usually, the ambulance would not arrive at the scheduled time and we would therefore place a reminder call to the dispatch operator on the scheduled day. The ambulance would then arrive late, which would often result in a missed appointment. In that common scenario, the patient would be sent back to us having not been seen. This would require a re-booking and result in delayed access to services. Obviously, this is a remarkably inefficient use of resources, is inconvenient for the patient and may result in poor health outcomes. Moreover, any ambulance that is diverted to transport non-emergency cases is then not available for true emergency cases.

During most of my time at Madwaleni Hospital, there was not an ambulance stationed on site at the hospital.

There was supposed to be a dedicated obstetric ambulance on site, including after hours, to facilitate rapid transfer of obstetric emergencies. This ambulance was frequently not on site and the contact number for the driver was not provided to us. The ambulances were normally in Mthatha, in which case the absolute shortest amount of time it would take for the ambulance to arrive to Madwaleni was about 90 minutes. However, due to the shortage of ambulances, response times varied greatly. On average, it took several hours for an ambulance to arrive. It could also take as many as 12 or more hours and sometimes the ambulance wouldn't arrive at all.

An ambulance would typically be staffed with a driver and an assistant to monitor the patients in transit.

But often, there would only be a driver in the ambulance. This would mean that patients would be left unattended in the back of the ambulance during transportation.

We were also often concerned about the ambulance’s capacity to provide medical care en route due to the frequent lack of important medical equipment in the ambulances. For much of 2013, for example, I understand that there was a shortage of working incubators in ambulances. This would often cause delays in transporting small babies.

Moreover, the ambulance drivers, for the most part, had very limited medical knowledge. This effected our decisions to transport patients; we were often concerned that patients would not survive during transit. We would therefore sometimes choose not to transport patients even though they ideally should have been treated at another facility.

In certain emergencies, we were able to make use of a helicopter service. This was, however, only feasible when weather conditions allowed. To my knowledge, we used this service three times in 2013, each time for small babies.

The people who rely on Madwaleni Hospital require PPT and ambulance services that are better than those I have described above. In my time at Madwaleni Hospital, PPT and ambulance services were defined by scarcity and uncertainty.

The inevitable consequences of such a system include preventable morbidity and death.
4. Response times

Key findings

• 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.
• It is important that response time is accurately measured as the number of operational vehicles or staff members do not predict response time.
• The method of calculating response times is crucial. Time measured between dispatch and arrival of an ambulance does not take into account the time between a call being placed and an ambulance being dispatched. Submissions to the commission indicated that there is frequently a delay in this period, which may not be taken into account in the department’s reporting.
• There does not appear to be a way of recording cases where a call was made but an ambulance was never dispatched.
• In the hearing, superintendent-general Thobile Mbengashe announced that while the targets remain that urban P1 calls should be responded to in 15 minutes and rural P1 calls in 40 minutes with all calls supposed to be responded to within one hour, after two hours the matter could be reported to a more senior official and after four hours, the use of a private ambulance could be authorised. It is not clear how these different timeframes fit together, whether and to whom they have been communicated and how patients can make use of the new mechanisms.

Recommendations

1. The ECDoH to ensure that all performance indicators relating to response times are calculated in a manner that takes into account all relevant factors, and that the method of calculation should be clearly explained in planning and reporting documents.
2. 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.
3. 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.
4. The performance indicator relating to interfacility transfers should be reviewed by the ECDoH to provide for an appropriate timeframe in which transfers should occur.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. The number of instances in which the response time 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 annually in the reporting documents of the department.
On Friday, 29 September, 2014 at around 14h00 I called an ambulance for my sister. She was HIV positive, had tuberculosis and was suffering from bedsores, and general body pain. She was having fits and was dehydrated, had lost her appetite and had lost a lot of weight. I was told that we could not get an ambulance to transport her because it was a Friday and we were told that only people who were injured had access on that particular day. I was advised that I had to take my sister to the local clinic. I could not pay for private transportation either to the clinic or to Mount Frere Hospital as it cost R150 and R500 respectively. I was told to go to and wait by the nearby school in the hope that an ambulance would come.

We waited and waited. At 20h00 I called the ambulance again and I was accused of exaggerating my sister’s condition, an accusation I vehemently denied. I was told that we could wait at the school for an ambulance but that no ambulance would be sent for a terminally ill person. We waited again until 22h00 but still the ambulance did not arrive so I called again. At 06h00 the next day I again called the ambulance and was told that no ambulance would attend to my sister on a weekend. I was told that I should hire a private car to take my sister to the hospital.

I contacted The Daily Sun out of anger and frustration at the lack of care towards my sister. The reporters arrived on Monday and documented the story. It took reporting our tragedy to the newspapers to get any response from the Department of Health. Officials from the Bisho and East London offices called after the story broke in the papers saying I could lay a complaint, denying that refusal to ferry uninjured patients was something that occurred, and promising to send an ambulance.

When the ambulance finally came it did not have any equipment at all and was only staffed by a driver, leaving my sister unattended in the back. I accompanied my sister, expecting that we would be taken to Frere Hospital. Instead we were taken to Empilweni Health Centre where we were turned away by a male nurse after having given us Brufen and Panado tablets because, according to him, we did not belong there! We then had to return home in a hired car.

A relative came to visit my sister on 3 October, 2014 and was shocked at her condition. He immediately hired a car that took us to Mooiplaas Clinic. She continued getting worse and an ambulance then had to take her to Frere Hospital, where she was admitted. She passed away on 7 October, 2014.

I am not sure but I can’t help but wonder if my sister would still be here if she had not been denied emergency medical services. I am very angry and upset about the way my sister was treated by the Eastern Cape Department of Health. We have no choice but to rely on the Eastern Cape Department of Health and it treated us badly and let us down.
Directional signage on the pavement at the Holy Cross Hospital in Flagstaff.
5. Human resources

Key findings

• The ECDoH has insufficient staff to roster the vehicles in its fleet, meaning that not all vehicles are rostered.
• 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, non-profit organisations (NPOs) and former health practitioners provide an invaluable contribution to the delivery of health care services to people in need.
• The budget for staff training is not commensurate with the need for training.
• The EMS staff complement is overwhelmingly low level staff with only basic training.
• There is currently no funding for call centre staff.
• Call centre staff have not been appropriately trained until this point, but the ECDoH has now arranged for call dispatch training, for the purposes of triage, efficient dispatch practices and sensitivity and human rights training.

Recommendations

1. 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.
2. 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.
3. ECDoH human resources planning should further prioritise the training and recruitment of EMS staff with intermediate or advanced life support training.
4. 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.
5. 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.
6. 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.
7. The ECDoH in collaboration with the National Department of Health 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.
Patients at Madwaleni waiting for transport to Mthatha.
6. Accessibility of emergency medical services

Key findings

• EMS can be particularly inaccessible for people with disabilities.
• The difficult landscape and historical underdevelopment of the Eastern Cape requires not only the development of better road infrastructure (which will take a long time) but also short and medium term solutions to ensure that people and health facilities are accessible. This includes the procurement of EMS vehicles with 4x4 capabilities as a priority.
• Difficulty in locating communities in order to respond to an emergency call delays the ability of ambulances to respond timeously, and in that way, delays access to treatment with devastating effects. The current practice of obtaining directions from local police stations or requiring individuals to wait in the street for an ambulance also causes delays in responding, and exposes people to a high level of risk for their safety and well-being. Although these measures may be necessary in the immediate term, alternative solutions must be developed that take into account the burden placed on individuals, exposure to risk, and challenges faced by different groups. The ECDoH is required to develop a formal policy and strategy in collaboration with other departments with a view to addressing the challenge in the short, medium and long term.

Recommendations

1. 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.
2. 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 communities.
3. 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.
4. 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 that require immediate or timely medical care.
5. 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 that require immediate or timely medical care. Call centre agents should be adequately trained on the correct interpretation and application of the policy.
6. 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.
7. Budget and planning

**Key findings**

- Inconsistent or inadequate planning has negatively impacted on the ECDoH’s achievement of targets and its ability to implement identified priorities
- The EMS budget has steadily increased over the past decade, albeit there has been a trend of underspending of the budget.
- 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.

**Recommendations**

1. 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.
2. 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 by the ECDoH.
3. 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 ensure the process is transparent.
4. 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.
5. The ECDoH should adopt a human rights and gender-based approach to 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.
PEOPLE’S STORIES

MANTONGOMANI NODANGA, AN UNEMPLOYED RESIDENT OF XHORA VILLAGE IN XHORA MOUTH IN THE AMATHOLE DISTRICT

My sole source of income is an old age pension of R1 200 per month. My wife, six dependants and I all live off this grant. I have lived in Xhora Mouth for over 70 years. I must go to hospital at least once per month for diabetes treatment. Depending on my state of health, I must sometimes go to the hospital for emergency treatment for my diabetes. This can at times happen every three months. The last incident was in November, 2013 when my diabetes was causing me problems.

Throughout the 70 years I have lived in the village, the community has struggled with access to ambulances. There are no ambulances that come to our village. Ambulances are only available for hospital-to-hospital transfers and not for picking us up from our homes when there are emergencies.

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 the government’s protection and respect.

It costs me R24 per trip to take public transport to the hospital. In emergencies, I must hire a private vehicle. In 2013 I had to hire a car because I needed to get to the hospital. This cost me R600. The closest hospital is Madwaleni Hospital and it takes three hours to travel there using the public transport system. It takes about half as much time in a private vehicle. Therefore, there is a major advantage in hiring the private vehicle in emergency situations.

Given my financial situation, these costs are a major burden. An emergency trip to the hospital wipes out half of my income and therefore puts my family in a terrible situation. We are forced to sacrifice other essentials such as food or take money from loan sharks who charge exorbitant interest rates.

At times, these financial considerations lead me to forgo visits to the hospital because the cost of going to hospital has such severe consequences for my family.

It is unacceptable that this community is treated this way. It is as if we are not human enough to receive the services that people in other places in the country receive.
8. Community engagement

Key findings

- 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.
- Insufficient meaningful community engagement occurs to meet the obligations of the ECDoH.

Recommendations

1. 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 viewpoints from all groups in society are solicited, with specific emphasis on vulnerable and marginalised groups.

2. 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 appropriate language used and the mechanism 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.

3. 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.
PEOPLE’S STORIES

NOMPHUMZILE KHUNQWANA,
AN UNEMPLOYED RESIDENT OF MPoola VILLAGE IN THE ALFRED NZO DISTRICT

My husband works in the mines in Johannesburg and lives with our two unemployed sons. We also have two teenage daughters who live with me. Our only form of income is the money my husband sends us.

My nineteen-year-old daughter was pregnant and due to give birth at the end of 2013. She had high blood pressure so the nurses at the local clinic insisted that she gave birth at a hospital. She experienced birth pains in early December, and we immediately called for an ambulance from Mount Ayliff. We called at 16h00 and waited and waited. We kept calling periodically and we were told that the ambulance was busy. Four hours later, with the nurse’s warning firmly in mind, we decided to hire a private car to take us to the hospital. The driver charged us R500, which we could ill afford, to take us to Madzikane Hospital. When my daughter arrived at the hospital we were told that the baby’s heart was beating slowly and she had to be transferred to Mthatha. They could not perform a Caesarian operation until the next day as she was too swollen because of her high blood pressure. She lost her baby – my grandchild – as a result.

The ambulance service arrived at midnight – a full EIGHT hours after the initial phone call. If the ambulance had not taken so long I can only wonder if my grandchild would have survived.
I am unemployed and live on my disability grant which, because I am in a wheelchair, amounts to R1500 instead of R1200. In 2004, I was diagnosed with tuberculosis of the spine and I am now unable to walk. In order to move around I use a wheelchair.

Nqileni Village is completely undeveloped. My situation is made worse by the fact that my house is situated in a valley. Even in my own yard, I only have a 10-meter radius in which my wheelchair can move. Beyond those 10 meters is a rocky area that I cannot access in my wheelchair without assistance.

There are three roads near my village although none of them come to my village. The first road, which is closest to us in comparison to others, is so horrible that all forms of mobile transportation refuse to use it when coming to our village. The second road is about a two-hour walk from our village. Villagers have to walk for two hours in order to access it. But before that, they have to climb up the valley, then cross a forest and eventually arrive at a taxi stop on that road. The last road, which also has a taxi stop, is a thirty-minute walk away from where I live. If one is in a wheelchair, however, it takes one hour to get to the point where we access taxis.

The chronically sick, the disabled and the old who regularly have to see a doctor or health care worker are required to travel to the hospital on a monthly basis. We have no mobile clinic. This means that we have to hire cars to pick us up when we are ill. This costs R100 per trip in a private vehicle and R22 per trip in a taxi. Even these hired vehicles do not come to our homes but rather wait for us on the roads, which, as mentioned, are far away. If it is raining, we are unable to make it to the roads.

Most of the people in my village are unemployed. Many depend on social grants – child grants of R300 or disability grants of R1200. Paying these R100 amounts to hired cars plunges us into even more severe poverty than we are already in.

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

Another problem that I have is that even the taxis are not keen to transport me because I am in a wheelchair. They say taking me slows them down. So even this option is not always available.

Returning from the hospital is the same perilous journey.

Even though I am disabled and in a wheelchair, an ambulance or patient transport vehicle is never dispatched to transport me home.

If transportation were available, I would be attending physiotherapy regularly and my condition would stabilise and I would have a better life. If ambulances were available, we would all be safer and more financially secure.
9. Intergovernmental coordination

Key findings

• The delivery of an efficient emergency medical service (as well as health outcomes) are impacted by a wide range of factors that require collaboration between departments in developing appropriate solutions. Insufficient coordination between departments 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.

• The lack of communication between departments in the Eastern Cape was clear in the submissions made by representatives of the ECDoH and Provincial Treasury who differed on key issues such as the number of EMS vehicles in the ECDoH fleet.

• While the full extent of interdepartmental collaboration was not examined in detail during the hearing process, further coordination with other departments may help to address the prevailing challenges identified in the commission’s report including issues relating to the locating of communities, additional financial burden placed on families, the stigma against welfare beneficiaries, and sufficient monitoring of planning and performance, amongst others.

Recommendations

1. 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.

2. 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.

3. 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.

4. 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.
I live in Isilatsha Village with one of my grandchildren and my only surviving child who both rely on me for their survival. Even though I am unemployed, I am the only one who brings food to the house. I earn my living by selling fruit and vegetables on the street. This is my sole source of income.

When I woke up on the morning of 31 December, 2007 I had no idea that I was going to lose one of my daughters under the most tragic and inhumane circumstances. New Year’s Eve is a time of celebration, reflection and enjoying the company of one’s family members. For my family though, this was and will continue to be a time of extreme anguish.

My daughter, who had been sick for some time, suddenly became worse. I observed that she was in agonising pain and could not walk as a result of it. She was not eating or drinking anything. I did not know what was happening to her. I felt helpless and hopeless.

At 15h00, I decided to call an ambulance. I was told that all the ambulances were busy and that there was no ambulance to collect my daughter. I continued calling between that time and 22h00 and every time I was told that there were no available ambulances.

No parent should see any of their children in the condition that my daughter was in. My helplessness was made even worse by the fact that the health care system on which my daughter’s life depended was letting us down. The only people who could help my daughter were not there when we needed them and when my daughter’s life hinged on their coming to help us.

It was at 22h00 when I decided to call my neighbour who has a vehicle to take my child to the hospital. My reason for hesitating in calling him was confirmed when he charged me R300 for helping my daughter access vital health care services.

My daughter passed away on the way to the hospital. As a result of her not passing away while in hospital we were turned away when we reached the hospital and told to take her dead body back with us and to find a mortuary for her. As if the trauma of having my daughter die in the car on the way to hospital was not enough, I then had to drive with her body, next to me in the car, back to the mortuary. Not only was my daughter let down by the emergency medical services, I as a mother was then treated so callously. It was a dehumanising and extremely painful experience.

What accentuates it is that I went through a similar experience in September 2014 with my mother.
10. Report back to the commission

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 within 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.
THUNYIWE BHENGWANA, ISILATSHA VILLAGE

I am a 56-year-old unemployed man from Isilatsha Village in the Eastern Cape. In February 2008, my epileptic mother was very sick. She had been experiencing epileptic fits all night and had started to swell.

At around 07h00 we realised we needed help and called an ambulance. Because we had been told that ambulances did not come during the weekend I decided to take her to the police station with the help of a church elder in the hope that we could get an ambulance from there. The police called for an ambulance, but were told that the ambulances were at Cecilia Makiwane Hospital and couldn’t attend to my mother.

An ambulance finally arrived at 17h00 at the police station where we were still waiting. The ambulance picked my mother up and I accompanied her.

Instead of going straight to the hospital, the ambulance driver told me that they were still going to fetch someone at Nyara Village and another person at Mooiplaas.

We were taken to Empilweni Clinic but we were not attended to. Eventually my mother was referred to Frere Hospital in East London. I got a loan for the R100 fee for a private car to transport us to the hospital. My mother was admitted to the wards at Frere Hospital and stayed there for a week. She died the following Saturday.

I am certain that the ambulance service and Empilweni Clinic let my beloved mother and me down.
NURSES AND THE BURDEN OF A POOR EMS SYSTEM

Kholiswa Tota, DENOSA Provincial Secretary

Nurses are the ones who care for mothers in the early, uncertain hours. Who comfort them through the long night of waiting. I cannot describe the moment that a nurse has to tell the brutal news—the ambulance will not come for you.

Let me say first that the crisis in emergency medical services and patient transport is acute in the Eastern Cape but extends to most provinces, the Free State and Mpumalanga perhaps chief amongst them.

In broad strokes, we know what is needed. More and better ambulances. More and better trained staff. More and better equipment. More and better planning and budgeting. More understanding from those in the halls of power that their decisions are felt severely by people who depend on them in their most vulnerable and desperate moments of life. Less energy spent by those in power on confusing the facts and more spent on delivering services.

Across the Eastern Cape, DENOSA nurses will all tell you these things:

• We regularly receive patients whom we know we could have saved had the ambulance responded on time.
• We regularly lose patients to follow up, for example to HIV or TB treatment, and know it is simply because the clinic is too far and they are too poor and there is no transportation. Those patients often come back when they are too sick for us to help them.
• We wait with expectant mothers for hours and plead with a distant dispatch operator. We have watched the baby or the woman or both die when we know they could have been saved.
• We care for patients with physical and mental disabilities that should have been prevented by efficient systems of patient transport and emergency medical services.
• We pray when we send the injured or sick child away in an ambulance that has neither the staff nor equipment to care for her during the transfer to hospital.

I gave expert testimony on behalf and from the perspective of these nurses at the commission’s hearings into emergency medical services and planned patient transport in the Eastern Cape. I also witnessed in those hearings, as all nurses in the Eastern Cape witness daily throughout their careers, the deep pain of those who have survived but had their lives crushed by a system that has failed them. In honour of that pain and in honour of those who didn’t survive, and so that others in the future should not suffer as they have, DENOSA calls on the Eastern Cape Department of Health to be vigilant in its implementation of the commission’s report.
EXPERT ANALYSIS

CATASTROPHIC EXPENDITURE ON HEALTH

Dr Jane Goudge, Director of Health Policy, University of the Witwatersand

There is a widely accepted international framework by which to calculate and categorise the “direct cost burden” of out of pocket expenditure on health. Direct cost burden is a measure of the proportion of household expenditure that is spent on health care, or, as in this case, an aspect thereof: transportation to access health care services. Direct cost burden indicates the financial burden that the cost of seeking treatment, and in this case specifically the cost of transportation to access health care services, places on a household.

Within existing literature, a direct cost burden of:
• 0–2.5% of household expenditure spent on health care is considered a low burden;
• 2.5–5% of household expenditure spent on health care is considered a moderate burden;
• above 5% of household expenditure spent on health care is considered a high burden; and
• above 10% of household expenditure spent on health care is considered a catastrophic burden.

It is well accepted in the international literature that ‘catastrophic’ refers to some longer term impact on the household’s well-being. This might include incurring a debt, or reducing expenditure on food or other items required to meet the household’s basic needs.

I had the opportunity to view submissions made to the commission from individual health care users. My findings were worrying. Many health care service users spend huge sums of money on emergency transport when an ambulance is unavailable. For some patients, such expenditure is incurred regularly. Siphelo Marongo’s (not his real name) son has a chronic mental condition that requires him to be taken to hospital on an emergency basis. This happens “regularly”. He explains that ambulances do not provide services to his community and he therefore must hire a car at a cost of R500 to R600. His income consists of a disability pension in the amount of R1 200 per month. An emergency trip to the hospital is therefore approximately 42% – 50% of Mr Marongo’s monthly income.

The submission of Mantongomani Nodanga explains that his sole source of income is an old age pension of R1 200 per month and that he supports seven dependents on this income. He explains that there are no PPT or ambulance services available to his community. He must go to hospital at least once each month on a non-emergency basis in regard to his diabetes. A trip to the hospital that is not an emergency, and for which he can take “public transport”, costs Mr Nodanga R24. Mr Nodanga must also from time to time be transported to hospital on an emergency basis, in which case he must hire a private vehicle at a cost of R600. He reports that, on average, this occurs approximately four times per year. At the time he made his submission to the commission in early 2014, it had last occurred in November of 2013. Mr Nondanga therefore spends at least 50% of his monthly income on transport to hospital several times each year.

Mrs Laqwela must go to hospital on average twice per month in regard to epilepsy. When she has severe fits, she must go to hospital on an emergency basis and must hire a private vehicle at a cost of R400 to R450. This happens “occasionally” but has happened three times in a single month. Mrs Laqwela and her husband share...
a combined income of R2 400 per month. She explains that she has had to borrow money from loan sharks to cover the cost of this transport as well as sacrifice on “other essential items such as food”. Where Mrs Laqwela hires a private vehicle once in a month, she spends around 19% of her household income on emergency transport. When she had to get to the hospital three times in the month in an emergency, she spent 56% of her household income.

For Khuluulwa Mtshiswa, who has an income of R1 500, the cost of transport to the hospital means that she does not attend regular physiotherapy sessions (as prescribed by her doctor).

“Two neighbours died from various illnesses because we could not get them transport. There has never been an ambulance that has agreed to meet us on the road; we always have to pay for private transport to get us to Zithulele Hospital or Jalamba Clinic,” says Manyadu Mpisekhaya who lives in Folokwe.

For each of the people discussed above, the cost of transport for accessing health care services is likely to cause them to forgo essentials, like food for example, or the health care services themselves. Out of pocket expenditure on such transport is likely to have catastrophic consequences for many households and individuals in the Eastern Cape. Out of pocket expenditure at these catastrophic levels 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 by the South African government.
Thandekha gave birth to her first child at home, because she lived too far from the hospital. Although she planned to catch public transport to get there when her labour began, her water broke late at night, long after the last taxis stopped running. When her baby was a year old, she took him to the hospital because he was not yet able to sit up on his own. She was told he has brain damage, because of his difficult birth. She carried him on her back to the clinic for health care, for as long as she could, but eventually he became too heavy. He died of pneumonia at the age of ten, because his mother had no way to get him to the hospital.

Accessing health care services in a time of an emergency is a traumatic experience for anybody. For people in rural areas the outcome of poor emergency medical services can prove fatal, or leave one severely, and unnecessarily, disabled. This very disability then increases the costs and difficulties with accessing further health care.

Nozuzile is unable to walk as a result of contracting tuberculosis of the spine a year ago. Her disability has forced her to leave her home and village to move in with her brother who lives nearer to health care services. To transport Nozuzile to the clinic her brother's family puts her on a steel bed with a mattress and six of them carry her up the steep hill to her appointment. To take a taxi from her brother's village to the hospital costs the average person R20. Nozuzile and her family spend R300 (one way) to hire a private vehicle for the same trip.

The World Disability Report, published by the World Health Organisation in 2011, estimates a worldwide prevalence of 15%. In rural areas where poverty and unemployment are high the prevalence of disability is increased especially among vulnerable groups such as women, children and the elderly.

People with disabilities are likely to access general and specialist health services more frequently than the general population. If one trip to the hospital can cost a person with a disability fifteen times more than the average person, imagine the cost of regular medical follow ups. This financial cost becomes a burden that extends beyond the person with a disability and affects the whole family's health and standard of living.

Planned patient transport is not wheelchair friendly and in many areas only transports patients between the district and tertiary hospitals, not from their homes or clinics. There have been instances where a person with a disability will be asked to leave their wheelchair behind when attending a tertiary hospital, leaving them stranded and reliant on the generosity of others to help them get to their appointment. The patient transport vehicle also leaves early each morning from the district hospital. Most people arrive the day before their appointment and then spend the night sleeping on the cold ground in the out patients department.

Nontshumayelo broke both her legs and one of her arms in a motor vehicle accident. She had to attend a
medical review at the local tertiary orthopaedic hospital and was transported there in an ambulance. After her appointment with the doctor there was no ambulance to take her home and Nontshumayelo was left to lie on a cold stretcher all night without the ability to move herself. Her family were forced to arrange a private vehicle to travel the 150km to bring her home again.

On the 26th of March 2015 a group of people with disabilities and their families attended the South African Human Rights Commission hearing in East London. They spoke out on how poor EMS services and planned patient transport affects their health, quality of life and dignity. Our Constitution and the United Nations Convention on the rights of persons with disabilities, ratified by South Africa’s government, has been put in place to protect the human rights and dignity of persons with a disability. Will the South African Human Rights Commission and National Department of Health hear their pleas for help? Will people with disabilities come to know and trust a health care service that is accessible, affordable, equitable and reliable? Unless the dire lack of EMS and planned patient transport are addressed, the current system will simply perpetuate the vicious cycle of ill health, disability and poverty.
On 8 December 2014, I was called by my neighbour who had a very ill daughter. When I arrived, I immediately noticed that my neighbour’s daughter was in deep pain. The child had a swollen tummy and was complaining about excessive pain. The child could not walk and was lying prostrate on the floor of the house.

I then called for an ambulance because from what we were witnessing it was clear that the child needed urgent medical attention and we did not have the finances to hire a private vehicle to come and pick up the child. My neighbour and I are unemployed. We rely on social welfare for our survival. An ambulance was the only option we had.

When I decided to call the ambulance the time was just after 07h00. The dispatch operator informed me that the ambulance had gone to get petrol. I called again several times and I was repeatedly told that the ambulance had gone to get petrol.

By the time the ambulance arrived (seven hours after my initial call), the child was dead. She had died an awful death. We do not know what the cause of death was. We do know that the child was in great pain for more than six hours before she gave up and died. Had the ambulance arrived on time this child would have had a better chance at survival.
The Eastern Cape has about 6.5 million people, or 12.6% of the country’s population, making it the third largest province by population\(^1\).

The population is growing, but slower than it is in other provinces, meaning that the Eastern Cape’s share of the national population is shrinking. The Eastern Cape therefore receives less of the national budget\(^2\). Meanwhile, the Eastern Cape Department of Health (ECDoH) has reported that the number of people relying on public health care services has increased faster than the rate of population growth as the number of people able to afford private services has dwindled\(^3\). Thus the province has to provide health care services to more people with a smaller proportion of the national budget. This, in part, explains the limited resources available to the ECDoH.

However, limited resources alone do not explain the Emergency Medical Services (EMS) system failures in the province. Some of those failures are attributable to the ECDoH’s poor budgeting and expenditure as well as inadequate planning.

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2. Ibid.
“There are many challenges for disabled people and simply getting to Wilo Clinic is one of them.” – Lungile Maraqa
TABLE A: ALLOCATION TO EMS FROM TOTAL HEALTH BUDGET: 2010/11 – 2016/17 (R’000s)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health budget</td>
<td>13272828</td>
<td>14892282</td>
<td>15602512</td>
<td>17062410</td>
<td>17509012</td>
<td>18234588</td>
<td>18892969</td>
</tr>
<tr>
<td>EMS budget</td>
<td>536,913</td>
<td>644,588</td>
<td>619,525</td>
<td>812,946</td>
<td>798,435</td>
<td>971,832</td>
<td>989,247</td>
</tr>
<tr>
<td>EMS as % of budget</td>
<td>4%</td>
<td>4.3%</td>
<td>4%</td>
<td>4.7%</td>
<td>4.6%</td>
<td>4.9%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Aside from how much money there is, it also matters what is done with the money. Table B shows how between 2010/11 and 2016/17 the department has sometimes underspent and other times overspent the money allocated to EMS by very significant amounts.

TABLE B: TRENDS IN REAL VALUE OF EXPENDITURE FOR EMS, 2010/11-2016/17 (2013 R’000s)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EMS</td>
<td>629442</td>
<td>719767</td>
<td>654999</td>
<td>825889</td>
<td>756810</td>
<td>806083</td>
<td>803798</td>
</tr>
<tr>
<td>% change</td>
<td>14%</td>
<td>-9%</td>
<td>26%</td>
<td>-8%</td>
<td>7%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>15560209</td>
<td>16629179</td>
<td>16495907</td>
<td>17183546</td>
<td>16596220</td>
<td>16398453</td>
<td>16120056</td>
</tr>
<tr>
<td>% change</td>
<td>7%</td>
<td>-1%</td>
<td>4%</td>
<td>-3%</td>
<td>-1%</td>
<td>-2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Planning

The ECDoH’s planning has also undermined service delivery. This isn’t a new problem—a 2004 PSAM research study on the state of public health care in the provinces detailed poor planning throughout the early 2000s. Unfortunately, many of the planning problems pointed out in the 2004 report remain today. Each year the ECDoH identifies priority areas (frequently including the improvement of EMS) but fails to plan for how these improvements will occur. The shifting priorities are laid out in Table C below. The increased employment of qualified staff for EMS is planned without an equally increased budget for the training and employment of that staff (in 2014/15 the ECDoH prioritised increasing the number of staff members for EMS but decreased the budget for the compensation of employees). The expansion of an automated call taking and dispatch system is planned year after year and the same achievements in this regard reported on each following year. Indicators are often poorly defined, unclear or immeasurable. Or they shift around year after year so that it’s near impossible to figure out exactly where we are and from whence we’ve come.

TABLE C: PRIORITIES OF THE EMS PROGRAMME

<table>
<thead>
<tr>
<th>Year</th>
<th>Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>• Ensure eradication of one-man crew province-wide is maintained; and</td>
</tr>
<tr>
<td></td>
<td>• Acquisition of at least 100 emergency vehicles per annum as required by the</td>
</tr>
<tr>
<td></td>
<td>turn-around strategy</td>
</tr>
<tr>
<td>2009/10</td>
<td>• Eradication of one-man crew, province-wide; and</td>
</tr>
<tr>
<td></td>
<td>• Acquisition of additional vehicles.</td>
</tr>
<tr>
<td>2010/11</td>
<td>• To provide a reliable and efficient EMS service by increasing the number</td>
</tr>
<tr>
<td></td>
<td>of EMS vehicles for the communities of the Eastern Cape.</td>
</tr>
<tr>
<td>2011/12</td>
<td>• Placement of emergency services vehicles at strategic locations to improve</td>
</tr>
<tr>
<td></td>
<td>response times.</td>
</tr>
<tr>
<td>2012/13</td>
<td>• To increase response times.</td>
</tr>
<tr>
<td>2013/14</td>
<td>• Build management capacity and employment of EMS management teams;</td>
</tr>
<tr>
<td></td>
<td>• Improve call taking and dispatching ability by rolling out the computerised</td>
</tr>
<tr>
<td></td>
<td>call-taking and dispatching system (CRM) to the Alfred Nzo and the Chris</td>
</tr>
<tr>
<td></td>
<td>Hani EMS centres;</td>
</tr>
<tr>
<td></td>
<td>• Increase the staff mix for ILS and ECT as well as paramedics in the districts;</td>
</tr>
<tr>
<td></td>
<td>• Increase the EMS fleet to include dedicated fleet for inter hospital, XDR/MDR and maternity transfers;</td>
</tr>
<tr>
<td></td>
<td>• 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);</td>
</tr>
<tr>
<td></td>
<td>• Finalise the organogram for call centres in order to have dedicated staff employed within the EMS control rooms;</td>
</tr>
<tr>
<td></td>
<td>• All EMS vehicles fitted with satellite tracking systems, which will be linked to the call centres;</td>
</tr>
<tr>
<td></td>
<td>• Fill vacant operational posts in order to increase the number of rostered ambulances;</td>
</tr>
<tr>
<td></td>
<td>• 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).</td>
</tr>
<tr>
<td>2014/15</td>
<td>• Improve call taking and dispatching ability by rolling out the computerised</td>
</tr>
<tr>
<td></td>
<td>call-taking and dispatching system (CRM) to the Alfred Nzo and the Chris Hani EMS centres;</td>
</tr>
<tr>
<td></td>
<td>• Increase the EMS fleet to include dedicated fleet for inter hospital, XDR/MDR and maternity transfers.</td>
</tr>
<tr>
<td>2015/16</td>
<td>• Improve call taking and dispatching ability by rolling out the computerised</td>
</tr>
<tr>
<td></td>
<td>call-taking and dispatching system (CRM) to the Alfred Nzo and the Chris Hani EMS centres;</td>
</tr>
<tr>
<td></td>
<td>• Increase the EMS fleet to include dedicated fleet for inter hospital, XDR/MDR and maternity transfers.</td>
</tr>
</tbody>
</table>

In sum, EMS services in the Eastern Cape are partly a casualty of a long history of poor planning and budgeting. A proper investigation of this issue from a human rights perspective is thus long overdue, especially as the state of the system has a real human impact, including unnecessary pain, worsening injury and disease and ultimately death.
Assisted living is an essential service that is not provided by the Eastern Cape Department of Health or any other state agency. We currently have 40 residents, mainly pensioners. The average age of our residents is 75. As a result, we frequently need to transport our residents to health facilities.

We, however, have great difficulty accessing emergency medical services.

In my seven years experience in this facility I have found that ambulances are unlikely to arrive when we need them most. The various excuses cited include that ambulances have ‘broken down’. Some arrive days after our initial request.

We therefore call private ambulances from Graaff-Reinet, at great cost to either the resident or the home itself, as they are more reliable in cases that are life-threatening.

We have taken to calling and booking the ambulance one week in advance in cases that are less life-threatening so as to ensure that they arrive. This tactic isn’t always successful, however. One instance involves a resident who had an appointment scheduled for 09h00. We asked that the ambulance arrive at 07h00. The ambulance hadn’t arrived at 10h00. When I called the switchboard I was informed that there had been a shift change and the week-long booking had not been recorded! There are sadly many other examples of this nature.
NHCC is located in the Nyandeni sub-district of the OR Tambo district. It serves a catchment area of over 260 000 people. The closest tertiary hospital is the Nelson Mandela Academic Hospital (NMAH). Eastern Cape health department ambulances are typically stationed in Mthatha, which is approximately 80 kilometres from NHCC. The road is tarred but its condition is poor. The closest district hospital to NHCC is Zithulele Hospital, which is 25 kilometres away via a road that is not tarred.

In 2010, E Meents and T Boyies published a study on response times of ambulances at NHCC. The findings of this study were published in the South African Medical Journal. The study considered and analysed response times to all calls made for ambulances to the health department from NHCC between 1 July, 2009 and 31 September, 2009. A total of 30 calls were made during the period of the study. The results are shown in the table below:

<table>
<thead>
<tr>
<th>Response time in hours</th>
<th>Failed to arrive in under 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrivals</td>
<td></td>
</tr>
<tr>
<td>1 - 2</td>
<td>1 (3.3%)</td>
</tr>
<tr>
<td>2 - 3</td>
<td>4 (13.3%)</td>
</tr>
<tr>
<td>3 - 4</td>
<td>6 (20%)</td>
</tr>
<tr>
<td>4 - 5</td>
<td>4 (13.3%)</td>
</tr>
<tr>
<td>5 - 6</td>
<td>4 (13.3%)</td>
</tr>
<tr>
<td>6 - 12</td>
<td>2 (6.7%)</td>
</tr>
</tbody>
</table>

1. Meets, E and Boyles, T “Emergency Medical Services - poor response times in the rural Eastern Cape” 2010, SAMJ
At the time of the study, the health department had published and distributed a poster stating:

“All citizens in need of emergency services will be attended to with courtesy by qualified personnel and a fully equipped ambulance within one hour in the rural areas and 45 minutes in urban at all times.”

Contrary to the stated standard the average response time was almost four hours. In five cases (16.7%), the ambulance did not arrive or arrived after 12 hours of being called. The ambulance base that was constructed closer to NHCC after the study remained inoperational for years after its construction.

The study noted that the unavailability and delay of transport is a major cause of perinatal death (the death of a baby immediately before or after birth).

It referred to a study of perinatal deaths at Zithulele Hospital around the same time period which identified the unavailability and delay of transport as the most common “avoidable” factor in perinatal deaths².

The study concludes: “sixteen years after the end of the apartheid era, South Africa shows an unacceptable EMS response time which is an important and basic component of health care service in the former Transkei. EMS services must be assessed and improvement wisely planned to ensure the basic rights of government sector patients.”

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On 8 May 2015 the National Department of Health gazetted emergency medical services regulations. The regulations provide for the regulation of both public and private emergency medical services including for a procedure of obtaining and renewing a license to run an emergency medical service, inspection of an emergency medical service, the establishment of an emergency medical services advisory committee and the powers of EMS personnel.

The regulations require that an ambulance or medical rescue unit be staffed by a minimum of two persons, and that a medical response vehicle be staffed by a minimum of one person. Ambulances must be configured in such a way that medical personnel have complete access to a patient in order to begin and maintain life support.

A list of specific equipment that should be in an ambulance at all times is provided. Such equipment includes a stretcher for patients, gas cylinders, oxygen cylinder and masks, adequate electrical power for specialised medical equipment, swabs and a current map of the area covered by the ambulance amongst many others.

These regulations form part of the legal framework within which EMS in the Eastern Cape must operate and the Eastern Cape Department of Health is required to implement the regulations. A proper implementation of the regulations will go a long way in making sure that the people of Eastern Cape enjoy their constitutionally guaranteed right not to be refused emergency medical treatment.
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