

# A Global Review of Provisions on Emergency Care in National Constitutions

TAYLOR W. BURKHOLDER, MADELINE ROSS, LILY VARTANYAN, AND HARVEEN BERGQUIST

## Abstract

National constitutions are important tools for the realization of the right to health, and constitutional law linking health and human rights has been associated with improved access to health resources. Meanwhile, emergency care is a lifesaving service delivery platform with the potential to address much of the death and disability in low- and middle-income countries (LMICs). Yet even where services exist, access to emergency care may be systematically limited for vulnerable populations, except where laws explicitly protect the right to emergency care. We therefore sought to catalog and describe constitutional provisions related to emergency care. Through a comprehensive review of 195 national constitutions, we searched provisions for terms related to emergency care and performed qualitative framework analysis on these provisions. Eleven provisions met inclusion criteria, representing ten LMICs with constitutions written since 1996. While seven of the eleven provisions guarantee access to emergency care to all people, three narrow this guarantee to citizens only. Only three constitutions address the affordability of emergency care. While these constitutional provisions represent an important step toward the legal guarantee of access to emergency care for all people, further attention must be paid to the impact of such laws and regulation on the accessibility of emergency care and its related reduction of death and disability globally.

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Competing interests: None declared.

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## Introduction

Emergency medical conditions—including injuries, communicable and noncommunicable diseases, acute decompensation of chronic conditions, and complications of pregnancy—require timely, high-quality care to prevent death and permanent disability.<sup>1</sup> These health conditions are estimated to represent over half of global deaths and up to 2.1 billion disability-adjusted life years annually.<sup>2</sup> Whereas other parts of the health system may be incapable of the timely recognition and management of such conditions, emergency care is a service delivery platform intentionally oriented toward timely identification and management.<sup>3</sup> The integration of emergency care systems into the overall health system therefore has potential to save lives, particularly in low- and middle-income countries (LMICs), where the burden of these conditions is highest and the outcomes are disproportionately worse.<sup>4</sup>

Access to emergency care is markedly limited in much of the world. Estimates in Africa, for example, suggest that only 71% of people live within two hours of a hospital that could potentially provide emergency care.<sup>5</sup> Yet this method likely overestimates the true availability and accessibility of emergency care in these countries, since many hospitals do not have the trained personnel and resources capable of providing adequate emergency care.<sup>6</sup> Additionally, there are many other barriers to accessing emergency care that are not included in this geospatial method of estimating access. Issues of affordability (financial accessibility), discrimination against vulnerable populations, and quality and acceptability of emergency care practices can also create barriers to accessing care during a health emergency.<sup>7</sup> Barriers to accessing emergency care have been linked to delays in receiving care and to avoidable deaths.<sup>8</sup>

Reports of people being barred from hospitals due to the inability to levy upfront payments, or being required to purchase emergency medications and supplies before they can be administered, are not uncommon.<sup>9</sup> These and other barriers to accessing emergency care not only result in otherwise avoidable death and disability but also represent

systematic violations of human rights. As of the early 2000s, all nations had ratified at least one international treaty that enshrines the right to the highest attainable standard of health.<sup>10</sup> According to the United Nations Committee on Economic, Social and Cultural Rights' General Comment 14, the right to the highest attainable standard of health can be framed in terms of the AAAQ framework: availability, accessibility, acceptability, and quality. Special attention is paid to two dimensions of accessibility—nondiscrimination and affordability—to avoid the exclusion of vulnerable populations from health care programs.<sup>11</sup> The time-dependent nature of emergency conditions leaves people vulnerable to undue financial demands from providers and facilities. The concept of a right to emergency care has recently entered the academic discourse, along with a call to include a rights-based approach to developing emergency care systems.<sup>12</sup>

Simultaneously, the global agenda on universal health coverage focuses on improving access to care, ensuring quality care, and protecting against financial risk.<sup>13</sup> Recognizing this and the potential to save substantial lives, the 72nd World Health Assembly passed Resolution 72.16, titled “Emergency Care Systems for Universal Health Coverage: Ensuring Timely Care for the Acutely Ill and Injured,” in May 2019.<sup>14</sup> The resolution signals a public commitment by United Nations member states to build and strengthen emergency care systems that will improve access to and the affordability of lifesaving care as an essential component of the overall health system.

As part of its guidance on the development of such health system frameworks, the World Health Organization (WHO) has described six “building blocks” fundamental to best practices in this process. The sixth building block, leadership and governance, is vital to achieving high levels of availability and accessibility of quality emergency care within the broader health system. The realization of good governance relies on the coordination of varying, yet overlapping, mechanisms to formalize intended health system frameworks among a wide spectrum of actors, including governments, nongovernmental organizations, private compa-

nies and corporations, medical practitioners, the general public, and others. These mechanisms span all levels of organization, including international treaties, national constitutional and statutory law, and national and local regulations, guidelines, and policies.

At the highest level, international treaties obligate the ratifying parties to fulfill legal stipulations in the agreement. A recent comprehensive review of United Nations treaties found that eight treaties included language directly addressing the need for emergency and essential surgical care and anesthesia.<sup>15</sup> Given that emergency care systems are integral to the provision of emergency and essential surgical care and anesthesia, these treaty provisions can be applied to emergency care as a surrogate.

Although the enforcement of international treaties is challenging and often limited, these human rights laws have been used at the national level to substantiate legal claims around access to essential medications.<sup>16</sup> The use of international treaties in such a way may obviate the need for domestic law in countries that have ratified one of these treaties if a judicial challenge rules that the treaty obligations apply to the provision of emergency care.

However, given the inconsistency with which international treaties are both upheld and applied on a country-by-country basis, constitutional law serves as a powerful mandate to guarantee the right to health at the national level. Despite how widely legal systems vary in structure around the world, constitutions can be readily appraised and comparatively analyzed given their inherent uniformity in existence.<sup>17</sup> Constitutional law has previously been shown to produce tangible results. One study found that constitutional law was the most important contributor to expanding access to essential medications, as demonstrated by favorable judicial rulings when the right to access such medications was challenged in court.<sup>18</sup> These laws can serve both as indicators of nations' commitment toward health-related rights and as foundational directives in the creation of health policies and programs.<sup>19</sup>

### *Study objective*

To date, there have been no formal studies regarding

the existence or content of laws governing access to emergency care globally. Therefore, legislators and policy makers have a paucity of information on how to best draft and reform laws governing access to emergency care. Although we do not seek to develop a single "model text" for countries wishing to implement constitutional laws or amendments—owing to the complex nature of cultures, resource availability, and health care systems internationally—an analysis of common components of existing laws is likely to be useful for policy makers who are considering this approach to governing emergency care accessibility. In this study, we sought to (1) quantify and catalog constitutional provisions on emergency care worldwide and (2) qualitatively describe the characteristics of existing constitutional provisions on emergency care.

## Methods

### *Comprehensive review*

We conducted a comprehensive review of national constitutions from 195 countries as compiled by the Constitute Project (<https://www.constitute-project.org>). All constitutions were retrieved in their original English versions or English-language translations on January 26, 2019, and subsequently imported into ATLAS.ti to search for the terms "emergency," "illness," "injury," "life threatening," "life-threatening," "medical care," "medical treatment," "healthcare," "health-care," and "health care." Any constitutional provision (also known as clause or article) containing a search term was then compiled into Microsoft Excel for screening.

Two independent reviewers (MR and LV) screened each identified constitutional provision for inclusion if it was an original article or amendment that pertained to the delivery of emergency or acute care in any facility or pre-hospital setting for an individual experiencing a perceived health emergency. Provisions were excluded if they (1) addressed a state of national emergency or other non-health emergency law or regulation (e.g. armed conflict), (2) addressed a disaster or infectious epidemic rather than an everyday, individual health emergency, (3) addressed the health status of an

elected or appointed official as it related to his/her ability to perform the duties of office, (4) addressed non-health emergencies (e.g. fire, hostage situation, legal damages), or (5) related to health care provision or protected health status but did NOT directly address emergency or acute care. The final exclusion criteria were selected in order to focus the review on constitutional law that directly and unmistakably guarantees access to emergency care. A senior reviewer (TB) resolved any discordant inclusion decisions and randomly re-screened an additional 10% of the provisions to ensure systematic agreement.

Data collection in MS Excel included verbatim text from the included provision(s) as well as the country name, year of ratification, and amendment status. Three reviewers (TB, MR, HB) then conducted a framework analysis using a mixed inductive and deductive qualitative approach. A mixed approach was selected in order to explore overlap with previously identified domains of the right to emergency care while also leaving space to discover unexpected components of existing constitutional provisions. Using a set of preliminary codes, the reviewers independently coded the constitutional texts according

to pre-existing analytical frameworks, with new codes inductively added as deemed necessary by the reviewers. The code book was refined and texts were iteratively coded until consensus was reached by all reviewers and no new codes emerged. Thematic analysis of the codes was performed in ATLAS.ti followed by indexing according to framework analysis in MS Excel.

### *Analytical framework*

This review employed the use of three existing frameworks for the right to the highest attainable standard of health (“right to health”) and constitutional laws pertaining to right to health issues (Box 1). The first two frameworks draw from international human rights standards outlined in General Comment 14. Provisions pertaining to the right to health can be categorized by the type of legal obligation and by the AAAQ framework. Legal obligations can be divided into responsibilities to respect, protect, and promote (or fulfill) the right to health, while the AAAQ framework classifies right to health issues according to availability, accessibility, acceptability, and quality.<sup>20</sup> Legal obligations and the AAAQ framework are therefore

Box 1. Constructs used for framework analysis of constitutional provisions

#### **1. Availability, accessibility, acceptability, and quality (AAAQ):**

**Availability:** Health facilities and services are present in sufficient quantity.

**Accessibility:** Health facilities and services are within reach and can be utilized by everyone without discrimination.

**Acceptability:** Health facilities and services are respectful of medical ethics and culturally appropriate.

**Quality:** Health facilities and services are scientifically and medically appropriate and of good quality.

#### **2. Respect, protect, and promote:**

**Respect:** States refrain from interfering with the enjoyment of the right to health.

**Protect:** States take measures that prevent third parties from interfering with the right to health.

**Promote:** States adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward the full realization of the right to health.

#### **3. Kinney-Clark typology:**

**Statement of aspiration:** The constitution states a goal in relation to the health of the country's citizens.

**Statement of entitlement:** The constitution enshrines a right to health, health care, or public health services.

**Statement of duty:** The constitution imposes a duty to provide health care or public health services.

**Programmatic statement:** The constitution specifies approaches for the financing, delivery, or regulation of health care and public health services.

**Referential statement:** The constitution specifically refers to an international or regional human rights treaty recognizing a human right to health or health care.

clear, objective classifications of constitutional law that guarantee access to emergency care, and they have previously been used to analyze constitutional texts in other health system domains.<sup>21</sup>

The third framework used was derived from the Kinney-Clark typology of constitutional provisions on health.<sup>22</sup> In this taxonomy, constitutional provisions can be divided into five categories based on the intent and function of the provision: statements of aspiration, statements of entitlement, statements of duty, programmatic statements, and referential statements (Box 1). Classifying provisions that pertain to access to emergency care according to this framework allows for a more objective assessment of the level of government commitment and potentially of the enforceability of the law.

## Results

From the 195 constitutions compiled and searched, a total of 1,280 unique provisions were identified for screening, of which 1,269 were excluded based on predefined criteria. Eleven articles ultimately met inclusion, representing ten countries with constitutional laws containing provisions regarding emergency care (Appendix 1). Figure 1 shows the PRISMA flow diagram of screening results.

All ten countries are classified by WHO as low- or middle-income countries (three are classified as low income, four as lower-middle income, and three as upper-middle income). When mapped according to WHO regions, six of the ten countries are located in the African region. The remaining four countries are located in the Americas, the Eastern Mediterranean, the Western Pacific, and Southeast Asia. The earliest constitution to include a provision guaranteeing emergency care was passed in 1996.

As classified by the AAAQ framework, none of the included constitutional provisions directly addresses the availability, acceptability, or quality of emergency care. However, accessibility is addressed by nine of the ten constitutions in two distinct ways: nondiscrimination and affordability. Six of the constitutions guarantee universal access to emergency

care; three limit access to citizens only; and one implies (but does not directly specify) accessibility as it relates to nondiscrimination, stating that “for no reason” may a person be refused care. In terms of affordability, free emergency care is guaranteed in two of the ten constitutions (Sudan and South Sudan). Affordability is additionally addressed by one further constitution (Somalia), which states that access could not be limited by “economic capability.” Figure 2 maps countries with constitutional provisions on emergency care according to the AAAQ framework.

When analyzed under the obligations set forth by General Comment 14, the constitutional provisions were found to incorporate varying levels of commitment to the fulfillment of emergency care. One country (Zimbabwe) addresses all three levels of obligation: to respect, to protect, and to promote. However, the remaining nine countries are split, with five requiring respect for emergency care and four imposing protection of the right to emergency care.

Finally, as coded by the Kinney-Clark typology, six constitutions include statements of entitlement and five include statements of duty (Zimbabwe included statements of both), all surpassing the most basic level of statement of aspiration, but none addressing programmatic or referential imperatives. The combined results of the framework analysis are reported in Table 1.

## Discussion

Only 10 constitutions out of the 195 screened include provisions related to emergency care, demonstrating that a minority of countries have chosen to guarantee emergency care as a right in their most fundamental law. The reasons for this are likely multifactorial. The second half of the 20th century saw both a growth in the human rights movement, with an increase in the recognition of the right to health, and a surge in the adoption of constitutions containing more detailed rights, including not only civil and political rights but also economic, social, and cultural rights. All nations have now ratified at least one international agreement articulating

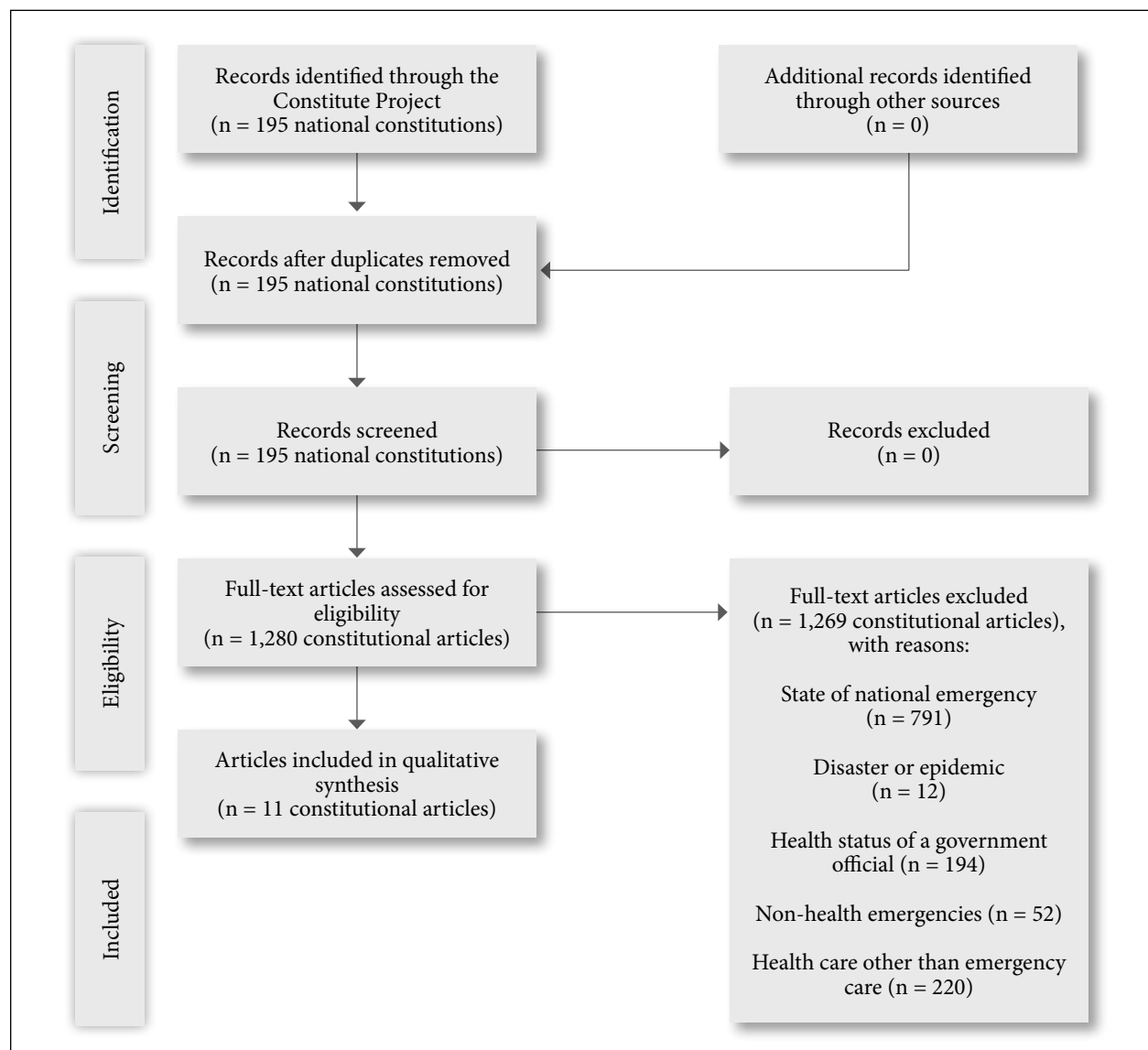
the right to health. Since then, several studies have demonstrated an increasing number of nations incorporating variations of health-related provisions in their national constitutions.<sup>23</sup>

Emergency care, however, is a newer health system delivery innovation, only recently acknowledged in many health system frameworks. Constitutions adopted before the advent of emergency care in the mid to late 20th century, and much later for many countries, are not likely to reference this system. As a result, all 10 of the constitutions included in our study were written or revised after 1996, with South Africa representing

the earliest incorporation of an emergency care provision into a constitution. We did not encounter any constitutional amendments that address a right to emergency care in those countries whose constitutions predate the advent of emergency care.

Countries with constitutional provisions meeting our inclusion criteria revealed an Afro-centric geographic distribution and a predominance of low- and middle-income levels. According to Jody Heymann et al., provisions addressing the overall right to health, defined as “constitutional references to physical or overall well-being, health protection, health security and/or a life free of illness or dis-

FIGURE 1. PRISMA flow diagram



ease,” are most common in low-income countries.<sup>24</sup> Not surprisingly, constitutions incorporating a right to emergency care as part of the right to health also demonstrate this predominance.

It may be more crucial for governments and policy makers in LMICs to support a constitutional right to emergency care, given that emergency care systems have been shown to address a wide range of illnesses and injuries that disproportionately lead to death and disability in LMIC populations.<sup>25</sup> Others have theorized that the constitutional incorporation of economic, social, and cultural rights plays a different role in different types and stages of national systems. With regard to the right to health, Colleen Flood and Aeyal Gross recommend that nations transitioning to democracy, and thus toward equity in general, include health rights in their constitutions in an attempt to address societal inequities.<sup>26</sup>

Acknowledging the important role that national constitutions can play in fulfilling the right

to health, we focused our framework analysis on the AAAQ framework from General Comment 14. The first essential element of the AAAQ framework is availability. Though the availability of emergency care may seem implicit in the discussion of accessibility of such services, none of the 10 constitutions referencing emergency care explicitly mandate that the care exist in sufficient quantity.

In contrast, accessibility is addressed in all 10 constitutions. In General Comment 14, accessibility is subdivided into the categories of nondiscrimination, physical accessibility, affordability, and information accessibility. Nondiscrimination in emergency care is best addressed by six of the ten constitutions. Kenya stipulates universal access by stating that “[a] person shall not be denied emergency medical treatment.”<sup>27</sup> Meanwhile, South Africa decrees that “[n]o one may be refused emergency medical treatment.”<sup>28</sup> In another example of nondiscrimination, Egypt states that “[d]enying any form of medical treatment to any human

FIGURE 2. Map of countries with constitutional provisions on emergency care



in emergency or life-threatening situations is a crime.<sup>29</sup> A seventh constitution (Ecuador) implies this same universal access, as well as the accompanying enforcement, in its article 365, stating that “[f]or no reason shall public or private institutions

or healthcare professionals refuse emergency care. This refusal shall be punishable by law.<sup>30</sup> The remaining three countries that address emergency care in constitutional provisions inherently limit access by using the term “citizen” in place of “per-

TABLE 1. Framework analysis: Characteristics of constitutional provisions

Country	WHO region	Income level*	Article number	Kinney-Clark typology†	Access: Affordability	Access: Nondiscrimination	Government obligation‡
Ecuador	Americas	Upper-middle income	365	Duty	Not specified	N/S	Protect
Arab Republic of Egypt	Eastern Mediterranean	Lower-middle income	18	Duty	Not specified	All people	Protect
Republic of Fiji	Western Pacific	Upper-middle income	38	Entitlement	Not specified	All people	Respect
Republic of Kenya	Africa	Lower-middle income	43.2	Entitlement	Not specified	All people	Respect
Federal Democratic Republic of Nepal	Southeast Asia	Low income	35.1	Entitlement	Not specified	Limited (citizens)	Respect
Federal Republic of Somalia	Africa	Low income	27.2	Entitlement	Addressed	All people	Respect
Republic of South Africa	Africa	Upper-middle income	27.3	Entitlement	Not specified	All people	Respect
Republic of South Sudan	Africa	Low income	31	Duty	Free	Limited (citizens)	Promote
Republic of the Sudan	Africa	Lower-middle income	46	Duty	Free	Limited (citizens)	Promote
Republic of Zimbabwe	Africa	Lower-middle income	29.2	Duty	Not specified	All people	Protect
			76	Duty & entitlement			Respect & promote

\* 2019 World Bank income classification (datahelpdesk.worldbank.org)  
 † The Kinney-Clark typology classifies constitutional provisions into statements of duty, entitlement, or aspiration, as well as programmatic or referential statements  
 ‡ As defined by General Comment 14



son” or “human.” For example, Nepal specifies that “no citizen shall be deprived of emergency health care,” thereby excluding vulnerable and marginalized populations, such as migrants or refugees, and potentially violating principles of the right to health.<sup>31</sup>

Affordability, as a subclassification of accessibility, is addressed by only three constitutions, two of which are classified as low income and one as lower-middle income by the World Bank. Sudan and South Sudan both state that emergency care will be free. Somalia, meanwhile, states that “no one may be denied healthcare for any reason, including lack of economic capability.”<sup>32</sup> In practice, these commitments will require substantial governmental funding or insurance schemes. It is important to note that seeking care has been linked to catastrophic health expenditures, further worsening the cycle of poverty and poor health.<sup>33</sup> In the context of emergency conditions, this is likely even more important for LMICs that are saddled with a disproportionate burden of conditions amenable to emergency care.<sup>34</sup> The two other categories of accessibility—physical and information accessibility—are not specifically addressed in any of the constitutions included in our study.

Likewise, the notion of acceptability—which encompasses cultural appropriateness and abidance by medical ethics—is not addressed by any of the 10 constitutions. Nor is quality, which refers to scientific or medical appropriateness. Without an emphasis on these attributes at the constitutional level, downstream policymaking may not yield focused guidance on these core components of comprehensive, effective emergency care delivery. Furthermore, any benefit that the availability and accessibility of emergency care affords may be negated if the care does not successfully manage the death and disability of emergent medical conditions through quality emergency care. As much as the human rights-based approach to health system development aims to develop the “capacity of duty bearers to meet their obligations,” it also serves to empower “rights-holders to effectively claim their health rights.”<sup>35</sup> Without explicit attention to the acceptability or quality of emergency care systems

in the law, it remains unclear if rights-holders will be able to demonstrate these rights as effectively in the judicial system.

When we applied the Kinney-Clark typology for health-related provisions in national constitutions, we classified the majority of articles as either statements of duty or statements of entitlement. For example, article 29 of the Constitution of Zimbabwe reads, “The State must take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution,” representing a statement of duty on the part of the government.<sup>36</sup> In contrast, article 38.2 of the Constitution of Fiji states, “A person must not be denied emergency medical treatment,” enshrining an entitlement of the people but not specifically addressing the role of the government.<sup>37</sup> We found no constitutional provisions that could be classified as statements of aspiration, programmatic statements, or referential (to treaties or other statutes) statements. While programmatic statements would have been more detailed and prescriptive, it is not surprising that this level of detail is often omitted from constitutional provisions. However, the statements of duty and entitlement serve to prioritize a particular agenda and enable subsequent legislation, regulation, and judicial rulings that elaborate on the specifics of the guarantee of access to emergency care.

According to General Comment 14, governments must respect, protect, and promote (or fulfill) the right to health. Of the 11 provisions identified in our search, many contain language that suggest an obligation to respect or protect a right to emergency care, yet only three contain language that implies a duty to actively promote this right. Whereas the obligation to respect requires nations to refrain from interfering with the right to emergency care and the obligation to protect requires nations to prevent third parties from violating the right, an obligation to fulfill or promote would necessitate nations to “adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures toward the full realization of the right to health.”<sup>38</sup>

The overall significance of identifying 10 con-

stitutions that address access to emergency care in LMICs is twofold. From a human rights perspective, these provisions establish a legal guarantee for access to a lifesaving service that, without such laws, could be afforded to some but denied to others based on factors such as ability to pay, national origin, or other discriminated status. From a public health perspective, these constitutional provisions—in conjunction with not-yet catalogued laws and regulations—are hypothesized determinants of increased access to quality emergency care. The aim of increasing access to quality emergency care is to reduce a substantial proportion of the global burden of disease that disproportionately affects LMICs. While there have been no studies demonstrating an association between constitutional laws and improved health emergency outcomes, anecdotal descriptions of post-ratification progress in countries such as Kenya and South Africa suggest that constitutional laws should not be ignored by policy makers. In fact, the increasing use of such constitutional provisions since their first appearance in 1996 could indicate a trend toward the adoption of constitutional guarantees of emergency care in more countries in the near future.

### *Limitations*

Our study is limited to constitutional law, and as such, our results do not necessarily correlate with the prevalence or characteristics of other governance mechanisms for guaranteeing access to emergency care, such as statutory law (legislation), regulations, policies, and court rulings. For example, the United States, with a constitution long predating the advent of emergency care, has a statute protecting people's right to access emergency care (called the Emergency Medical Treatment and Labor Act) but does not have a constitutional guarantee.<sup>39</sup>

The Constitute Project is a repository of national constitutions and includes English translations of documents originally published in other languages. There is thus the potential for subtle alterations in the meaning of articles that have been translated into English. Our search returned only 11 provisions from 10 national constitutions, and

many of these provisions employ similar wording. The limited number of texts available for qualitative analysis and the homogeneity of their wording restricts the identification of other important themes for legislating access to emergency care. Finally, our study did not aim to correlate the presence of constitutional provisions on emergency care to any real-time markers of accessibility or emergency care system development.

Further studies are needed to understand the impact and effectiveness of constitutional provisions on emergency care. There remain questions regarding downstream legislation and regulation, as well as the judicial challenges that are made possible by such constitutional provisions. With a limited number of constitutions containing guarantees of emergency care accessibility, it is not currently feasible to correlate with health or human rights outcomes without a more detailed causal link analysis. However, countries such as Kenya have seen further codification of the right to emergency care since the passage of their constitutions, including through legislation and regulations that further detail and codify the right to emergency care.<sup>40</sup> Future studies are needed to assess the degree to which these constitutional rights impact health and human rights outcomes. Such analysis could provide insights into the barriers that need to be overcome in order to truly guarantee access to emergency care. Additionally, there remains uncertainty regarding which components (e.g., scope of coverage, types of obligations, penalties, and enforcement) of emergency care legislation are necessary, which components can be practically and ethically modified to cultural context and resource availability, and which financing options are best suited to govern access to emergency care.

### **Conclusion**

Constitutional law has the potential to empower governments to respect, protect, and promote the right to emergency care, an essential lifesaving health resource. As demonstrated by our review of national constitutions from 195 countries, constitutional guarantees of this right currently exist on a

limited basis and are phrased as either statements of duty or statements of entitlement. They address nondiscrimination and affordability but do not address the acceptability or quality of emergency care. Despite the limited number of constitutions that guarantee access to emergency care, the provisions of the 10 that were identified speak to the potential to harness such governance tools to expand the right to emergency care where none previously

existed. While consensus is still needed regarding the most essential components of these provisions, these findings demonstrate a recent movement to codify and guarantee emergency care in many of the countries that are most in need of strengthened emergency care systems. The international community is urged to consider how constitutional laws can best improve the availability, accessibility, acceptability, and quality of emergency care globally.

#### APPENDIX 1. Full text of constitutional provisions on emergency care

Country	Year of ratification	Article number	Article text
<b>Ecuador</b>	2008 (revised 2015)	365	For no reason shall public or private institutions or healthcare professionals refuse emergency care. This refusal shall be punishable by law.
Arab Republic of <b>Egypt</b>	2014	18	Every citizen is entitled to health and to comprehensive health care with quality criteria. The state guarantees to maintain and support public health facilities that provide health services to the people, and work on enhancing their efficiency and their fair geographical distribution. The state commits to allocate a percentage of government expenditure that is no less than 3% of Gross Domestic Product (GDP) to health. The percentage will gradually increase to reach global rates. The state commits to the establishment of a comprehensive health care system for all Egyptians covering all diseases. The contribution of citizens to its subscriptions or their exemption therefrom is based on their income rates. Denying any form of medical treatment to any human in emergency or life-threatening situations is a crime. The state commits to improving the conditions of physicians, nursing staff, and health sector workers, and achieving equity for them. All health facilities and health related products, materials, and health-related means of advertisement are subject to state oversight. The state encourages the participation of the private and public sectors in providing health care services as per the law.
Republic of <b>Fiji</b>	2013	38	1. The State must take reasonable measures within its available resources to achieve the progressive realisation of the right of every person to health, and to the conditions and facilities necessary to good health, and to health care services, including reproductive health care. 2. A person must not be denied emergency medical treatment.
Republic of <b>Kenya</b>	2010	43	1. Every person has the right- a. to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; 2. A person shall not be denied emergency medical treatment.
Federal Democratic Republic of <b>Nepal</b>	2015 (revised 2016)	35	1. Every citizen shall have the right to seek basic health care services from the state and no citizen shall be deprived of emergency health care. 2. Each person shall have the right to be informed about his/her health condition with regard to health care services. 3. Each person shall have equal access to health care. 4. Each citizen shall have the right to access to clean water and hygiene.
Federal Republic of <b>Somalia</b>	2012	27	1. Every person has the right to clean potable water. 2. Every person has the right to healthcare, and no one may be denied emergency healthcare for any reason, including lack of economic capability.
Republic of <b>South Africa</b>	1996 (revised 2012)	27	1. Everyone has the right to have access to- a. health care services, including reproductive health care; b. sufficient food and water; and c. social security, including, if they are unable to support themselves and their dependents, appropriate social assistance. 2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. 3. No one may be refused emergency medical treatment.

APPENDIX 1. *Continued*

Country	Year of ratification	Article number	Article text
Republic of <b>South Sudan</b>	2011 (revised 2013)	31	All levels of government shall promote public health, establish, rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all citizens.
Republic of the <b>Sudan</b>	2005	46	The State shall promote public health, establish, rehabilitate, develop basic medical and diagnostic institutions, provide free primary health care and emergency services for all citizens.
Republic of <b>Zimbabwe</b>	2013 (revised 2017)	29	1. The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe. 2. The State must take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution. 3. The State must take all preventive measures within the limits of the resources available to it, including education and public awareness programmes, against the spread of disease.
		76	1. Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services. 2. Every person living with a chronic illness has the right to have access to basic healthcare services for the illness. 3. No person may be refused emergency medical treatment in any health-care institution. 4. The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.

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