

NPAG Policy Brief: Establishing the National Emergency Medical Treatment and Labor Act (NEMTALA) in Nigeria

Executive Summary

Nigeria continues to face an acute crisis in the provision of equitable, timely, and life-saving emergency healthcare. Despite attempts at reform—most notably via the National Health Act (2014)—critical gaps persist in legal enforcement, prehospital care delivery, and protection of vulnerable patients. Many are still denied emergency treatment due to inability to pay, bureaucratic roadblocks, or institutional apathy.

This policy brief proposes the National Emergency Medical Treatment and Labor Act (NEMTALA), inspired by the U.S. Emergency Medical Treatment and Labor Act (EMTALA). NEMTALA would legally mandate the provision of emergency care irrespective of a patient's financial status, require stabilization of all emergency medical conditions before transfer or discharge and establish a framework for prehospital emergency medical services (EMS).

The brief outlines the current state of emergency care in Nigeria, draws lessons from EMTALA, highlights gaps in Nigerian law, and offers a legislative and implementation roadmap to establish NEMTALA as a cornerstone of health equity and patient protection.

Background

Nigeria's fragmented emergency care landscape is characterized by systemic neglect, weak infrastructure, and limited legal protections. Prehospital care—such as ambulance response, first responder action, and roadside stabilization—is nearly nonexistent in many parts of the country. Where services exist, they are fragmented across private vendors, state-specific agencies, or underfunded government programs.

The National Health Act (2014) aimed to establish a nationwide standard for health services, including the launch of the Basic Healthcare Provision Fund, which—under its NEMTC Gateway—called for the establishment of effective emergency medical response services and a national ambulance system across all 36 states and the Federal Capital Territory (FCT) by 2019. However, the Act does not specifically mandate emergency treatment irrespective of payment, nor does it address transfer standards, prehospital coordination, or liability protection for individuals rendering aid. Moreover, many healthcare workers are unaware of the law's provisions, and enforcement mechanisms remain weak or inactive.

Empirical research, such as the work by Onyema et al. and Suleiman et al., underscores that prehospital trauma and delays in receiving care are major contributors to Nigeria's high trauma mortality rate. These shortcomings are compounded by the absence of a Good Samaritan legal framework, making bystanders hesitant to assist during emergencies.

Problem Analysis

1. **Denial of Emergency Treatment:** Patients in life-threatening situations are often turned away at hospitals for lack of upfront payment or legal documents (e.g., police reports for gunshot wounds). This practice disproportionately affects the poor, accident victims, and pregnant women in labor.
2. **Prehospital Care Vacuum:** There is no nationally coordinated EMS system. Ambulances are few, under-equipped, and often misused for non-emergency transport. Most paramedics lack standardized training. Victims frequently rely on commercial transport or private vehicles to reach hospitals, often fatally late.
3. **Legal Liability Gaps:** There is no Good Samaritan Law in Nigeria. Well-meaning individuals who attempt to help at accident scenes risk arrest or litigation, leading to widespread public reluctance to intervene during emergencies.
4. **Scattered Regulatory Framework:** Laws related to emergency care (e.g., Road Traffic Act, National Health Act) are disjointed and do not mandate minimum emergency response obligations for healthcare providers.
5. **Urban-Rural Divide:** Emergency services and trauma centers are heavily concentrated in urban areas, leaving rural Nigerians disproportionately underserved.
6. **Poor Awareness and Training:** The general population lacks first aid training, and public campaigns on emergency response have been minimal. Even health professionals may be unaware of their obligations to provide emergency care.

Case Study: EMTALA in the United States

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted by the U.S. Congress in 1986 in response to a widespread and unethical practice known as “patient dumping.” This practice involved private hospitals—particularly those in urban areas—refusing treatment to individuals who were uninsured or underinsured. Many of these patients, often in critical condition, were either transferred to public hospitals without proper stabilization or denied care entirely. Media investigations and public outcry in the early 1980s highlighted horrifying cases where poor and minority patients died after being turned away from emergency departments. These incidents revealed systemic discrimination in access to care and demanded legislative intervention.

In response, EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Its primary goal was to establish that any individual presenting to a hospital emergency department must receive a medical screening and stabilizing treatment before any consideration of discharge or transfer. The legislation imposed specific obligations:

1. **Medical Screening Examination (MSE):** Every hospital with an emergency department must provide an appropriate medical screening to determine whether an emergency medical condition (EMC) exists. This examination must be conducted prior to any

inquiry about insurance status or method of payment. Asking about a patient's financial situation before performing the MSE constitutes a direct violation of EMTALA. The purpose of this provision is to ensure that clinical judgment, not administrative or financial gatekeeping, governs initial emergency care. Every hospital with an emergency department must provide an appropriate medical screening to determine whether an emergency medical condition (EMC) exists.

2. **Stabilizing Treatment Requirement:** If an EMC is identified, the hospital must treat the condition until it is stabilized, regardless of the patient's insurance or financial status. Under EMTALA, a condition is considered 'stabilized' when, within reasonable medical probability, no material deterioration of the patient's condition is likely to occur during or because of the transfer or discharge. Stabilization means securing vital signs, controlling acute symptoms, and mitigating risk to life or bodily function, allowing the patient to be safely transferred or released without imminent danger. This standard applies equally to all patients and serves as a critical legal threshold for determining appropriate emergency care completion.
3. **Transfer Regulations:** If the hospital lacks the capacity to treat the EMC, it must transfer the patient to a capable facility, following strict guidelines for consent, medical justification, and documentation.
4. **Specialist On-call Requirements:** Hospitals must maintain on-call rosters for specialists to ensure prompt response to emergencies that require higher levels of care.
5. **Penalties for Noncompliance:** Hospitals and physicians found in violation of EMTALA can face significant civil monetary penalties—up to \$100,000 per violation—and may be excluded from participation in federal healthcare programs like Medicare and Medicaid.

Outcomes and Impact:

- EMTALA became a foundational patient protection law in U.S. healthcare. It created an enforceable right to emergency care and transformed emergency departments into access points for millions of underserved individuals.
- It significantly curtailed patient dumping and prompted institutional reforms in hospital triage, documentation, and emergency readiness.
- It also brought to light the financial pressures faced by hospitals providing unfunded emergency care, leading to the development of community benefit programs and government safety-net subsidies.
- Despite criticisms over underfunding and overuse of emergency departments, EMTALA remains a landmark law protecting the most vulnerable.

EMTALA serves as a model for Nigeria, where many of the same barriers—out-of-pocket payment demands, institutional refusals, lack of emergency coordination—still persist today. A Nigerian equivalent must adapt its provisions for a decentralized and underfunded health system while retaining its core objective: ensuring that no life is lost due to financial or legal exclusion at the point of emergency care.

Proposed Policy: NEMTALA (National Emergency Medical Treatment and Labor Act)

NEMTALA would be the first law in Nigeria to codify emergency medical care as a legal right and obligation. It would address both hospital-based and prehospital shortcomings by establishing minimum standards and enforcement tools.

Legal Scope:

- Applies to all public and private hospitals, clinics, and mobile health providers licensed to operate in Nigeria.
- Includes medical, surgical, psychiatric, obstetric, pediatric, and trauma-related emergencies.

Core Provisions:

1. **Mandatory Medical Screening Examination (MSE):** All hospitals with emergency departments must perform an appropriate and timely MSE for any individual who presents with a potential emergency condition. This screening must occur prior to any inquiry about the individual's insurance status, ability to pay, or legal standing, and must be performed by personnel designated as qualified under institutional policy and national health regulations.
2. **Stabilization Requirement:** If an emergency medical condition is found, the facility must provide all medically necessary treatment to stabilize the condition. Stabilization, as defined in NEMTALA, means that no material deterioration is likely to occur during or as a result of discharge or transfer.
3. **Safe Transfer Protocol:** Patients may only be transferred if (a) the patient has been stabilized, or (b) the benefits of transfer outweigh the risks, and (c) the receiving facility has agreed to accept the patient. Documentation and communication with receiving providers must be included in all cases.
4. **Specialist Availability Requirements:** Facilities must ensure that relevant on-call specialists are available to respond to emergency consultations in a timely manner. Policies should define call schedules, responsibilities, and escalation processes.
5. **Penalties and Enforcement:** NEMTALA would empower a federal oversight body (e.g., the Federal Ministry of Health or NHIA) to investigate complaints, impose civil penalties, and suspend operating licenses for repeat violations. Patients denied emergency care may also file formal grievances.
6. **Public Reporting and Auditing:** Health facilities would be required to report denial-of-care incidents and be subject to random audits to ensure compliance with NEMTALA provisions.
7. **Whistleblower Protections:** NEMTALA should include clear legal protections for healthcare workers who report violations in good faith. No staff member—whether physician, nurse, or administrative personnel—should face retaliation, dismissal, demotion, or harassment for reporting instances where emergency care was improperly denied or delayed.
8. **Defined Scope and Exemptions:** To ensure clarity and avoid misinterpretation, NEMTALA should explicitly define what constitutes an emergency medical condition and what types of healthcare facilities are subject to its provisions. Like EMTALA, exemptions should be made for facilities that do not offer emergency services—such as

specialized clinics, elective surgery centers, or diagnostic-only facilities—provided they do not present themselves as providers of emergency care. This will protect resource-constrained facilities from liability and focus enforcement where emergency care is actively promoted. NEMTALA should also delineate when and how exceptions may apply (e.g., during natural disasters or overwhelming mass casualty events), ensuring there are no blanket excuses for noncompliance.

9. **Phased Rollout Considerations:** While a phased or pilot rollout is often used to test laws before full-scale adoption, Nigeria’s history with policy implementation suggests that partial enforcement without strong political will can lead to neglect, abandonment, or indefinite stagnation. NEMTALA must avoid becoming another under-enforced statute. A phased rollout can still serve a critical function: it allows for operational testing, resource calibration, and enforcement refinement. Starting with well-resourced federal and teaching hospitals enables a structured trial of procedures, data systems, and reporting mechanisms. When clearly defined and time-bound, a phased approach ensures readiness without sacrificing national enforcement. Therefore, any phased approach must include a clear national timeline, fixed benchmarks, and public reporting obligations. If a pilot is conducted, it must be time-bound, independently evaluated, and immediately followed by legislative action to extend nationwide enforcement. To maintain momentum, implementation should be backed by federal funding, regular reporting to the National Assembly, and inclusion in the strategic health development plan.

Implementation Strategy: Pathway for NEMTALA Execution

1. Stakeholder Coordination and Pre-Enactment Engagement*

- Convene key stakeholders—including regulatory groups (FMOH, SMOH, MDCN, NMA, NHIA etc.) and relevant health advocacy and advisory groups (e.g., NPAG, ANPA etc.) —prior to bill passage.
- Define what constitutes an Emergency Medical Condition (EMC) and clarify who qualifies to perform MSEs (medical screening exams).
- Co-develop national standards for screening, stabilization, transfer, and compliance mechanisms.
- Draft the implementation roadmap with clearly defined roles, benchmarks, and pilot site selection.

2. Legislative Action*

- Introduce NEMTALA as a stand-alone bill in the House of Representatives.
- Align with the National Assembly Committees on Health and Justice for oversight support.
- Include stakeholder-informed definitions and enforcement structures in the bill to ensure smooth post-passage activation.

3. Capacity Building and Public Education

- Develop CME-accredited training modules on NEMTALA protocols for clinicians, hospital administrators, and legal teams.
- Organize orientation sessions for police, security personnel, and EMT responders.
- Launch national public awareness campaigns highlighting patient rights under NEMTALA and obligations of care providers.

4. Institutional Reform and Readiness

- Require tertiary and high-volume private hospitals to complete NEMTALA facility readiness assessments.
- Establish dedicated NEMTALA monitoring units at federal and state health ministries.
- Standardize documentation for audits, transfer records, and complaint reporting.

5. Phased Rollout and Financing Strategy

- Pilot NEMTALA in six states with high emergency/trauma burdens and operational teaching hospitals.
- Monitor pilot outcomes and use findings to refine policy, legal tools, and implementation logistics.
- Allocate a fixed percentage of the Basic Healthcare Provision Fund to NEMTALA enforcement and training.
- Attract private sector and donor co-financing for hospital compliance support and infrastructure.
- Scale NEMTALA nationally over 2–3 years based on independently verified benchmarks and public performance reports.

This implementation framework ensures NEMTALA is not just passed but effectively activated nationwide—strengthening accountability, increasing emergency access, and delivering on the law’s promise of life-saving care for all.

****Contingency for Accelerated Legislative Passage***

In the event that NEMTALA is fast-tracked through the National Assembly before full stakeholder coordination can occur, the law should mandate the creation of a NEMTALA Implementation Taskforce within 30–60 days of enactment. This taskforce—led by the Federal Ministry of Health and including key regulatory and professional bodies—will be responsible for finalizing operational definitions (such as what constitutes an Emergency Medical Condition), establishing rollout benchmarks, selecting pilot sites, and coordinating public and provider education. This ensures that technical input is preserved, even if stakeholder engagement begins post-enactment, thereby protecting the law’s enforceability and minimizing future implementation delays.

Expected Outcomes

- Improved emergency response times and coverage.
 - Reduction in trauma- and labor-related mortality.
 - Legal accountability for hospitals and providers.
 - Empowerment of citizens to act in emergencies.
 - Increased public trust in the healthcare system.
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Conclusion

Nigeria stands at a pivotal moment to correct longstanding inequities in emergency healthcare—inequities that not only endanger lives but also hinder the country’s financial growth in healthcare, including the development of medical tourism and a globally competitive health sector. NEMTALA would provide the legal and operational framework to protect lives, hold institutions accountable, and modernize the country’s approach to urgent medical care. With clear obligations for hospitals, protection for bystanders, and structured prehospital systems, NEMTALA will become a landmark in public health legislation.

We urge the Nigerian National Assembly to prioritize this reform and collaborate with civil society, healthcare leaders, and international partners to implement NEMTALA effectively and equitably.

Prepared for: House of Representatives of the Federal Republic of Nigeria
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May 2025