Timely Emergency Medical Care: Response-Time Standards and Public Accountability in Ukraine

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Abstract. The article examines the legal significance of ambulance response-time standards and their relationship with public accountability in Ukraine. Its purpose is to identify how these standards should be connected to institutional duties, the review of delays and the protection of patients' rights. Doctrinal legal analysis and systematic interpretation are combined with a focused functional comparison with England and examination of European Court of Human Rights case law. The findings distinguish compliance with an aggregate performance measure from the legal assessment of an individual delayed response. The percentages of permitted exceedances in Ukrainian regulation require interpretation together with the circumstances specified in that regulation; they cannot independently establish the lawfulness of a particular delay. The study differentiates regulatory and territorial planning duties from provider management, dispatch functions and clinical judgement. It develops criteria for reviewing delays through the applicable duty, the responsible actor, contemporaneously available information, operational constraints, feasible alternatives and subsequent corrective action. Particular attention is paid to armed conflict, where immediate threats to ambulance personnel must be assessed alongside preparedness and continuity arrangements. The article proposes clarifying the methodology for assessing exceedances, integrating review information into existing dispatch records and linking complaint findings to measures assigned to competent institutions. The English comparison demonstrates the importance of identifying the legal status of response-time commitments and distinguishing system indicators from clinical outcomes. The proposed framework supports reasoned scrutiny of delayed care without presuming that every missed time standard establishes liability. Its practical effects require evaluation using lawfully accessible incident records and patient outcomes.

Key words: emergency medical care; ambulance response time; public accountability; patients' rights; administrative duties; dispatch; armed conflict; judicial protection.

INTRODUCTION

A response-time standard gives a patient a concrete expectation of emergency assistance. Its legal significance becomes less clear when an ambulance arrives late: the same interval may reflect an avoidable dispatch failure, a shortage of available teams or a route made inaccessible by an attack. A legal framework must enable these circumstances to be examined while identifying who was obliged and able to act. World Health Assembly Resolution WHA72.16 connects timely emergency care with governance, coordination and systematic data collection [19].

Ukraine provides a significant setting for this inquiry because legally prescribed arrival times operate within a system exposed to sustained disruption. In its report of 08.05.2026, WHO documented more than 3,000 attacks on healthcare since the full-scale invasion and identified ambulances and other medical transport among the affected services [20]. These observations establish the relevance of operational constraints. They do not determine whether any particular delayed response was preventable or unlawful.

The literature supplies complementary perspectives. B. Lohvynenko identifies fragmented regulation, overlapping institutional questions and the need to clarify the responsibilities of emergency care actors [8, p. 52]. J. Coster and her co-authors show that meaningful ambulance performance assessment also concerns dispatch accuracy, patient experience and time to definitive care [4, p. 249]. P. Hansen and his co-authors report very low certainty in the evidence concerning response time and survival across heterogeneous patient groups [7, p. 2]. Their findings caution against treating a time threshold as sufficient proof of clinical causation.

V. Teremetskyi and his co-authors connect the provision of socially significant medical services during war and recovery with infrastructure, financing and legal support [12, pp. 1, 5]. This institutional perspective is relevant to preparedness, although their proposals concerning financing other medical services cannot be transferred automatically to emergency care. The present article examines a narrower legal question: how a response-time requirement should connect institutional performance with the assessment of an individual delay.

The purpose is to examine the legal significance of ambulance response-time standards in Ukraine and develop a framework linking them to public authorities' duties, the review of delays and patient protection. Public accountability denotes the obligation to explain and justify public action, submit it to competent scrutiny and address identified deficiencies. It is distinguished from legal liability, which depends on the conditions of the applicable disciplinary, civil, administrative or criminal regime.

METHODS

The study uses doctrinal analysis of the Ukrainian legal framework and sources available as of 21.08.2026. Systematic interpretation connects the Law "On Emergency Medical Care" with regulations on response times, emergency care centres, dispatch and call handling. Constitutional guarantees, procedural legislation and data

protection rules establish the relevant limits and safeguards. Analysis distinguishes existing requirements from interpretative conclusions and proposals for amendment.

England is selected for a focused functional comparison because official documents expressly distinguish legal rights from service pledges and separately report ambulance system indicators and clinical outcomes. The comparison examines legal status, measurement and accountability; it does not rank national services or equate call categories. European Court of Human Rights case law provides a framework for assessing state obligations in healthcare, with due regard to the limits of extending hospital-related reasoning to prehospital services. Published research informs the treatment of performance measures. No patient records, interviews or original response-time dataset were collected; the study therefore makes no finding about the prevalence of unlawful delays or the clinical effectiveness of its recommendations.

RESULTS

The legal meaning of a response-time standard

Article 49 of the Constitution recognises the right to healthcare and requires conditions for accessible medical services [13]. Article 5 of the Law "On Emergency Medical Care" connects accessibility, timeliness, quality and continuous readiness [18]. For the purposes of this study, timely access means access organised in accordance with the urgency of the patient's condition, applicable response requirements and continuity of necessary assistance. Ambulance arrival is one measurable stage within that broader relationship.

Paragraph 1, subparagraphs 3 and 4 of Cabinet of Ministers Resolution No. 1271 of 16.12.2020 prescribe arrival within 10 minutes for critical calls and 20 minutes for emergency calls. Time runs from receipt by the call-taking dispatcher of the centre's operational dispatch service. The same provisions permit exceedances in no more than 25% and 15% of cases, respectively, in view of circumstances independent of the organisation of the emergency care system, including traffic, weather, seasonal factors and the epidemiological situation [3].

The resulting standard has three analytically distinct functions. It directs the organisation of a timely response; supplies a benchmark for evaluating service performance; and provides relevant evidence when a particular delay is reviewed. Each function requires a different inquiry. An aggregate percentage describes a set of responses, whereas an individual complaint concerns the duties and circumstances of a particular event. Neither inquiry can be completed merely by substituting the result of the other.

In our interpretation, the percentage allowance must be read together with the stated external circumstances. It is not an unconditional allocation of calls that may be delayed. A service's compliance with the percentage limit cannot establish that a specific misclassified or overlooked call was handled lawfully. Conversely, an individual exceedance does not establish all the elements of an offence or a damages claim. The applicable duty, conduct, evidential requirements and legally relevant consequences remain to be determined.

The exceedance clauses do not themselves specify a reporting period, a geographical denominator or a uniform method for classifying causes. This limited observation does not establish the absence of all relevant reporting instructions. It identifies matters that should be expressly connected to the legal standard. A national average could otherwise conceal repeated delays affecting a smaller locality, while exclusion of records with missing timestamps could make apparently improved performance reflect incomplete recording.

Attributing duties across the emergency care system

Article 6 of the emergency care Law assigns standard-setting and related functions to the Cabinet of Ministers, regulatory functions to the Ministry of Health, and territorial planning and organisational responsibilities to the specified regional bodies [18]. An accountability inquiry should identify the concrete measure within those powers. A challenge concerning an unresolved planning deficiency requires different evidence and a different responsible actor from an allegation that an available ambulance was dispatched late.

At provider level, paragraph 4 of the Model Regulation approved by Resolution No. 1116 of 21.11.2012 assigns the centre tasks relating to compliance with arrival standards, emergency preparedness and control of the timeliness and quality of care provided by teams [1]. The centre is therefore a material level of organisational review. Nevertheless, a management failure must be attributed through its actual responsibilities and available resources, including whether it could correct a problem itself or needed a decision from another competent institution.

Operational responsibility is more specific. Paragraphs 8–10 of the dispatch procedure approved by Resolution No. 1118 of 21.11.2012 distinguish call-taking from dispatch and coordination functions. Paragraph 12 provides for automatic priority assignment following selection of the patient-condition code and permits dispatcher adjustment in the circumstances it specifies [2]. A review should consequently preserve both the information entered and the decision subsequently taken. A recorded system output does not explain whether the initial information was accurate or whether a permitted human intervention was justified.

These distinctions also prevent a category error. Clinical prioritisation, employment duties and public administration may contribute to one service pathway, but they retain different legal characteristics. Public ownership of a centre does not automatically turn every dispatch or clinical decision into an administrative act. The relevant function and relationship must be established before selecting a supervisory mechanism, legal remedy or defendant.

The Rules approved by Ministry of Health Order No. 583 of 26.03.2021 provide for dispatcher advice on basic life support where necessary and allow callers to contact the senior duty medical professional in non-standard or disputed situations [9]. These existing mechanisms show that assistance during a wait matters independently of arrival. Whether additional advice, reassessment or escalation was appropriate

must be assessed using the caller's information and applicable professional requirements, rather than knowledge acquired after the outcome.

Evidence and review of an individual delay

A useful review begins by reconstructing the chronology: the first recorded contact; receipt by the emergency medical dispatch service; initial priority; assignment and acceptance by a team; departure; arrival; and any intervening update or transfer. These events have different meanings. Receipt by a 112 operator, for example, should not silently replace the specific starting point in Resolution No. 1271. Recording the earlier contact as well would allow an upstream transfer delay to be examined without altering the legal definition of the arrival interval.

There is already an evidential foundation. Article 8, paragraph 4 of the emergency care Law requires information about the call and caller, including its audio recording and the dispatch service's response, to be retained for three years [18]. Paragraphs 5 and 14 of the dispatch procedure regulate recording and updates to response information [2]. The proposed review record should draw on those existing records and distinguish contemporaneous entries from later explanations. A technical outage should be recorded as an evidential limitation, rather than replaced by an invented timestamp.

The proposed assessment has six linked questions: which duty applied; which actor could perform it; what information was available at the relevant time; which constraint caused the delay; which feasible alternative was considered or used; and what corrective action followed. These are criteria for organisational and legal scrutiny, not a new statutory test of liability. Where compensation or a sanction is sought, the additional elements and burden of proof of that particular legal regime must be established.

For illustration, a delayed response may involve an incorrectly recorded address, an unavailable crew or an impassable route. These hypothetical examples do not imply identical fault. The inquiry into the address concerns the information obtained and verification undertaken; the crew shortage raises deployment and, potentially, recurrent capacity issues; the route obstruction concerns its timing, available warnings and practicable alternatives. Several causes may operate together. Identifying an external obstacle should not end the examination of a separate, avoidable failure that prolonged its effect.

Review information must remain proportionate to its purpose. Article 6, paragraph 3 of the Law "On Personal Data Protection" requires relevant, adequate and non-excessive data [17]. Access should therefore follow the reviewer's lawful function, with identifiable clinical information protected and public reporting based on appropriately anonymised or aggregated data. Operational locations and routes also require a separate security assessment. Accountability does not require publishing the underlying call recordings or exposing patients and crews.

Armed conflict and the limits of reasonable operational demands

The immediate safety of ambulance personnel is part of the conditions under which assistance can be provided. WHO's documentation of attacks on medical transport confirms the relevance of this concern [20]. Yet "wartime conditions" is too general an explanation for legal review. The circumstances to be established include the location and duration of the threat, the information available, the operational restriction imposed and the possibility of maintaining communication or arranging another feasible form of assistance.

Two temporal levels should be examined separately. At the incident level, a direct threat may make immediate movement impossible. At the preparedness level, recurring disruptions may require consideration of reserve communications, alternative deployment or coordination with other services. The Model Regulation expressly addresses the centre's work during a special period and emergencies [1]. Our proposed distinction helps assess whether the immediate constraint and the earlier organisational response were adequately addressed, without assuming unlimited resources or requiring crews to enter an objectively unsafe area.

Teremetskyi's analysis identifies legality, a legitimate aim, necessity and the proportionality of interference as criteria for evaluating restrictions [11, p. 343]. Applied here as an analytical approach, these considerations support asking whether a safety-related limitation addressed an identifiable threat and whether a practicable, less restrictive alternative existed. They do not authorise disregard of mandatory clinical rules or supply powers absent from legislation. The specific legal basis and operational circumstances remain decisive.

Continuity also requires attention to transfers between dispatch services. Paragraphs 18 and 19 of the dispatch procedure allow inter-service redirection and require an out-of-area call to be accepted and processed through the prescribed route, including alternative communication where technical redirection is unavailable [2]. As an implementation proposal, the record should identify the receiving service and confirmation of acceptance. This would make a transfer traceable and help prevent responsibility from becoming unclear while the patient continues to wait.

Patient protection and the boundaries of liability

A complaint provides a route for obtaining an explanation and identifying defects even where a damages claim has not been established. Within its scope, Article 7 of the Law "On Citizens' Appeals" requires referral to the competent recipient and prohibits sending a complaint for determination to the body or official whose conduct is challenged [14]. Internal factual verification and external examination of a complaint must therefore be distinguished. A substantive response should address the event and the challenged conduct, rather than merely repeat the service's overall compliance rate.

The appropriate judicial route depends on the legal relationship. Articles 5 and 19 of the Code of Administrative

Justice concern the protection of rights in public-law disputes, including challenges to a public authority's act or omission [16]. An allegation concerning a public planning duty must identify that duty and the claimant's affected right or interest. Claims for harm caused in healthcare provision may instead engage civil rules, including Article 1172 of the Civil Code concerning harm caused by an employee in performing employment duties [15]. The institution's public ownership does not settle jurisdiction.

Article 15 of the emergency care Law identifies late assistance among violations for which the legally applicable forms of liability may arise [18]. It does not establish a single automatic sanction for every missed arrival time. Organisational improvement may be needed even when individual culpability is not demonstrated. Conversely, satisfactory aggregate performance cannot extinguish liability otherwise established under the relevant law.

The European Court of Human Rights adds a further distinction. In Lopes de Sousa Fernandes v. Portugal, the Grand Chamber connected the regulatory obligation with effective implementation and supervision, while limiting substantive state responsibility for healthcare failures to exceptional circumstances. It distinguished knowing denial of life-saving emergency treatment and qualifying systemic dysfunction from ordinary medical negligence. The judgment also addresses effective and independent judicial mechanisms for examining deaths in healthcare [6, paras. 189–196, 214–221]. These principles inform scrutiny of the regulatory framework; they do not establish a Convention guarantee that every ambulance must arrive within a prescribed number of minutes.

DISCUSSION

The English comparison demonstrates why a time commitment must be classified before its legal effects are inferred. The Handbook to the NHS Constitution distinguishes enforceable rights from pledges supported by management and regulatory arrangements. Ambulance response standards appear among the waiting-time pledges: Category 1 has a seven-minute mean and a 15-minute standard for 90% of responses; Category 2 has corresponding figures of 18 and 40 minutes [5]. These commitments should not be presented as unconditional individual entitlements.

This differs from the legislative form of Ukraine's Cabinet resolution, but the comparison is functional rather than hierarchical. A legally binding regulation and a service pledge may both use population-level measures while operating through different enforcement arrangements. Their numerical values are not directly comparable without aligning call definitions, measurement rules and service context. Ukraine's critical category should therefore not be treated as an exact counterpart of England's Category 1.

NHS England separately publishes ambulance system indicators and clinical outcomes and provides specifications for data suppliers [10]. The relevant lesson is the explicit definition of what each indicator measures. Coster and her co-authors' inclusion of dispatch accuracy, patient experience and time to definitive care supports a broader evaluative approach [4, p. 249]. Response-time compliance, clinical appropriateness and the lawfulness of institutional conduct should be assessed through connected but distinct evidence.

Three improvements follow. First, the Cabinet of Ministers should clarify the implementation of the exceedance clauses in Resolution No. 1271. The framework should identify the competent body responsible for specifying the reporting period, relevant population of calls, territorial breakdown and treatment of missing or corrected records. It should also make explicit that an aggregate allowance does not dispense with examination of an individual complaint. Any binding methodology should be adopted through an appropriate legal instrument within the issuing body's competence.

Second, the dispatch and review framework should connect each material delay to existing event records, using a consistent classification of causes and allowing more than one contributing factor. Automated flags could identify records for review, while documented professional assessment would determine their significance. A flag should initiate scrutiny rather than impose a sanction. Clinical urgency and the need to assist the patient must take priority over completing additional explanatory fields during an emergency.

Third, substantiated review findings should result in a measure assigned to the institution competent to implement it, with a deadline and subsequent verification. A dispatch training problem, an equipment failure and a territorial deployment deficit require different responses. The proposed process would connect evidence, explanation, competent scrutiny, corrective action and follow-up. It would also enable recurrent problems to be escalated to the body controlling the necessary decision or resources, without transferring statutory powers through an internal instruction.

The contribution is therefore a framework for connecting legally prescribed arrival times to institutional duties and individual review. Its value depends on implementation: additional records may become burdensome, cause classifications may be used defensively, and aggregated reporting may conceal unequal access. These risks support integrating the proposals into existing records and testing them through independent examination of anonymised cases. The present doctrinal study cannot demonstrate that the recommendations shorten response times or improve survival; those outcomes require empirical evaluation.

CONCLUSION

Ambulance response-time standards in Ukraine operate as organisational requirements, performance benchmarks and relevant evidence in the assessment of

delayed assistance. The permitted percentages of exceedances must be interpreted together with the circumstances specified in the regulation. Aggregate compliance neither establishes the lawfulness of every response nor resolves the rights of an individual patient; an exceedance likewise does not independently establish all the conditions of liability.

Public accountability requires attribution of a concrete duty to the actor competent to fulfil it, supported by evidence of the information, constraints and alternatives present at the time. Regulatory and territorial responsibilities must be distinguished from provider management, dispatch functions and clinical judgement. During armed conflict, scrutiny should address both immediate safety constraints and the adequacy of preparation for recurring disruptions, without treating the existence of war as a complete explanation of each delay.

The proposed improvements are to clarify the methodology for assessing exceedances, integrate delay review into existing records and link findings to corrective measures with identifiable institutional responsibility. A focused comparison with England confirms the importance of specifying the legal status and measurement of response-time commitments. The resulting framework can support reasoned patient protection and institutional learning, while its practical benefits remain subject to empirical assessment.

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