Jack Stout

INTERFACE

What The Feds Should Know

An Open Letter to the Inspector General

At the time of this writing, a study affecting our industry, the ambulance service industry, is being conducted by the Department of Health and Human Services (DHHS), Office of the Inspector General. The scope of this study seems deceptively modest--two questions: What has caused Medicare payments for ambulance services to increase from $30 million in 1974 to $300 million in 1984? And, why the "explosion" of advanced life support (ALS) services?

Findings from this study will almost certainly influence changes in Medicare policy, and changes are surely in order. But intended or not, understood or not, such changes (or even a decision against change) will profoundly affect the very nature and structure of our industry. Let me explain.

A Fast Ride

Prior to the late 1960s, ambulance service at best meant a fast ride to the hospital. A loosely organized and largely unregulated assortment of funeral homes, "mom and pop" businesses and volunteer services constituted the bulk of the "industry." In most urban areas, multiple firms engaged in retail competition, or, in some cases, merely worked to maintain an appearance of competition.

Response times were unknown and unmonitored; vehicles were barely modified (sometimes unmodified) funeral cars; and companies bragged if attendants had any training at all. Most didn't. The public expected little and, with few exceptions, got it.

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Rising Expectations

Then during the late 1960s, physicians and public officials gradually began to understand that some patients could benefit dramatically from more clinically sophisticated on scene and en route care. For these patients, a fast ride was not enough. Rising expectations were caused partly by what we had learned in Vietnam (e.g., it was safer to be wounded in Vietnam than on the streets of America's cities), and partly by developments in medical technology, electronics, and communications.

> ***"In the early 1970s, public opinion of the private ambulance industry reached an all-time low."***

For some, the opportunity to do more was irresistible. A handful of physicians got involved in local communities, promoting innovations in the training and equipment of ambulance personnel, and in the procedures they were allowed to perform. Thus, in a scattering of local "hotspots," more clinically advanced services emerged, often outside the authority of medical practice statutes and amid bitter controversy.

Where market conditions allowed, private ambulance firms sometimes participated in these early innovations. But where market conditions were less favorable, efforts of local government to simply require better service, through ordinance and regulation, often failed – sometimes dramatically. For reasons unknown at the time, the private sector seemed unwilling or unable to respond to the growing demand for more advanced, on-board medical capability, and agencies of local government, often fire departments, seized the opportunity.

The Move Toward Socialization

At the start of the 1970s, a few scattered communities were served by ambulance organizations capable, in varying degrees, of performing clinically advanced procedures – some private, some socialized. But most of America continued to rely upon "non-systems" of multiple private providers engaged in retail competition.

Throughout the 1970s, and in spite of numerous creative efforts, multiple-provider systems, and retail competition, failed in city after city to meet the growing demand for more sophisticated prehospital care. Experience would eventually show that these failures were caused by the form of competition being relied upon – not by some mysterious incompatability between private enterprise and the needs of emergency patients. Unfortunately, and with long range consequences adverse to the public interest, the causes of this widespread failure went unexamined. Private firms operating under impossible market conditions, and in no position to change those conditions, took the blame. By the early 1970s, local television newscasts were showing funeral home ambulance crews engaged in fistfights over dead bodies while injured patients were ignored. In investigative reports, newpapers exposed bad response times, bad maintenance practices, wallet biopsies and worse.

The public image of the private ambulance industry was already on the ropes when the successful motion picture, "Mother, Jugs, and Speed," portrayed private ambulance crews as zany social misfits whose primary aim was to sabotage their competition while ripping off the welfare system. Then came a nearly fatal blow – Jack Webb's tremendously popular "Emergency" television series. Millions of Americans learned to identify paramedic services

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with fire department operations.

In the early 1970s, public expectations reached an all time high, while public opinion of the private ambulance industry reached an all time low. With the passage of the federal EMS Act of 1973, millions of federal dollars would be spent to encourage development of more clinically sophisticated emergency services. Much of this money would be used as "seed money" to encourage proliferation of locally subsidized, government-operated services.

The seeds took root. By 1985, the average local tax subsidy of ambulance services was about four dollars per capita per year, and nearly 50 percent of U.S. citizens were served by government-operated emergency services. With a powerful push from the federal government, our industry's private sector was increasingly relegated to the role of non-emergency provider.

During the same period, the conventional wisdom of socialized service was being quietly challenged, both clinically and economically, by a small number of privately operated ambulance systems – systems which could duplicate and even exceed the quality of government-operated services, without subsidy and at far lower cost per patient served. How did they do it? Could their methods be reproduced in other communities? Why did these firms succeed where most had clearly failed? DHEW (now DHHS) spent over $30 million on EMS research, but spent nothing to learn the secrets of America's most efficient prehospital care systems.

Nails In The Coffin

If the federal government had deliberately set out to bury private providers of primary emergency services, it could not have done better than devise the series of policies and programs that were, in fact, implemented between 1973 and 1985.

Item: Federal grant programs heavily favored government operated services and even required assurances of ongoing state and local tax support. As the industry grew more dependent upon local tax support, natural market areas were chopped up into mono-jurisdictional mini-markets. Potential economies of scale were destroyed, along with the potential for unsubsidized services of high quality and financial stability.

Item: Under Medicare policies, the token rates charged by heavily subsidized government providers unfairly (and illogically) reduced reimbursement

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paid to unsubsidized private firms. Thus, by a perversion of cost/price relationship, high cost/low price government providers appeared, to the public, more efficient than far more productive unsubsidized private providers. Incredibly, even companies in other communities, sharing the same "prevailing rate," received lower Medicare payments because of subsidy they didn't receive, by communities they didn't serve. Medicare policy made subsidy contagious.

Item: Until only recently, Medicare policies recognized no difference between the cost of ALS service versus that of basic transport service, making it difficult or impossible (in many markets) for even the most efficient firms to provide unsubsidized ALS services. (While this policy has been changed, its administration remains inconsistent and restrictive.)

Item: Medicaid programs often mimic Medicare policies as regards reimbursement for ambulance services. Thus, unless offset by local subsidy, much of the cost of indigent care must be shifted to other patients' bills. The resulting higher prices (or reduction in quality of care) are then blamed on the private provider and become an issue in the political decision to socialize service.

The administration of federal grants under the EMS Act of 1973, and the administration of the Medicare and Medicaid programs have profoundly influenced the evolution of our industry. In the hospital industry, Medicare and Medicaid programs reduced the restrictive influence of local tax support, paving the way for development of a nationwide network of sophisticated institutions serving natural medical trade areas. In contrast, federal intervention in the ambulance industry has encouraged dependence upon local tax support, destroyed economies of scale, and encouraged socialization of an entire industry. In communities able to afford it, astonishingly inefficient systems have been the result. Where waste is not an option, antiquated levels of service persist. Though widespread, these effects are not yet universal.

Four Wrong Assumptions

With a few remarkable and truly instructive exceptions, today's prehospital care systems reflect the conventional wisdom of the early 1970s – mainly four untested assumptions about how ambulance services can best be provided.

Assumption: The private sector failed. *Fact*: We now know that retail competition is not and cannot be a useful economic force in the ambulance service industry. But where "competition for the market" has replaced "competition within the market," private providers are meeting the industry's highest performance standards, at the industry's lowest costs for comparable services.

Assumption: Local tax support is necessary and desirable. *Fact*: Where this conventional wisdom of the 1970s has been abandoned, our industry's highest quality services are delivered with little or no local tax support. We now know that the main effect of subsidy is to finance inefficiency while hiding high production costs behind token retail prices.

Assumption: EMS should be a responsibility of local government. *Fact*: Local government is neither an efficient provider nor an effective buyer of primary

health care services. Unlike traditional local services, this industry's growing economies of scale call for development of strong, multi-jurisdictional provider organizations serving natural medical trade areas. Financial involvement by local government only stifles this essential evolution of our industry.

Assumption: Economy will be served by using specialized production strategies – i.e., less capable and less expensive crews specialize in non-emergency and not-very-serious emergency work, while more expensive resources are reserved for more serious cases. *Fact:* Where crews and equipment are specialized, fluctuating patterns of demand create alternating periods of overload/idle time for both emergency and non-emergency crews, often on a daily basis. Using flexible production strategies, instead of specialization, America's most efficient prehospital care systems are full service, all ALS systems – systems where call screening, transport refusals, and on scene collections have been banned, and where every patient, emergency or not, is served by a fully capable paramedic unit.

These four assumptions were the basis of policy in implementing the EMS Act 1973, and they influence the Medicare and Medicaid assumption that specialized production strategies are a "given," and that it is desirable to divide production forces into "emergency" vs. "non-emergency" missions.

The federal government's promotion of those assumptions, however unintentional, has come very close to wiping out superior system designs based upon alternative, and far more accurate, assumptions. Only a handful of such alternative designs have survived to prove their validity.

It Can Happen Again

The 10-fold increase in Medicare payments for ambulance services since 1974, and the more recent "explosion" of ALS services, are results of several causes – some positive, some not. Faced with shrinking local budgets, even the most heavily subsidized systems are raising rates and billing third party payers. For some government providers, the increased revenues merely extend the tenure of an inefficient system, postponing its inevitable demise.

Where socialized systems serve more affluent communities, higher rates and more aggressive third party billings often serve only to finance increasing inefficiency. Medicare's failure to adjust for the effects of subsidy when setting allowable charges has done more than unfairly punish unsubsidized private providers – it has also furnished a windfall for heavily subsidized government services, many of whose subsidies alone exceed the highest fees charged by private providers of comparable services.

Communities served by private providers of primary emergency services are replacing subsidy dollars with more cost-based fee structures. In some cities, unsubsidized private firms are upgrading their services to handle the peak period overloads of government providers who, for fear of liability, have abandoned call screening. Because of risk of abandonment charges when a government paramedic unit "hands off" to a private basic life support (BLS) crew, governments operating non-transporting ALS rescue services are beginning to demand that their private transport providers upgrade to the ALS level.

"With a few remarkable exceptions, today's prehospital care systems reflect the wisdom of the early 1970s."

Besides the obvious economic effects of rapidly improving quality of care, and simple inflation, the above-described trends largely explain the increases in both Medicare payments for ambulance services and in the number of ALS providers. However, the desirability of these trends cannot be assessed simply in terms of their impact upon Medicare payments.

It is entirely possible to develop policy changes that will simultaneously reduce Medicare payments for ambulance services, wipe out our industry's best managed firms, and guarantee the dominance of our industry's least productive systems and organizations. To do better, policies must be deliberately designed to reward, or at least not punish, efficient systems and providers. At a minimum, such policies must not be blind to the false economy of heavily subsidized token user fees.

Conclusion.

I cannot within the scope of this letter furnish specific recommendations and supporting rationale. I have attempted to describe the evolution to date of America's prehospital care industry, and the not entirely positive influence of federal policy upon that evolution. For brevity, I have omitted supporting references. However, the claims made throughout this letter can, if required, be fully supported.

An exciting opportunity does exist to employ Medicare policy as a positive force in the evolution of our industry, while holding the line on federal expenditures. But an equal opportunity also exists to extend and magnify mistakes of the past. Federal policies have encouraged and rewarded proliferation of government-operated systems whose combined revenues from local tax subsidies, third party payments, and private paying patients are often double or more the revenues required for production of comparable services by privately operated systems of superior design. Regardless of the extent to which local tax dollars are offsetting Medicare obligations, the effect is two dollars spent for every Medicare dollar saved. We can surely do better.

This letter is not about public versus private prehospital care systems. Private providers of low quality service do exist, and some government providers operate at reasonable levels of productivity. The purpose of this letter is to call to your attention the historical bias of past federal policies, and the economic mutations already caused. It need not continue. □