Jack Stout

INTERFACE

Please, Don't Call It Competition

The man on the phone represented an organization that had just won an exclusive contract to transport 32,000 emergency patients annually—guaranteed payment. A beautiful, easy-to-serve city with an enormously lucrative non-emergency market to boot. The city, the market, and the money could add up to the most desirable contract in the history of our industry. The caller told Judy Jameson that he knew our company designed prehospital care systems and managed competitive procurements, and would we be willing to share some information?

Judy said we'd try to help. And then something incredible happened. The caller, representing the winner of what should be one of our industry's most desirable business opportunities, asked if we would send written information on: procedures for loading patients into ambulances; en route medical protocols; dispatch procedures and telephone protocols; relationships with hospitals and nursing homes; on-board inventory controls; and more.

You must be wondering how an organization in need of such basic information could possibly win a major ambulance service contract—or *any* competitively awarded EMS contract, for that matter. What happened to the bids of America's most experienced and reputable private providers?

The caller was with the Phoenix Fire Department, now the official "winner" of one of the largest and potentially most desirable ambulance service contracts in the history of EMS. But what did the Phoenix F.D. really win—and how?

AAA Reacts:

There are strong emotions involved here. The following is from a letter dated May 23, 1985 to the mayor of Phoenix from William Stanley, president of the American Ambulance Association (AAA):

"The American Ambulance Association has monitored the city's ambulance service selection process in recent weeks. It has been a disheartening spectacle.

"The Association . . . objects to being subjected to what has come to be a sham selection process. The elimination of qualified low bids for no reason and the evident need of insider information for selection makes a mockery of the selection process, insults the integrity of our political and free enterprise systems, and ultimately will jeopardize emergency transportation service in the city of Phoenix. Your citizens have not been well served."

Inoculate Your City. If your company is a private provider of primary emergency services, what happened in Phoenix matters to you. In the May 27 issue of no less than *Fortune* magazine, writer Jeremy Main calls Phoenix "a well-run city of 866,000, (which) encourages municipal departments to join the competition with private contractors." Local governments often borrow ideas from one another, and what happened in Phoenix could be contagious.

Reputation notwithstanding, Phoenix has conducted what is perhaps the most seriously flawed ambulance service procurement ever held by a major city. It is, as Bill Stanley said, disheartening, especially since it appears unlikely that Phoenix will admit and correct its mistake.

However sad this experience may be, it is not enough to express dismay and opposition. To inoculate other cities against a similar infection, the Phoenix procurement must be recognized throughout our industry for what it was—a dismal procurement failure.

What Didn't Happen

No matter what you've heard about the Phoenix fiasco, it was not, in my opinion, the result of stupidity, incompetence, or a conspiracy to monopolize emergency transport services within the fire department. The "elimination of qualified low bids for no reason" was also not the problem. If qualified low bids were rejected (and that may be determined in court), such rejections were the *result* of a bad procurement process but tell us nothing at all about the causes.

Phoenix's procurement process started going sour long before the first request for proposal (RFP) draft was written. Problems with an antiquated system structure were misdiagnosed, and efforts were made to treat the wrong disease. Choices were made while options remained a mystery. Business decisions were made without knowledge of the business.

In the aftermath, an award was made. It hardly mattered. It was a bad system design and a bad business arrangement. The contract called for BLS services at ALS cost. High subsidy levels, call screening, and handoffs of emergency patients to BLS crews would still prevail, *no matter who got the contract.* The procurement's clinical and response time standards would, even if met, be a major breach of contract in many cities and could even get you arrested in some.

No, the problem wasn't in the contract award or even entirely in the RFP. And if there wasn't a conspiracy, or stupidity, or incompetence, then what *did* go wrong in Phoenix?

Wrong Diagnosis

Like a lot of other cities during the last decade, Phoenix decided to socialize its paramedic services. The *Emergency* television series furnished the model for more than a few municipal paramedic systems, and Phoenix followed the trend. Non-transporting fire department paramedic units relied upon private BLS firms for patient transport services.

While script writers made the model work well on TV, it suffered

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If you have a question, a problem or a solution related to the public/private interface in prehospital care, address your letter to "Interface," jems, *P.O. Box 1026, Solana Beach, CA 92075.*

from a number of financial and operational problems not found in more modern prehospital system designs. One of those problems was the model's dependence upon multiple private firms for patient transport service. A few cities briefly tried call rotation but quickly noticed the obvious—if calls are rotated among three providers, the chances of dispatching the nearest unit are 1-in-3; if calls are rotated among four ambulance firms, the chances are 1-in-4; and so on. Most systems using the television model didn't even try using call rotation because it obviously could never work. Those that tried it quickly switched to other methods. . . except Phoenix.

Phoenix kept trying to make call rotation work long after nearly everyone else had abandoned the concept, at times rotating calls among seven different firms! The city even required the private firms to sign contracts promising to make call rotation work, as though a legal document could somehow change the rules of chance.

When response-time problems continued (which was inevitable under call rotation), city officials and even the local press blamed the private providers. All had signed agreements promising to meet (not very stringent) response-time standards, and all had failed.

Perceived bickering among the private firms further damaged their community image. Before call rotation, the city had used a hopelessly oversimplified zone coverage plan. Some zones were economically more desirable than others, and the plan provided no financial adjustment. Predictably, the private firms assigned to less desirable zones objected.

The city, perhaps ignorant of antitrust constraints on the private firms, had suggested that the companies develop their own plan for rotating zone assignments. Understandably, the firms did not propose such a plan, and the city did not have the expertise to develop an economically workable zone coverage program. To the public the private operators seemed more interested in profits than in service, and the city's decision to switch to call rotation looked like a reasonable solution to the zone coverage problems.

Of course, call rotation failed miserably. The local firms, and the private ambulance industry in general, took the blame for the results of the city's own policy decisions. By the time political pressures forced a solution to the response time problems, the seed of fully socialized EMS had already been planted and fertilized.

Ignorance of Options

Once it was clear that the system wasn't working, Phoenix set out to examine the alternatives. Two management reports (MB 85-1 and MB 85-2), prepared by city staff, chronicled the system's persistent problems and attempted to outline the advantages, disadvantages, and applicability of alternative system structures.

Unfortunately these reports contained numerous misconceptions about alternative system designs, both operational and financial, as well as a number of statements that were simply false. For example, regarding deployment strategies, the reports stated that "without dedicated ambulances operating from fixed or known decentralized locations, there is less predictability of response time or availability." This statement is simply not true. Some of the most demanding response-time standards in the U.S. are routinely achieved by fully professionalized, full-service systems using neither dedicated ambulances nor static post-locations.

Regarding the public utility model, the reports were deeply confusing. They said the public utility model requires that fire departments must stop providing non-transporting paramedic rescue service. In fact non-transporting first responders are a key element of the public utility model, and paramedic first responders would be an added asset. Management report BM 85-1 stated that the Kansas City system had never gone to bid when in fact the highly publicized Kansas City competition was then the largest ever conducted. The same report detailed over $3 million in Kansas City's financed start-up costs but failed to mention that the ambulance system makes those payments or that Kansas City's subsidy level has steadily declined since the system was installed.

The reports quoted Alan Jameson and me extensively, often out of context and often to support statements with which neither Alan

nor I would ever have agreed. But the greatest damage was done by what was *not* reported. Absolutely essential financial factors were omitted entirely. For example: What is the total cost of the present prehospital care system—not just the paramedic or emergency transportation or non-emergency components? What would be the total cost of alternative systems? What would heavily subsidized emergency rates do to the region's Medicare reimbursement profile and to the other providers who must depend upon that profile? Why have other recently implemented systems avoided substantial subsidization? Where superb paramedic services exist without substantial subsidy, how did they do it? Might a subscription program be in order? Is there a way to take advantage of Phoenix's incredibly desirable non-emergency market to further emergency coverage? Given industry economies of scale, is it smart or necessary to use a single emergency provider in a city the size of Phoenix? Is there any advantage to separating billing/collection functions when you intend to pay on a per-run basis anyway?

These and many other issues were either casually covered or not discussed at all. In fact some of the most viable solutions to Phoenix's problems (e.g., Tacoma's model) were never mentioned and those that were discussed were riddled with errors and misconceptions. In short, after misdiagnosing the system's problem, Phoenix officials compounded their confusion by grossly underestimating the complexity of our industry.

Superficially, the ambulance industry seems anything but complex, so it is not uncommon for public officials and even the press to approach EMS with unwarranted confidence in their understandings of how prehospital care systems actually work.

Some people believe the city's reluctance to abandon call rotation, the faulty diagnosis of the problem and the incomplete, even erroneous management reports were all part of a deliberate (and successful) plan to first discredit private providers, discourage strong competition, then monopolize emergency transport within the fire department. I doubt it. To devise such a plan would require a knowledge of our industry that simply does not exist in Phoenix city government.

The Design Behind the RFP

Every ambulance service contractor must operate within a larger system design—a design over which that contractor has little or no control. *No contract and no contractors can overcome performance problems that are inherent features of a poorly conceived system structure.* Phoenix's chronic response-time problems furnish a perfect example.

But because response-time problems are easy to detect and easy to report, they tend to divert attention away from other, more complex problems. Any system which attempts to restrict paramedic units to certain kinds of calls risk the kind of embarrassment recently experienced by the Dallas system—which is not known for having response-time problems. Any system which hands off patients to BLS crews risks the charge of abandonment.

"The final pitch was the development of an offensive, unsound, and unfair business proposition — the Phoenix RFP."

Any system which separates the emergency and non-emergency markets loses economies of scale, invites cream skimming, loses peak load capacity, risks non-emergency patients' lives and increases its own subsidy requirements. I could go on. The point is that the generic type of system used by Phoenix is the least efficient of today's prehospital system structures, but the narrow focus upon response-time problems has completely obscured that fact.

Phoenix's solution to its response-time problems preserved the basic generic system configuration—the television model. Under the new system, the emergency and non-emergency markets will still be separated, most transportation (even of emergency patients) will still be done by BLS crews, and the system's dependence upon subsidies will actually increase—*no matter who won the transport contract.*

It is true that the new system should solve the system's response-time problem. It should also effect an actual deterioration in the quality of other ambulance services in the area. That is, by depressing the area's Medicare profile and by eliminating the emergency transport revenues of local private firms, it is likely that these firms will no longer be able to support their existing ALS production capacity. Thus the new Phoenix system will actually reduce the total ALS production capacity of area providers.

But the effects of the poor system design don't end there. The combination of subsidy and rates in the new Phoenix system will be plenty to finance eight-minute maximum response times and full paramedic transport service in the context of a better system design. The problem is that Phoenix will be getting a 10-minute maximum and BLS transport service.

Even before the RFP was written, Phoenix's chosen system design had assured that nearly all the strongest ambulance companies in the U.S. would decline to submit proposals. The contract was for the purchase of a mundane, even antiquated level of emergency transportation services, leaving the high visibility paramedic rescue work exclusively to the fire department. The contract might have made some money, but its showcase value would have been worse than zero.

Thus even before the RFP was written, the design of the system had already guaranteed that the most important aspect of the service, the paramedic program, would remain exclusively within the fire department and that most of our industry's strongest firms would decline to become associated with an expensive system producing mediocre performance. Not even the most elegant RFP could have changed that sad truth.

The Phoenix RFP

Unfairly blamed for the city's decision to use call rotation, the local ambulance companies, in fact, the entire private ambulance industry, already had one strike against them. (Contrast the private service image with that of the Phoenix F.D. which enjoys one of the strongest public relations programs of any fire department in the U.S.) Then the city blew its search for alternatives and stuck with an outdated system design that would relegate the private sector to a mundane role in an expensive system giving mediocre service. Strike two.

The final pitch was the development of an offensive, unsound, and unfair business

proposition—the Phoenix RFP. Even if the procurement hadn't already been doomed by previous events, the RFP would have finished the job all by itself. There isn't space here to tell all that was wrong with that RFP. A few of the highlights:

The RFP's clinical standards called for the lowest quality of service allowed under Arizona law. Response-time requirements, though an improvement for Phoenix, were so lax that meeting them would constitute a major breach of contract in many U.S. cities. Any potential bidder with a national reputation for excellence was forced to weigh profit potential against the certainty of being associated with an embarrassing level of service.

The procurement was a free-for-all. Bids would be accepted from anyone who would show "prior experience in the field or a related field." And given the low level of service required, our industry's most qualified firms knew they might be bidding against just about anyone, including firms lacking the expertise to accurately estimate costs. Furthermore, the RFP offered no evidence that Phoenix officials were interested in excellence or could even tell the difference. Since it is expensive to prepare a proper bid for a procurement of this size, and since there was a good chance that an inexperienced firm (e.g., Phoenix Fire Department) would win the award, most top firms simply stayed away.

Though it was known that Phoenix F.D. intended to bid, the RFP provided no information at all as to how that agency's proposal would be compared with those of private firms. Would general overhead be added and on what basis? What about the agency's cost of working capital? Would private bidders have access to the same public facilities that would be available for use by the fire department, or would a "rental" amount be included in the department's bid? Would penalties be deducted from the fire department's budget? If the fire department wins the bid but proves unable to do the job within the contract budget, will the contract then be offered to the company submitting the best private offer? Not one of these important issues was addressed in the Phoenix RFP.

The RFP was silent on the definition of response-time exemptions, even though substantial penalties were defined. Its provisions contained a confusing blend of "level-of-effort" and "performance contracting" commitments. It stifled pursuit of efficiency by specifying numerous deployment requirements and by mandating use of "dedicated" units.

The RFP was unfair. It required the contractor to fulfill the city's current and future mutual aid commitments "without additional compensation." It required the contractor to indemnify the city against liability arising out of the performance of the contract but offered no similar protection to the contractor against claims arising out of errors made by the city (e.g., dispatching errors or call screening mistakes made by city dispatchers). The contractor could be fired if there were "four or more valid complaints of rude, impolite or demeaning treatment . . . during any 30-day period . . . the validity of which complaints are determined to exist by the city in its sole discretion." The same is true if there were more than two Code 3 response times in excess of 15 minutes during any 30-day period—no exceptions defined.

The business arrangement created numerous conflicts and risks for both parties. The contractor would be paid by the city on a per-run basis for every patient transported, while the city would set rates and collect bills. Such an arrangement would create a powerful incentive for the contractor to help generate more 911 calls and fewer transport refusals, regardless of whether the city could collect. Even if the contractor resisted that temptation, constant disputes over transport decisions would create the opposite appearance. With rates set below cost and the normal problems of collecting for emergency services, the city would lose money on every transport made by the contractor, creating conflicting interests of major proportions.

Even the financial risk to the contractor was almost impossible to handicap. Retail rates for the services rendered by the contractor would be set by the city and the city would handle billings and collections. What would happen if contractor payments exceeded revenues by far more than the city projected? The RFP had the answer. The contractor would finance the new system's start-up costs (except for the communications

infrastructure) amortized over a three-year contract. But if the city found the new system too expensive, the following provision could solve the problem: "...the continuation of any agreement after the close of any given fiscal year shall be subject to council budget approval of the city of Phoenix...The city does not represent that said budget item will be actually adopted..."

Many government agencies are restricted in their ability to make multiyear financial commitments. Phoenix is not unique. But other cities under similar circumstances provide contingency funding for early termination payments, set up public trusts or non-profit corporations to manage the contract or devise other means to furnish reasonable safety for the contractor's capital investment. The Phoenix RFP simply passed the entire risk to the contractor, making it quite possible that the contractor could lose its investment through no fault of its own.

The business structure was also unclear. If the customer called 911, the contractor provided the service, and the city collected the bill, who is the retailer? With whom does the patient have an implied contract? If the bill is issued in the name of the city, then is the contractor operating under the city's *Arizona* license? What name goes on the side of vehicles...city of Phoenix or the contractor's logo? On all of these important business questions the RFP was silent.

These are just a few of the flaws in the Phoenix RFP. There were many more, but two that deserve special mention. A truly qualified bidder might have submitted an alternative proposal, suggesting changes in the system structure and offering a workable business arrangement. But the Phoenix RFP stated flatly that Phoenix was not interested in other ideas. The language of two RFP provisions made that clear:

"...the city views the notion of any 'exception' in response to the proposal as an attempt by a proposer to vary the terms of the proposal, which may in fact result in giving to any proposer noting such an exception an unfair advantage over other proposers..."

And, "The submission of a proposal herein by a proposer constitutes an agreement by the proposer that it will not insist on or use any standard contract agreements, documents or forms, and that it waives all provisions of its standard agreement. The language for the contract to be executed will be drafted by the city of Phoenix under the supervision of the city attorney of the city of Phoenix and shall be the controlling document."

If there ever was a chance that some qualified company would take the time and trouble to offer constructive alternatives, the language of these provisions surely killed it. It is easy to see why some people still believe it was a setup. First socialize the paramedic services, then institute call rotation. Blame the results on private providers, and then call for reform. Design a system that will preserve socialized paramedic services, no matter how the bid comes out, both to discourage participation by many of the strongest firms and to hedge the bet on winning the bid. Then produce an RFP that is so undesirable that the only firms which should be interested are the local firms whose financial lives are on the line.

If it works, the strongest companies won't bid at all, every bid will offer equally unimpressive services, and the fire department will win the bid. If it doesn't work, the fire department will still be in the paramedic business and the locked-in prices will prevent the private contractor from developing paramedic capability.

I know it's easy to see it that way, because the city's actions, if not its motives, were exactly as described. But I can't think of a single reason why a fire department would want to run a BLS transport service, especially at a loss. The Phoenix Fire Department did not conduct the faulty research, did not design the faulty system and did not develop that amazing RFP. In fact it no longer matters who or what bizarre combination of circumstances would cause a government with such a reputation to blunder so totally.

The fact is it happened. Along with the American Ambulance Association, I too would like to see Phoenix admit error and rise from the ashes. That's up to Phoenix. But what about the rest of us? What can we learn from the Phoenix experience?

Lessons from Phoenix

On the negative side, we must make every effort to be certain that the Phoenix EMS procurement never serves as a model for any other city.

Unfortunately, that means the Phoenix procurement must be openly and accurately criticized, even at the risk of offending certain officials. Statements by the American Ambulance Association, and this article, reduce the likelihood that others will borrow from the Phoenix procurement.

On the positive side, there are two important lessons. First, as a highly specialized and widely misunderstood industry, we must recognize that leadership will have to come from within. We should never expect that government officials, left alone, will be qualified to effectively intervene in this industry. The American Ambulance Association protest came far too late. And I must confess that I had been following developments in Phoenix before the RFP was released but postponed writing about the impending problems until after the fact.

Mending my ways, I have helped conduct one well-received workshop on EMS procurements, and more are being co-sponsored by *jems* two days prior to the *EMS Today* conferences. The California Ambulance Association is reportedly working closely with the California EMS Authority toward development of effective procurement guidelines. Ft. Wayne's (Ind.) Three Rivers Ambulance Authority is helping fund a comparative study of nine different prehospital care systems to serve as a benchmark for judging the fairness of local rates, subsidies and quality of services.

This is the kind of leadership that we must begin to deliver if we want the "demand side" of our industry (i.e., government buyers and regulators) to keep pace with the rapid evolution of the "supply side" (i.e., private primary emergency providers).

Secondly private providers must learn it is impossible to participate in a faulty procurement process without lending an appearance of credibility to that same process. While the temptation to bid may be great, especially for local firms whose very existence may be at stake, public refusal to participate with a clear explanation of the reasons may be the only way to prevent an irreversible error.

Then What *Did* Happen?

I said it wasn't stupidity or incompetence or a conspiracy that caused Phoenix officials to capture the worst procurement award. So what was it? Even where the most heavily subsidized and least efficient prehospital care systems prevail, the amount of subsidy is but a tiny percentage of the government's annual budget. Years of providing a dramatic lifesaving service free to the customer, combined with a professional public relations program, have made it politically difficult to seriously question the fire department's role within the basic system structure, a fact which was made clear in a citizen poll sponsored by the Arizona Labor Council.

The only *perceived* problem was transport vehicle response times, apparently a small problem within a simple industry. There was simply no political reason to look beyond a simple solution to the immediate problem. Not surprisingly, the city's "Management Reports" justified that position. Rewrite "If it ain't broke, don't fix it" as follows: "If they don't know it's broke. . ." □