INTERFACE

by Jack L. Stout

Giving the Best the Edge

Topics covered in "Interface" include questions of law, labor relations, purchasing practices, public safeguards, bidding procedures, regulation, and business relationships. On occasion, Mr. Stout will include material from guest columnists, real-world case histories, news of upcoming procurements, and answers to readers' questions. If you have a question, a problem, or a solution related to the public/private interface in ALS, address your letter to: "Interface," jems, P.O. Box 1026, Solana Beach, CA 92075.

The scene was a medium sized Michigan community. Throughout the entire county, only two cities had ALS services, and both were examples of non-transporting government-operated prehospital care. If you lived outside those two cities, you couldn't get ALS at all.

Well over one-half million dollars a year in local tax subsidy was going into the ambulance service system. Most of the BLS transport service was provided by two private companies owned by the same people. The two private companies wanted to provide ALS service to the surrounding areas, but so far were unable to obtain the medical control approval required for state ALS licensure.

The local physicians were concerned about medical control and accountability in a system relying upon two small ALS providers, each of whom provided non-transporting rescue service and relied upon a "patient handoff" to a transporting BLS provider. Call volumes were barely big enough to support one good provider of ALS services, and with two government agencies already licensed, how could the situation be helped by licensing a third provider? Maybe a fourth? Where would it stop? And what about those people outside the cities served by the two government ALS providers?

In some ways, the private company owners had a pretty good deal. The two biggest cities provided, at taxpayers' expense, the most expensive and sophisticated elements of ALS service delivery, but referred every single transport to the private owners. Not one dime of the system's fee-for-service revenues was used to offset the cities' operating costs. On the other hand, the private owners wanted to provide ALS service to the surrounding townships, and the surrounding townships wanted ALS services.

> ***"When a community decides to depend upon the private sector for an essential public service, it must structure a business opportunity that attracts the best, discourages the others, and protects the community from failure."***

Elected officials, some of them at least, began to wonder about the efficiency of the whole thing. Cost per emergency patient transport was way over $400, but you had to add the private companies' bills to local government's costs to find that out. Some consumer groups wanted to get government out of the ambulance business, and that sounded okay to at least one city manager, provided some reliable service alternative could be created, and a safe means of transition could be achieved.

As for the paramedics themselves, many were truly tired of the annual political uncertainty. The question came up every year, and every year the whole system design was up for debate.

Sounds like a ripe situation for progressive change, doesn't it? Virtually everybody was dissatisfied with the system, and given the size of local tax subsidy already being spent, financing change should be easy. But what change?

Let's Go Private

It's not that umpteen ambulance studies hadn't been done by various groups over the past several years. Umpteen studies had been done. But for one reason or another, none of the recommendations seemed to take root. But then an idea caught the eye of city officials and a handful of involved citizens. Get government out of the ambulance business, and turn the whole thing over to a qualified private company selected by competitive bid.

The logic was hard to dispute. If the private sector can do the job, why have socialized ambulance services? Several communities have already proven that the private sector can "do the job," even where "the job" is defined as ultra-high-performance ambulance services. And several communities have also proven that it is perfectly possible to design a safe and smooth transition to such a system, and to gradually reduce local subsidies, even to zero, in the process. Even more important, a qualified private provider of ALS service could cover the entire county, bringing ALS services to the rural townships, with or without tax subsidy, and medical control and accountability would be infinitely enhanced through bona fide central dispatching, eliminating the "patient handoff," and the spector of a growing hodgepodge of tiny ALS providers.

Going private would improve medical control and accountability, save taxpayers' dollars, bring ALS service to the rural townships, and maybe even end the annual debate. Going private, it seemed, held a smorgasbord of advantages, and no disadvantages.

If It's That Simple

It did occur to some people that if "going private" was all that rosy, why did hundreds of American cities, large and small, "go public" in the first place? Wasn't the private ambulance operator here first? Some people thought about that. Some didn't.

There are three kinds of private ambulance service systems: those that deliver high-performance ALS service at reasonable costs; those that don't; and those that work okay for a while, but lack long-term stability. If you want the first kind, experience shows there aren't many choices. Only a handful of cities have systems like

that, and their similarities are striking. And if you further narrow down the field to include only unsubsidized private systems capable of an eight-minute maximum paramedic response time on 90 percent of emergency requests, you're down to one or two types of single provider ALS systems — the old faithful Public Utility Model and what I call, for lack of a better term, the "exclusive franchise" model. They are both variations of the same theme.

Everyone's An Expert

I'll bet you have noticed it, too. When it comes to EMS, everyone's an expert. It all seems so simple. A patient, a telephone call, an ambulance, a trip to the hospital, an ambulance bill, another patient, another phone call, and so on. The decision to go private has so much appeal that nearly everyone catches the fever. Doesn't going private simply mean that government gets out of the ambulance business? If government gets out, does nothing, and leaves the private sector alone, won't everything be all right?

Caught up in the zeal to promote the private sector, the well-meaning but unsuspecting citizen may actually promote a system structure which will ultimately destroy the most qualified private operator, leaving his corporate bones to be picked over by cream-skimming competitors, creditors, and even an occasional attorney general.

As of this writing, there has arisen in this Michigan community a great clamor, supported in part by the local private ambulance owners themselves, in favor of not only going private—but of also eliminating all forms of local government regulation and involvement as well. I cannot predict the outcome for this community, but we can all learn a lesson from this experience. We can learn that the theory of privatization is easy to sell, but its safe and effective implementation is a great deal more difficult. And we can learn what it takes to make a safe place for qualified private providers—a community where the good guys win and the bad guys, at least the less capable guys, lose.

When a community decides to depend upon the private sector for an essential public service, it must structure a business opportunity that attracts the best, discourages the others, protects the community from private sector failure and protects the private sector from destruction from causes beyond the private company's reasonable control. In the September '83 "Interface" column, we discussed ways of protecting the public from private sector failure. In an upcoming "Interface" column, we shall discuss bid processes which encourage the best and discourage the others. What follows here is a discussion of factors which have either caused the collapse of or threatened the existence of some of the finest private providers of ALS services.

Sell Them What They Think They Want

A number of companies supplying paramedic ambulance services under contract to cities have fallen into this trap. Inexperienced city staffers design a new ambulance system on paper, sell it to the elected officials, and a request for proposal is released. A well-organized provider of ALS services makes

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The Three Rivers Ambulance Authority operates under the Public Utility Model for Fort Wayne/Allen County, Indiana and is empowered to establish and monitor uniform standards for regulation, rate setting, and general oversight of advanced life support services.

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Deadline for consideration is February 15, 1984. Send complete resume and salary history to Robert Barry, Chairman Search Committee, Three Rivers Ambulance Authority, 307 E. Murray, P.O. Box 11724, Fort Wayne, IN 46860.

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For more information and an application, write to: Emergency Department — University Hospital Advanced Paramedic Training Program, Oregon Health Sciences University, 3181 S.W. Sam Jackson Pk. Rd., Portland, Oregon 97201

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an offer, often flattering the local people by praising the system design and "business-like approach" the city is taking.

The private bidder had a choice. Faced with deciding whether to tell the city the truth about the proposed system design, or put a price on the service and go for the deal, the company sacrificed its long-run reputation for short-term cash flow. It's an old story; I've seen it a dozen times myself.

The company performs as required, but because the overall system design is seriously flawed, service is less than adequate and efficiency suffers. Over time, these deficiencies become gradually exposed, and the public officials are faced with the dilemma of either blaming their own system design or blaming the contracted provider.

Later, perhaps even years later, the city officials are contacted by other communities as a reference. The answer goes something like this, "Our private provider is not *technically* in breach of the contract, but frankly we aren't very happy with the service." A capable private company's service reputation is gradually eroded, new awards go to others, and when business volume begins to drop, the company is even less eager to decline a local offering on grounds of poor system design.

The lesson is clear. *It is the responsibility of local government—not private industry—to provide an EMS system framework within which a competent private provider may perform with the certainty that good contract performance means good system performance.* Local government cannot ignore this responsibility. Laissez-faire ambulance systems have proven themselves failures time and time again. They are in fact the reason socialized ambulance systems were created. But laissez-faire is not the only unworkable approach to private sector participation in this industry. There must be a hundred other bad designs—each with its own superficial appeal.

Cream-Skimmer Competition

Private ambulance owners all over America, even owners of ordinary BLS organizations, have found a number of ways to reduce or at least control competition. Probably the simplest and one of the most effective methods is to "be busy" when the phone rings from the wrong part of town. If you refer all the losses from uncollectibles to your competition, retaining the rest of the business for yourself, you can control or eliminate much of your competition. (911 systems with multiple provider call rotation furnish a marvelous opportunity for this kind of cream-skimming business practice.)

Companies specializing in only non-emergency transfer work are superb cream-skimmers. The collection rate from non-emergency work is much higher than from emergency work, sometimes nearly double, so even if emergency rates are higher, the actual collections from a non-emergency transfer may be almost the same as from an emergency run. But the cost of performing non-emergency transfer work is considerably lower than the cost of emergency work, especially if the emergency company fails to perform non-emergency work using off-peak production capacity. The non-emergency specialist company can literally drain half of the revenues out of emergency ambulance systems.

> ***"The collection rate from non-emergency work is much higher than from emergency work — sometimes nearly double."***

To combat cream-skimming business practices, many ALS companies have adopted some of the same techniques. In fact, in unregulated environments, the successful emergency operator is almost forced to engage in the same sort of competitive practices. It's a matter of survival.

The unsubsidized ALS provider faced with serious cream-skimming competition must either cut back production capacity or somehow control or eliminate competition. If service cutback is not an option, the only choice left is to control the competition. Here, the ALS provider can borrow from the BLS industry. He can form multiple companies, advertising numerous numbers in the yellow pages, giving the appearance of added competition. If the community uses call rotation, he increases his own percentage of such referrals, and decreases his competitor's accordingly.

He can recruit the referral business of hospitals and nursing homes, using a variety of both appropriate and questionable marketing techniques. And when faced with an intruder from a neighboring community, he can even place an ambulance of his own in the intruder's backyard, withdrawing from the competition when the intruder gets the message.

He can also buy out the cream-skimming competitor, merge, or work some sort of business trade—any deal that will preserve the market base necessary to sustain life-saving ALS response time performance.

The lesson here is that a community does no one any favors when it relies upon a private provider of ALS

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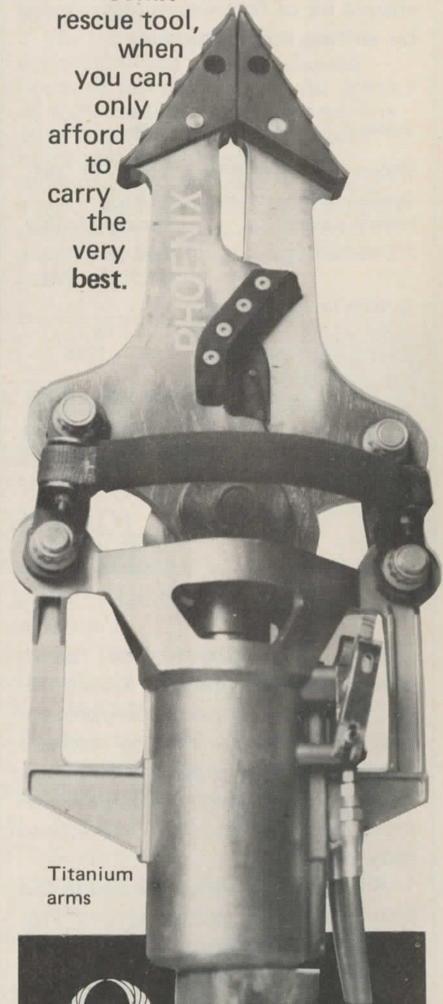

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INVITATION TO BID

The Little Rock Ambulance Authority announces an invitation to receive bids to provide Operations Contractor service under a public utility model procurement. Deadline for receipt of requests for the bidders' package shall be 5:00 p.m. Central Standard Time February 27, 1984. Request for the bidders' package must be in writing and accompanied by a $100 deposit which cover costs of materials and mailing, refundable only upon presentation of receipt by bidders' representatives, in person, at the pre-bid conference in Little Rock Arkansas, March 15, 1984.

This procurement schedule should be as follows, unless altered by written communication:

Event	Date
Bidders' package available	February 7, 1984
Deadline for requests for bidders' package	5:00 p.m. February 27, 1984
Pre-bid Conference	9:00 a.m. March 15, 1984
Deadline for submission of all bid documents **excluding** bid prices	5:00 p.m. June 1, 1984
Authority's confidential review of submitted materials	June 18, 1984
Deadline for receipt of bid prices	5:00 p.m. July 13, 1984
Anticipated Award of Contract	August 1, 1984
Startup of services	November 1, 1984

Mr. Jack Stout has been designated Procurement Coordinator. No other person shall represent the Authority concerning matters relating to this procurement. Any information regarding this procurement received from another source may be in error.

All correspondence related to the procurement should be sent to: Procurement Coordinator, Little Rock Ambulance Authority, P.O. Box 2452, Little Rock, Arkansas 72203.

Repeat: Deadline for receipt of requests for the bidders' package shall be 5:00 p.m. Central Standard Time, February 27, 1984.

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services but does not afford that provider with reasonable protection from cream-skimming competition. As long as the community is willing to subsidize the losses from cream-skimming activities, such protection may be unnecessary. But the community that wishes to "go private" must accept either the responsibility to subsidize or to regulate to eliminate cream-skimming business practices.

Anti-Trust Quicksand

This complex legal issue will soon be dealt with in greater depth by anti-trust attorney, George Leonard, writing as an "Interface" guest columnist. For now, keep in mind that while local government may risk exposure to anti-trust litigation by regulating local ambulance providers, a private company may risk even greater exposure by engaging in the kinds of anti-cream-skimming activities discussed above.

Just as the BLS transport provider in a community served by tax-supported non-transporting ALS service has a giant advantage over any new competitor, the reverse is also true. No ambulance company is more vulnerable to attack and destruction from cream-skimming than an unsubsidized private provider of primary ALS service. Such a company's operating costs are higher, its responsibilities are enormously greater, and its corporate attention must be devoted to clinical excellence and response time performance. Such a company has neither the time nor the price structure to do battle with cream-skimming competitors who have no real responsibility other than to themselves, and that to make money.

The private company whose experience has been acquired providing transportation services referred by a tax-supported non-transporting ALS service is itself a sort of ultimate cream-skimmer. It has enjoyed the system's fee-for-service revenues while a great deal of system costs have been absorbed by the government rescue agency. This is the most profitable possible market position attainable in the American ambulance industry. No company in this position has ever failed to make money. It is one thing to be confident that you can hold off other cream-skimmers from such a secure business position; but it is a mistake to think that such experience is in any way analogous to defending one's self from cream-skimmers, without risk of violating anti-trust laws, when your company has accepted a range of service obligations and responsibilities that extend far beyond the simple business world of the BLS provider.

The lesson here is that, however brave the novice ALS provider may be, the community is wrong to expect that provider to risk anti-trust litigation in order to protect itself from unfair cream-skimming competition, in order to protect the community from the ALS provider's own possible financial collapse. The community that desires largely unsubsidized private ALS service cannot protect itself against private sector failure without also eliminating the need for its private provider to risk serious anti-trust litigation.

"A community does no one any favors when it relies upon a private ALS provider but does not afford that provider with reasonable protecion from cream-skimming competition."

(Street competition at the retail level has been proven to be both ineffective and dangerous to the public. However, *restructured* competition in the form of periodic bidding may, according to some legal experts, be viewed as a reasonable restructuring of competition, and under certain circumstances, might be found pro-competitive.)

Unregulated (Unapproved) Rates

ALS service with life-saving response time performance doesn't come cheap. When a community's ambulance service system consists of a conglomeration of public agencies and private companies, subsidization takes several forms. Even when a city decides to hire a private ALS contractor, leaving BLS and non-emergency service to others, the total cost to the public (subsidies and fees) remains hidden. (Alan Jameson's four-part *jems* series documented these factors in detail.)

But when an unsubsidized private provider is relied upon by a community to furnish clinically excellent services meeting the eight-minute maximum response time requirement, and especially if that provider is expected to serve all neighborhoods of the community with equal reliability, the actual cost of good ambulance service becomes immediately apparent to everyone. The problem is that even if the total

cost to the public of such service is entirely reasonable, even extremely low by industry standards, chances are the private provider will be subjected to uninformed and unfair criticism, or even attack, because of his rate structure.

Imagine yourself the owner of a really efficient high-performance ALS company delivering state-of-the-art service to your community at a true cost to the public that is far below, perhaps even less than half, that of government operated systems. Imagine also that your rates are at least comparable to and in most cases lower than rates charged for a similar level of service by other unsubsidized private providers around the country.

Now try to explain that to the local newspapers, the city council, the county commission, your local association of retired persons, and a great many of your customers after receiving your bill. You are reminded how cheap it used to be, how fast the price inflated, how much cheaper it was when there were multiple private companies, how much lower ambulance prices are in neighboring communities, and even how much less expensive ALS service is in the town the mayor's brother, a physician, lives in. No one locally has even heard of an ambulance service with rates as high as yours.

In one real-world case, one of the most efficient companies in the United States was accused of "lucrative business" and "huge profits." (That company's rate of return on gross sales was something less than 3 percent.)

In another case, a 24-year old company, one of the most sophisticated if not efficient private ALS providers of its time, had its rates frozen by an increasingly troubled local government. One of the big eight accounting firms was retained to go over the company's books, but the issue dragged on for so long that the company went bankrupt before the city could decide.

Sometimes communities faced with what they feel are high rates will decide that the system needs "a little more competition" to hold prices down. New competition drains off the revenue base, destroys economies of scale, increases costs, and eventually wipes out the financial base which allowed high-performance ALS to exist without subsidy in the first place.

A good ALS provider needs rate regulation more than the community does. He needs it for its limited but essential protection from unfair criticism. Professionally conducted, a periodic rate review hearing can be the absolute salvation of a high-performance unsubsidized ALS provider. But it must focus upon *adjusted comparisons*.

What does the term "adjusted comparisons" mean? It means a comparison of the services and prices offered by the local provider with other services and prices in other cities, adjusted to account for differences in clinical sophistication, response time reliability, geographic difficulty of service delivery, and above all direct or indirect local tax subsidy.

The unsubsidized rates of high performance ALS providers are almost always compared, formally and informally, with subsidized rates of similar providers, unsubsidized rates of less sophisticated service delivery, rates of public and private providers (subsidized and unsubsidized) rendering similar services but with far less reliable response time performance, and so on. Useless and unfair comparisons.

The lesson in this is that any community that wishes to depend upon the private sector for the delivery of really excellent ambulance services owes it to the provider to establish rate regulation through local ordinance, and to structure the rate control mechanism using an independently and professionally prepared analysis of adjustable comparable costs. □

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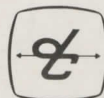

David Clark COMPANY
INCORPORATED
360 Franklin Street, Worcester, MA 01604
(617) 756-6216 Telex 920482

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