WRESTLING WITH *the Big Three Policy Issues*

"Please, just make it go away," pleaded the beleaguered city council chairman. *It*, of course, was *the EMS problem*. The chairman continued: "Everyone's an expert; everyone has an opinion. But the opinions are all different. The fire department can do it cheaper... a private contractor would save us money... user fees should fund the ambulance service... only barbarians would send a bill to an EMS victim. We thought we had this issue resolved three years ago, and again a year after that. EMS controversy is like Freddy Kruger—it just won't go away. We've hired you as our EMS consultant, but what we really need is an exorcist."

Local elected officials across the United States are learning that no other responsibility of local government is more vigorously misunderstood or politically risky than EMS policy-making. Since every EMS policy choice brings with it both advantages and disadvantages, there are no easy answers. In the words of Dr. Richard Biery, director of health for Kansas City, Mo., "EMS policy-making is at best a process of deciding which advantages are most important to your community and which disadvantages your community is willing to live with."

The key to quality EMS policy-making then, is to understand the full range of EMS policy choices available to your community and the advantages and disadvantages inherent to each option. In actual practice, the process is complicated by the fact that a policy decision made in one area (e.g., finance) often limits the options available in other areas (e.g., provider selection). This article identifies the three most commonly faced and politically difficult EMS policy issues, and summarizes the implications of optional solutions.

Number One: Who Should Pay for EMS?

The basic choice is between user fees (i.e., fee-for-service revenues and so-called subscription membership programs) vs. a local tax subsidy. While most EMS systems are financed by a combination of the two, funding ratios run the full spectrum from 100 percent user-fee financing to 100 percent local tax support.

In metropolitan areas, local tax support for EMS currently ranges from a high of about $24 per capita per year to a low of zero, with the average being somewhere around $6 to $8. Surprisingly, there is no reliable correlation between the level of local tax subsidy and the resulting quality and reliability of service. That is, some of the EMS industry's most infamous systems are also among its most heavily subsidized (e.g., the Detroit, Mich., and Washington, D.C., systems), while some of our least subsidized systems enjoy excellent reputations for clinical sophistication and response time reliability (e.g., the Tulsa, Okla.; Fort Wayne, Ind.; Kansas City, Mo.; and Fort Worth, Texas, systems).

It should be mentioned that an unusually well-devised plan for improving Washington, D.C.'s EMS system was recently completed by the Office of Productivity Management Services, the city's in-house consulting group. If the plan is implemented as proposed, dramatic improvements will occur without increasing local tax requirements, and a decrease in subsidy is actually possible.

The primary effect of local tax subsidizing EMS is to *reduce the price below cost*. For example, an EMS system serving a community of 500,000 people from a total annual operating budget of $7 million with an annual volume of 30,000 patient transports (i.e., transports—not "runs") has per-transport costs of $266. Assuming an unadjusted collection rate of 60 percent and no local tax subsidy, the system can break even by charging an average user fee of $444 per patient transport—generating $13,320,000 in annual receivables.

Because of the 60 percent collection rate, for every dollar of local tax subsidy, the system's annual receivables generated from user fees can be reduced by $1.66. Thus, $3 in subsidy per capita per year (i.e., $1.5

Local elected officials across the United States are learning that no other responsibility of local government is more vigorously misunderstood or politically risky than EMS policy-making.

million annually) would allow an average reduction in user fees of $83 per patient transport. In short, the primary effect of $3 per capita per year in local tax subsidy would be the reduction of average user-fee charges from $444 to $361. The policy question: *Is an average reduction of $83 in EMS user fees the best use of $3 per capita per year in local tax support, or are there other community needs on which this money might be better spent? And if an $83 reduction is good, wouldn't double or triple the reduction at double or triple the subsidy be even better?*

To answer this question, elected officials must consider not only the community's competing needs, but also the question of who really benefits from EMS subsidies. In most communities, between 40 percent and 50 percent of EMS subsidies actually offset financial obligations of third-party payers—e.g., Medicare, Medicaid, private insurance companies, HMOs, independent practice associations (IPAs), etc.

Wishing to benefit local residents rather than third-party payers, the city of Fort Worth recently voted to apply its modest EMS subsidy to fund the costs of the Medicare "contractual allowance," rather than continuing to fund across-the-board user-fee reductions. Strongly supported by the Senior Citizens Alliance, this policy change allowed the EMS system to "accept assignment" on Medicare payments. As a result, user fees went up, but out-of-pocket costs to the majority of users declined by approximately 60 percent. (Only in the convoluted world of the United State's health-care finances can an increase in price produce a decrease in cost.)

In some cases, substantial subsidies are needed to support the cost of inefficient production methods. User fees approaching or even exceeding $1,000 per patient transport would be needed to fund the operations of more than a few heavily subsidized EMS systems if subsidies were not available. And, where user-fees are very low, or where collection efforts are lax, system abuse may be inadvertently encouraged.

It is sometimes argued that higher EMS user fees may be dangerous to people in serious need of EMS—people who may by-pass the system to avoid its costs. A counter argument holds that those who experience serious medical emergencies and who are likely to incur thousands of dollars in hospital and physician costs are unlikely to be concerned over a few hundred dollars in prehospital care costs. The fact is that no definitive study of "price-elasticity" in the EMS market has been done. However, where user-fees have been increased substantially as a result of subsidy reductions (e.g., Fort Wayne), no siginificant reduction in EMS call volumes has been experienced. (However, a change in the *character* of call volume has been reported, i.e., a slight increase in calls of a more serious nature and a slight reduction in calls of a less serious nature.)

Except where poor economies of scale prevent the use of more efficient production methods, the benefits of EMS subsidy are primarily political—i.e., lowering user fees or avoiding difficult changes required to improve production efficiency. But because of growing pressures on local tax resources, such choices are no longer realistically available to many communities. Fortunately, with sound system design and competent management, quality EMS does not necessarily depend on local tax support.

Number Two: Who Should Provide EMS?

First, what part of the EMS system are we talking about? Ambulance services or first-responder services? Every good EMS system has both. With their substantial resources and declining demand for fire suppression services, fire departments offer the best opportunity for delivering low-cost first-responder services of good quality and reliability. Provided by existing personnel using firefighting apparatus, first-responder service at the BLS or EMT-AD (automated defibrillator) level costs as little as $27 per patient served, including fuel, training, medical equipment, accelerated vehicle maintenance and depreciation. (Paramedic-level first-response delivered from ALS engines costs more—e.g., "premium pay" for firefighter/paramedics and additional training costs.)

However, where first-responder services are provided by separate "rescue crews," the costs are much higher, often exceeding $400,000 per unit in annual operating costs. The decision as to who should provide first-responder services is primarily determined by the fire department's view of the EMS role. Where fire department personnel view EMS as a legitimate, primary responsibility that can reasonably be performed by existing personnel, the fire department is the natural and most economical provider of first-responder services. Elsewhere, alternatives should be considered.

From a cost-benefit perspective, the best bargain in first-responder services appears to be EMT-AD level service provided by existing fire department personnel using existing apparatus.

Ambulance services must be analyzed differently. Patient flow patterns in most medical trade areas do not respect local geopolitical boundaries. In life-threatening situations, the "nearest *appropriate* hospital" (given the patient's condition) may be well outside the municipality in which the call originates. In nonlife-threatening emergencies, the hospital of the patient's choice (e.g., where the family physician has admitting privileges or the patient's HMO hospital) may be similarly far removed. Considerations of economies of scale, patient flow patterns and peak-load demand characteristics indicate a preference for multi-jurisdictional ambulance service.

The basic choices available for delivering ambulance services are private contractors, fire departments and government "third services." While exceptions to the rule can always be found, the dominant advantages and disadvantages of each are as follows:

Private Ambulance Service: Advantages include superior cost-containment; economies of scale from multi-jurisdictional operation and delivery of routine transport services; effective use of innovative production methods (e.g., peak-load staffing, system status management); and easier provider replacement in the event of inadequate performance. (Most, but not all, quality EMS systems having little or no local tax subsidy use private ambulance contractors.) Disadvantages include the need for relatively sophisticated contracting methods to ensure performance and continuity of care, and dealing with the complexities of regulating any "privatized" public service.

Fire Department Ambulance Service: Advantages include organizational stability that can lead to clinical progress and, generally, good community support. Good working relations with firefighter first-responders may be easier to maintain. Disadvantages are the flip side of the advantages—i.e., too much "stability" can mean stagnation, resistance to change, excessive cost inflation, even opposition to external evaluation and physician control. Community support cultivated over time can make a change of providers politically difficult, even when appropriate.

Government Third Service: Advantages include easier departure from the traditional staffing and deployment practices of the fire service industry and generally lower costs when compared with fire department ambulance services. Disadvantages include loss of the advantages of both the fire service model and the use of private contractors. (It is widely agreed that a civilian third service *within* a fire department may incorporate the worst of both worlds.)

While the above advantages and disadvantages generally hold true over time, exceptions are not uncommon. Heavily subsidized "privatized" systems do exist, as do relatively unsubsidized fire department ambulance services and government third services. The range of quality and economic efficiency *within* each of the three categories is far greater than the average differences *among* the three categories. Bad management can destroy the advantages inherent to even the best system design, and good management can, at least for a time, overcome the failings of a poor system design.

Number Three: Who Should Provide Routine Transport Service?

This question can be the most volatile. Where financial resources are limited but high quality EMS is desired, the solution is often to establish a single-provider, all-ALS, full-service system. By using the income generated from routine transfers to fund more ALS production capacity than would otherwise be possible, the all-ALS, full-service system generates more reliable peak-load ALS coverage at lower cost than "tiered" systems. There is, of course, more to it than that: priority dispatching replaces call screening; peak-load staffing replaces constant manning; highly refined system status management replaces static deployment. (Warning: Without these operational refinements, the advantages inherent in the all-ALS, full-service system cannot be realized.)

Where routine transport services are provided by the community's primary emergency provider using ALS units—rather than by "cream skimmers" or by separate BLS units—total system costs are lower, and ambulance service, both emergency and routine, is better. Thus, the advantage of the single-provider, all-ALS, full-service ambulance system is higher quality at substantially lower total system costs. Its disadvantage is elimination of consumer choice among competing providers of routine transport service.

The list of communities whose elected officials found the political will to adopt the single-provider, all-ALS, full-service system is impressive and growing. And in most cases, the loss of competition *within the market* has been offset by the addition of bid competition *for the market*—a far more effective form of competition in the EMS industry. (See "To Bid or Not To Bid," December 1987 *JEMS*.)

There are, of course, many other EMS policy questions that must be addressed by local government. Will medical quality control be internal or external, funded or volunteer, authoritative or voluntary, unified or fragmented? Should our system be mono-jurisdictional or multi-jurisdictional? If multi-jurisdictional, who should control it? Is our community large enough to be divided into zones, with a different provider assignment to each zone? Should we use bid competition to select our provider? If so, what criteria should we use to award the contract?

These and other policy questions must, of course, eventually be answered. But, compared with "the big three," politically they're all pieces of cake. ■

Jack Stout has been at the forefront of innovations in the design and implementation of EMS systems for the past dozen years. 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.