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EMERGENCY MEDICAL SERVICES

Privatization and Prehospital Emergency Medical Services

Monograph 1



International Association
of Fire Fighters



Emergency Medical Services

Privatization and Prehospital Emergency Medical Services Monograph 1



**Department of Emergency Medical Services
International Association of Fire Fighters, AFL-CIO, CLC**

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Foreword

Today, more than 80% of fire departments perform some level of emergency medical services (EMS), making professional fire fighters the largest group of providers of prehospital emergency care in North America. No other organization – public or private – is capable of providing prehospital emergency response as efficiently and effectively as fire departments. Fire department operations are geared to rapid response, whether it is for EMS or fire suppression. Cross-trained/dual-role fire fighters are trained to aggressively attack their work whether it involves fire, rescue, or medical emergency. It is no surprise that study after study has shown that fire department-based prehospital emergency medical care systems are superior to other provider types.

As we look to the future of prehospital emergency medical care, however, we must re-evaluate our role in the context of a rapidly evolving medical care system. Drawing on what we have learned during the past century, we must create a vision for the future of fire-based EMS. This vision must include legislation for the protection of fire-based systems, public education, prevention, and the possibly expansion of the scope of practice for paramedics. This vision must consider the effects of managed care organizations on prehospital EMS, as well as revenue recovery for the services fire fighters perform. We should support legislation to protect fire-based systems from the threat of privatization and to protect the citizens we serve by preserving the nation's universal emergency access number, 9-1-1. The information in this series of monographs is designed to guide local fire department leaders through the process of developing a vision for the future of a fire-based EMS system. This monograph is the **first** in the series and addresses privatization of emergency medical services. This monograph should be useful for IAFF members and fire service leaders who are preparing to contend with private ambulance service providers.

The role of the professional fire fighter is constantly changing. We are multi-faceted first responders, answering not only fire calls but also rescue, hazardous materials, and emergency medical calls. By confronting the challenge of change, we can continue to meet the needs of the communities we serve and do what we do best — protect property and save lives.

Harold A. Schaitberger
General President

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Privatization and Prehospital EMS

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Appendix 1. Privatization of Emergency Medical Services Case Studies.

INTRODUCTION

Public officials and citizens may be faced with a decision regarding the most appropriate provider of prehospital emergency medical services in their community. The options for emergency medical service (EMS) providers may include the fire department, a private ambulance service, a combination of the two, or various other provider types. As communities evaluate their emergency medical care needs, they may focus exclusively on patient transportation since third party payers for emergency medical services reimburse only for transport. Research on patient survival, however, has demonstrated that rapid, on-scene medical intervention produces the best patient outcomes. Therefore, designing a community's EMS system should be approached from a global perspective. Though each component (initial response, ALS, transport, etc.) must be considered individually, the system must function as a single entity with all the elements fully integrated.

It is no secret that in some cases, a private ambulance provider could provide the transport component of an EMS system more cheaply than a publically-provided system. It is also known, however, that a private provider cannot optimally provide an **entire** EMS system more efficiently nor more effectively than a fire department. The infrastructure of the local fire department can be exploited to provide optimal response for emergency medical calls. Community leaders should examine the resources available for EMS within their fire department. The community should then determine the role fire fighters will play in the overall EMS system. That role may include delivery of the entire system.

Decision makers must consider not only the cost associated with EMS provision, but also response time, quality of service, associated revenue, and patient outcome in selecting a provider and designing an effective, cost-efficient EMS system.

WHAT IS PRIVATIZATION?

Privatization describes the process of shifting the provision of a public service from the government to a private sector enterprise. Private sector enterprises include nongovernmental firms, partnerships, joint ventures, corporations, or other legal entities engaged in commercial activity for profit.

There are two approaches of privatization that are likely to impact the delivery of public provided fire-based prehospital emergency medical services – contracting out and public/private partnership.

CONTRACTING OUT

Contracting out may be defined as a governmental entity employing a private sector enterprise and its employees to perform a service, rather than directly performing the service. The government may still pay and assume responsibility for the service but hire a private company to provide the service. In the United States, contracting out is the most frequently used form of privatization. It may also be referred to as outsourcing. A recent variation to contracting out is “managed competition.” This contracting process permits a governmental agency to prepare a proposal and submit a bid to compete with private bidders for the right to provide a public-sector service. The process is usually defined in a “request for proposal” (RFP) released by the local government.

PUBLIC/PRIVATE PARTNERSHIP

A public/private partnership may be defined as a coordinated, collaborative effort between a private company and a government agency for the provision of essential services to the public. This partnership should be mutually beneficial to all parties concerned, including the public.

THE CONCEPT OF PRIVATIZING ESSENTIAL PUBLIC SERVICES

The primary goal of a private corporation is return on investment. If it fails to thrive financially, the private corporation faces ruin. Only individuals who have an ownership interest in the corporation (a corporation's shareholders) have a right to vote on corporate matters. The corporation is designed to regulate private interest and exists mainly for private gain.¹⁻²

The nature of private industry must be recognized by community leaders considering contracting with a private ambulance provider for a critical municipal function, such as emergency medical services. Public officials should also recognize the effectiveness and the economic value of the fire department providing a "whole" EMS system compared to contracting "pieces" of a system to a private company. When comparing system cost, the marginal cost of the fire department providing emergency medical services should be compared to the total cost of a private company providing a complete EMS system without fire department involvement. This costing method provides a clear picture of the true cost of the entire EMS system.

Recently, the U.S. General Accounting Office (GAO) was asked to identify lessons learned by, and related experiences of, state and city governments in implementing privatization efforts. The document released following this study (GAO-GGD-97-48) provides a profile for privatization. That profile includes six components that should exist for privatization to occur. The components include the following.

- **A political champion** — Privatization can best be introduced and sustained when a political leader champions it.
- **Implementation structure** — Government leaders must establish an

organizational and analytical structure to ensure effective implementation. Such a structure can include a government-wide commission to identify privatization opportunities and set privatization policy or a staff office that can support agencies in their privatization efforts and oversee implementation.

- **Legislative and resource changes** — Governments may need to enact legislative changes and/or reduce governmental resources to encourage use of privatization.
- **Reliable cost data** — Reliable cost data on governmental activities are needed to support informed privatization decisions and to access overall performance.
- **Strategies for work transition** — Governments will need strategies to manage workforce transition.
- **Monitoring and oversight** — Sophisticated monitoring and oversight are needed to protect the government's interest when its role in the delivery of services is reduced through privatization.

Fire department officials should recognize attempts to develop these components within their own local governments as threats of privatization and should take action to prevent or counter these attempts.

FIRE-BASED VERSUS PRIVATE EMS - A DIFFERENCE OF PHILOSOPHIES AND SERVICE

FIRE-BASED EMS

Unlike private contractors and other single-role providers, fire departments have the flexibility to provide prehospital emergency medical care by utilizing fire apparatus staffed with cross-trained/dual-role fire fighter emergency medical technicians (EMTs) and paramedics. Fire-based systems can maintain the shortest possible response times while avoiding duplication of services by cross training employees to function effectively in fire suppression, rescue, and EMS. Fire departments can deploy emergency response units in superior numbers from strategic locations than single-role private providers can while maintaining their profits.

PRIVATE EMS

Third party payers, such as private health insurers, Medicare, and Medicaid, only underwrite the portion of prehospital emergency medical care associated with transporting a patient to the hospital. Private contractors, therefore, attempt to maximize profit by transporting a maximum number of patients with as few ambulances as possible. Efforts by private EMS corporations to maximize productive time for ambulances could result in a decreased level of service to the community.

It may not be cost effective for a private ambulance company to maintain multiple ambulances available for timely response in a way that is acceptable to the community. Reliance on an ambulance/transport-based system to provide critical initial response to medical emergencies thus results in increased response times for service to any given call. This tradeoff between profit and response time interval is at the heart of the EMS privatization dilemma.

**RESPONSE TIME
INTERVAL**

It is in the economic interest of a private ambulance company to have their response time benchmark of performance set as high as possible. If response time benchmarks are not established high enough, private providers may rely on fire departments to “frontload” the system. Frontloading advanced life support systems occur when a fire department provides paramedics on first responder vehicles and a private ambulance company provides transport, and therefore collects the revenue.

Private-for-profit EMS contractors and other single-role providers maintain that their performance should be measured against a response time standard of 8 minutes and 59 seconds. Research in EMS indicates that if emergency medical intervention is delayed as long as 9 minutes, patient survival of cardiac arrests approaches zero.³ Even the private-for-profit ambulance contractors agree that, in the face of their 9 minute response time, the fire service is best positioned to provide the required time-critical medical interventions in less than 9 minutes to ensure optimal victim survivability.⁴

Response time intervals must weigh heavily in an assessment of a specific EMS system’s effectiveness. The National Institutes of Health suggest first responders should arrive on the scene in less than 5 minutes, 90% of the time.⁵ Fire departments, on average, deliver basic life support (BLS) and advanced life support (ALS) response times in 3-5 minutes.⁶

As response time requirements become more stringent, a private provider, without fire department involvement, is forced to maintain and support increasing levels of surplus production capacity (more staffed ambulances) to handle the demand pattern fluctuations that prevail throughout this industry. The effect of this excess production capacity means an increase to the provider’s cost per patient served.⁷

PATIENT TRANSPORT

Public officials must realize that ambulance transportation alone does not represent patient care or an EMS system. There are two factors at the heart of prehospital emergency medical care: (1) the call for service is potentially life threatening and time critical; and (2) the time and location of any particular medical emergency cannot be predicted. Given these two factors, an EMS system that sacrifices response times in favor of patient transport or ambulance services is really rationing access to those resources that have the greatest impact on an individual patient's chance of survival.

PUBLIC SUBSIDIES TO PRIVATE CORPORATIONS

An often overlooked aspect of EMS privatization is the profit enhancement or service subsidy that municipalities provide to private ambulance corporations in the absence of an official partnership agreement. These subsidies are in the form of system essentials provided to private companies by local fire departments. By using these “free” resources, the private providers claim they operate “high performance” EMS systems.

In these so called “high performance” systems, local fire departments provide initial response, assessment, and even treatment for emergency medical incidents while private companies provide patient transport. Certainly, fire service personnel and vehicles typically are deployed to achieve maximum response availability and optimal geographic coverage. Most fire departments arrive at the scene within 3 to 5 minutes of receiving the call. By relying on the municipality to provide first response, private providers can increase their response times to 10 or even 12 minutes (90% of the time), reduce the number of ambulances required on the street (reduce overhead), and reduce the cost of service (or enhance profit).

To increase profits, private providers may not only increase response time, but also reduce staffing. A reduction in staffing may take the form of changing from a paramedic staffed ambulance to an EMT or EMT-I staffed ambulance in communities where fire department paramedics can be used to ride with the patient to the hospital.

Another example of public departments subsidizing private providers is an agreement that permits private ambulances to be deployed from public fire stations. Private ambulance providers may request the use of stations rent free where they are the selected EMS transport provider. These facilities, paid for by the local taxpayers enhance private company’ profit

by reducing the cost to the private provider.

Local officials must be wary of private companies attempting to benefit from any resources funded by the municipality. Any time the term “high performance” is used to describe the EMS system where a private ambulance provider operates, it may indicate that there are enhancements contributed by the municipality. The marginal cost of these enhancements should be evaluated, and this amount should be charged back to the private corporation.

As mentioned, some community leaders may consider a combination of the fire department and a private ambulance company as the most effective system design based on the needs in their community. If this option is explored, fire department officials must become intimately involved in system planning and implementation and the development of a written contractual agreement. The agreement should include provisions that detail the public/private partnership recognizing that partnership means equal work, equal benefit.

DEVELOPING PUBLIC/PRIVATE PARTNERSHIPS

Public/private partnerships or cooperatives range from complex contracts awarded after bidding to verbal agreements, establishments, or mutual understandings between top executives of the municipality and the private company. Emergency medical services partnership agreements may include a single EMS system component or a combination of components, as in the following examples:

- Delegation of response roles or tiered response— Fire department responds as BLS first responder with private provider following for ALS response and transport.
- Delegation of response and transport roles—Fire department responds as ALS first responder with private provider following for ALS transport.
- Delegation of transport roles or tiered transport — Fire department provides all ALS response and transport while private company provides BLS transport and transport between patient care facilities.
- Time of day or geographic coverage assistance — Private company provides ALS and transport but enlists fire department assistance during peak call times or in areas of the jurisdiction that are difficult to reach.
- Unit hour purchases – During peak call times, disaster situations, or during work slow down or stoppage on the part of the private company employees, private company attempts to purchase labor from the fire department in an effort to maintain appropriate EMS coverage; private company may also subcontract with the fire department on an on-going basis for the purchase of labor or equipment hours.
- Mass purchase of vehicles, equipment, or supplies – Fire departments and private ambulance companies may form purchase agreements in an effort to cut cost of buying EMS related items.
- Sharing management resources – Fire departments form agreements with private companies to provide joint training or EMS billing services.

Before entering into any agreement with a private EMS provider, fire department officials must look critically at the proposal and demand the following:

- A mutually beneficial agreement – Any public/private agreement should yield a “win/win” situation for all parties involved. A partnership should not have the fire department providing resources without receiving something of equal value in return.
- Ongoing contract with private company top management – Private EMS companies are notorious for high turn-over rates. Be sure the private representative is credible and enabled to speak on behalf of the company.
- Full accounting of the company’s activities in other communities – Some private EMS companies may view a public/private agreement as a doorway to a greater role in the overall system. Fire department officials should be prepared to recognize such hidden agendas based on previous company activity.
- A comprehensive and detailed proposal – Fire department officials should examine the details of any public/private partnership proposal, compare them to the private company’s available resources, and be sure the company can deliver what it has proposed. For example, the company should be able to provide an adequate number of personnel and vehicles to consistently meet specified response time requirements.

Fire department officials should consider how the fire department can recover costs that benefit the private provider when negotiating a public private agreement, including the following costs:

- Costs of medical equipment and supplies used on a patient prior to transport – All insurance billing for such items must be done in conjunction with transport. However, fire departments may bill private ambulance companies for such services.
- Costs of initial training and continuing education for fire fighter/EMTs and paramedics – These personnel frontload an EMS system and provide rapid response and on-scene care that is not reimbursed while the private company bills and collects revenue from transport. Large private ambulance corporations have made agreements to pay for these services.

-
- Costs associated with providing emergency dispatch and communications —If such services are provided with municipal employees and resources.

An example of such an agreement exist in Rancho Cucamongo, California. The public private partnership is between the Rancho Cucamongo Fire District and MedTrans, a division of Laidlaw (now AMR). Relevant sections of that contract follow.

PUBLIC/PRIVATE FIRST-RESPONDER AGREEMENT

This agreement is made between the RANCHO CUCOMONGA FIRE PROTECTION DISTRICT, hereinafter referred to as "DISTRICT", the CITY OF RANCHO CUCOMONGA, hereinafter referred to as "CITY", and MEDTRANS, a subsidiary of Laidlaw Medical Transport, Inc., a Delaware corporation, d.b.a. MERCY, hereinafter referred to as "MERCY", to assist in the financing and the provision of improved prehospital emergency medical services within the areas served by the DISTRICT.

3. Responsibilities of Parties.

a. Responsibilities of MERCY

(1) Upon the commencement of DISTRICT'S ALS service, MERCY shall pay to DISTRICT, on or before the fifth day of each month, the sum of \$17,500 each month for the first twelve (2) months in return for receiving service support from DISTRICT'S ALS First Response System. The monthly payment amount shall be adjusted at the beginning of each subsequent year from the date of commencement of DISTRICT ALS services.

(2) Commencing with the second year of the term of this Agreement, and at the beginning of each subsequent year thereafter, MERCY'S monthly payment to DISTRICT shall be adjusted in accordance with the percentage change in the prior year's total number of emergency ambulance responses. Calendar year 1994 shall be the base year for purposes of this adjustment. The total monthly payment shall be computed by dividing the prior year's total number of emergency ambulance responses by the total number of emergency ambulance responses in the base year

(1994), then multiplying the resulting quotient by the initial monthly payment (\$17,500).

The adjusted monthly payment, established by use of the formula set forth above, shall be subject to a further adjustment, commencing with the second year of the term of this Agreement and annually thereafter, based upon the percentage change in the Consumer Price Index, published by the U.S. Department of Labor Bureau of Labor Statistics, for the Los Angeles-Anaheim-Riverside statistical area (1982-84=00) for all urban consumers. The formula for adjusting the monthly payment to be made to DISTRICT, in mathematical terms, shall be as follows:

$$\text{Adjusted monthly payment} = \frac{\text{prior year's responses}}{1994 \text{ responses}} \times \$17,500 \times \% \text{ change in CPI}$$

(4) MERCY shall comply with all applicable city, county, state and federal statutes, ordinances, regulations, policies and procedures related to the provision of emergency ambulance service. Billing, collection and reimbursement for services shall be subject to the limits imposed under San Bernardino County rate setting procedures.

(5) Following MERCY's provision of EMS at the scene of any incident, MERCY shall promptly return DISTRICT personnel to DISTRICT fire stations, by MERCY's vehicles, taxicab, or otherwise, when DISTRICT personnel have, in the opinion of MERCY's personnel, been required to accompany MERCY personnel during patient transport. Further, MERCY shall replace any and all disposable medical supplies, including drugs and other medications normally supplied by receiving emergency care facilities, as may be utilized by DISTRICT's personnel as part of their provision of emergency medical services.

PROBLEMS WITH PRIVATIZATION

Local government officials may view privatization of emergency medical services as an easy answer to problems of trimming municipal budgets. The EMS Case Studies in Appendix 1 show that privatization has resulted in decreased levels of service and that public departments typically are more cost effective. In addition to costs and levels of service, local decision makers exploring the option of privatization must consider the following.

- Private companies are able to provide cheaper services only through lower wages and fewer benefits for their employees, a reduction in the services provided, or both lower compensation and decreased service. Private providers must make a minimum profit, while fire departments can return surplus resulting from operations to the system or further reduce the price of services offered to the citizens.
- Private companies may seek to develop monopolies or facilitate sole provider areas in certain geographic locations, forcing local governments to rely on a specific contractor even if costs rise or quality of service declines.
- Calculations of the initial cost savings to the government typically do not include the costs of agencies that monitor and administer the contracts, nor does it include the costs of those governmental agencies that may provide service subsidies to the private company (as with municipal fire departments providing initial response for private ambulance companies). Private contractors typically bid on pieces of the system focusing only on that cost rather than the cost of the entire system.
- Corporate providers may attempt to influence the mission of government by allowing the profit motive to affect decisions. Therefore, it is profit, not public welfare or need, that receives first priority. If a municipality becomes dependent on a private company to provide EMS, the welfare of the community may be compromised whenever it conflicts with the company's financial goals. For example, decreases in the number of ambulances provided or a decrease in levels of response personnel training may result.
- Local jurisdictions may not be able to rely on private EMS providers on an ongoing basis. The jurisdiction may face continual battles over increasing subsidy requirements. In addition, private labor forces,

unlike fire departments, have the legal right to strike, leaving the jurisdiction without EMS services.

- A contract with a private EMS provider does not ensure that the provider is solvent, and a firm's economic hardship could result in temporary or permanent disruption of service.

PRIVATE AMBULANCE PROVIDERS: THE CORPORATIONS

AMERICAN MEDICAL RESPONSE, INC. (AMR) (NYSE: EMT)⁸⁻⁹

In addition to general considerations about privatization, it is useful for fire department officials to know about the various private providers that may be competing against them to provide EMS service. Fire department leaders must be prepared to present comprehensive information to municipal officials who may not realize the full ramifications of privatizing their EMS service. The following information should provide a foundation for more detailed research about specific private EMS companies.

AMR was formed in February 1992 with the objective of becoming the leading national provider of ambulance services. The company went public and concurrently merged four regional ambulance providers (two in California, one in Connecticut, and one in Delaware). In 1994, the company signed a \$55 million deal with Computer Science Corporation to set up an electronic network for its billing and collection activities.

AMR's strategy includes:

- Acquire companies to form "beachheads" for future growth
- Expand these markets by acquiring smaller "lock-on" providers in areas contiguous to their beachheads and bid on contracts to serve surrounding areas
- Eliminate redundancies and unnecessary costs through consolidation and regional integration
- Add ancillary services to extend their involvement in the prehospital market

As of September 1996, AMR had operations in 28 states and responded to 2.6 million calls annually. The company operates a fleet of 2,455

vehicles including 1,775 ambulances, 23 critical care units, 436 wheelchair vans, and 221 support vehicles. AMR employs 3,400 paramedics; 3,600 EMTs, 450 van drivers; and 2,850 other employees, including dispatchers and administrators. AMR's annual revenue is \$750 million.

AMR's Prospectus

AMR's future growth strategies are to offer managed care organizations and other payers a range of new services which collectively can be described as "medical pathway management." AMR plans to use technologically advanced call dispatch centers to triage patients to the most appropriate medical pathway, which will reduce costs for the payers. These new services will be offered in three main phases which began in 1996.

Phase I:

- Triage patients to all forms of medical transportation
- Check insurance eligibility and ensure that patients remain in the health plan networks

Phase II:

- Offer health advice by phone, using protocols designated by the payer
- Offer recorded health education messages

Phase III:

- Use mobile resources to offer urgent medical care in the home
- Triage to all forms of medical treatment and schedule appointments

AMR also plans to expand into the management of physician groups and hospital emergency rooms. AMR hopes to be able to thus contract patient care from the prehospital scene through the emergency room up until admission to the hospital. Additionally, AMR plans to pursue large contracts with managed care organizations and various industries to offer on-site services including assessment, treatment of minor injuries, and employee health surveillance.

In June 1993, Laidlaw, the Canadian waste and transportation giant, made its first acquisition of an ambulance company, MedTrans, in San Diego, California. From that beginning, Laidlaw has acquired more than 40 ambulance companies across the U.S. including CareLine, Inc., the third largest ambulance corporation in the U.S (as of October 1995) with an anticipated net revenue of more than \$600 million. The ambulance transportation division of the Laidlaw corporation continues to be called MedTrans.

MedTrans operates in 23 states. The three largest markets are in California, Texas, and Florida. Other markets include Georgia, Alabama, Massachusetts, and Pennsylvania. MedTrans employs more than 10,000 employees, deploys 2,200 ambulances, and provides 2.6 million transports per year. Laidlaw states that continued growth will come from business expansion and further strategic acquisitions. The company plans to aggressively pursue privatization efforts of public EMS systems and expects to continue to win market share through successful competitive bids.

Laidlaw/MedTrans' Prospectus

MedTrans' future growth strategies include building alliances with international EMS organizations, and continuing to acquire companies in the U.S. Laidlaw/MedTrans is also pursuing broad coverage contracts with managed care organizations.

SPECIAL NOTE: ¹¹

On Monday, January 6, 1997, Laidlaw announced that it will purchase American Medical Response (AMR) in a \$1.12 billion transaction. The new company will have operations in 37 states, keep the American Medical Response name, and will be run by the top three AMR executives. The new AMR will be restructured into 4 geographically based groups - southern, eastern, central, and western. The restructuring will also create two separate operating units - health care transportation and health care services. Annualized revenue is projected in excess of \$1.3 billion.

The Rural/Metro Corporation was founded in 1948 as a subscription fire suppression service. In 1978, the company sold stock to employees who now own more than 50% of the company. Rural/Metro promotes the company as the leading provider of ambulance, fire protection, and other safety services to municipal, residential, hospital, commercial, and industrial customers in the United States. Ambulance services account for 78% of the company's revenue.¹³⁻¹⁴ Rural/Metro provides ambulance services in Arkansas, Alabama, Arizona, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Nebraska, New York, Ohio, Pennsylvania, South Carolina, Tennessee, and Texas. On February 11, 1997, Rural Metro announced the purchase of 7 ambulance services in Ontario, Canada. This will be the company's first ambulance service outside the United States and will be known as Rural Metro Ontario.

Rural/Metro's Prospectus

Rural/Metro's strategy is to build market strength and create local and regional operations. The company also expects to expand into managed care contracting and assume the role of gatekeeper of 9-1-1. This effort will be facilitated by a recent agreement with National Health Enhancement Systems, Inc. The companies will contract to provide intake and telephone triage as well as transportation.

Rural/Metro was the first private ambulance corporation to gain a statewide non-emergency transport contract with a managed care organization.

PRIVATIZATION TACTICS

Private providers aggressively pursue opportunities presented through municipal requests for bids. The following are examples of privatization tactics observed throughout the United States and Canada.

- Private providers tout the attributes of being a large multi-jurisdictional operation.
- Private providers promote the use of global positioning satellite (GPS) systems that pinpoint and monitor each ambulance's location to facilitate the use of system status management. Company executives claim that this system improves vehicle utilization and decreases capital and human resource expenditures. Public officials should recognize that technology is not necessarily an adequate substitute for an effective communications system already in place.
- Private company officials claim that the most efficient and least expensive EMS system uses a fire department to provide initial response to all medical emergencies for patient stabilization and initial treatment (since these are public safety issues). Only then does the private ambulance company respond to provide additional patient care transport (providing public health services).
- Private company representatives claim the company has significant purchasing power to buy ambulances, defibrillators, and other expensive technological equipment at the lowest possible prices.
- Private providers claim that community members are protected by the company's risk management systems and ability to obtain insurance and bonding.

In addition to those listed above, private EMS corporations may engage in more aggressive efforts to privatize fire-based EMS systems, including the following.

- Bringing lawsuits to challenge the fire department's right to provide EMS services alleging antitrust violations
- Managers or other staff from the company seeking election to city

councils or county commissions or otherwise becoming active in local decision making

- Forming local Political Action Committees (PAC) funds to support local candidates
- Aggressively lobbying municipal leaders, including city council or county commission members
- Mounting a public relations campaign that is extremely critical of fire unions (IAFF and its locals)
- Making presentations regarding the instability of the revenue derived from EMS transport that instills fear and doubt in community leaders
- Issuing unsolicited proposals to local governments for the purpose of obtaining a contract
- Bringing in “EMS experts,” including attorneys and accountants to speak before municipal decision makers
- Promoting the use of 3-digit numbers other than 9-1-1 for accessing emergency and non-emergency ambulance services
- Marketing with state-of-the-art customized video and written materials
- Implementing public relations/media campaigns, including newspaper ads, direct mail and billboards, promoting no tax-base funded services, or downgrading the fire department
- Proposing public/private cooperation using the fire department to perform first responder ALS services while the private company provides backup ALS and transport services (Companies may offer a sum of money to the municipality to offset the cost of training fire fighters as paramedics, as in San Jose, California)
- Filing formal rebuttals to fire department proposals
- Seeking to contract to provide non-emergency or inter-facility transport to gain entry into a community
- Providing various community services including CPR classes, standby service at sports events and concerts, and public education for fire and injury prevention to gain name recognition

Points that won't be discussed by a private EMS provider include:

- Specifics regarding response times
- Specifics regarding availability
- Specifics regarding multi-discipline responses (for example, mass casualty)

Regardless of the tactics used, fire service leaders should maintain that decision makers must look at what their community is getting for the price, particularly in equal access to all citizens regardless of ability to pay, response time performance, personnel capabilities, and overall system efficiency. Fire service leaders must help local officials recognize

PROPONENTS OF PRIVATIZATION

that no other organization can perform as effectively or efficiently as the fire service.

In addition to private EMS companies, several organizations or their representatives may try to become involved in the public debate over privatizing EMS services. Private EMS providers have a trade organization representing their interests – The American Ambulance Association. In addition, there are several private organizations that support efforts to privatize government functions through training and by generating policy statements, position statements, and other materials quoted by privatization advocates. Fire department leaders should review carefully any information from these sources.

**THE AMERICAN
AMBULANCE ASSOCIATION
(AAA)¹⁵**

The American Ambulance Association is the national trade association that represents providers of fee-for-service ground ambulance transportation. The association's membership encompasses all categories of private ambulance providers, including volunteer ambulance corporations, hospital-based ambulance providers, and government-owned and operated services.

The AAA was formed in 1979. Its stated mission is to develop programs that advance the delivery of quality prehospital care services through education, information, and legislative advocacy. Its goals are to promote private ambulance companies and assist in the development of public/private partnerships to provide medical transportation services.

The American Ambulance Association actively promotes privatization throughout the United States. Specific efforts include the following:

- Distributing and promoting the AAA's manual "Contracting For Emergency Ambulance Services: A Guide to Effective System Design" to municipal leaders throughout the United States
- Lobbying state elected officials to pass legislation that would prevent the fire service from providing EMS transport services (Tucker Bill AB 3156, CA)
- Maintaining and distributing political action funds to candidates and elected officials sympathetic to their agenda
- Pushing federal agencies to ensure ambulance reimbursement protection
- Lobbying individual members of Congress and sponsoring programs in which Congressional leaders ride along with on-duty private ambulance providers (Stars-of-Life Program)

OTHER ORGANIZATIONS

There are various policy oriented organizations (think tanks) throughout the United States that are avid proponents of the privatization of public Services. Fire service leaders should be aware of local involvement by any of the following.

The Reason Foundation (founded in 1978)

The Reason Foundation is the leading national advocate of privatization. The Foundation conducts training, including how-to guides, case studies, and competitive government workshops. The Foundation also conducts policy research and publishes various papers and newsletters. The most recent publication regarding prehospital emergency medical services is titled "Privatizing Emergency Medical Service: How Cities Can Cut Costs and Save Lives" (December 1995).

The Goldwater Institute (founded 1988)

The Goldwater Institute was established as an independent, non partisan

research and educational organization dedicated to the study of public policy. Through its research papers, editorials and policy briefings, the Institute promotes public policy founded upon the principles of limited government, economic freedom and individual responsibility.

To promote these principles and assist leaders in developing policies based on limited government and a free market approach, the Goldwater Institute conducts research on timely issues, as well as organizes briefings, policy conferences, and workshops. The Institute relies on contributions from the private sector, including individuals, corporations, and foundations. The Goldwater Institute neither seeks nor accepts public funding.

Heading the Institute's research agenda are several studies: privatizing welfare, indigent healthcare options for states, issues of urban and suburban development, and emergency medical services operations.

American Enterprise Institute (founded 1943)

The American Enterprise Institute promotes free-enterprise. The Institute has several publications that advocate privatization including "Competition and Monopoly in Medical Care."

The Heritage Foundation (founded 1973)

The Heritage Foundation is considered the most powerful conservative think tank in the country. The Foundation concentrates on economic issues and provides information on virtually all areas of privatization.

And other organizations:

- The National Center for Policy Alternatives
- The National Council for Public/Private Partnerships
- International Privatization Group

CONCLUSION

Fire Fighters are the nation's emergency medical services first responders. Over the last several years, large corporations have moved aggressively into the emergency medical field, drawn by the potential to make large profits from patient transportation. However, the fact remains that no other organization – public or private – is capable of providing prehospital emergency response as efficiently and effectively as fire departments. Considering cost, universal access, response time, survival rates, and quality of patient care, the fire service is the optimal choice for prehospital emergency care services.

IAFF local affiliate leaders that sense a threat of privatization, real or potential, are encouraged to contact their District Vice President, state or provincial presidents, and IAFF headquarters for assistance. Other materials available include:

- Effectiveness of Fire-Based EMS
- Emergency Medical Services - A Guide Book For Fire-Based Systems
- EMS, The Right Response (Video)
- The Myth of Privatization Manual (for community leaders)
- EMS Privatization Deterrent Kit for Fire-Based Systems

ENDNOTES

- 1 REVISED MODEL BUSINESS CORPORATION ACT (1995)
- 2 MAYS, S., "PRIVATIZATION OF MUNICIPAL SERVICES: A CONTAGION IN THE BODY POLITIC," 1995 DUQUESNE UNIVERSITY, DUQUESNE LAW REVIEW
- 3 EISENBERG, M.S., ET AL., "PREDICTING SURVIVAL FROM OUT-OF-HOSPITAL CARDIAC ARREST: A GRAPHIC MODEL," ANNALS OF EMERGENCY MEDICINE; NOVEMBER 1993; PP. 1652-1658.
- 4 "CONTRACTING FOR EMERGENCY AMBULANCE SERVICE, A GUIDE TO EFFECTIVE SYSTEM DESIGN"; AMERICAN AMBULANCE ASSOCIATION.
- 5 "STAFFING AND EQUIPPING EMERGENCY MEDICAL SERVICES SYSTEMS: RAPID IDENTIFICATION OF TREATMENT OF ACUTE MYOCARDIAL INFARCTION," NATIONAL INSTITUTES OF HEALTH PUBLICATION NO. 93-3304, SEPTEMBER 1993; P. 10.
- 6 "NATIONAL SURVEY, FIRE DEPARTMENT OPERATIONS IN THE UNITED STATES AND CANADA"; PHOENIX FIRE DEPARTMENT, 1995.
- 7 "CONTRACTING FOR EMERGENCY AMBULANCE SERVICE, A GUIDE TO EFFECTIVE SYSTEM DESIGN," AMERICAN AMBULANCE ASSOCIATION.
- 8 HOOVER'S HANDBOOK OF EMERGING COMPANIES, THE REFERENCE PRESS, INC., 1995; AMERICAN MEDICAL RESPONSE COMPANY PROFILE, SHIRLEY, PAUL T., PRESIDENT & CHIEF EXECUTIVE OFFICER, SEPTEMBER 1996; AMERICAN MEDICAL RESPONSE, 1995 ANNUAL REPORT.
- 9 AMERICAN MEDICAL RESPONSE, FIRST QUARTER 1996, REPORT TO SHAREHOLDERS.
- 10 LAIDLAW PRESIDENT'S ADDRESS TO THE GENERAL MEETING OF SHAREHOLDERS, JANUARY 1996; LAIDLAW'S 1995 ANNUAL REPORT.
- 11 "LAIDLAW PURCHASING AMERICAN MEDICAL RESPONSE," EMS INSIDER, FEBRUARY 1997.
- 12 RURAL METRO FINANCIAL REPORT 1995.
- 13 RURAL METRO CORPORATION, PAINE WEBBER, INC., ET AL., PROSPECTUS, APRIL 15, 1996.
- 14 RURAL METRO AMBULANCE, "EXTRAORDINARY PEOPLE, EXTRAORDINARY CARE," SCOTTSDALE, AZ.
- 15 AMERICAN AMBULANCE ASSOCIATION LETTER TO 1992 CONFERENCE PARTICIPANTS; AMERICAN AMBULANCE ASSOCIATION 1996 STRATEGIC PLAN DRAFT; AMERICAN AMBULANCE ASSOCIATION, "CONTRACTING FOR EMERGENCY AMBULANCE SERVICES: A GUIDE TO EFFECTIVE SYSTEM DESIGN."

GLOSSARY

Advanced Life Support (ALS) – All basic life support measures, plus invasive medical procedures including intravenous therapy, cardiac defibrillation, administration of medications and solutions, use of adjunctive ventilation devices, and other procedures which may be authorized by state law and performed under medical control.

Ambulance – A vehicle designed and operated for transportation of ill and injured persons, equipped and staffed to provide for first aid or life support measures to be applied during transportation.

Basic Life Support (BLS) – Generally limited to airway maintenance, ventilation (breathing) support, CPR, hemorrhage control, splinting of fractures, management of spinal injury, protection and transportation of the patient with accepted procedures.

Cross-Trained/Dual-Role (CT/DR) – An emergency service that allows personnel trained in emergency situations to perform to the full extent of their training, whether the situation should call for firefighting or medical intervention for a victim. This system type offers a greater level of efficiency than its single-role counterparts.

Emergency Medical Services – The provision of services to patients with medical emergencies. Emergency medical services has emerged as a field whose purpose is to reduce the incidence of preventable life-threatening and disabling injuries and acute illness whenever possible, and to minimize the physical and emotional impact of injuries and illnesses which do occur. The EMS field derives its origins and body of scientific knowledge from the related fields of medicine, public health, health care systems administration, and public safety.

EMS System – A comprehensive, coordinated arrangement of resources and functions which are organized to respond in a timely, staged manner to targeted medical emergencies, regardless of their cause and the patient's ability to pay, and to minimize their physical and emotional impact.

APPENDIX 1.

PRIVATIZATION OF EMERGENCY MEDICAL SERVICES: CASE STUDIES

There are a number of communities that have moved from privatized EMS systems to a public sector system. Reasons for changing from private providers have included poor service from the private provider and desire to retain revenue associated with EMS transport for the municipality. Specific examples are given below.

Case 1: San Jose, CA (Public/Private Partnership)

Emergency medical services in San Jose, California are provided through a public/private EMS partnership. Prior to 1995, the EMS system in San Jose consisted of the San Jose Fire Department providing first responder services, including defibrillation, while advanced life support (ALS) and ambulance transportation was provided by a private ambulance service. The private contractor maintained 11 ambulances staffed with 2 paramedics for ALS response. These units typically responded within 10 minutes. For this level of response and patient transportation, the private contractor charged an average of \$627 per transport, for a total gross revenue of approximately \$8.8 million. Because the private ambulance provider's response times were greater than the medically accepted standard of 8 minutes, the likelihood that a patient would survive an out-of-hospital cardiac arrest was only 7.2%.

The San Jose Fire Department, in an effort to improve the overall EMS system and enhance patient survival following cardiac arrest, submitted a proposal for a fire-based EMS system, inclusive of transport. The fire department's proposal included the deployment of 30 ALS engine companies and 14 ambulances. Fire fighters would respond in 7 minutes or less, 90% of the time. The reduction in the response time interval for ALS alone would increase the predicted cardiac arrest survival rate to 17.7%.

Recognizing that the Fire Department had presented a viable system design, the private contractor became concerned. This concern led to the development of a plan for a public/private partnership. The cooperative plan required the fire department to deploy the 30 ALS engine companies and provide first response in 7 minutes or less, 90% of the time. For this system enhancement (called "front loading the ALS"), the private corporation was willing to pay \$1.1 million to the City to cover the cost of sending fire fighters through paramedic training. Since the City of San Jose had not, until that time, received any revenue associated with EMS provision, the offer appeared lucrative and was accepted.

The public/private partnership in San Jose now deploys 30 ALS engines staffed with 3 fire fighters and 1 fire fighter/paramedic, and 11 private ALS transports staffed with 1 EMT and 1 paramedic. Since the fire department provides the initial response with a paramedic, the predicted cardiac arrest survival rate is equivalent to that of a full fire-based system including transport.

On the surface, it appears that through this public/private partnership the private provider is making a payment to the City for the first responder service subsidy and recording this as a cost on their balance sheet. However, a closer analysis reveals that the cost of this payment to the City was offset through other service reductions. The net economic impact to the City is zero, while this arrangement enhances the private corporation's profits. The City provides additional personnel; and the private provider negotiated an increase in the response time interval required for ambulances to arrive on scene and a decrease in ambulance staffing. Response time requirements were increased from 10 to 12 minutes, 90% of the time. The staffing on the ambulances was reduced from 2 paramedics to 1 EMT and 1 paramedic. As part of the package, the private provider was granted a four year extension of the contract with Santa Clara County (including San Jose), California. The contract, including a public/private alliance with the San Jose Fire Department, should provide approximately \$25 million annually to the private corporation.¹

Case 2: Big Spring, Texas

The emergency medical services system in Big Spring, Texas began to evolve in July 1989. The City's Ambulance Advisory Committee held a meeting at which Rural/Metro Corporation, the provider of EMS at the time, claimed an anticipated loss of revenue for 1990. Rural/Metro executives requested an additional \$57,000 from the City to cover this anticipated loss. In the same meeting Rural/Metro executives also requested a 25% increase in the City's cash subsidy and indicated that the fee for service would increase \$30-\$40 per patient transported. During this committee meeting, Rural/Metro reported their average response time for EMS calls was 6.2 minutes.

Following this meeting, Rural/Metro was granted a contract extension of 5 years (1990 - 1995) to continue to provide EMS and ambulance transport in Big Spring. Contract requirements included the number of ambulances to be operated in the City, staffing levels, guarantee of response times, monthly operations reports, and the providing EMS continuing education for the Big Spring Fire Department personnel.

¹ American Medical Response, 1995 Annual Report, p. 2.

In 1994, members of the Big Spring Fire Department assessed Rural/Metro's compliance with the contract requirements. Preliminary research showed several areas of non-compliance:

- Rural/Metro was not regularly providing monthly operations reports
- Rural/Metro was not making EMS continuing education available to the Big Spring Fire Department
- Rural/Metro was not staffing two ALS and two BLS vehicles in Big Spring; Only one ALS truck was staffed full-time; and the others were operated as needed by on call personnel
- Rural/Metro did not provide an ambulance vehicle housed within the Big Spring Fire Department facilities as a BLS back-up
- Rural/Metro frequently reported average response times of 6.0 minutes – well above the standard established in the contract

The City of Big Spring then released a request for proposal (RFP) for emergency medical services. Motivated by a desire to improve the prehospital EMS system for Big Spring residents, the local fire department submitted a proposal. The RFP required: four vehicles available in the City (two ALS/two BLS) 24 hours a day; on-call personnel could be used for non-emergency transfers only; and response times between 3.5 and 5 minutes.

The fire department proposed to more than double the number of ambulances provided at the time. Ambulances would be stationed and deployed from Big Spring fire stations. The proposal also included the cross training of fire fighters as paramedics for more efficient use of personnel. The fire department's proposal offered increased service, a reduction in response times, and a lower cost than the City paid to Rural/Metro as a subsidy.

Rural/Metro responded to the fire department's bid by portraying the proposal and the fire fighter's ability to provide EMS as inadequate. Corporate representatives distributed fliers to City Council members falsely charging that fire-based EMS would drive up costs, reduce service, and expose the City to great financial risks. The Fire Department and IAFF Local 2922 prepared and presented a formal rebuttal to these claims.

On March 28, 1995, the City Council voted 6 to 1 to accept the fire fighters' bid and awarded them the EMS contract for the City of Big Spring. In June 1995, the Big Spring Fire Department was approached by Howard County to provide EMS in the balance of the county. Shortly thereafter, the Big Spring Fire Department was awarded the Howard County contract.

The first monthly report was released by the Big Spring Fire Department in November 1995 showing improvement in response times compared to the private provider's times. The Fire Department's response time in the City was 4.01 minutes, less than the State's 4.24 minute average. On-scene times were 14.57 minutes, also less than the State's average, 18.1 minutes.

On the first anniversary of the fire-based system, City officials stated they were pleased with the performance of the Fire Department, reporting that response times were on target with the American Heart Association (AHA) guidelines for prehospital cardiac care. The Fire Department has made several improvements following the first year of operation. For example, the fee structure was amended to make the service more affordable. The City also established an enterprise account for the fire department ambulance service, allowing the service to act as an independent revenue generating entity. This means that the service will be able to pay for needed equipment without drawing from the City's general fund. In fact, the total operating revenue reported at the end of September 1996 was more than \$730,000.

Through careful planning and implementation of the Big Spring Fire Department's EMS plan, the citizens now enjoy improved response times, increased efficiency, and better continuity of care, provided by a cost-effective municipal transport system.

Case 3: Deerfield Beach, Florida ²

In 1992, the City Manager of Deerfield Beach, Florida was faced with the prospect of cutting essential services or increasing taxes and he invited the department heads to submit methods of increasing revenue. The Fire Chief then met with his administrative staff. This group reaffirmed that the department had a long history of revenue generation, yet there was one area that had not been explored as a significant source of revenue — ambulance transport.

At the time, the Deerfield Beach Fire Rescue (DBFR) Department was one component of a two-tiered EMS system. Two Fire Department paramedics would respond in a transport capable ambulance and

² Stravino, A., "The Hostile Takeover of Transport Territory," Fire Chief, May 1994, pp. 70-77.

initiate patient care. Then, a private ambulance would arrive to provide patient transport. The Fire Department's average response time was 3 to 4 minutes. The response times for the private ambulance averaged 9 to 11 minutes. If advanced life support (ALS) was necessary, ALS would start upon the arrival of fire department paramedics, and continue throughout transport with a fire department paramedic and fire department equipment remaining with the patient in the private provider's vehicle. The Fire Department ambulance would follow the private ambulance to the hospital to pick up the fire fighter/paramedic and fire department equipment. The Fire Department provided all medical supplies and equipment and administered all patient care, while the private ambulance company transported and billed the patient and collected the revenue for the service.

The Fire Chief began to explore revenue sources for Deerfield Beach from ambulance transport. He planned a study to determine the feasibility of converting the private ambulance system to a fire-based EMS system that included transport. There was strong labor/management support for the initiative and all Fire Department staff participated in the study. After a three month in-depth study, the Fire Chief recommended a one-tier fire-based system to the City Manager. The study revealed that patient care and the level of service would both improve if Fire Department paramedics were able to provide continuity of care throughout transport. Cost recovery issues were also considered. Revenue projections showed that DBFR could expect to collect 60% of the total amount billed. The Fire Chief recommended a six-month trial implementation of the one-tiered patient transport system to show that the fire department's predictions were accurate.

During the trial period, a large scale public education program was implemented to help the citizens of Deerfield Beach understand the proposed change in the operation of the EMS system. As a result, there was widespread community support for the fire department. The final decision, at this point, was to come from the City Commissioners.

Just prior to the City Commissioners' final vote, the private ambulance company launched an aggressive effort to defeat the proposed system change. The company offered to provide EMS transport service at no cost to the City (a zero subsidy agreement). The offer had little effect on the commissioners. Recognizing this, the private company then offered to pay the City \$500,000 to retain the full EMS contract, adding that the City could save another \$500,000 by laying off the fire fighters who work as paramedics. The commissioners were offended by these maneuvers. In fact, one commissioner, who had not been a strong supporter of DBFR, asked the private company representative if the company really suggested a layoff of 24 fire fighters. The answer was yes. The Commissioner then asked if the private provider employees could strike. Again, the answer was yes. The Commissioner then advised the private company representative that public employees could not strike nor had there ever been a

service delivery problem or complaint concerning city employees. The commissioners dismissed the private provider's proposals.

The DBFR trial period was set to begin in October 1992; however, Hurricane Andrew hastened the trial's start. On August 23, 1992 Andrew hit South Florida. At 4 a.m., the private provider notified the fire department communication center that it would no longer accept ambulance calls because the storm's winds were so strong. Shortly thereafter, the communication center received a call for a patient with difficulty breathing. The Fire Department responded, provided care, and transported the patient who had severe pulmonary edema, saving the patient's life. By the next day, the DBFR Department had transported four patients to the hospital and continues to provide transport to this day.