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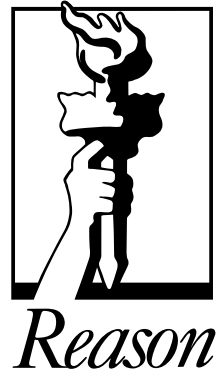
August 2003

# EMERGENCY MEDICAL SERVICES PRIVATIZATION: FREQUENTLY ASKED QUESTIONS

by Ted Balaker and Adam B. Summers



POLICY  
STUDY  
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# Emergency Medical Services Privatization

By Ted Balaker and Adam B. Summers

## 1. What is privatization?

Privatization is a broad term that describes moving a public policy issue from more government control to less. In other words, privatization occurs when the private sector is given more responsibility to provide a given service. Privatization allows for more competition and more choices for customers.

For our purposes, think of emergency medical services (EMS) as comprised of two general components: first response and the transportation of the patient to a hospital. Although first responders often do provide extremely important medical attention, most medical care is provided by the transport crew. Under EMS privatization, a private provider is responsible for all or part of the paramedic function. Local governments are usually legally responsible for EMS, and some governments fulfill this duty by providing the service themselves, usually as part of their fire departments. A city interested in privatization may choose to contract the entire paramedic function to a private ambulance company or implement a public-private partnership. A common arrangement is to contract with a private provider for patient transport and rely on the fire department for first response.

Firefighters, fire prevention programs, and safer building practices have been tremendously successful in decreasing the instances of fires. Since fire departments now respond to fewer fire calls, and since fire departments are commonly dispersed throughout communities, many cities choose to provide first response through the fire department. Cities take advantage of experienced available manpower that will likely be fairly close to any emergency call.

## 2. How common is EMS privatization?

The International City/County Managers Association (ICMA) conducts periodic surveys that ask municipalities and counties how services are provided. Of the nearly 1,600 respondents to the most recent available survey (based on 1997-1998 data), 36.9 percent of municipalities and counties had privatized ambulance service.<sup>1</sup> The *Journal of Emergency Medical Services* (JEMS) surveys EMS provision in America's 200 largest cities, and finds that first response is dominated by public fire departments (nearly 97 percent). However, private for-profit firms most commonly provide patient transport (38 percent). Since an additional 4.3 percent of patient transporters are private not-for-profit firms, private firms account for 42.1 percent of patient transporters.<sup>2</sup>

Since the JEMS survey only includes cities (and not, for example, counties), it actually understates the degree to which private providers serve large populations. For example, the survey overlooks two celebrated private providers. A private provider serves the 1 million residents of Pinellas County, Florida. Tulsa and Oklahoma City combined efforts and created the Emergency Medical Services Authority (EMSA) to oversee emergency medical service. EMSA contracts with a private provider to serve the 1.1 million residents in its jurisdiction.<sup>3</sup>

## 3. How is EMS funded and how are the poor served?

Most EMS systems are funded by two principal sources, local tax money and user fees. Some EMS providers offer annual subscriptions similar to auto-club memberships. In this arrangement, subscribers pay a modest upfront fee and do not receive bills for EMS services.

EMS systems can be funded entirely by taxes, entirely by user fees, or by a combination of the two. Since higher user fees can allow for lower taxes, and since third-party payers cover most of the user fee, a high user fee need not necessarily worry customers. In fact, cities with little or no user fees actually use taxpayers to, in-effect, subsidize insurance companies and government reimbursing agencies.

Recent changes to the Medicare fee schedule will likely mean decreased reimbursements from the federal government to most EMS providers. Cities may respond to decreased reimbursements by increasing subsidies to EMS providers or allowing providers to charge patients more in order to recoup the real cost of service.

JEMS reports that in 2001 the average patient bill for ambulance transport was \$448. It is important to note that cost of the patient bill, as well as total cost, can vary widely depending upon the area served and the tradeoff between patient billing and taxpayer subsidies. For 2001, private for-profit providers reported the highest average rate (\$574).<sup>4</sup> Again, this figure can be somewhat misleading since JEMS did not consider the presence or absence of system subsidies.

EMS providers are legally obligated to serve all customers, regardless of their ability to pay. When serving Medicaid customers, EMS providers must often absorb the funding gap between the Medicaid reimbursement and the actual cost of the service. In order to help offset such costs, EMS providers must be especially vigilant about maximizing reimbursement from other sources.

#### 4. Why do cities privatize EMS?

The best reason to privatize EMS is to save lives. Private providers generally combine more advanced technology, and better system design.<sup>5</sup>

Automatic Vehicle Location (AVL) technology allows EMS providers to quicken response time by locating and dispatching the ambulance nearest to the emergency site. JEMS notes that private providers are more likely to use AVL technology: “Private transport agencies continue to report the highest percentage of AVL use at 40 percent, with the fire department transport providers reporting the second highest rate at 20 percent.”<sup>6</sup> Similarly, 70 percent of private EMS providers report using defibrillation devices to treat patients suffering from heart attacks, compared to 40 percent of public fire departments.<sup>7</sup> Moreover, private providers are more likely to implement safety assurance technology like the ambulance road safety system (See Question 6).

Private providers developed, and are more likely to use, innovative system design tools that increase performance by emphasizing flexibility. These tools allow providers to respond quickly—and even anticipate—changes in the time and place of emergency calls (See Question 8).

Since private providers must compete to gain and maintain contracts, they also more commonly adopt practices that nurture accountability. JEMS reports that private, for-profit transport providers have the greatest number of agencies (84 percent) subjected to external review.<sup>8</sup> (For more on accountability, see Question 6.)

Since public agencies may compete for contracts, privatization can spur public providers to reassess their performance goals. Even the possibility of privatization can improve a city’s emergency medical services. For example, take this excerpt from *Fire Chief*, a publication written primarily for public fire and emergency services employees:

*To compete against private-sector providers, you need to know what your customers want most and how to provide those services the best ... To survive, both private-sector and government institutions need to know the costs of their operations and how their performance compares to their competitors’ in the eyes of their customers. For fire-based EMS agencies, the desire to be seen as a better choice than private-sector firms has renewed interest in performance measurements and benchmarking. In fact, many local governments no longer see performance measurement as an option—it’s a requirement.<sup>9</sup>*

A bonus for cities is that private EMS providers can offer high performance and still cost less (See Question 7).

#### 5. How can we trust the private sector with matters of life and death?

Many people regard EMS as an inherently governmental task and see it as a leap of faith to place lives in private hands. Since so many people are only familiar with government-provided EMS, it’s natural for EMS privatization to be met with some initial apprehension. Even those friendly to privatization in other areas, like water service or garbage collection, may be slow to embrace privatized EMS. After all, if emergency response is poor, people die.

But so many cities privatize EMS precisely because the stakes are so high. EMS is too vital to shield from competition. Those skeptical of privatization should consider the limitations cities already endure under the alternative. The real leap of faith is to commit to one provider, forever, regardless of performance. Public EMS monopolies lack much in the way of “carrot or stick” incentives, and as such they have little hope of being rewarded for strong performance and little fear that poor performance will lead to their replacement. A private provider cannot compel a city to use its services, so it must pay special attention to customer satisfaction. Private providers know that a good reputation is the best way to expand into new markets.

Privatization allows cities to benefit from a level of technology, specialization, and expertise only available in the private sector. Competition provides us with ever-improving drugs and medical devices. It makes sense that it would also provide us with better EMS.

The bottom line is that privatizing EMS is not a matter of trust—it’s a matter of contract. A city doesn’t hand a contract to a private provider and walk away with fingers crossed, hoping that the firm will make good on its performance promises. Under privatization, elected officials still maintain crucial oversight roles. Officials shop for the best EMS provider, and set performance standards.

<b>Table 1: Three Steps to Successful Performance-based Contracting</b>	
▪	Ends, Not Means Spell out <i>what</i> you expect the results to be, but leave the <i>how</i> up to the contractor.
▪	Carrot and Stick Build financial incentives and penalties directly into the contract.
▪	Trust but Verify Subject the contractor to quality assurance monitoring.

One of the most crucial elements of successful privatization is a performance-based contract (See Table 1). In order to hold a provider accountable, contracts must clearly specify performance objectives like response time, productivity, and cost. If a private provider does not live up to the performance objectives for a given time frame, the provider should suffer financial penalty. Ultimately, poor performance should cancel the contract. Even if a private provider meets its contractual obligations, once a contract’s term is up, cities may still seek bids from other firms. There is always the chance that someone could do the job even better.

Officials in Richmond, Virginia learned how performance-based contracting can rescue a struggling EMS system (See Case Study No. 1), while those in Hawaii struggle with the aftermath of weak contracting practices (See Case Study No. 2).

### Case Study No. 1: Richmond, Virginia

**Lesson: Without a performance-based contract, accountability suffers.**

**Lesson: Privatization works best when competition flourishes.**

Prior to 1991, Richmond's EMS was operated by a combination of a private provider and four volunteer squads. There was no performance-based contract to enforce accountability, and little hope for competition. Equipment was shoddy, some areas were not served, response time was slow, and sometimes ambulances didn't show up at emergencies at all. The private provider simply asked for more and more subsidies for poorer and poorer performance.

Richmond yearned for a system that appreciated competition and enforced accountability. The city's mounting frustration prompted the formation of the Richmond Ambulance Authority (RAA). RAA would oversee emergency medical service and shop for private providers. Richmond began by opening the contract to competitive bids. Now the new private provider is subjected to strict performance measures and oversight. Today the contract is not a long-term commitment. It comes up for bid periodically, and poor performance can dissolve a contract at any time. The RAA even owns the EMS infrastructure in hopes of providing a smoother transition in the event the city decides to change providers. Since 1991, Richmond's public-private-partnership has developed into a worldwide model for performance. Some performance improvements include:

- Better cardiac arrest survivability rate: Prior to 1991, the chances of surviving an out-of-hospital cardiac arrest were less than 5 percent. Today, the chances of surviving an out-of-hospital cardiac arrest have increased to 20 percent.
- More advanced equipment: Prior to 1991, the city had a tiered ambulance fleet with both Basic Life Support (BLS) and Advanced Life Support (ALS) ambulances. A cardiac arrest patient might only receive the lower-tech BLS ambulance. Today ALS-equipped ambulances respond to all emergency calls.
- Faster response time: Prior to 1991, ambulance response times were slow and varied from one part of the city to another. Today, ambulances are on the scene of life-threatening emergencies in less than 8 minutes and 59 seconds in more than 90% of all responses.

### Case Study No. 2: Hawaii

**Lesson: Poorly conceived contracts and weak performance monitoring can hurt privatization.**

Hawaii's Emergency Medical Services and Injury Prevention System Branch is responsible for allocating over \$30 million in EMS contracts. The state auditor revealed a system unfamiliar with many of the foundations of successful privatization. Some of the troubling findings:

- "In 1996, the branch improperly entered into a continuous agreement with a collection agency without going through a competitive award method ..."
- "The branch also disregarded sound contracting practices by allowing contractors to render services before contracts were fully and properly executed ... [The branch's] \$17.21 million contract with the City and County of Honolulu for FY2001-02 was not signed until more than *eight months* into the contract period.
- "[The branch] made little effort to monitor the performance of many of its contracts. We found that required reports, including reports on drug utilization and service provision, were missing or unaccounted for. We also found that inadequate contract monitoring resulted in a number of questionable contract expenditures."
- "[L]ax controls over the branch's billing process for emergency transport services resulted in revenue loss to the State ... [W]e estimate that the State lost approximately \$1 million in uncollected fees for ambulance services provided in Maui, Hawaii, and Kauai counties during [FY200-01]."<sup>10</sup>



## 6. Aren't public agencies more accountable than private providers?

Some worry that private providers will be further removed from the democratic process, and, therefore, less accountable to customers, elected officials, and voters. But without the threat of getting fired, accountability means little.

A poorly performing public EMS provider may be subject to public criticisms. Mayors may shake their fists and demand improvement, but without the threat of being replaced there is little hope for substantive improvement. Without competition it is difficult to even define what accountability would be. If, after demands for improvement from the city council, the public provider improves response time by five seconds, is that evidence of accountability? We still don't know how the public provider's performance compares to other providers that would emerge from a competitive bidding process.

Without competition communities may find themselves saddled with an unresponsive provider. Take the sad story of Detroit's Errol Shaw, Jr. (See Case Study No. 3).

### Case Study No. 3: Detroit, Michigan

#### Lesson: Publicly provided service does not guarantee accountability.

Detroit police shot a deaf-mute when he did not respond to their demands that he drop the rake he was holding. Errol Shaw, Jr. lay bleeding from gunshot wounds for 12 minutes before police decided to stop waiting for the Detroit Fire Department ambulance and transported Shaw to the hospital themselves. The ambulance arrived 28 minutes after the first of two 911 calls, and Shaw was already in the emergency room. Shaw eventually died from his wounds.<sup>11</sup>

A 1997 study revealed that Detroit EMS took an average of 9 to 10 minutes to respond to calls. By comparison, EMS crews in Canton and Columbus, Ohio took half as long.<sup>12</sup> A review of internal fire department records for the day of Shaw's death showed that "more than 60 percent of the ambulances in Detroit's fleet were out of service or in disrepair." Of the city's 44 EMS vehicles, 13 were out of service and 14 of the remaining 31 available for service suffered from poor brakes, broken computers that are used to communicate with dispatchers, missing antennas that are used for transmitting patient information to hospitals, broken air conditioners (considered important for treating cardiac patients), and other defects. Even the unit that responded to the Shaw call 28 minutes later arrived with smoke pouring out of the hood.<sup>13</sup>

Public employee unions may actually resist adopting features that improve accountability. For example, a private EMS provider developed an ambulance road safety system that assures drivers will operate ambulances responsibly. Each time a driver makes a mistake (e.g. drives without a seat belt, corners too tightly, backs up without a spotter) the device sounds and records the incident. Since drivers know their performance is monitored and subject to regular review, they take care to drive safely.

While unions may regard accountability measures with suspicion, there may be reason to be optimistic about EMS employees' attitudes toward accountability. The JEMS Salary Survey 2001 investigated attrition rates across many different kinds of EMS providers. The survey found that EMS employees don't shirk from evaluation. In fact, they seem to enjoy it. Attrition rates were actually lower for personnel subjected to performance reviews compared to those who were not.<sup>14</sup> The survey's authors suggest a link between efficacy and job satisfaction: "Providing employees

with feedback on their performance enables them to become more proficient and, thus, more successful.”<sup>15</sup>

Comparing the higher rates of private providers subject to quality review, JEMS suggests that the possibility of competition may lead public providers to improve accountability:

*The percent difference in external review between first response and transport providers will likely change as more fire departments contract with private providers, participate in joint powers and inter-local agreements, as well as compete for performance-based contracts.*<sup>16</sup>

Private providers must constantly prove themselves if they wish to keep a contract. And when EMS contracts expire, elected officials may revisit their performance measurements to seek even better service. Pinellas County, Florida used competitive bidding to shop for a performance upgrade (See Case Study No. 4).

Case Study No. 4: Pinellas County, Florida
<b>Lesson: Privatization allows for performance upgrades.</b>
<b>Lesson: Efficient system design improves performance and saves money.</b>
<p>Prior to the late 1980s, Pinellas County public EMS inspired little confidence. After the county turned to privatization and opened the contract up for bid, service improved substantially. Still, even though officials were pleased with the provider’s performance, they decided to again open the contract to competitive bidding. Although the incumbent provider (Sunstar) won the bid, the result was higher performance standards, including:</p> <ul style="list-style-type: none"> <li>▪ Faster response time: Emergency response times were reduced by 30 seconds, with 90 percent reliability.</li> <li>▪ Faster non-emergency response: Compliance was increased from 90 percent to 95 percent.</li> <li>▪ Better equipment: Equipment and software in the dispatch/communications center was upgraded.</li> </ul> <p>Before the county awarded the new contract, the local fire department entered a bid to provide EMS. An important factor in the county’s decision was system design. The fire department staffing schedules are 24 hours on, 48 hours off. Such an arrangement hampers both performance and cost containment. Thanks to an approach called “peak-load staffing,” the private ambulance provider responds to 1/3 more EMS calls, with 1/3 of the employees, at 2/3 of the cost.</p> <p>Since the new contract, Pinellas County’s EMS has received many performance awards. In 2001, it became the first provider to be a repeat winner of Florida’s Provider of the Year Award.</p>

If a private provider does not perform well, it suffers financial penalties. Since elected officials still oversee private providers, voters can blame or praise their elected officials for EMS performance.

## 7. Won’t private providers cut corners to increase profits?

Some worry that a private provider might sacrifice quality to improve its bottom line. Critics may even describe privatization as a kind of reverse auction where cities desperate to save money sell off services to the lowest bidder. However, private providers generally champion technology upgrades and design innovations that allow for improved performance (See Questions 4 and 8).

It is well known that private providers are self-interested. What receives little attention is that public agencies are self-interested as well. Even with its tradition of public service, fire departments will admit that they want to increase their budgets to preserve jobs.<sup>17</sup> Fire departments may even try to break into markets usually served by the private sector, like non-emergency medical transportation, to generate more revenue.<sup>18</sup>

Private providers certainly are interested in making money, but they know that skimping on quality is not the way to enjoy long-term success. Private providers will expand their business and earn new contracts by slowly building a reputation for quality service and reliability.

EMS providers subject to competition must constantly ask themselves how they can improve. This ever-present search to innovate has uncovered many opportunities to deliver services more efficiently. Some are quite obvious. The focus on paramedic service can make capital investment less expensive. For example, one hook-and-ladder fire truck can cost six times more than an ambulance.

Private providers also usually take great care in accounts receivable management. Compared to public agencies, private providers average higher collection rates for user fees. Improved billing and collection can also decrease or eliminate the need for tax subsidies.

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Private providers will expand their business and earn new contracts by slowly building a reputation for quality service and reliability.

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Salary disparity may be the most obvious cost saver. Employees of private providers generally earn smaller salaries than their public sector counterparts, and those apprehensive of privatization have valid concerns that lower salaries may lead to higher attrition rates.

However, the JEMS Salary Survey 2001 suggests there is more to retaining employees than paying high salaries. The survey compared unionized and non-unionized EMS positions such as paramedics, EMTs, and dispatchers, and found that unionized employees tend to earn more than their non-unionized counterparts. For example, a unionized paramedic can expect to out-earn a non-unionized paramedic by about \$5,000 per year.<sup>19</sup> Still, the survey authors were surprised to find no relationship between union membership and lower attrition rates:

*These results appear to support the contention that non-unionized organizations can be as successful at addressing employee concerns as those with unions, even in light of apparent lower average salaries.<sup>20</sup>*

Other efficiency innovations may be less obvious than differences in salary. Increased experimentation has spurred continued improvements in system design—improvements that increase performance and reduce costs. Pinellas County, Florida found that private system design innovations allowed their provider to improve performance and still cut costs (See Case Study No. 4). Private providers pioneered peak-load staffing and other tools key to high-performing system design. (See Question 8).

## 8. How has private innovation improved EMS system design?

EMS providers governed by rigid, centralized design risk being caught off-guard by quickly changing demand. High-performing systems emphasize flexibility. They use tools that allow them to respond quickly, and even anticipate, changes in the time and place of demand. Although private providers are more likely to use these tools, all providers—public and private—can greatly improve performance by emphasizing flexibility. In fact, the key to superior performance is not necessarily whether the provider is public or private, but whether the system is designed for efficient and effective performance.<sup>21</sup>

The three tools listed below represent the backbone of high-performance system design:

**Peak-load staffing:** Since EMS calls occur at statistically predictable hourly and day-of-week patterns, efficient EMS systems increase staff at peak times and decrease staff during slow times. “Peak-load staffing” is a break from the traditional fire department arrangement of 24-hour shifts where peak-level staffing is always maintained. Such constant staffing can produce huge cost increases. As noted earlier, public fire departments nearly always provide first response service in America’s 200 largest cities. Among these first responders, 84 percent of crewmembers work 24-hour shifts (See Table 2). Private firms are much more likely to provide emergency transport, and this area enjoys greater variety in staffing arrangements (See Table 3).

**Event-driven deployment:** Just as high-performance EMS providers study call volume to learn *when* demand is highest, they also study patterns to learn *where* service will most likely be needed. Instead of deploying ambulances from fixed locations like fire stations, providers can position themselves in locations that allow for faster response. For example, an EMS provider may position ambulances closer to freeways during rush hour in anticipation of a higher rate of accidents. The study of geographic demand also incorporates analysis of traffic congestion patterns to allow ambulances to avoid heavy traffic whenever possible. The location at which paramedics are deployed can change from day to day and from hour to hour.

**Flexible production strategy:** The federal government used to promote the idea that operating two or more specialized ambulance fleets would heighten efficiency. A Basic Life Support (BLS) fleet would respond to non-emergency calls, and a more highly trained Advanced Life Support (ALS) fleet would respond to life-threatening calls. Eventually, the “specialized” fleet approach proved less effective and more costly than the “flexible” approach. The specialized approach relies on call screeners to quickly decide which fleet to dispatch. Such reliance on screeners can lead to an error-prone system that threatens patients’ lives. The flexible approach removes the threat of screener error by deploying ALS fleets to all calls. ALS fleets are flexible enough to respond to any kind of situation. The economies of scale present in a single fleet, single-provider system—coupled with efficiency gains from peak-load staffing and event-driven deployment—help offset the costs of deploying an all-ALS fleet.

Shift Type	Percentage of First Responders*	Percentage of Transport Teams
8 hours	4%	23%
10 hours	3%	16%
12 hours	7%	43%
14 hours	1%	5%
16 hours	1%	3%
24 hours	84%	43%
Percentage of respondents	94%	87%

Note: Many transport agencies provide a mixture of staffing patterns, combining 12-hour shifts with 8 and 24-hour shifts. This explains why the percentages don't tally to 100 percent in Table 3.

## 9. What causes privatization to fail?

Privatization can fail before it's even tried. Public sector employees often see privatization as a threat to their jobs. In an ICMA survey, the most frequently cited obstacle to privatization came from public employees (See Table 3).

30.1	Opposition from citizens
42.4	Opposition from elected officials
60.3	Opposition from local government line employees
32.0	Opposition from department heads
31.0	Restrictive labor contracts/agreements
17.0	Legal constraints
25.6	Insufficient supply of competent private deliverer
12.3	Lack of staff with sufficient expertise
22.1	Lack of empirical evidence on the effectiveness
16.5	Lack of precedent
4.8	Other

Since they are already motivated and organized, public employee unions are often eager to embark on aggressive campaigns against privatization. Privatization critics often ratchet up their efforts to attack EMS privatization. Critics play to concerns that private providers will compromise safety to increase profit. Such reaction is common to all areas of public policy. Regardless of the specific industry, public agencies and private firms that benefit when competition is stifled or prohibited will fight to maintain their privileges.

There certainly are examples of poorly performing private providers. Prior to 1991, Richmond, Virginia suffered under a private system with little accountability (See Case Study No. 1). However, if a city chooses not to renew a private provider's contract, this may be mistaken as a failure of privatization. Privatization supports a specific process (open, competitive bidding backed by contract) not a specific provider. If a patient changes doctors, we don't clamor for the public provision of doctors. Likewise, much of the benefit of privatization rests on the customer's ability to change providers.

Privatization is not a panacea. Contracts may be ill-conceived, performance monitoring may be lax, and service providers may not fulfill their obligations. Privatization simply decreases the chances of failure by emphasizing choice and accountability. Privatization allows customers to change their mind when something better comes along. The alternative to privatization is committing to one provider forever, regardless of performance. Such an arrangement is less likely to punish failure and reward success. The key distinction is not necessarily public versus private—it is competition versus monopoly.

The failure of privatization often has little to do with the particulars of EMS and more to do with the general guidelines for intelligent privatization. Poorly conceived contracts and weak performance monitoring can sour cities on privatization (See Case Study No. 2). Expectations, performance measurements, and financial incentives and penalties, should be clearly indicated in any contract.

Cities interested in privatizing EMS should pay special attention to potential pitfalls. Without a strong contract and proper performance monitoring, the benefits of privatization can quickly disappear.

## 10. Won't privatization lead to public sector layoffs?

In some cases, privatization can lead to public sector layoffs. Higher efficiency may allow a private provider to operate with fewer employees or a provider that currently serves a nearby area may already have a substantial workforce of its own. However, fears of massive layoffs are almost always unfounded. Given the high demand for EMTs and paramedics, it is unlikely the EMS industry will sustain significant layoffs—with or without privatization.

Both private providers bidding for contracts and the public officials who hire them are sensitive to public sector job security, so great pains are taken to avoid layoffs. When a city opts for privatization, a private provider will generally retain the vast majority—and in many cases all—of the formerly public employees. Often, cities award contracts to private providers on the condition that they hire the entire existing workforce, and make future staff reductions only through attrition or for cause.<sup>24</sup>

Many studies indicate that job loss from privatization is minimal. For example, in 1989, the National Commission on Employment Policy (NCEP), a research division of the U.S. Department of Labor, studied the effects of privatization on employees from a variety of jurisdictions across the nation over a five-year period. The report, regarded as the most comprehensive examination of privatization's impact on government employees, found that, of the more than 2,000 workers in 34 privatized city and county services, only 7 percent were laid off. More than 50 percent of the affected workers were hired by private contractors, approximately one-fourth (24 percent) of the employees transferred to other government positions, and 7 percent retired. The study concluded that "in the majority of cases, cities and counties have done a commendable job of protecting the jobs of public employees."

A 1995 study of privatization in Illinois municipalities found that only 3 percent of the 516 responding cities reported layoffs due to contracting. A 1999 follow-up survey of 220 Illinois cities found roughly the same percentage (3.8 percent) of cities reporting that employees were laid off as a result of privatization.<sup>25</sup>

## 11. How can I learn more about EMS privatization?

The publications listed below provide more details about privatization in general, and EMS privatization in particular. The fundamentals of successful privatization are the same from issue to issue, and much of privatization's success hinges on reacting wisely to the political landscape (See *How to Navigate the Politics of Privatization*), and proper contracting practices (See *Performance-based Contracting: Designing State-of-the-Art Contract Administration and Monitoring Systems*). For more details on how to take the first steps toward EMS privatization see *Privatizing Emergency Medical Service: How Cities Can Cut Costs and Save Lives*.

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# Related Reason Public Policy Institute Publications

Robert W. Poole, Jr., *Privatizing Emergency Medical Service: How Cities Can Cut Costs and Save Lives*, Reason Public Policy Institute How-to Guide No. 14, November 1995: [rppi.org/htg14.pdf](http://rppi.org/htg14.pdf)

Robin A. Johnson, *How to Navigate the Politics of Privatization*, Reason Public Policy Institute How-to Guide No. 20, July 2002: <http://www.rppi.org/htg20.html>

William D. Eggers, *Performance-based Contracting: Designing State-of-the-Art Contract Administration and Monitoring Systems*, Reason Public Policy Institute Policy Study No. 17, May 1997: [rppi.org/htg17.pdf](http://rppi.org/htg17.pdf)

Robin A. Johnson, *The Future of Local Emergency Medical Service: Ambulance Wars or Public-Private Truce?*, Reason Public Policy Institute Policy Brief No. 18, August 2001: [rppi.org/pbrief18.html](http://rppi.org/pbrief18.html)



# Endnotes

- <sup>1</sup> “Profile in Local Government Service Delivery Choices, 1997,” International City/County Management Association.
- <sup>2</sup> Monosky, Keith A., “200- City Survey,” *Journal of Emergency Medical Services*. February 2003, p. 37.
- <sup>3</sup> The JEMS Survey understates EMSA’s service area by listing Tulsa and Oklahoma City separately. For simplicity’s sake, we use the term “city” generically. Depending on the jurisdiction, “city” may be more properly understood as “county” or another kind of geographic designation that is used to describe an EMS provider’s service area.
- <sup>4</sup> Cady, Geoff, “200-City Survey,” *Journal of Emergency Medical Services*, February 2002, p. 70.
- <sup>5</sup> It is important to note that no significant across-the-board public vs. private performance or cost comparisons have been conducted. Such studies have been attempted, but public employee unions tell their members not to participate in them. Our understanding of EMS would be greatly improved by comparison studies, but it is likely that such studies would have to be conducted by academics who have no ties to either public or private EMS. Even without comprehensive comparisons, it is still possible to make wise assessments by piecing together the available evidence. We can investigate case studies, examine the different incentives present in public and private EMS, understand the logic behind differently designed systems, and analyze the various approaches to innovation and accountability.
- <sup>6</sup> Cady, “200-City Survey,” *Journal of Emergency Medical Services*. February 2002, p. 50.
- <sup>7</sup> “200-City Survey,” *Journal of Emergency Medical Services*. February 2001, p. 4.
- <sup>8</sup> Monosky, “200-City Survey,” *Journal of Emergency Medical Services*. February 2002, p. 61.
- <sup>9</sup> Terry L. Schenk, “Measures for Medics,” *Fire Chief*, January 1, 2001, p. 1.
- <sup>10</sup> State of Hawaii, Office of the Auditor, "Contract and Personnel Management Audit of the Emergency Medical Services and Injury Prevention System Branch," Report No. 02-14, October 2002.
- <sup>11</sup> Corey Dade and Suzette Hackney, “Slow EMS Led Police to Transport Victim,” *Detroit Free Press*, September 1, 2000.
- <sup>12</sup> *Ibid.*
- <sup>13</sup> Joe Swickard and David Ashenfelter, “Emergency Fleet Appears Sickly,” *Detroit Free Press*, September 2, 2000.
- <sup>14</sup> “Salary Survey 2001,” *Journal of Emergency Medical Services*, October 2001, p. 33.
- <sup>15</sup> *Ibid.*
- <sup>16</sup> “200-City Survey,” *Journal of Emergency Medical Services*, February 2002, p. 61.
- <sup>17</sup> Richard A. Narad and William Gillespie, “The Public vs. Private Debate: Separating Facts from Values,” *Prehospital Emergency Care*, 1998, Vol. 2, No. 3, p. 199.
- <sup>18</sup> “FFs competing with private ambulances,” *Fire Times*, June 18, 2003.

- <sup>19</sup> “Salary Survey 2001,” *Journal of Emergency Medical Services*. October 2001, p. 33.
- <sup>20</sup> *Ibid.*
- <sup>21</sup> Robert W. Poole, Jr., *Privatizing Emergency Medical Service: How Cities Can Cut Costs and Save Lives*, Reason Public Policy Institute How-to Guide No. 14, November 1995, p. 7.
- <sup>22</sup> “200-City Survey,” *Journal of Emergency Medical Services*, February 2003, p. 52.
- <sup>23</sup> *Ibid.*; “Profile in Local Government Service Delivery Choices, 1997,” International City/County Management Association.
- <sup>24</sup> Robin Johnson, “Privatization and Layoffs: The Real Story,” e-brief #112, Reason Public Policy Institute, March 13, 2001.
- <sup>25</sup> *Ibid.*



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