 EMS MYTHOLOGY

Part 8

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EMS Myth #8
Public-utility models are the most efficient model for providing prehospital care

Let me start by saying that I don’t think most proponents of public-utility EMS models (PUMs) have ever claimed that they are the most effective model for providing prehospital care. However, many in EMS have simply assumed the PUM was a tried-and-true model based on significant scientific and economic data. Furthermore, there are those who strongly promote the PUM as a preferred model for modern EMS systems. There are certainly some economic advantages for communities that choose PUMs, but there is more to EMS than economics, and that is the point I will pursue in this article. I have some experience with PUMs, having worked with two. So with this in mind, let’s examine some of the issues associated with PUMs in modern EMS.

History
The concept of a PUM was first proposed in the late 1970s by a team of economists and behavioral scientists from the University of Oklahoma. Known as the Health Policy Research Team and funded by a grant from the Kerr Foundation, they undertook a theoretical analysis of the prehospital care “industry.” The team was headed by Jack Stout, who was, at the time, a research fellow with the university. Stout subsequently left the university and founded an EMS consulting firm known as The Fourth Party. The PUM theory was first applied to EMS operations in Tulsa and Oklahoma City and later to several other Midwestern cities.

The theory behind the PUM was to operate EMS as a “public utility,” much like utility services (water, electricity, gas) or similar quasi-governmental entities or public trusts. Stout wrote of the PUM model, “When properly applied, this strategy appears to be capable of producing stable, clinically sound advanced life support prehospital care at a level of economic efficiency that can compete well with the best in the industry—and may even embarrass the rest of the industry.” Based on this, many started referring to PUMs as “high-performance systems.” Stout also described the PUM as “mainly a way of replacing competition at the retail level with a far more effective form of competition at the ‘wholesale’ level.”

A variant of the PUM is the “failed franchise” model. With this model, the PUM does not involve the ambulance contractor with rate setting or billing and collection activities—thus the role of the ambulance contractor is enhanced while the role of the PUM is reduced. The MedStar EMS operation in Fort Worth, TX, is an example of a failed franchise.

With a PUM, a quasi-governmental entity is established to oversee ambulance operations. This is referred to as the public authority or the ambulance authority. The ambulance authority is given exclusive control of all ambulance operations within its participating cities, and reports to governmental entities (cities, counties) that are part of the system. In addition to the ambulance authority, a public physician advisory board is established to make clinical recommendations for the system. The actual provision of ambulance service is by a private (usually for-profit) ambulance contractor. In some PUMs, the ambulance authority actually owns the ambulance fleet. Regardless of the system structure, the ambulance authority typically has the power to take over the ambulance operation if the ambulance contractor is found in breach of their contract. The authority also owns the trade names (i.e., MedStar, Sunstar, MAST, EMSA) and telephone numbers used by the system.

Although there was a significant push to install PUMs in many areas, the idea pretty much fizzled in the 1990s. There are still fewer than 20 EMS operations that utilize PUMs. Many cities found difficulty back-tracking from the PUMs because they made fiscal and statutory commitments that made it difficult to dismantle the system. It is often much harder to repeal laws and regulations than to enact them. Most PUMs were designed to eventually eliminate most governmental subsidy—although most have had subsidies increases over the last decade.

Many utilize subscription programs or memberships and similar programs as alternative funding sources.

The Scientific Evidence
As with system status management, PUMs are an EMS practice that’s not based on any scientific evidence. There are no studies demonstrating that PUMs are any better or any worse than any other type of system when it comes to patient outcomes. A whole lexicon of terms has been developed to illustrate the effectiveness of PUMs, and these have come to be applied to non-PUM EMS operations. Terms such as unit hour utilization
In many PUMs, employee salaries tend to be lower than in other types of EMS operations.

have come from PUMs and systems status management. Basically, they are indicators of how much of a system’s resources are being utilized, which has direct bearing on costs and profitability.

PUMs were developed when governmental entities were looking for ways to reduce the costs of ambulance operations and, to a lesser degree, as a result of the less-than-amiable relationship many cities had with their private ambulance services. The solution, in the case of PUMs, was to shift the burden of dealing with EMS to another governmental entity. Thus, a governmental entity was established that would regulate EMS and, through that, help to reduce costs. But when has a governmental entity done anything but increase costs and grow? Furthermore, when it comes to healthcare, governmental entities have a horrible track record. Some have said that socialized healthcare in the United States would be like a cross between the United States Postal Service and the Internal Revenue Service. I have nightmares just thinking about that one.

But with PUMs, you lay a second level of administration between the city and the ambulance contractor. Let’s look at one of the premier PUMs in the country: Pinellas County, FL, EMS, the largest PUM in the nation. In their fiscal year 2003 budget proposal, their total annual EMS budget request was $59,147,550. Of that, 19.2% was earmarked for administration (with 40 full-time employees), 44% was to go to first responders, and 36% was for the private ambulance contractor (Sunstar-AMR). That’s right: More money was to go to first responder organizations than to the ambulance transport provider. Is it any wonder that the annual average salary for an entry-level paramedic at Sunstar is $29,700 while an entry-level paramedic for the neighboring St. Petersburg Fire Department starts at an annual average salary of $35,470—more than 19% more?26

Conclusion

I am not an economist. But I don’t feel you have to be an economist to see the problems here. PUMs were created to save money and maximize resources—that is, get the most out of the employees and ambulances. Costs are minimized by using systems status management, which negates the need for fixed stations. Increased utilization of existing ambulances is maximized so as to decrease the total number of ambulances needed. But as I wrote last month, there is a lot more to EMS than running calls.

The structure of the PUM is such that approximately 10%-20% of the EMS budget goes to administrative functions of the ambulance authority. While in most PUMs the ambulance authority is responsible for some costs (i.e., billing) previously footed by the ambulance contractor, the ambulance contractor still must have its own management structure. There is therefore considerable overlap in management between the ambulance authority and the ambulance contractor. When you compare a PUM to other forms of EMS, consider this: Equipment costs are the same, supply costs are the same, fuel costs are the same. But...

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Postscript

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are the same, benefit costs are the same and support costs are the same. But with a PUM, you have two levels of management.

The only other budget variable that can "give" to support the added management costs is employee salaries—all in a system that is supposed to save money. In many PUMs, employed salaries tend to be lower than in other types of EMS operations. Thus, PUMs must either increase their salaries (through subsidy increases, subscriptions) or simply depend on an itinerant work force that will work for less. That is, they rely on a constant supply of young EMTs and paramedics looking for experience. So employee turnover rates tend to be high, with personnel eventually abandoning the PUM for more traditional EMS models with higher pay.

There are advantages and disadvantages to PUMs. They were a creature of the 1980s, and healthcare in general—and prehospital care in particular—has changed drastically since that time. Unfortunately, cities that bought into the PUMs are now stuck with a legal governmental entity (the ambulance authority) that continues to grow and demand more revenue. For example, the Pinellas County EMS budget has increased 23% from the year 2000, while payments to Sunstar have only increased by 14%.

City and county administrators wishing to dismantle their PUMs might first take some lessons from Buffy the Vampire Slayer—for the task would be daunting.

Postscript

I hope you have enjoyed the EMS Mythology series. The purpose of this series has been to stimulate thought and to question our practices. Emotions are a major part of our being, but they can also misdirect us on occasion. While there is a lot of art in EMS and medicine, there is an increasing amount of science. With the shrinking health-care dollar, we must ensure that we are helping a maximum number of people with the resources allotted to us.

References


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