OPEN FORUM:

What is the role of the federal government in emergency medical services? Participants in this *EMS* survey agree it is definitely *not* that of Great White Provider and Protector. The role envisioned is that of Stimulating Partner – one able to provide, because of its unique structure, physical, technical and financial help to local communities. Participants uniformly agree that in addition to such aid and assistance the federal government has an even greater responsibility – to serve as innovator, initiator and catalyst. There is a feeling that the next several years must be approached with a "Wait-And-See" attitude, as local and federal representatives strive to determine exactly what an emergency medical services system really is. With some twenty-two Washington agencies charged with responsibility for some little piece of the action; some small chunk of the package, it can be argued that the federal government is involved in EMS in a big way. Despite the many politicians involved in making themselves perfectly clear on a myriad number of issues, however, there is as yet no clear resolution of where the EMS buck actually stops on the federal level.

"The most crucial requirement now is the need for adequate funding..."

Gerald Looney, M.D., Associate Director, Department of Emergency Medicine; LAC/USC Medical Center, Los Angeles:

"I believe the federal government, in health care in particular, has a responsibility to step in and fill a void where one exists. We needed a treatment for polio; it is appropriate that NIH funded a massive effort to develop a vaccine. The federal government did not, however, become a massive immunization service. There is a huge void in emergency medical care now and the federal government must acknowledge leadership and seize the initiative, provide some seed money, initial expertise, advice and assistance – and then once the ball is rolling pull back and let the non-governmental people pick it up and carry it.

"As I testified in June at the EMS hearings, I believe that many of the "local" efforts would probably never have developed had it not been for the support and involvement of the federal government through the Highway Safety Program Standard on Emergency Medical Services. There has been more improvement in emergency services in the last four years than the preceding three decades of purely local effort and community responsibility, and most of this has been due to the National Highway Safety Act of 1966. I think we can now say that for the first time in our history parts of the United States are getting modern emergency care comparable to the care given in the jungles of Viet Nam.

"The most crucial requirement by far now is the need for adequate funding, both for immediate services and for further research and development. I believe it is imperative that maximum latitude and flexibility to new approaches be assured – there is no need to base an emergency system on past experiences while a whole vista of fresh opportunities opens before us."

How do private ambulance operations, established for years, fit in with a new approach?

We wish to thank the following for their participation and cooperation:

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"The dilemma here is that in most instances the private operator is a creature of recent vintage. Emergency care was really pretty good, as long as it was run by the hospitals, but suddenly after World War II hospitals stopped providing ambulance services. Private operators stepped in to fill the void – and of course if they hadn't, no one else would have. The hospitals sort of gave up their rights.

"My interest is in seeing a better balance, so that some hospitals start providing ambulance services. Obviously not all ambulance services can be hospital based, but if you really want to provide top notch care you can't let the local Mortician or local surgical supply representative be the one who provides the personnel. And that gets us into an interesting concept that of separating out emergency care from emergency transportation. If emergency care is viewed as a public responsibility, along with fire and police protection, and if the transportation part of emergency care is viewed as a seperate component, then the private operator has a very definite role to play. The best solution may be to have private operators work as subcontractors to the hospitals. The hospitals can then add the charges to their bills, as they do for x-rays, lab tests and things of that nature."

What do you think of the way in which the federal government is presently involved in EMS?

"Theoretically EMS should obviously be a health function, but it was initially given to an agency with no health responsibility or resources, The Dept. of Transportation. Nationally, I think there is a lack of admiration for HEW's ability to implement things so far. I'm hopeful that over the long haul they will learn how to carry the ball. There must be some seed money used for a sort of R&D phase for the next year or two; when it becomes apparent what the best way is to design emergency services we can implement new systems in deficient areas all across the country.

"Los Angeles is a good example of government involvement when it was needed. There was a tremendous need for paramedics, and nobody was meeting the need, including the medical and educational institutions. The County of Los Angeles perceived this need, and filled the void by starting a Paramedic Program. Now, two years later, educational institutions are beginning to respond, and I think probably the County can soon begin to think about moving out of the educational business. But the County saw the initial need – and filled it exceedingly well. I think government has to try to serve as a catalyst to initiate activity if the private sector is not responding. Once activity picks up and non-government agencies begin responding, government should pull back and phase out.

"I'd like to point out that the current HEW position, as stated at the June EMS hearings, is that we don't need any new legislation in emergency medical services (and I'm not sure that position can be well defended). If it is true that a big void does exist in emergency medical care, and has grown steadily worse over the past thirty years, and that there has been sufficient existing legislation all along, then somebody, somewhere, needs to be called to task for not having done something sooner."

Steven Lawton, Counsel to the Subcommittee on Public Health and Environment, House of Representatives, talks about the Emergency Medical Services Act of 1972.

"The legislation passed the House, but the Senate Bill was tacked to a measure which included ten or twelve other authorities, and the House and Senate never got together to work out a compromise bill. Now, with a new Congress, we start again. There is plenty of legislative history on both the House and Senate sides on the need for an Emergency Medical Services Bill. I'd guess that as soon as Congress gets into full swing they will report out their bills and get together on them in a hurry. We estimate we can have something to the President within the first six months of the new Congress."

How would the Bill work?

"The Bill would authorize federal assistance for the establishment of emergency medical services systems across the country. EMS could almost be called the missing link in adequate health care services. We heard statistics that nearly 10% of the yearly pre-coronary hospital

deaths could be prevented if proper care were administered at the scene or in route to a medical facility; that while more than 90% of hospitals maintain an emergency room only 10% are equipped to handle all medical and surgical emergencies; that only 5% of the nation's ambulance personnel have completed the minimum standard instruction course; that 5% have had no training at all.

"The Bill authorized $255 million to be spread out over a three year period for feasibility grants, initial operations grants, research and expansion and improvement of existing systems. The idea is to get an EMS system started in a community, or improve an existing system, with a view to the system becoming self-sufficient.

"To receive federal funding the EMS system must comply with a rather rigid set of requirements set up by the Subcommittee on Public Health and Environment, which include: 1) An adequate number of health professionals who meet rigid training requirements, 2) that the system be joined by a central communications system having, if possible, a universal emergency telephone number; 3) that vehicles and other transportation facilities be both adequate in number and also meet the standards prescribed by the Secretary of HEW; 4) that the system include adequate numbers of hospital emergency rooms; 5) that a standardized patient record-keeping system be maintained; 6) that all patients requiring such services have instant access to the system regardless of ability to pay; 7) that there be adequate provisions for transfer of emergency medical patients to facilities and 8) that programs for both follow-up care and vocational rehabilitation be provided. Finally, we provide for programs of public education to be conducted by the EMS system and for a system of peer review.

"The Committee found that there is a virtual absence of training of physicians in emergency techniques, so the Bill would authorize grants to medical, dental and osteopathic schools for research projects in the methods of emergency care and probably more important, for training programs in the techniques and methods of emergency care. We spoke with one physician who had gone to some forty different schools to complete his training as an emergency physician – rather a costly and cumbersome way to get an education."

Can private ambulance operators participate in the system?

"I think the private ambulance operators initially viewed this as being only an 'Ambulance' Bill, which authorized massive federal funding for ambulances in a community. Private ambulance operators are not precluded from contracting to provide transportation with the Emergency Medical Services System – the public, non-profit entity charged with, among other things, providing emergency transportation. Either a non-profit or a for-profit transportation system could enter into a contract or agreement."

What about long range funding?

"The grants authorized under the bill are not intended to continue ad infinitum. They are intended to establish and authorize initial operation for a two year period. The grants can be only one half the cost of operation for the first year and one quarter the cost of operation over the second year. The entity would then be required to be free standing, receiving its funding from the local community, fees, or other sources. This is not an attempt at continuing federal assistance – it is an effort to get things started."

"Our role is to stimulate development of all the pieces, and encourage the individual communities to put them all together"

Merlin K. DuVal, M.D., has been Assistant Secretary for Health, Department of Health, Education and Welfare, for the past year and a half. He likens the Federal approach to emergency medical systems to that of the approach to the Space Shot.

"We knew a great deal about projectiles, missile fuels, guidance systems, astronomy and so forth. But all the pieces had to be put together. They were, in a single package called the Space Program, and we put a man on the moon.

"In the same way we know a lot about the various pieces of an emergency medical services system. There are communities where the transportation system is extremely good; others where the quality of ambulance training is very high. Some where communications are first rate; others where emergency rooms are very good. The trick is to get them all together. Let's say there is a highway accident. All the pieces have to be working: Communications; capacity for a vehicle to arrive promptly; degree of training the ambulance attendants have received; equipment on the ambulance; capacity of the ambulance to get to a good emergency room within a reasonable period of time; capacity of the emergency room to be appropriately equipped and responsive to the particular type of emergency; backup in the hospital if necessary, and finally type of care, including rehabilitation and restoration.

"The final role of the Federal Government in emergency medical services is not really clear at this point. We feel our role now is to stimulate development of all the individual pieces in the community, and then to encourage the community to pull it all together. We started this year by singling out five total systems and some four to six subsystems for some federal support, no one of which would stand as a total system but on which we need more information. After six months or a year we will have developed quite a bit of information from these systems and we'll see then what might be the next step the government should take to serve as a catalyst to a community to get their emergency medical services pieces all together as a system."

"A total EMS system can work as well with a privately owned ambulance service as with one operated by a public agency"

Bill Burnett is on staff with the AMA Committee on Community Emergency Services and serves on the Commission on Emergency Medical Services. The Commission represents twelve medical specialty groups; its job is to look at the national picture and make recommendations on programming activities. The Committee is entirely an "in-house" group which works on AMA policies and procedures on emergency medical services. Burnett here discusses AMA proposed legislation, now dead, in which "The AMA laid out very clearly where they thought the Federal Government ought to be in emergency medical services.

"I'm firmly convinced the AMA will probably put in a very similar bill in the coming Congress. In essence, we say that all emergency medical services ought to be centered under one basic agency in the

federal government – a new administration established department in the Department of Health, Education and Welfare. We say that grants of monies should be made to state agencies and they in turn allocated down to local agencies; that private enterprise interests should have as equal opportunities to get grants and contracts as do government agencies; and that the agency handling emergency medical services encompass everything – the Department of Agriculture, the Highway people – everyone who has a part in emergency medical services.

Could you clarify the AMA position on privately operated ambulance companies?

"You will find that many private ambulance operators have done a rotten job – but you will find an equal, if not a greater number, who are conscientious people and do a fine job. There is a great movement afoot to provide emergency medical service as the third public service, fire and police being the first two. There is good thinking behind this point of view, but an emergency medical services system in a community can work just as well with a private ambulance operator if he conforms to all the standards everyone else has to conform to. None of the projects funded recently by the government included private operators – in fact some other pieces of legislation that were in the hopper during the last session of Congress specifically excluded the private operator. All he could get was money to help with planning – not for furnishing equipment or supplies. The proposed AMA legislation will include private ambulance operators. There are some excellent systems around the country that use private ambulance service . . . one that comes to mind is in Charlotte, North Carolina. The private ambulance company operates on a contract with the city, and provides the same service for Charlotte that the Fire Rescue Department does for Houston."

"We must work out the mechanics of a total EMS system and get some legislation before we consider the various components"

Joseph A. Fortuna, M.D., is training to become an Emergency Health Systems Specialist – "One who plans, develops and perhaps operates total emergency systems." He is with the Emergency Medical Services Special Project, Health Services and Mental Health Administration, at the Graduate Hospital of Pennsylvania.

"The real problem in emergency medical services today is organizational – it has nothing to do with money or the level of technology. It boils down to how you go about getting a community together to plan and pay for emergency care.

"Of course you can extrapolate this problem to the larger health care system, but one of the beauties of emergency health care is that it is somewhat more readily definable – it is certainly more visible then the rest of the health care system. As a result, people are more willing to involve themselves in consideration of solutions to problems in the emergency care field where they wouldn't be, for example, in ambulatory care. You can get a broader spectrum of the community involved.

"As far as the role of the federal government in EMS, a lot of things are happening – at least on paper, and partly in reality. HEW has been given the responsibility for improving emergency med-

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ical services systems, and as a result we have the five Model Projects. Plans are underway to establish a National Information and Data Center on Emergency Services and a technical assistance capability.

"The concept of an emergency medical services system is not something that has been tested, and that's what we're doing now in these special projects. Once it has been tested it would seem to me there is a role for the federal government in terms of helping communities develop these systems. In some cases that might be funding in part or of all the initial stages of development, in others it might just mean sending people in for some technical assistance."

How, specifically, would a community start?

"The first step is for a community to get itself together in whatever way it can, through a local political subdivision or a non-profit corporation or whatever (my preference is that it be at least on a CHP B Area basis, as the special projects are funded), and start planning. It can then put forth a comprehensive plan for an emergency medical services system and seek monies to fill in the elements of the plan. One of the problems today is that people seek monies for one specific area of it – like training for ambulance attendants – assuming this is the be all and end-all of the system. So you may then have excellent care on the way to the emergency room, but when you get to the door you may find a poorly staffed and equipped emergency room unable to handle the problem.

"One of the basic problems now is that there is usually difficulty in getting local funding for something as nebulous as planning and, to some extent for the initial operational phases. But I'm not sure the federal government should provide this initial money – we first need to find out what the best way is to spend money. We must work out the mechanics of a total system and get some legislation – then we can work on the components of the system."

What kind of technical assistance is available from the federal government?

"The capability for assistance is currently available through the Division of Emergency Health Services, not perhaps to the extent we'd like, but the EMS Special Project is working on the situation now and trying to evolve a better capability. Currently there are people in thirty seven states and many of the State health departments who are available to assist communities upgrade their emergency programs. We have many options as to how the final system works – it may end up being all federal people, or teams of experts from the private sector assisted by federal people. In the absence of a great number of people in the private sector who have this expertise it certainly would be helpful to have some kind of assistance available, and I think it is appropriate that it come from the federal government. There is a parallel in the Health Services Research Field – five years ago when the National Center for Health Services began there were very few people around who were trained in health service research. Today we're getting many well trained, well qualified people.

"Emergency medical services must be looked at as a multi-disciplinary kind of problem. It is not something that lies specifically in the realm of physicians, nurses, social workers, ambulance operators, communications or p.r. people. This is a field that needs the team approach."