



Coordination practice

CONTRACTING WITH PRE-HOSPITAL EMERGENCY MEDICAL SERVICE PROVIDERS IN ESTONIA

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The practice concerns the application of a market-type coordination mechanism. In 2001, a reform of pre-hospital emergency medical service (EMS) was undertaken in Estonia – the aim was to change the ambiguous, under-regulated and poorly administered EMS system into a semi-market system where all service providers would be subjected to competitive selection and legally enforceable contracts. However, in 2007, after six years of the experiment, the government abolished the competitive contracting system on the grounds of its unsuitability for the country's delivery mechanism. The introduction of purely market-based coordination had failed. Instead, strong elements of hierarchy- and network-type mechanisms were inserted into the EMS system. The process engaged different stakeholders, most important of which were the Ministry of Social Affairs, the Health Care Board, the Union of Estonian Emergency Medicine representing service providers and private companies seeking access to EMS. In its essence, the practice revolves around the will and capacity of different stakeholders to influence the administrative policy process.



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Preface

This coordination practice is a result of research within COCOPS Work Package 5: The Governance of Social Cohesion: Innovative Coordination Practices in Public Management.

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The COCOPS project (Coordinating for Cohesion in the Public Sector of the Future) seeks to comparatively and quantitatively assess the impact of New Public Management style reforms in European countries, drawing on a team of European public administration scholars from 11 universities in 10 countries.

The specific objectives of Work Package 5 are:

- To search and identify emerging coordination practices and related steering instruments in public management in European public sectors.
- To compile a case study catalogue of such coordination practices with direct utility to public managers and the research community.
- To analyse the functioning of such coordination practices and to assess their value in countering public sector fragmentation and delivering public value.

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1. THE COORDINATION LANDSCAPE

Main country characteristics: ESTONIA

General political-administrative structure

Estonia is a small parliamentary democracy with a land area of 45,227 km² and a population of 1.29 million. Estonia regained independence in August 1991. Since 1991, both majority and minority governments have been in power, typically with 2-4 political parties in the governing coalition. The dominating worldview of the coalitions has been neo-liberal as the two main parties carrying the worldview – Pro Patria Union and the Reform Party – have been firmly institutionalised in the political landscape and with a long record in power. The latter has been holding the position of Prime Minister since 2005 and has persisted in government since 1999 (12 years in a row). The formal head of state, the President, has a mainly representative and a ceremonial role. 226 municipalities are responsible for providing public services related to primary and secondary education, social care, spatial planning, local transport etc. 15 county governments function as regional units of the central government.

The executive power of the state is in the hands of the government. A central trait of the Estonian administrative system is its reliance on ministerial responsibility. Although the eleven ministries are small, they represent strong administrative actors that have considerable leverage over the issues belonging to their areas of governance. The role of the ministries is mostly confined to policy formulation while the implementation of the policies is carried out by various agencies under their supervision. In accordance with the ministerial responsibility, all public organisations are more or less directly subordinated or linked to specific ministries. Due to the constraints on resources (money, people, expertise), the ministries' capacity to supervise and steer their subordinate agencies' daily functioning is limited. The general framework of vertical coordination relies strongly on ex-ante control mechanisms. Regardless of the investments made into developing the strategic planning, ex-post control tools are often used as an ad-hoc reaction to specific problems. Due to the complexity of the issues handled by the agencies and their frequent monopoly of expert knowledge the influence of agencies on policy-making can be very high. With a hope to foster the vertical coordination through integration and hierarchy, the administrative developments of the last few years have been dominated by mergers of institutions, measures of standardisation, optimisation and centralisation.

Since regaining independence, the Estonian state has gone through major economic and administrative reforms. The radical shift of political regime from communism to democracy necessitated changes in the institutional structure of the state. Among other things, it meant reforming the mechanisms of cooperation and coordination in a situation where the

	<p>communist party as a central coordinating power disappeared. Furthermore, Estonia inherited an institutionally fragmented administrative system with a high number of relatively autonomous individual organisations. Consequently, the general trend of reforms over the two decades has been towards aggregating the system and establishing mechanisms for steering, control and cooperation. A weak civil society and a minor role for the trade unions has allowed governments to push through considerable changes quickly and with little consultation.</p> <p>The accession to the EU has also been a crucial factor of administrative development. On the one hand, the administrative capacity requirements of the EU had a considerable influence on the development of administrative procedures and structures. On the other, after gaining the membership in 2004, Estonia has aimed to make maximum use of the EU structural funds, among other things, using the EU financial support for developing its public administration and training of civil servants.</p> <p>In recent years, the global economic crisis has induced government to look for further sources of economy and efficiency within the public administration. All of the reforms have taken place in the context of the very small size of Estonia that has also had a significant impact on the development of its state and public administration. This has been reflected in the constant search for the efficient use of resources, multi-functionality of organisations and positions, a big role for individuals as well as a reliance on informal communication and cooperation.</p>
<p>Coordination discourse</p>	<p>In terms of horizontal coordination, Estonia operates a segmented administrative system where the responsibility for public policies and programmes lies with individual ministries. Such an arrangement is also supported by budgetary and strategic planning frameworks. The central coordinating units in the system such as the Government Office and the Ministry of Finance are equipped with restricted coordinating powers and, in addition, often constrained by limited resources. However, the Government Office that mostly had the identity of a technical support unit to the Cabinet until lately has strengthened its coordinating function. It hosts the units for EU coordination, strategic planning and development of civil-service top executives. The Ministry of Finance with its responsibility for the budgetary process has the strongest coordinating power in the system.</p> <p>Horizontal coordination mechanisms that have been built into the system (e.g. consultation of draft regulations, management of EU affairs) are mostly based on network-type cooperation and in that way reinforce the central role of ministries in deciding over the policies falling to their areas of governance. High expectations have been related to using ICT solutions in fostering the exchange of information and positions between the institutions and to e-government in general. Nevertheless, even in cases where the policy proposals demand an official opinion of the ministries,</p>

	<p>they often take a formal approach and provide detailed positions only on issues directly concerning the issues in their areas of governance. The initiatives of creating more unity within the system have met with institutional resistance and have moved on slowly.</p> <p>Problems due to the segmented system of public administration have become more and more evident. Consequently, there is a call for better horizontal integration of policy sectors and for a whole-of-government approach. As has been recently pointed out by OECD, the Estonian administrative system's ability to work in a "joined-up fashion" has shined more in times of crisis or when a more immediate policy response has been needed than in "business-as-usual" activities. The cooperation on these occasions has relied heavily on personal contacts and informal networks. As a follow-up to the OECD report, the government adopted an action plan for implementing its recommendations. Among other things, it foresaw a continuation with the centralisation of the support services within public administration (mostly accounting and personnel records), strengthening the cooperation of secretaries generals and vice-secretaries generals, supporting rotation within public service as well as reviewing the strategic aims of the government organisations.</p>
Policy area	<p>The general legislative framework of the policy field of health is created by two laws – the Health Services Organization Act from 2001 and the Health Insurance Act from 2002. Estonian health insurance is a social insurance that relies on the principle of solidarity. The social tax paid for the working population is also used to cover the costs of health services provided to several other groups in the society. The Health Services Organization Act establishes the general regulatory framework for the provision of health services by providing the legislative basis for the different branches of the health-care system – primary, secondary and emergency care. The current institutional structure has evolved through two decades. The most radical reforms were undertaken in the years 1991-1994, when the health-insurance system was introduced and the reform of the primary care launched. The 2000s saw the initiation of a comprehensive reform of the hospital network. There has been an important role for international actors in the reform of Estonia's health care, most notably for the World Bank.</p> <p>The main institutions of Estonia's health system are the Ministry of Social Affairs, the Health Board, the State Agency of Medicines, the Estonian Health Insurance Fund, the National Institute for Health Development and the health-services providers. The <i>Ministry of Social Affairs</i> is responsible for national health-care policy – preparation of draft legislation, preparation, approval and coordination of implementation of health-care development plans, collection and analysis of statistical data. There are several agencies functioning in the area of governance of the Ministry.</p> <p>The aim of the <i>Health Board</i> is to implement the national health policy, it supervises the provision of health services, performs the recognition of</p>

	<p>professional qualifications and registration of professionals, performs registration and supervision of the activity licenses of health-service providers, etc. The Board was created in 2010 by merging three existing agencies. The <i>State Agency of Medicines</i> focuses on guaranteeing the quality and safety of the medicinal products, raising the public knowledge about medicines and guaranteeing the rights of persons participating in clinical research of medical products. The <i>Estonian Health Insurance Fund</i> is a public law institution that manages the health insurance and covers the costs of health services according to the contracts made with health-services providers. The <i>National Institute of Health Development</i> is a research and development agency that is responsible for health promotion and the collection, analysis and access to information about the health of Estonia's population. The health-care providers mostly function in the form of private legal persons, owned by the state, local government and by the private sector. As a whole, the functioning of the health-care system is mostly based on regulation and contracts. The dominating coordination mechanism in the field of health is market-based coordination.</p>
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<p>2. COORDINATION PRACTICE: Contracting with pre-hospital emergency medical-service providers in Estonia</p>	
<p>2.1. Substance</p>	
<p>Country</p>	<p>Estonia</p>
<p>Area</p>	<p>Health</p>
<p>Main characteristics of the practice</p>	<p>The practice concerns the application of a market-type coordination mechanism. In 2001, a reform of pre-hospital emergency medical service (EMS) was undertaken in Estonia – the aim was to change the ambiguous, under-regulated and poorly administered EMS system into a semi-market system where all service providers would be subjected to competitive selection and legally enforceable contracts. It was hoped that by introducing market competition and contracting mechanisms, the EMS provision could be made more efficient and effective. It was an attempt to foster vertical coordination in a policy field that had thus far developed with minimum government intervention. However, in 2007, after six years of the experiment, the government abolished the competitive contracting system on the grounds of its unsuitability for the country's delivery mechanism. The introduction of purely market-based coordination had failed.</p> <p>The failure to implement the planned changes in reorganising the vertical coordination was to a great extent influenced by how the horizontal coordination was evolving. The process engaged different stakeholders,</p>

	<p>most important of which were the Ministry of Social Affairs, the Health Care Board, the Union of Estonian Emergency Medicine representing service providers and private companies seeking access to EMS. Emergency medical care was defined in the 2001 Estonian Health Services Organization Act §16 as “out-patient health services for the initial diagnosis and treatment of life-threatening diseases, injuries and intoxication and, if necessary, for the transportation of the person requiring care to a hospital”.</p>
<p>Background and initiation of the practice</p>	<p>In 1990s, the complicated endeavours of introducing public health insurance and establishing the profession and system of family doctors in the primary care put emergency care and the pre-hospital emergency medical services (EMS) into an obscure position for years. Nevertheless, it was agreed at the beginning of the 1990s that EMS was part of the health system. Such an intricate position between the internal security and health, as well as between the primary and secondary care has characterised the position of EMS and its development also in the later years.</p> <p>The introduction of the contracting regime in EMS in 2001 was part of a larger reform of health-services organisation in Estonia. It was initiated with the adoption of the Health Services Organization Act in May 2001. The aim of the Act was to establish a new general legislative framework for the provision of health services with providing detailed regulations on the different branches of the health-care system – primary, secondary and emergency care.</p> <p>Prior to the regulatory change introduced in 2001, the EMS provision was under-regulated, lacking clear legal and administrative mechanisms and administered on an ad-hoc basis. The 1994 Health Organization Act contained only one sentence on emergency care stating that it was financed from the state budget. There were no provisions in the law on the responsibility for organising the emergency medical service. The county governors, without any guiding framework for conducting the procedures, were responsible for contracting with EMS providers, while the Ministry of Social Affairs made decisions on the resource allocation. In most of the contracts, the terms and conditions of service delivery were vaguely specified, and in some cases the service was delivered without any written agreement. The location and make-up of the emergency crews was not based on any systematic analysis, but on the legacy of the previous years. During this period, EMS was financed from different central government sources, but as the allocations fell short in covering all costs, the owners of the EMS providers voluntarily covered part of the costs.</p> <p>The general idea of the change was to finish the creation of fully functional health care (semi-)markets in Estonia where the (semi-)privatised, previously governmental EMS organisations competed with private providers for government-awarded contracts. This marketisation was introduced with the aim to increase the efficiency and effectiveness of EMS</p>

	and other health-care services by introducing market-type incentives.
Time frame	<p>The experiment of competitive contracting for the pre-hospital EMS lasted for six years – from 2001 to 2007. In practice, the open competitive tendering regime never was fully implemented and was replaced with negotiated contracting in 2007.</p> <p>A detailed time frame was the following:</p> <ul style="list-style-type: none"> - On 9 May 2001 Riigikogu adopted the new Health Services Organization Act. - On 7 March 2003 the Minister of Social Affairs approved the order for selecting the providers of EMS through competitive bidding. - On 18 March 2003 the competitive bidding was announced by the Health Care Board with a deadline for submitting the declarations of interest by 14 April and making the final bids by 23 May. - On 22 April 2003 the bidding committee decided to prolong the deadline for making the bids by 1 October 2003. - On 8 September 2003 the competitive bidding was prolonged again without providing a specific new date. - On 1 June 2004 the bidding committee decided to recall the competitive bidding process. - On 2 May 2006 the amendment bill of the Health Services Organization Act was initiated in Riigikogu, which, among other things, altered the existing system for contracting EMS so that the requirement for public bidding would apply only in exceptional circumstances, for example when the existing division of service areas was changed. The amendment bill was adopted in November 2006 and came into force on 1 January 2007. - In practice, no competitive EMS biddings were carried out as of 2012.
2.2. Structure and actors	
Basic features	<p>EMS is a public service that is provided to persons in need of instant medical aid on the whole territory of Estonia regardless of them being covered by health insurance or citizenship. The coordination practice initiated was intended to change the way the state was organising the service.</p> <p>The initial policy change was motivated and influenced by the overall marketisation logic applied to the rest of the Estonian health-care sector at the beginning of the 2000s. However, the introduction of the contracting regime in EMS was not based on any systematic analysis taking into account EMS and its market specificities. Neither was it a rational attempt at performance management. It was mostly about stakeholder influence on</p>

	<p>the policy-making process. The most influential stakeholders affecting the policy process were at the same time subjects of the policy itself – the providers (i.e. the Union of Estonian Medical Emergency). The government lacked a clear vision of EMS strategy and proper delivery mechanisms.</p>
<p>Main tools</p>	<p>In 1999 a strategic development plan for EMS was developed and adopted for the first time since the regained independence. The development plan provided the first guidelines for EMS provision, emphasising the need to establish proper regulation and clear responsibilities for the government as financier-evaluator and for providers as contract-based EMS delivery units. The plan did not include any indications on specific delivery mechanisms to be applied, although a potential emergence of private monopoly was seen as a serious threat to the system.</p> <p>In 2001, as a result of the new Act and other documents regulating the health-care provision, the Estonian state forced the existing EMS providers, alongside the other medical-services providers, to be transformed into private law bodies. It was never a classic privatisation process of selling government assets to the private sector, but government and municipal agencies retained full ownership rights of the transformed agencies.</p> <p>The organisations that were, or wanted to become, EMS providers had to apply for operational license and to prove their ability to cope with the input requirements set by the government. As a result of the licensing, which was carried out in 2001 under the new regulation, all the previous providers and one new provider got accredited. The new provider entering the market was, both in 2001 and 2012, the only EMS provider in Estonia which was 100% based on private capital and was not controlled by municipal or state authorities. The license gave the providers the opportunity to deliver the service until the state-wide bidding process was to be initiated.</p> <p>After recalling the competitive bidding in 2004 the government decided to prolong the existing contracts without a competitive tendering process for up to five years. During the negotiations, the Health Care Board acted as the contracting agency, while the local government officials or executive personnel of the EMS organisations represented the providers. The negotiations only covered a limited range of topics, mainly concerning the kind of service that the provider was able to deliver for the pre-established budget allocated by the Parliament. Although the legal documents provided the Health Care Board with an opportunity to design output-based contracts, the contracts employed were strictly input-based, and resource allocation was dependent on the cost model authorised by the Ministry of Social Affairs.</p>

Main actors	<p>There were four different groups of stakeholders involved in the Estonian EMS policy process:</p> <ul style="list-style-type: none"> - Political elite favouring a market-based health-care sector – since EMS formed just a fraction of the overall health-care budget and there were other, more extensive topics on the table (like the hospital and the primary-care reform), it was not the main priority of the political elite. - The executive branch responsible for EMS policy formulation and implementation (Ministry of Social Affairs and Health Care Board) – the executive institutions did not have a clear policy vision on EMS, either, and their approach was mostly reactive by trying to cope with reality on an ad-hoc basis. Furthermore, the Health Care Board lacked proper administrative capacity. - The providers – the Union of Estonian Emergency Medicine (UEEM) representing the providers was the main pressure group influencing the development and adoption of the policy. There were altogether 45 EMS providers in 1999. Their form of ownership varied from government agencies to not-for-profit organisations. In 2004, there were 26 EMS providers with 90 ambulances in Estonia. UEEM put more emphasis on stable financing and the need for government-controlled providers. They saw EMS as an inherently governmental function with high public interest (e.g. in case of disasters) that should aim at responsiveness rather than market-based incentives. - Private providers – the private providers valued the competitive approach which would open up more possibilities for them. But as there was just one serious private provider entering the market, their voice remained weak.
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2.3. Impacts and effects

	<p>The attempt to coordinate the provision of EMS through competitive bidding failed. Although the law still foresees a possibility to arrange open bidding for EMS in a few restricted occasions, no tenders have been undertaken as of 2012. As a result, the purely market-type coordination system was replaced with a mixed system having characteristics from market, hierarchy as well as network types of coordination mechanisms.</p> <p>The main reasons for the failure of applying the market-type mechanism can be summarised as follows. First of all, the government did not have an internal capacity for administering the contracts, and the policy that binds the goals, means and ends of EMS was not in place. The executive had not performed necessary analyses in order to decide on the logistics of the EMS crews in light of the changes in the hospital network as well as social and economic conditions in general. It did not actually know how many and what kind of crews were needed and in which locations. Furthermore,</p>
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although the financing of EMS had been cost-based, the bidding committee did not have an overview of how the money had actually been used and what was the real structure of the costs. Altogether, the government had set no criteria to assess the tenders. As there was a new private provider participating in the bidding that had entered the EMS market already in the capital Tallinn and wanted to provide the service also in other regions in Estonia, it appeared to be an especially big problem. The committee had to deal with real competition between the existing public-sector providers and a new private-sector provider.

Secondly, the competitive tendering was initiated without the Health Care Board knowing the size of the EMS budget. As the state budget had not been passed yet in the Parliament, there was no certainty with regard to the EMS budget, either. Furthermore, in spite of the existence of the cost model, the deficit in the EMS budget exceeded 20% in 2003 according to the Health Care Board. The owners of the EMS providers (local governments as well as state- and local-government-owned hospitals), for instance, donated EEK 1 million in 2004 to their EMS providers. The officials admitted that the competitive bidding had to be cancelled because of a lack of resources – as a result of the competition the government would have encountered a dilemma of either cutting the number of financed ambulances or lowering quality standards. Thus, the market-price mechanisms were never enabled to become fully functional.

In addition, it was claimed by the critics that “the government was afraid of the tendering going to the wrong direction” (Ilisson 2004). They argued that the government did not want the independent private provider to enter the market and there were at least three reasons for that. The first was the fear that in order to enter the market, the possible private providers make abnormally low bids and, once they get to be in a stronger position, they demand a higher price. The second reason was the fact that the government had not set criteria that would allow it to favour some providers over others, and that the legislators had already fixed the resources for allocation in advance. Finally, an additional argument was found in internal security and the need to assure the constant availability of EMS service, which was more difficult when relying on contractual relationships with private providers.

By 2007, strong elements of hierarchy- and network-type mechanisms had been inserted in to the EMS system. The providers were financed based on a government-imposed cost model, and the EMS providers did not have managerial autonomy in terms of resource allocation. However, the EMS providers still played a crucial role in the policy-making and, thus, were able to negotiate on the general principles with regard to the essence of the cost-model as well as overall quality standards. There were no output or outcome-based administrative and incentive mechanisms introduced in the contracting system.

2.4. Lessons learned and policy recommendations

The experience with the introduction of the market-type coordination mechanism into Estonian EMS delivery leads to several lessons.

- The selection and introduction of a coordination mechanism may have nothing to do with perceived problems in public-service delivery if strong path dependencies are present (existing decentralised EMS system in Estonia and general health-care-reform principles).
- Marketisation as a coordination strategy can lead to problems (e.g. loss of control over policy-making, costs and coordination), which can be reinforced by the presence of strong external stakeholders with diverging or conflicting values. In the end, the changes in service-delivery mechanisms mainly echoed the values supported by the UEEM. It was in the interest of UEEM to avoid competitive contracting arrangements because this threatened the positions and values they held.
- The problems stemming from different and conflicting values were amplified by the weak capacity of the government in preparing the competitive regime and administering contracts. The contract administrator and review body, the Health Care Board, was understaffed. The basic idea of marketisation assumes the presence of a strong contracting agency (“smart buyer”) which has the basic knowledge, tools and understanding about the service, market and logic of contracting-out, but which was not the case here.
- Creating effective (i.e. competitive) service markets is usually one of the main problems in social-service-contracting and even more in the context of transition societies. But even if this problem can be overcome, other crucial elements of market-type coordination mechanisms have to be fulfilled (i.e. linking performance and price). In Estonia, the number of potential service providers was sufficient; however, this was not sufficient in order to make the market-type coordination mechanism work.
- The evolution of a coordination mechanism can highly depend on the stakeholders’ motivation. EMS continued to be delivered in spite of constant under-financing due to a number of reasons – public authorities maintained a controlling position in almost all provider organisations; they were willing to cover some costs, and big providers and subunits of hospitals existed which were interested in using their EMS units to get patients into their hospitals. In a way, the system was cost-efficient for the government since external resources were used. However, at the same time there was no information available for the government on the kind of service the providers delivered for the

	<p>allocated money.</p> <ul style="list-style-type: none"> - Reactions to the problems stemming from marketisation did not lead to a radical change in the applied coordination instrument in the Estonian EMS, but to the emergence of a mixed system. This was reflected by using network-type instruments in designing policy, setting quality indicators and negotiating over the cost model, market-type instruments in contracting (via selection rather than competition) with private providers, and hierarchy-type instruments in imposing a unified cost-model by the government over the providers.
<p>2.5. Further information</p>	
<p>Data and references</p>	<p>The data and information used in the study were drawn from a number of legislative and administrative documents, including both external and internal auditing reports and state budgets. Twenty-four (24) EMS contracts were reviewed. Semi-structured interviews were conducted with public officials and representatives of contractors.</p> <p>Ilisson, A. 2004. Kiirabikonkurss jäi tulemuseta (EMS Tender Ended with No Result). Available at http://epl.ee/artikkel/264603.</p> <p>Jesse, M., J. Habicht, A. Aaviksoo, A. Koppel, A. Irs and S. Thomson. 2004. <i>Health Care Systems in Transition: Estonia</i>. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.</p> <p>Jesse, M. 2008. "Governance of the Health System, Health Insurance Fund and Hospitals in Estonia: Opportunities to Improve Performance." <i>Health Financing Policy Paper 2008/4</i>. Copenhagen: World Health Organization.</p> <p>Lember, M. 2002. "A Policy of Introducing a New Contract and Funding System of General Practice in Estonia." <i>International Journal of Health Planning and Management</i> 17, 41-53.</p> <p>Lember, V. 2008. "New Public Management, Contracting and Emergency Medical Service in Estonia." Paper presented at the European Consortium of Political Research Joint Sessions, 11-16 April, Rennes, France.</p> <p>Lember, V. 2006. "On Importance of Ex Ante Analysis in Implementing Contracting Out: Lessons from the Estonian Emergency Medical Service." In K. Staranova, W. Dunn and S. Pushkarev. <i>Implementation: The Missing Link in Public Administration</i>. Bratislava: NISPACee, 111-124.</p> <p>OECD. 2011. <i>Estonia: Towards a Single Government Approach. Assessment and Recommendations</i>. Paris: OECD.</p> <p>Sarapuu, K. 2012. "Estonia." In K. Verhoest, S. van Thiel, G. Bouckaert and P. Laegreid (eds). <i>Government Agencies: Practices and Lessons from 30 Countries</i>. Basingstoke: Palgrave Macmillan Ltd, 277-287.</p>

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