New Public Management Reforms, Contracting-out and Emergency Medical Service in Estonia

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Introduction

The delivery of social and welfare services through the use of contracting out and other New Public Management (NPM) tools has received much attention from academics in both developed and transition countries. Initial theoretical approaches regard contracting out as a panacea for government problems (see e.g. Boyne, 1998); but these have been challenged by emergent approaches that treat contracting out as another tool among other alternatives including hierarchy (Lane, 2000; Sclar, 2000; Salamon, 2002; Van Slyke, 2003; Brown et al., 2006). It has been pointed out that the success of using contracting out tool depends on the interplay of different variables such as the nature of the service (e.g. Lane, 2000), the internal capacity of governmental agencies responsible for contracting (e.g. Kettl, 1993; Brown and Potoski, 2003); the legal and institutional environment influencing the actors (e.g. Moe, 1992; Brown et al, 2006); the level of competitiveness present on service markets (e.g. Hart et al, 1997; Lane, 2000) and the values promoted by the stakeholders involved (e.g. Hood, 1997; Brown et al., 2006). Thus far, most of the attention has been given to evaluating the level of success or failure of various contracting out initiatives and the role of these variables to the outcome. But studies on how these variables affect the actual development and decision-making of contracting out in different contexts remain largely unexplored.

The purpose of this paper is to fill these important research gaps by assessing the applicability of current contracting out theories in the context of welfare service contracting. The paper takes the case of the emergency medical service (EMS) in Estonia, giving an in-depth analysis of the situation by taking into account the specific context of a country.
The Estonian EMS serves a unique case for at least two reasons. First, EMS is a public service in which governments around the world have introduced varying delivery mechanisms ranging from direct government provision to privatized systems (see, e.g. Poole). This suggests that the application of contracting out into EMS is context specific. Second, Estonia has undergone rapid change in the past two decades, from a communist country to a modern EU member state. This allows for an analysis of contracting regimes in different contexts. Since the restoration of Estonia’s independence in 1991, EMS has been delivered through different contracting arrangements. In 2001, EMS reform went through the phase that aimed to change the ambiguous, under-regulated and poorly administered EMS system into a semi-market system where all service providers had to be subjected to competitive selection and legally enforceable contracts. In the best tradition of the NPM paradigm it was hoped that by introducing market competition and contracting mechanisms, the EMS provision can be made more efficient and effective. In 2007, the government abolished the competitive contracting system on the grounds of its unsuitability for the country’s delivery mechanism.

In order to fulfill the purpose of the study, the paper starts with an examination of the applicability of established theories on contracting out in the context of a transition country as manifested in the case of Estonia’s EMS. The data and information used in the study are 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.

The empirical analysis of the study is twofold. First, it assesses the decision of the Estonian government to abolish the competitive contracting regime in EMS delivery. Was the government’s decision based on poor outcomes of the service, lack of proper preconditions, or some other reasons? Here a hypothesis has been formed: that the way the EMS delivery system was developed ignored the inherent logic of contracting out and therefore the decision to abolish the competitive delivery system was justified. Second, it examines the factors that resulted in the shift from the initial reform strategy by juxtaposing the factors recognized from established theory with the variables it excludes. Here a hypothesis has been formed: that the particular contracting out reform initiative failed because of factors and variables not explained by, or indicated in, current theories.
1 Contracting out public services and New Public Management

Under financial pressure in the last three decades, welfare states have ventured into contracting out in order to maintain, or even increase, the standard of their functions and services. Governments have started to look for an answer to the question that Ronald H. Coase posed in 1937: What is more preferable between horizontal or vertical integration in executing state functions? The emergence of contracting out of public services is often associated with the introduction of the concept of New Public Management (NPM), which has its theoretical roots in public choice theory, transaction cost theory and principal-agent theory – all of which are founded on principles of contestability, user choice, transparency and incentive structures (see Hood, 1991). Broadly speaking, NPM is based on an expectation that if public sector acted more like the private sector, the delivery of public services would be more efficient, with higher quality and more responsive to the public needs (Savas, 1987; Osborne and Gaebeler, 1992).

Contracting out has been seen as one of the main tools in achieving the goals of the NPM. In addition, it is believed that contracting for services and market testing are the best ways to learn the actual price of public services. Following the main ideas of the public choice school, proponents of contracting claim that because of information asymmetry (i.e., when politicians do not have enough information to control bureaucrats), traditional (Weberian) public organizations are inefficient (Lane, 2000). Since human behavior is primarily motivated by selfishness, there is a need for competitive pressures to redirect it towards public interests and hence competitive mechanisms and privatization must be applied to reform the supply of public goods (Boyne, 1998). Numerous authors have already provided explanations of the internal logic of, as well as prescriptions of specific techniques in, contracting out (see, e.g., Donahue, 1989; Wisniewski, 1992; Shleifer, 1998; Boyne, 1998; Domberger, 1998; Behn and Kant, 1999).

The emergence of contracting out seems to be a consequence of dissatisfaction with overall performance of public sector. Although contracting and contracts are not absolutely new in public sector management, it was in the 1970s and 1980s when public sector contracting started to gain growing importance (Boston, 2000). During the same period, specifically in the late 1980s, a process of transformation started in Central and Eastern Europe (CEE). Due to the fact that macro-economic reforms in the region were strongly promoted under the auspices
of international donors like the IMF and the World Bank, organizations which promote the application of NPM principles, the countries in CEE were also compelled to introduce market type administrative instruments whenever possible. Eager to “return to the western world” (Lauristin and Vihalemm, 1997), Estonia and other CEE countries became “good” students of neo-liberal reforms and the idea of introducing NPM to governance did not meet strong political opposition. Estonia’s health care sector, where NPM ideas were initially implemented, is currently administered as a semi-market with service providers competing for contracts allocated by the government. Hence, the application of NPM reforms in CEE has not only resulted from the dissatisfaction with the public sector, but also from the way the transformation process was influenced.

2 Contracting out and the post-NPM era

The implementation of public service contracting as well as other NPM tools has not proven to be clear-cut success stories, neither for established western welfare states nor for developing and transforming states. After many years of experiments, European and other governments (e.g., New Zealand) have moved on from straightforward execution of NPM-based reforms to combining the central role and activities of government with selective application of NPM tools. Thus, at this time, one can talk more of a post-NPM era, or in case of some countries, a Neo-Weberian State (Pollit and Bouckaert, 2004). The post-NPM era does not take marketization as one of the primary goals of government reform policies, but as just an option to be used under specific circumstances.

It has been observed in a number of studies that the transitional context of a society makes it even more problematic to successfully contract out public services because of weak civil service and ineffective markets (Brown, 2001; Keefer, 1999; Nemec, 2001; Nemec et al 2005; Lember, 2004). Interestingly, these reasons are similar to the problems inherent in old democracies. NPM was originally based on the idea of market competition being the main incentive mechanism which should determine the opportunistic behavior of external service providers and lead to more effective and efficient service delivery. However, most public services lack competition, and serious principal-agent and transaction costs problems arise as a result of contracting out of public services (Kettl, 1993; Lane, 2000; Sclar, 2000; Van Slyke, 2003). Governments often lack the ability to act as “smart buyers” (Kettl, 1993); and due to scarcity of resources they are reluctant to invest in building up internal management
capacities. Critics argue that contrary to expectations, competition-based public service contracting has produced severe problems because of specification and output measurability problems and the incomplete nature of contracts (Lane, 2000; Hart et al., 1997). Services of technical nature, which are easy to measure and evaluate, are claimed to be more suitable for contracting out than so-called “soft services” (Lane, 2000). In this context, social services stand out as an example in which competition is lacking and the task of gathering information about providers’ behavior and service outcome is most complicated (Johnston & Romzek, 1999; Van Slyke, 2003).

Therefore, in the post-NPM era, contracting out is perceived more as a context specific activity – that is to say, public services must be contracted out only if certain preconditions are in place. Here a distinction can be made between values, institutions and market-related conditions (Brown et al. 2006) and political, legal, administrative and economic limits (Hirch, 1995; Boston, 2000; Lember, 2004). The main characteristics determining the applicability of contracting out as an alternative service delivery tool are summarized in Table 1.

Some studies have suggested that in particular circumstances contracting out may be a more effective tool than in-house provision even without competitive incentives. Shleifer (1998), for instance, has pointed out that private ownership per se can be more effective in the area of service innovation. And, as explained by Brown et al. (2006, p. 325): “If the goals are innovation and efficiency, then contracting with a private vendor may be more desirable, because private employees operate with higher-powered, compensation-based, and profit oriented incentives.”

Similarly, if the conditions necessary for competitive process cannot be met, relational contracting has been suggested as an alternative. Relational contracting should be preferred when there is a history of cooperation between partners or when there is uncertainty and resource scarcity (Dehoog, 1990; DeHoog and Salamon, 2002). The other advantages of relational contracting stem from lower transaction costs, greater flexibility in reacting to changing circumstances and better use of professional expertise (ibid.). In the case of relational contracting, the purpose of both parties is to develop a stable partnership that is not based on competition but on inter-organizational trust (Sclar, 2000). The goal is to avoid agency problems, which arise “when two parties have divergent interests or objectives and the agent has an informational advantage over the principal” (Ferris and Graddy, 1998, p. 227).
### Table 1. Factors determining the applicability of contracting out as an alternative service delivery tool

<table>
<thead>
<tr>
<th>Factors</th>
<th>Variables</th>
<th>Examples</th>
</tr>
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<tbody>
<tr>
<td>Political limits/values</td>
<td>Values held by institutions and stakeholders involved in particular contracting out process</td>
<td>Efficiency, effectiveness, responsibility, equity of treatment, empowerment, consumerism, hidden (amoral) goals</td>
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<td></td>
<td>Services that are inherently governmental in nature and/or with high public interest</td>
<td>Services, including use of coercion</td>
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<td>Institutional settings</td>
<td>Public law</td>
<td>Established legal environment</td>
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<td></td>
<td>Administrative/organizational arrangements</td>
<td>Management capacity (skills for planning and coordinating service delivery; negotiating with vendors; monitoring task completion and executing incentives; having specific technical skills, such as writing contracts)</td>
</tr>
<tr>
<td>Market effectiveness</td>
<td>Specific nature of services and markets</td>
<td>Access to information</td>
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<td></td>
<td></td>
<td>Level of competitiveness</td>
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<td></td>
<td></td>
<td>Nature of service (measurability)</td>
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<td></td>
<td></td>
<td>Transaction costs</td>
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<td></td>
<td></td>
<td>Uncertainty of future activities</td>
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<td></td>
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<td>Asset specificity (entry and exit costs)</td>
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<td></td>
<td></td>
<td>Opportunistic behavior (moral hazard and adverse selection)</td>
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<td></td>
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<td>Incomplete contracts (non-contractable quality factors)</td>
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</tbody>
</table>

(Source: Based on Hart et al, 1997; Hood, 1997; Lember, 2004; Brown et al. 2006)

### 3 Emergency Medical Service in Estonia: Establishing the Case

Three phases can be identified in the development of the EMS in Estonia: from chaotic era (1991-2001), to competitive tendering regime (2001-2007), and to uncompetitive contracting
The first phase started with the restoration of Estonia’s independence in 1991 and lasted until the government adopted a complete package of new regulations in 2001. This phase can be characterized as a chaotic era in which the system was administered on an ad hoc basis. Prior to the regulatory change introduced in 2001, the EMS provision was under-regulated, lacking clear legal and administrative mechanisms. The county governors, without any guiding framework for conducting the procedures, were made responsible for contracting with EMS providers, while the Ministry of Social Affairs made decisions on resource allocation (State Audit Office, 1999). In most of the contracts, the terms and conditions of service delivery were vaguely specified, and in some cases the service was delivered without a written agreement (Project Lootus, 2000). During this period, the EMS was financed from different central government sources, but as the allocations fell short in covering all costs, the owners voluntarily covered part of the costs (e.g., investments in equipment). For instance, in 1997, the city of Tartu donated EEK 630 000 to the local EMS provider (EPLOnline, 1998).

Table 2. Phases of EMS development in Estonia

<table>
<thead>
<tr>
<th>Phase</th>
<th>Period</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaotic era</td>
<td>1991-2001</td>
<td>Ad-hoc administration; “no policy” policy; no legal framework;</td>
</tr>
<tr>
<td>Competitive tendering</td>
<td>2001-2007</td>
<td>Semi-market approach; competitive tendering; vague policy; lack of resources; government cost model</td>
</tr>
<tr>
<td>Uncompetitive contracting</td>
<td>2007-…</td>
<td>Towards relational contracting (?); government cost model; possible consolidation of providers (?)</td>
</tr>
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</table>

Furthermore, during the first phase of contracting, functions such as policy formulation, monitoring and evaluation were absent and the most important quality standard was the operational license that EMS providers had to obtain. There was also no permanent staff
employed to review the contracts. As a non-permanent councilor of EMS to the Ministry of Social Affairs observed: “The government has laid aside administrative functions of EMS by letting the work to be done by volunteers and the Union of Estonian Emergency Medicine.” (EPLOnline, 1997).

The second phase started in 1999 when for the first time a strategic development plan for the EMS was developed and adopted. The development plan provided the first guidelines for EMS provision, emphasizing on 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 to the creation of private monopoly was seen as a serious threat to the system.

During the second phase, the Health Care Board recruited two officials to overview the whole process. The Union of Estonian Emergency Medicine was the main pressure group influencing the development and adoption of the policy. The reform, which materialized through the adoption of a new legal framework, aimed to change the state-run, ambiguous, under-regulated and poorly administered EMS system into a semi-market system in which all service providers are to be competitively selected and act under legally enforceable contracts.

In 2001, as a result of the new act and other documents regulating the health care provision, the Estonian state forced the EMS providers alongside with the other medical services providers to be privatized. It was never a classic privatization process of the sale of government assets to private sector, but government agencies were transformed into government-owned private legal bodies. Therefore, this may be referred to as a putative privatization rather than classical privatization.

The idea of the change was to finish the creation of fully functional health care markets where the privatized, previously governmental organizations competed with private providers for government-awarded contracts.\(^1\) This marketization was introduced with the aim to increase

\(^1\) All other health care providers contracting for public resources, except EMS providers, compete for the contracts awarded by an autonomous public law body, the Estonian Health Insurance Fund.
efficiency and effectiveness of the EMS and other health care services by building up a system based on market-type incentive mechanisms (Jesse et al., 2004).

The organizations that were, or wanted to become, EMS providers had to apply for operational license where they had 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 and still is the only EMS provider in Estonia which is 100% based on private capital and is 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, which was supposed to be on 2003 but was postponed several times. In 2004, the bidding process was declared a failure. The officials admitted that the competitive bidding had to be cancelled because of lack of resources – as a result of the competition, the government would encounter a dilemma either to cut the number of financed ambulances or to lower quality standards (Ilisson, 2004). At the same time, in reaction to the abolition of competition, one of the participants accused the government of being “hypocritical” by stating that: “The government was afraid of the tendering going to the wrong direction” (ibid.).

Critics claimed that the government did not want the independent private provider to enter the market for at least two reasons. The first was the fear that in order to enter the market, the possible private providers make low bids and, once they get to be in a stronger position, they demand higher price. The other reason was the fact that the government had not set a criteria (price and other measurable outputs) that would allow it to favor some providers over others, and that the legislators had already fixed in advance the resources for allocation.

Consequently, the government decided to automatically prolong the existing contracts without new competitive tendering process. During the negotiations, the Health Care Board acted as the contracting agency, while the (local) government officials or executive personnel represented the providers. The negotiations only covered a limited range of topics, mainly concerning the kind of service that the provider is 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 are
strictly input-based and resource allocation is dependent on the cost model authorized by the Ministry. ²

Moreover, during the second phase, government financing was insufficient. The owners of the EMS providers (local and municipal governments as well as state-owned hospitals), for instance, donated EEK 1 million in 2004 for their EMS providers (Ministry of Social Affairs, 2006). In 2003, the Health Care Board noted that the deficit in EMS budget exceeded 20%.

The third phase was marked by the government’s abolition of the competitive principle in selecting EMS providers in 2007. According to the present system, all the previously accredited EMS providers were offered a contract up to five years. This contract will be automatically prolonged unless the provider violates the contract. In 2007, the government developed new requirements for providers. The contracts can be described as standard, detailed, and input-based. Among other things, the new requirement indicates that the providers’ internal accounting principles have to be in accordance with the public sector principles and the government had the right to review all spending, and that the contractor has the obligation to return unspent or misspent funds (i.e., resources not spent on EMS). Financial monitoring is very detailed (split into 77 subcategories); performance monitoring and evaluation principles are related only to input-based aspects (e.g., availability of cars; equipment standards; service and personnel standards); and no output- or outcome-based criteria are introduced. The contractors have to carry out self-evaluation four times a year based on standard forms developed by the government.

As with previous agreements, the cooperation includes the possibility of penalties, although no rewards or other positive incentives are foreseen to be introduced. As of the end of 2007, four officials were recruited to administer the EMS on behalf of the Health Care Board. Financing of EMS has constantly increased because of rapid economic growth and pressure to higher wages. The EMS budget in 2008 comprised 415% of the budget in 1998 and 256% of the budget in 2003.

² In spite of the existence of the cost model, the shortage of the EMS budget in 2005 was around 30%, as estimated by the representative of a contractor.
4 Analysis

In analyzing the Estonian EMS case, one may jump to the conclusion that this is another example of an NPM reform that failed to meet its goals. Indeed, after six years of NPM experiment, the government eventually decided to abandon the idea of competitive tendering. As the Head of the EMS Department under the Board of Health Care stated in 2004: “The competitive tendering has been pointless since its beginning /…/.” (Ilisson, 2004).

However, a more detailed analysis is needed to understand the worthiness of NPM-based ideas in EMS as well as the context of an outcome. Are NPM-based ideas in EMS not worthy of consideration for service delivery? Does a context specific pattern exists which influenced the outcome of the whole process? In other words, what were the factors and variables that led to the government’s decision to abandon the competitive contracting regime? This section offers an analysis of the process following the theoretical framework outlined above by examining these factors and variables – values, market, and institutions.

4.1 Values

In order to analyze the values associated with the contracting out initiative, one must identify the stakeholders involved in the process. There are five different groups of stakeholders involved in the Estonian EMS policy process: [a] political elite favoring market-based health care sector, [b] the executive branch responsible for EMS policy formulation and implementation (Ministry of Social Affairs and Health Care Board), [c] the government-controlled providers (Union of Estonian Emergency Medicine), [d] private providers, and [e] the unions.

At the outset of health care reforms in Estonia, it was hoped that privatization and semi-market approach enhance the quality of medical services and at the same time keep the costs under control. The general political agreement then was that the aims of health care reforms were directed towards the attainment of the traditional NPM-driven goals. The same values were the driving force for EMS reform as well. Nonetheless, the stakeholders in the EMS policy process had different values that often contradicted with the general goals. Since the EMS formed just a fraction of the overall health care budget, it was not the main priority of the political elite.
The executive branch did not have a clear policy vision and most of the time did reactive implementation by trying to cope with reality on an ad hoc basis. This can also be called as a “no policy” policy, which often describes the naïve attitude of Estonia and other transformation countries towards how a neo-liberal country should operate. In 2004, the State Audit Office came to conclusions: that there is still no common understanding regarding the kind of EMS Estonia should concentrate on; that the functions of different parties in first level medical aid are not clearly divided; and that the work of the alarm centers are ineffective (State Audit Office, 2004).

The Union of Estonian Emergency Medicine (UEEM) represents the EMS providers. The UEEM has largely influenced the policy process, whereas the internal capacity of the Ministry of Social Affairs has remained weak (State Audit Office, 1999, 2004). UEEM emphasized more on stable financing and the need for government-controlled providers. They saw the EMS as an inherently governmental function with high public interest (e.g., in case of catastrophes) that should aim at responsiveness rather than market-based incentives.

The private providers, of course, 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.

The unions have become more active during the past decades, but their activities have been directed only towards compensation issues of EMS workers. This has had direct influence on increase of EMS salaries but not directly on delivery mechanisms as such.

Therefore, it should not be a surprise that in the end the changes in service delivery mechanisms echoed mainly the values supported by the UEEM. It is in the interest of UEEM to avoid competitive contracting arrangements because this would threaten the positions and values they hold.

4.2 Market

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. This may especially be the case with EMS because there exist relatively high entrance barriers to the EMS markets in terms of the need for high-skilled workforce and investments.
The situation of the Estonian EMS market cannot be described as „thin“. There were altogether 45 EMS providers in 1999. In 2004, there were 26 EMS providers with 90 ambulances in Estonia and by the end of 2007 the respective figures were 24 and 90. Taking into account the smallness of Estonia (1.4 million inhabitants and 45,226 km$^2$), the number of providers may indicate that there are actually too many small providers on the market—e.g., from the viewpoint of economies of scale. Based on the cost model employed by the Ministry of Social Affairs it can be said that the administrative costs of providers having more than eight brigades are lower compared to providers having less than four brigades. The nature of EMS would have allowed the government to use a variety of techniques to overcome the problems of thin markets and monopolies such as by: encouraging the existing and potential providers to enter the market (read: market creation); splitting service delivery into multiple contracts; allowing public agencies to compete against private providers; and employing joint-contracting in which a portion of the service is retained in-house (Brown et al., 2006).

Short-term contracts and the potential for ex post competition in Estonian EMS are factors that support the probability of a successful marketization. The EMS is a service that has measurable outputs. Apart from measuring response rates, the Estonian government has never specified the expected results to be reached. It has been suggested that EMS performance measurement “should have a rapid response time, relatively low cost per unit of activity, and high productivity.” (Poole, 1995, p. 8). At the same time O’Meara (2005) states that “These could include the easily quantified structural factors such as staff numbers and skill sets, process factors that measure what is done and how, and the crucial outcomes measures related to clinical care, stakeholder satisfaction and financial accountability”.

It is beyond the objectives of this paper to suggest the precise indicators that could be used to evaluate the effectiveness of the EMS in Estonia since there is no common understanding on this issue among EMS researchers (e.g., O’Meara, 2005; MacFarlane and Benn, 2003). However, one may consider using a contracting regime to influence the outcomes of the EMS in Estonia by evaluating outputs against agreed performance indicators. This has not yet happened in Estonia. In spite of the fact that there exists some information about response time, it has never been made a subject in the contracts with the providers—meaning, that the performance measurement as an incentive mechanism does not influence the EMS in Estonia.

The service has been delivered despite of constant under-financing mainly due to a number of
reasons: that public authorities have maintained a controlling position in almost all provider organizations; that they are voluntarily willing to cover some costs; and that there exist big providers and subunits of hospitals which are interested in using their EMS units to get patients into their hospitals. In a way, the system is cost-efficient for the government since external resources are used, but at the same time there is no information available on the kind of service the providers deliver for the allocated money (i.e., the true price of the service remains unclear).

As the competitive market is not seen as appropriate incentive mechanism, what then is the logic of having a contracting regime with 24 service providers without market incentives? As pointed out earlier, the providers have no discretion over the allocation of government funds and that making profits from state funds is not allowed. This means that, for example, if a provider finds ways to cut costs through innovative solutions, the surplus has to be returned to the government. Hence, the providers are not motivated by the government to come up with innovative solutions. Another idea is to build up a relational contracting regime based on trust. Again, if one looks at the way the contracts are written and implemented—that is, providers are left without discretionary powers—it could be observed that this system is closer to traditional bureaucratic control assuming the presence of opportunistically behaving agents than to trust-based cooperation aiming at better quality of service.

4.3 Institutions (the “smart buyer” perspective)

The problems stemming from different and conflicting values were amplified by the weak capacity of the government in administering contracts. The basic idea of marketization assumes the presence of a strong contracting agency which has the basic knowledge, tools and understanding about the logic of contracting out. In this particular case, the government ignored this basic idea. The contract administrator and review body, the Health Care Board, has been understaffed until recent years. The government has regarded the administration of the contracting regime not as an implementation issue but as a legal one. In fact, in response to the observation of the State Audit Office about the weak administrative capacity of the Ministry of Social Affairs in organizing EMS, the Ministry opened a new post for a lawyer (State Audit Office, 2004). The low administrative capacity has brought along several unfavorable consequences.

In the 1990s, the EMS was administered without any rules and a clear system. In 2003, the
competitive tendering was initiated without the Health Care Board knowing the size of the EMS budget. In addition, the government had no criteria (price and other measurable outputs) to assess the tenderers, and the quality standards and logistics plan were not in place (EPL Online, 2003; Pesur, 2003).

By 2007, it has reached a situation where the contracting relationship is run like any other traditional bureaucratic organization emphasising on input control. The providers do not have managerial autonomy in terms of resource allocation. The current contracting relationships are based on detailed legal regulation concerning inputs and without any references on expected results. There are no output or outcome-based administrative and incentive mechanisms introduced in the contracting system and the government does not link service performance with incentive mechanisms. The monitoring and control of EMS providers have been extremely vague until this time (State Audit Office, 2004). For instance, it was only in 2004 that the Ministry of Social Affairs performed an audit of the EMS system. Quality is highly dependent on the medical ethics of the EMS personnel.

In sum, the government has turned the competitive contracting idea upside down. Instead of putting emphasis on achieving optimal outputs with lowest costs by giving private agencies discretionary powers, the current system focuses on detailed input control.

5 Discussion and conclusion

The current study aimed at analyzing the interplay of three main categories of variables – values, markets and institutions – determining the contracting out process. The study stemmed from two research questions. Firstly, how these variables affect the actual development and decision making of contracting out under different contexts. And secondly, to what extent was the decision of the government of Estonia to abolish the competitive contracting regime in organizing the EMS justified? As a result, the case-study analysis in this paper has demonstrated that the existing theory is to a certain extent sufficient for retrospective explanation of contracting out initiatives under different environmental contexts. The

3 The government occasionally orders quality monitoring service from UEEM regarding input quality standards. In 2007, the government audited all the providers in respect to inputs such as personnel issues (resources spent on salaries) and equipment’s accordance with standards.
empirical and theoretical evidence suggest that, in most cases, contracting out fails because of lack of competition. However, this was not the reason for the failure of the Estonian EMS. On the contrary, the government never introduced competition even though the preconditions for it were already present. This is not to say that the role of markets is overestimated; rather this indicates that contracting out may fail even if competition is present.

Underdeveloped institutional environments (mainly, low internal capacity) often cause contracting failure. This thesis is clearly supported in this study, as evidence point clearly to the facts that the government failed to act as “smart buyer” when organizing contracting for EMS.

With regard to the issue of values in the contracting process, the study supports the empirical and theoretical evidence that suggest the importance of values as a determining factor in the whole contracting process. The case study shows that it was never about rational managerial decision-making on whether certain values could be better promoted through contracting or through other means. It was about who has more influence in the policy-making process. A peculiar aspect of the EMS case was that the most influential stakeholders affecting the policy process were at the same time subjects of the policy itself—i.e., the providers. Moreover, the government lacked a clear vision of EMS strategy and proper delivery mechanism. And in the end, the whole policy reflected best the values promoted by the main EMS providers themselves. Based on the current study it may be concluded that the future studies should take into consideration also the stakeholder analysis when assessing the outcome of certain contracting out initiatives. Transitional context only strengthens this claim.

When answering the research question concerning the particular decision of the Estonian government to abolish the EMS competitive tendering regime, one might come up with different explanations. On the one hand, it seems that the decision was justified, as the stakeholders formulating the policy could not agree on the main principles of the EMS delivery system. Unstable environment contracts do poorly compared with hierarchies (Deakin and Walsh, 1996). On the other hand, the decision can be criticized, as the government abolished the competitive regime without trying to implement the system following the inherent logic of contracting.

From a theoretical perspective, taking into account the specific context in Estonia in the 1990s, the most suitable answer seems to be that the competitive contracting approach should
not have been the option for the government in the first place. Although there were enough potential for effective markets, the circumstances were riddled with several shortcomings: there was a constant shortage of resources, the government did not have any internal capacity for administering contracts and the policy that binds the goals, means and ends of the EMS was not in place. These shortcomings were resolved, at least at a minimum level, only in 2007; but the government lacked the will or knowledge to further develop the competitive system. Instead, a delivery system was created that does not fit either in the framework of competitive or relational contracting. Hence, there were more opportunities for successful competition in 2007 than in 1998 or 2003.

There are still many important questions that this study has not addressed and which must therefore be subject to future investigations and further discussions. Firstly, are there any objective reasons that speak in favor of the current system compared to, for instance, the creation of state agencies or fully vertical system? Secondly, what is the impact of policy role models on the decision-making process in contracting out? Considering the fact that the development of the EMS delivery system has been directly influenced by the adverse experience of some Danish and Swedish public agencies, can a country simply take in the EMS and other social policy lessons learned in another country? Addressing these questions adequately would thus require comparative studies of EMS provision from country to country in Europe and elsewhere in order to assess the suitability of different delivery solutions for distinct and specific contexts.

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