Intro

My name is Jonathan Bates. I am a pediatrician and have been the CEO of Arkansas Children's Hospital for the past ten years. Prior to that I worked for ten years in the Southern California market and before that in Boston.

Background about ACH: size, situation within AR market; relation to other children's hospitals

Arkansas Children's Hospital (ACH) has served as the only specialty children's hospital in the state since its founding 90 years ago. It is licensed at 269 beds, admits about 11,000 children a year and provides 250,000 outpatient visits. The medical staff is largely composed of physicians employed by the University in the College of Medicine. ACH is one of the 10 largest children's hospitals in the US, and is not located in one of the 100 largest cities. Our geographic market extends throughout Arkansas and into the adjoining states. The most critically ill are brought to Little Rock by our fleet of ground and helicopter transports.

ACH is an independent 501(c) (3) organization with a self-perpetuating board. Our annual operating budget is $250 million and we employ almost 3000 people. Almost half our beds are intensive care beds and on a typical day we have 200 children hospitalized of which 40 or 1 out of 5 require mechanical ventilation, an extraordinary figure!

There are level III Neonatal Intensive Care Units (NICUs) in other hospitals and some care rendered to less critically ill children and older adolescents, but there is a sort of de facto regionalization for pediatrics in Arkansas.

Cost drivers: Pharmaceuticals, technology, labor costs, regulation

Our costs are not primarily driven by competition or lack of it in Little Rock or even in Arkansas. Instead such forces as the cost of drugs, technology, rising labor costs and regulations have a much stronger impact.

The issue of rising costs for pharmaceuticals is familiar and I only want to illustrate the problem with an example peculiar to pediatrics: nitric oxide. This drug is really a gas composed of two atoms: one nitrogen and one oxygen. That's all. When administered via a breathing tube to certain neonates it is life-saving, safe and avoids a long, costly and complex course of care. You can buy a tank of nitric oxide for non-medical uses for a few hundred dollars, a tank that could treat literally thousands of newborns. But because of various patent and licensure circumstances, it costs the hospital more than $5,000 for the first day of administration and $2500 each day thereafter.

There are any number of examples concerning technology, PET scanners, gamma knives, robotic surgical devices, CT scanners in operating rooms, non-invasive treatments. Virtually all of these technologies provide some tangible improvement in the outcomes and care for patients, yet each adds to the costs of the hospital and in turn to the charge structure. If our physicians determine that the standard of care around the country involves the use of one of these costly technologies (and if we agree on review of the data), it is very likely that technology will be purchased and put to use.

Hospital budgets mainly consist of salaries: nurses, technicians, pharmacists, as well as secretaries and housekeepers. The recent scarcity of licensed personnel has resulted in a bidding race around salaries and other compensation as each hospital tries to get and keep a skilled staff. Until these jobs become sufficiently attractive and enough people enter those professions, we will see continued pressure on costs for labor. As an example, our hospital employs two nuclear medicine technicians who handle the radiology studies involving radioactive materials and we were paying them about

$60,000 annually. Two years ago, another hospital in Arkansas decided they needed such skills on their payroll rather than renting that service from an agency. They approached our two people and offered them a 50% increase in salary to $90,000 annually. Although we scrambled to increase wages in a counter bid, we did lose one tech to the other hospital. Examples in nursing are even more dramatic with hospitals in other states advertising in Arkansas for nurses and offering a host of incentives such as sign-on bonuses, retention bonuses, and at times even automobiles.

The fourth driver on cost is regulation. We experience what seems like an unending stream of regulation from Congress, Agencies and certification bodies which restrict our flexibility. The good intentions of most of these regulations is clear, but the havoc they wreak in daily practice is not so apparent. The Emergency Medical Treatment and Active Labor Act (EMTALA) came about in an effort to avoid hospitals turning their backs on needy patients. But what it also includes are provisions that allow any hospital in America to transfer a patient who needs one of our special services to our hospital if our capacity to render that service is intact. We provide a heart-lung support program for children awaiting heart transplant. If we have an open machine and staff, then any hospital in America can force us to accept a transfer of such a patient, even if there are closer hospitals. The costs for such patients can run well over $100,000 and we have no option to avoid those costs and many of the patients transferred to us under EMTALA are unable to pay and have no insurance or Medicaid.

Another example comes via the Health Insurance Portability and Affordability Act (HIPAA) which calls for more stringent practices regarding patient information and confidentiality (among a host of other issues). We understand that law to mean that each time the hospital renders a service (such as handling the refilling of a prescription over the phone), we are obliged to a) send a written statement of the hospital's policies regarding confidentiality b) attempt to get the patient (or parent in our situation) to sign that he or she has received the notice and return it to the hospital and c) track the returns and have the results available for federal review. Obviously this will drive up our costs, and confuse our patients.

More common sense flexibility in these matters could help a lot in avoiding this ill-considered costs.

Quality Drivers: Individual pride, demands of patients

With respect to quality, my sense is that the whole industry is moving from informal or anecdotal quality to an approach that is systematic and more rigorous. In more and more areas, we have reliable comparative information about outcomes and quality of care. In those areas that are strong, we try and maintain that quality. In areas that are not, we address them by determining what the problem may be and attack that. Many physicians are still uneasy about such work and often challenge the basis for the comparisons ("Your numbers are wrong"). We still lag well behind our colleagues in other industries who achieve six sigma and better routinely.

We see high quality and the ability to create high quality as essential to our hospital. The families seek it out, we compete with other children's hospitals around the country on that basis, and employers are interested in that quality as part of their health plans for themselves and their employees.

The pressures and encouragement from the Institute of Medicine and Leapfrog help with keeping this agenda active, but there is a danger of oversimplification and over-regulation. Most of the hospitals I know believe that forcing physician computer order

entry will be difficult, costly and counterproductive in the short run. Several very visible reversals by well-known hospitals recently highlight this problem.

And the question of the relationship of cost and quality is still challenging. We are told that real quality doesn't cost any more than poor quality. Sometimes that is true. But sometimes high quality is more costly. We are told that surgeons and hospitals that do more cases have higher quality. But if volume leads to quality, wouldn't that mean that so-called Medicaid mills would have the highest quality? In some instances we think that higher quality leads to more volume as patients seek out the best places for care.

Let's agree that quality is central, that it should be rigorous, that it should be public and that we still have a lot to learn about how to manage it.

Now, I'd like to talk briefly about competition. The inherent cost structures for a hospital such as ACH with very dependent patients, high levels of technology, high levels of acuity mean that ACH looks very high cost to the payers in our community, especially in comparison with other hospitals not specializing in pediatrics. We struggle with the tension of ACH not having a competitor and commanding higher reimbursement.

We consider our competition in two ways. First for routine care we price as competitively as possible to the local market for such things as simple appendectomy or broken leg. But for complex work such as neonatal intensive care or the heart-lung support I described earlier, we consider our competition to be other pediatric center in the south-central US (Memphis, Dallas, Houston, Kansas City, etc) and do our best to be competitive with them in terms of service, quality, and price. We know from examining the medicare cost reports filed by such hospitals that our costs are more tightly managed.

We need to have a substantial volume of patients, a critical mass, to be efficient and to render high quality. So our strategy is to contract with every possible plan in the state to make it possible for any child who needs our services to come to us. We strive to negotiate rates with each payer that will keep us afloat and not align more closely with one payer than another. We call it the Switzerland strategy. Perhaps you will get another perspective on this point from others later this afternoon.

In summary, ACH experiences competition beyond the city boundaries for staff, and for contracts and for patients. Probably adding a pediatric competitor to Arkansas would just split what is now a critical mass into two subcritical masses resulting in a diminution of services. We see the key drivers of cost being such factors as pharmaceutical costs, technology, labor costs and regulation costs.

Thank you.