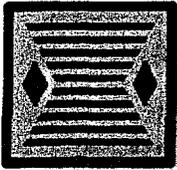


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**REVIEW OF THE PRIVATE PATIENT FACILITY
AT ST. ANNES BAY HOSPITAL
OCHO RIOS, JAMAICA**

DRAFT

Ray Quinn
Nick Weston

October 1993

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DRAFT FOR DISCUSSION

Review of the Private Patient Facility at St Annes Bay Hospital

Ocho Rios, Jamaica

This review was commissioned by the Health Sector Initiatives Project of the Jamaican Ministry of Health, under the sponsorship of the USAID programme and is based on a site visit undertaken in September 1993.

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October 1993

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Introduction

Stanmore Consulting Services (SCS), the health-care management consultancy arm of the Royal National Orthopaedic Hospital Trust (RNOHT), were engaged by the Jamaican Ministry of Health, Health Sector Initiatives Project (HSIP) to undertake a review of the private patient unit at the St. Annes Bay Hospital.

The purpose of this review was to assess the operation and performance of this service and offer recommendations which may improve the service to patients and in addition to identify good practices which may be used in the development of private facilities in other public hospitals in Jamaica. An example of a further development is to be found at the Bustamante Hospital for Children, Kingston, where a feasibility study is being completed which investigates the potential for a private paediatric facility within the grounds of the hospital.

Terms of Reference

To review the operation and performance of the private patient unit (PPU) at St Annes Bay Hospital. The review is to include an analysis of the following specific areas

- organisation
- management
- staffing
- operation
- financial performance

of the unit, with a view to identifying good practices which can be replicated elsewhere in the Health Service. In particular to identify the basis of the PPU's cost structure and pricing policy in order to obtain a better understanding of the actual rate of return which the facility makes on assets employed.

Based upon the findings of the review and their experience of the operation of private patient facilities, the management consultants will prepare a report which critically appraises the current organisation and operation of the facility and identify any weaknesses within the current system. The report will also make recommendations as to how improvements could be made as well as identifying good practices within the unit which could be used as a model for further similar developments elsewhere within the Health Service.

Consultancy Approach

The review took place week commencing Monday 27th September 1993. Initial information (eg number of beds, hospital location) had previously been obtained from the Health Services Initiatives Project (HSIP) section of the Ministry of Health. HSIP had (under the guidance of SCS) pre arranged a series of interviews with key personnel at the hospital. The interviews were carried out at St Annes Bay Hospital by the consultancy team over a three day period from Monday 27th September 1993. The personnel that the consultancy team had interviews with were :

Dr W W Wilson	Surgeon and Senior Medical Officer for the hospital
Dr Whitelock	Medical Specialist
Dr Abel	Consultant Psychiatrist
Dr Hall	Consultant Obstetrician /Gynaecologist
Matron Duckworth-Wilson	Head nurse in charge of private ward
Matron Willis	Nurse in charge of hospital
Mrs McKenzie	Hospital Administrator
Mrs A Roden-Simpson	Accountant (hospital accounts)
Mrs A Higgins	Assistant Accountant (responsible for the private ward accounts)
Miss Wheatley	Accounts Department
Miss A Wilson	Medical Records Department
Miss Barrett	Medical Records Department
Miss Thomas	Cashier
Mr C Fuller	Former Chairman, Special Committee for Private Ward
Mrs C Brown	Former Member, Special Committee for Private Ward

The consultants toured the private ward to identify the facilities and in addition looked around the site of St Annes Bay Hospital to obtain an overview of the location of the various services provided. Analysis of data and information was carried out by the consultants and where necessary raw data was aggregated into summary form to provide meaningful information.

In attempting to determine detail of the financial performance of the hospital, comparative operational cost data was obtained from the work done on the issue of unit costing by Touche Ross Ogle and Company.

Constraints

The Chief Executive Officer (CEO) for St Annes Bay Hospital, Mrs Gwen Hamilton was on leave during the week of the consultants' visit. Many of the queries raised with staff were unable to be answered in the CEO's absence. SCS were able to contact the CEO after their return to the UK and have a telephone conversation to discuss some of the queries and issues found during the visit to St Annes Bay.

Unfortunately due to the absence of the CEO, the consultants were unable to obtain copies of the annual report on the PPU's performance, made to the Special Committee which is responsible for its operation. A request for copies of the past two years reports was made during the telephone conversation with the CEO, but these were not available at the time of completion of the draft report.

The on site Hospital Administrator was not able to be of particular assistance in the review as she had only recently been appointed to the unit, from a position in the Telecommunications Ministry.

General Context of St Annes Bay Hospital.

St Annes Bay Hospital, is a 155 bedded Type B hospital, situated on the north coast of Jamaica and attracts patients from the parishes of St Anne, St Mary, Trelawney and Portland.

The nearest equivalent hospital to St Annes Bay is at Falmouth which is some 37 miles to the west. The private wing at this hospital is no longer functioning and we were informed that this is the situation with most of the private facilities in the public hospitals in Jamaica eg Kingston Public Hospital, Spanish Town Hospital. There is a small hospital at Port Maria which is approximately 20 miles to the east but this has no surgical facilities.

The catchment area for St Annes Bay Hospital is predominantly rural with the main centre of population being the tourist resort of Ocho Rios, which is approximately 7 miles east of St Annes Bay Hospital.

We were informed that some patients preferred to travel 60 miles across the island to Kingston despite the existence of comprehensive medical and surgical facilities at St Annes Bay Hospital.

The hospital suffers quite considerably from a lack of space, and in particular space for the office based and administrative functions. In addition we were told that some ward areas were extremely overcrowded, with for example up to 52 mothers accommodated in a 40 bed maternity unit.

History of the Private Patient Unit - Kaiser Ward

The funding for the initial development of the PPU came, by way of donations, from the local private sector. These funds were from various sectors of local industry with the main provider being the Kaiser Bauxite Company and as a mark of gratitude the private facility was named after them. In addition other providers of funds were given the opportunity to financially contribute and sponsor a ward room, these rooms are still named after the sponsors concerned.

Kaiser ward was closed for a period with resistance to its re-opening coming from within the hospital and from the Ministry of Health particularly from the Permanent Secretary of that time. Resistance within the hospital may well have been fueled by Enrolled Nurses on the private ward earning as much as a Staff Nurse on a public ward. It is unclear why there was resistance from the Ministry of Health. The ward was re-opened in 1984 following pressure from the local Chamber of Commerce and local industries (eg Jamaica Telephone Company), the local hotel and tourist association and the service clubs (eg Lions, Kiwanis) within the area. The tourist industry and telephone company were keen to have a private health facility for their employees.

On 30th November 1984 Ministerial agreement was given to form a Special Committee which would have oversight of the operation of the private ward. This committee was established effectively as a sub-committee under the direction and responsibility of the Health Board with limited managerial autonomy. The Special Committee consisted of the following members :

- Chairman of the Hospital Board (Mr C Fuller)
- Another member of the Hospital Board
- Representative from the Jamaican Hotels and Tourist Association (JHTA)
- Representative from the service clubs
- Senior Medical Officer
- Hospital Administrator
- Matron

The last three members were ex-officio members of the committee.

The original intention (and for some long while the fact) was for the committee to meet on a bi-monthly basis. Unfortunately as there is currently no official Health Board (due to the resignation of the previous Board following the recent elections, as is the customary practice in Jamaican public service) there can be no Special Committee for the Private Ward. In practice what has happened is that the members of the committee maintain some degree of oversight over the ward by way of "caretaker", but obviously cannot make any executive decisions from this informal position.

When the donations to establish the ward were being sought, a requirement from the sponsors was that a separate account from that of the hospital, should be established and maintained and that an annual report be produced (showing ward activities and receipts and expenditure for the private ward) to be presented to the Special Committee. We understand that once this report was agreed it was formally laid before the Health Board.

We understand that the committee was initially empowered to collect an additional \$50 per day towards paying salaries and feeding patients. To get nurses to work on the private ward, a sessional rate of pay was developed (8 hours per day). A Ward Sister was included in the structure to supervise staff, this has since evolved and now the role is included as part of the post a Matron grade nurse.

Clinical Organisation of Hospital and Kaiser Ward.

Consultants within the hospital do nearly all admissions to Kaiser Ward, with very restricted external admitting rights. Some junior doctors working in the hospital can admit patients, but only with the permission of an appropriate supervising consultant.

All consultants within the hospital have some private sessions and the SMO, Dr Wilson, has the privilege of having private patient consultations within the Hospital. This arrangement was agreed to in order that he spent the majority of his time on-site, rather than running a private practice from another location which would mean that he was less available to the hospital in case of urgent need. It is thus an arrangement which works to the benefit of the hospital.

The doctors working at St Annes Bay Hospital are as follows:

Consultants

Dr Wilson	General Surgery
Dr Whitelock	General Medicine
Dr Hall	Obstetrics and Gynaecology
Dr Betton	Paediatrics
Dr Abel	Psychiatry

In addition there is a general practitioner who undertakes some sessions in the Casualty department dealing with emergencies and assisting Dr Wilson. This position is analagous to the UKs NHS position of Clinical Assistant.

Junior Doctors

There are 4 junior doctors :-

Dr Hall's assistant.

Senior Physician

2 Interns (these are equivalent to Junior House Officers and must be under supervision all of the time).

Part Time Doctors

There are 2 doctors who provide a part time service to the hospital, they are

- Dr Blake A General Physician with a part time commitment to the hospital
- Dr Francis A General Physician who has sessional commitment to the hospital but whose work is primarily in the private sector.

In order to deal with the pressure of work in the maternity ward, the obstetrician, Dr Hall, has trained the midwives to identify those patients who require a consultants presence during birth.

Regular operating theatre sessions are held on Tuesday and Thursday with the orthopaedic specialist attending on Monday and Friday.

In managing the operating theatre, clinicians create their own lists and are supported in Theatre by 2 anaesthetic nurses, there being no clinician specialising in anaesthetics on site.

In terms of the general model of private practice at St Annes Bay, most consultants have offices located outside the hospital and undertake their work from these. In addition to the locally based consultants, some other consultant staff hold clinics in the area at weekends, coming up from Kingston. These individuals generate a small amount of work for the Hospital.

Patients are initially referred to the private sector from their General Practitioners or they may come into the hospital's outpatients department to see a junior doctor and are then referred to a consultant for private treatment as appropriate.

In the private sector a patient would normally expect to have to pay \$300 for a consultation with their local practitioner, as well as all of the diagnostic test and drug fees. In the state sector they can be seen for \$20 at the outpatients in the hospital. The \$20 fee will also include an x-ray with an extra \$20 required for medicines. Thus, we were informed, a number of patients will undertake their initial consultation through the state sector, and only then consider the use of a private in-patient bed.

Building Infrastructure and Location of Private Patient Unit

The PPU is in the same building that houses the outpatient department and medical records section the ground floor and the administration, and the finance department and Chief Executive's office on the first floor. The private ward is reasonably self-contained being located on the ground floor as the southern end of the building with glass doors dividing it from the other areas in the building. The building was constructed in the early 1960s and is newer than the remainder of the hospital. The ward is conveniently situated adjacent to the clinical support department of x ray and the pathology laboratories and within close proximity to the operating theatre.

Kaiser ward consists of 6 double rooms each having its own en-suite washing and toilet facilities. The "ward" rooms measure about 16ft x 12ft , not including the washroom/toilet area, and are divided into seperate bed-bays by curtains. Whilst the rooms we saw appeared clean and tidy enough, they had rather spartan furnishing and a "tired" appearance. They thus did not have the ambience and appeal as one would expect from a UK or USA based private facility, although they were on par with the facilities which we saw in Kingston at Nuttall Memorial and Andrews Memorial hospitals.

At an operational level, nurse monitoring of patients in private rooms is more difficult than those on an open ward. SCS were informed that the private rooms do not present too much of a problem for nurses, as each patient has a buzzer which the patient can press for attention. The two patients within a ward room usually monitor each other and call for assistance for the other if necessary. This is not usually necessary as there is normally a ward attendant checking on a regular basis.

The private patient unit consists of the following rooms and areas :

6 x 2 bedded ward rooms each with their own toilet and washing facilities

Matrons Office (this was built as a single room ward with en suite toilet and washing facilities)

Nurses Station

Sluice Room

Pantry (Kitchen)

Staff Room

Waiting Area for patient's relatives

A point put to us by the CEO was the wish to convert the Hospital Matrons office back to patient care uses as soon as possible, in order that this room could begin to generate extra income. The reason that the space is used as an office is that the entire building outside of Kaiser Ward is extremely cramped and office space is at a premium. We believe that the CEO's desire to change this room back to clinical use is entirely appropriate and that the possibility of turning a little used facility such as, possibly, the Board Room, into office space might be investigated.

It is recommended that Matron's office be returned to patient use as soon as possible as this would appear to be a loss of income generating space. The use of little used other facilities should be investigated as an alternative for Matron's office.

Management arrangements.

The Chief Executive Officer, by the very nature of their role, has total personal responsibility for St Annes Bay Hospital, however we were told that this did not extend to all aspects of the Kaiser Ward operation. There is no designated manager for the PPU although Matron Duckworth-Wilson, who is the nurse in charge of the PPU, appears to take most managerial decisions regarding this unit and is designated as supervisor. Matron Duckworth-Wilson reports to the CEO through Matron Willis who is the Matron for the whole hospital. Matron Duckworth-Wilson also has responsibility for Outpatients Department as well a role as Deputy Matron for the whole hospital.

We believe that the CEO not having a more active management role in the PPU is a historical hang-over and that it is inappropriate for her not to have complete responsibility for all activities within St Annes Bay Hospital. There is a lack of clarity as to what her responsibility is for this unit and what is expected of her role regarding the private facility. Currently the Special Committee for the Private Ward has the final say over activities within the unit, but they have not met for some time now. We recommend that as soon as a ward committee is formally constituted, a re-evaluation of the management arrangements should be undertaken. This is particularly so as the Kaiser Ward funds cannot, currently, be deployed for use across the rest of the hospital being effectively ring-fenced for use on the ward. Further the interaction of the ward with the rest of the hospital and the demands that it makes on the wider hotel and clinical support services can only be effectively managed by a single individual.

It seems reasonable to us that the CEOs request for management authority and commensurate responsibility should be granted.

There appears to be some lack of clarity over the accountability of all the different staff staff who have some function that contributes to the running of the PPU, this ranges from clinical support staff to administrative and finance staff. It is recommended that a clear organisational structure be developed to show clear accountabilities and responsibilities of managers and staff. It is further recommended that all accountability be to a single person, accountability to committees and management by committees has a high failure rate, at least to judge by the UK experience.

Staffing

Nursing

Nurse staffing was quoted by both doctors and nurse managers as being the main problem encountered in providing the service required, with low pay being the main reason for hospitals inability to retain qualified nursing staff. This is a problem all over Jamaica where nurses, once qualified and with 2-3 years experience, are attracted by offers of employment in the United States, where large increases in pay and better working conditions are available.

Some nurses are keen to work additional hours, often up to double their normal hours to earn extra money and one would have thought that a private patient facility would attract staff as there is an opportunity to work extra hours at additional rates of pay. The problem of working extra hours for staff with families is the additional childminder costs incurred and sometimes problems for the general homelife of the staff member as well as a major problem with late night transport.

Availability of local housing for staff is a continuing problem. There is a 20 bed residence block within the hospital grounds but this is insufficient for the needs. Some staff (including laboratory staff) have to travel long distances to and from work between shifts (eg from Moneague which is approximately 20 miles away). Taxis are often the only form of transport as public transport is either non existant or not running when nursing shifts change. The use of taxis is an expensive form of transport and reduces discretionary income for staff who have to rely on it, thus reducing the benefit of undertaking overtime and the motivation to continue working on the private unit, and possibly at the hospital.

The Ministry of Health pays some supplementary transportation costs for staff working unsociable hours, but these only apply to staff working on the public wards and this is usually insufficient to pay for the the taxi fares. We were told that certain other benefits for staff working on public wards are not available for staff on private wards.

It is recommended that further, creative, mechanisms for improving staff retention are investigated such as possibly :

- provision of more local accommodation - for example on-call rooms or overnight rooms for staff who work the later shift
- transport arrangements to and from the hospital - for example a hospital run bus service to get staff in to work and then home again
- the provision of creche facilities at or near the hospital, which might also generate extra income by sale of the service to other working mothers

The above could be funded or part funded by profits from the private wing if such profits are available.

A staff benefit which is available and is to be commended is that staff may use the private facilities at 50% of the fee (subject to there being a bed available). We were told that this staff benefit was popular and recommend that it should be continued.

Private Ward nurses get an honourarium payment every 6 months. This is a percentage of their pay to compensate them not getting a pension as public sector nurses. Any state nurses working part time on Kaiser Ward get part of an honourarium, again based on a service criteria. It was noted that in the near future Kaiser Ward will have to put up its fees when the pay rates for state nurses are increased.

There used to be 3 qualified nurses working on Kaiser Ward with each having a roster of 20 days (8 hour day) on duty and 8 days off, these were paid by the private ward committee. The ward now has to rely heavily on sessional nurses.

Kaiser Ward now has

1 full time Enrolled Nurse

6 regular sessional nurses (4 Registered Nurses + 2 Enrolled Nurses)

The nurses who work on both Kaiser ward and the public wards are allowed to work 3 days week, totalling 24hrs of extra duty, and can do up to 12 days over a 28 day period.

It was reported that on occasions (nights) there is no qualified nurse on duty on the Kaiser ward. A sample 4 week nursing schedule given to SCS showed no nurse rostered for the morning shift (7.00am - 3.00pm) on 13 occasions for a 28 day period. This could lead to serious medical legal issues if problems occurred as a result of this. One of the outcomes of this has been that the cardiac monitor has to remain idle or it has to be monitored by a doctor which is an expensive use of valuable staff resources. There needs to be at least one qualified nurse (RN or EN) on duty for each shift.

There is only one hour overlap between morning and afternoon shifts and none between the afternoon and evening shifts. It was reported to the consultancy team that this works satisfactorily and as such no change is recommended to this arrangement.

Sick and holiday leave cover is generally provided by nurses from the public wards doing overtime on Kaiser Ward and paid at overtime rates. Nurses from the public wards are given first choice to work on Kaiser Ward whenever the need occurs. If this continued over too long a period of time could produce tired nurses unable to work to optimum performance when required. However we believe the maximum allowable hours regulation for work on both public and private wards is a reasonable mechanism for regulating the volume of work undertaken and as such commend it.

Other ward staff.

Other staffing on the ward includes 3 female attendants on a rotation basis, one of whom is paid by the Ministry of Health and 2 who are paid by the private ward committee.

Fully trained and tested Ward Assistants (or Orderlies) are used from a pool of such staff when the bed occupancy goes above 6 patients. These assistants are also used when a geriatric patient is on the ward and requires additional care such as being turned every 4 hours. Patients often require extra care on the first day after surgery. This additional care incurs an extra cost and is hence charged to the patient or their relatives.

We commend the use of what were called locally "Pink Dress" nurses. The use of Care Assistants, as they are called within the UK, has been found to be of great benefit in the NHS, providing a group of staff who are able to support the more highly qualified nurses and who play an extremely valuable part in the management of a ward.

Many other groups of staff contribute a resource and hence a cost to the running of the Private Patients Unit. These include clinical support staff as well as cleaners, porters, administrative and finance staff.

Operational Performance

There is a complete mix of surgical and medical services available for patients using the private wing. In discussions it became apparent to us that at the day-to-day level the ward operated in a very smooth way and that it was seen as a well integrated part of the overall hospital. The clinical and nursing staff interviewed thought that the length of stay for private patients was the same as for the patients in the public wards, although it might have been slightly shorter with some discharges taking place at the earliest safe opportunity because of financial considerations.

The clinical and nursing service provision appeared to be working satisfactorily as patients seemed content when the consultancy team toured the private ward.

The types of condition regularly dealt with in Kaiser Ward include :

Surgical

Hysterectomy
Myomectomy
Hernia
Appendectomy
Caesarian Section

Medical

Diabetes
Hypertension
Cardiac
Delivered Mothers plus baby (if well enough)
Mild eclampsia

The rooms are initially allocated as follows:

Room 1	Surgical Female
Room 2	Surgical Male
Room 3	Obstetrics (including babies)
Room 4	Orthopaedic/Medical
Room 5	Medical
Room 6	Medical

There is a degree of flexibility in the allocation of the rooms depending on specialty demand.

A relatively recent development in the services offered by the Hospital, and thus Kaiser Ward, is the availability of psychiatric in-patient treatment for patients "who are not boisterous". Psychiatric patients are normally placed on the medical wards if they are public sector patients. It was reported that out of 75 psychiatric patients seen at St Annes Bay Hospital between January 1993 and June 1993 that 10% opted for private care. It is worth comparing the 75 patients seen against the figure of 121 seen at the Psychiatric wing of University Hospital, Kingston during the same period. Kingston having the much larger population, these figures were reported to us as indicating quite a high level of psychiatric morbidity.

It was thought that if there were specific private facilities for psychiatric patients about 40% of those patients would have the ability to pay and be willing to pay for a private service. To provide the service and attract patients there would need to be the availability of specialist skills and the infrastructure of the facility would have to be good.

The main categories of psychiatric patients are :

Schizophrenics

Depressives

Drug Abusers (includes tourists).

In general an untapped area of patients was seen by the Doctors as including

Tourists

Jamaicans who have retired to this area from the USA or UK and who are of some economic means

Teachers, police and other public servants who can pay through insurance schemes but who still use only the public health sector.

There is a policy that children under 12 years should not be admitted as they would take up a large bed and may have to share with an adult. Occasionally a large 10 year old may be admitted. There is also no provision for a parent to share a room with a child as is often required.

Patients are referred to the private ward by the following clinicians :

Dr Wilson	General Surgery Consultant
Dr Whitelock	General Medicine Consultant
Dr Hall	Obstetrics/Gynaecology Consultant
Dr Betton	Paediatric Consultant
Dr Wolf	Obstetrics/Gynaecology Houseman
Dr McCoy	Private Practitioner
Dr Black	Part Time
Dr Able	Psychiatry Consultant
Dr Wright	Orthopaedic Consultant

Issues relating to the Hospitals support services.

Apart from the clinical input to the ward (medical and some nursing), all other services both clinical and non clinical (hotel services) are provided by the hospital.

The private wing relies on the main hospital for the provision of clinical support services such as x-ray, pathology laboratory tests, physiotherapy, pharmaceutical products. There is no priority given to patients from the private wing although in theory there should be no or little waiting as the patient is sent for when the x-ray department is ready for them, specimens and blood are taken by technicians within the ward, and physiotherapists usually visit the wards.

There was some adverse criticism regarding the lack of clinical support services from the doctors interviewed. Problem areas identified included :

there is no ITU in the hospital

more laboratory equipment is required with qualified staff to handle such equipment so that the following tests can be performed more quickly and especially out of hours

eg urea and eletrolytes
 full blood count
 blood gases
 chest x ray

after 4.00pm some facilities ie blood count and sugar are available for emergency cases only. There are 2 private laboratories located in Ocho Rios. They offer a wide range of services but due to little competition are not seen to be functioning well and are considered slow and unreliable.

With only one physiotherapist employed by the hospital there is no physiotherapy treatment available at night and weekends

The above factors apply to the total hospital and not just the PPU but may well be seen as irritants for patients who are prepared to pay for a service.

For medico-legal reasons private maternity patients are advised to deliver in Kingston because of the poor facilities on the public ward at St Annes Bay Hospital. Patients do not like delivering in Kingston as they prefer to be near their family and relatives.

Patients who do chose to use the public services of St Annes Bay may start labour in the private ward then move to the public ward to deliver and return to the private ward with their baby if well enough. There are no trained obstetric nurses in the private ward and although there is a demand for deliveries on a private ward there is none of the equipment required on Kaiser Ward.

Most of the patients who use the PPU for obstetrics are from the lower middle classes (eg teachers, hotel staff). Patients from the upper classes go to the private hospitals in Kingston to deliver.

All catering (including special diet meals) is provided from the hospital kitchen. The private wing has a small kitchen (the pantry) for preparing drinks and snacks.

The main points of appeal to patients for using the private wing are :

- more privacy and comfort than one would get on a public ward
- more individual attention and individual nursing (patients can pay for their own nurse and have one to one nursing care if required)
- patients can have their own television or entertainment systems

Additional facilities which were suggested by various members of staff which would improve the quality of service provided include the following :

- Mother and baby room
- Single room (patients would be prepared to pay more)
- Air conditioning in some or all of rooms
- Ceiling or wall fans if full air conditioning not viable
- More standing fans
- Bed side lights
- Telephone in room
- Television supplied in every room
- Piped soft music
- Food trolley (to bring food from kitchen ensuring that it reaches ward in same condition that it left the kitchen).

A food trolley has been identified in Georgia, Atlanta by Dr Evans who visits St Annes Bay Hospital with an eye specialist team. It is anticipated that this will be delivered soon.

Client Base

Most patients come from the middle classes including

business people

staff from hotels and local industries (eg bauxite company) who may be assisted by their employers with fees or insurance

tourists (who only make up 1% of the cases at maximum)

referrals from cruise ships that dock at Ocho Rios
(mainly cardiac cases - approx. 4 per week)

Competition is mainly from the other private hospitals on the island such as those in Kingston and the two 17 bed hospitals run by doctors in Montego Bay. There are plans to open a similar private patient hospital in Ocho Rios, as these plans are in the early stages it is not known how much competition it will provide.

Bed Occupancy and throughput by speciality

A bed occupancy of 70% was quoted in interviews with doctors and other staff with an increase in May and June and a drop when doctors go on leave. An analysis by SCS however of data (January 1993 - June 1993) from the Medical Records Department provided the following information:

PERCENTAGE BED OCCUPANCY KAISER WARD

January	52%
February	72%
March	62%
April	81%
May	51%
June	55%

It can be seen that there is a considerable range in bed occupancy from a low in May of 51% to a high in April of 81%. The average was calculated as 62% which varies slightly from the 70% quoted although this sample was only taken for a 6 month period.

A similar analysis of data from the Medical Records Department by SCS (6 month sample - January 1993 to June 1993) provides an average monthly throughput by speciality shown as bed days per month and in percentage terms as a percentage of the the total bed days used.

Specialty	Average Bed Days per Month	% of Total Bed Days Used
Medical Male	48	22%
Medical Female	81	36%
Surgical Male	24	11%
Surgical Female	57	13%
Paediatric Medical	0	0%
Paediatric Surgical	1	2%
Obstetrics	11	5%
Orthopaedic	1	1%
Total	224	(62% of the total available bed days)

The bed occupancy seemed to us to be rather lower than one would desire. Private Hospital data in the UK indicates that, in general, an occupancy of at about 55% is required to achieve break-even.

There does not appear to be a clear audit trail of management information and when interviewed some staff while being aware of their own tasks did not know how their jobs interfaced into the complete organisation.

Financial systems and fee scale

The fees for staying at St Annes Bay are less than in Kingston as land and other facilities are more expensive in Kingston than in this part of the island. There is less of a demand for air conditioning in offices than in Kingston where the poor quality of the air caused by traffic pollution demands that doors and windows need to be closed. Thus we were told that the overall costs of providing the service were lower than in Town.

The fees for private treatment are normally twofold, based on one payment to the doctor for their services and a second payment to the private ward in the hospital for all other services. The fees to the doctor are agreed between the doctor and patient.

The in-patient fees to be paid to the hospital are currently \$2,500 for 5 days, this to be paid in advance - a refund is given if the stay is less than 5 days. After 5 days another \$2500 is required with the same refund arrangements pertaining.

The \$500 per day charged for staying on Kaiser Ward covers the patient for the room, staffing cleaning, catering and all utilities required to maintain the room (eg water, power). Other clinical usage such as x ray, pathology laboratory tests, pharmaceutical items and use of operating theatres are charged for as additional separate items. All of these are charged at pre-determined rates, except for drugs which are charged at cost plus 20% mark-up for handling and administration.

Cash is the required method of payment unless the patient is known to be of good reputation personally by the Chief Executive Officer or another senior member of staff. If the admitting clerk is not in attendance the the CEO or matron will take the down payment of \$2500 and admit the patient. It was reported however that fees are often not collected at weekends as there is no one of authority to collect them and this is a duty outside the remit of the nurses, at present.

Financial information for billing patients is generally obtained by staff completing a form attached to the patients medical record (Docket) and the totalised bill being entered into the Private Patient Register (a manually maintained ledger). A cashier prepares the invoice for the patient, this is itemised showing the room rate and individual prices for such items as x ray and drugs. A sample invoice is shown at Appendix 1 , which shows the higher day rate charged for a tourist. The cashier has a list of the fees to charge for each particular part of the treatment so that it can be shown as a separate item on the bill. A list of receipts and debtors is prepared each month and the CEO is responsible for contacting these patients for urgent payment.

When the private patient fee is received it is split into the amount for the private ward account and for the Ministry of Health. The split is \$ 200 to the Government income account in respect of the in-patient stay and \$ 300 a day to the Kaiser ward account, nominally to pay for the nursing staff on the ward and the added amenity. When we attempted to identify what volume of costs related to private pathology or x-ray tests we were informed that as all this money "was for the Government" the books would only show gross amounts lodged into the Hospital account and that we would have to go through the individual bills for private patients to identify the volume of activity and income relating to each service.

A ledger is maintained for Kaiser Ward showing income against expenditure. The largest entries being the "lodgements" of fees and salaries paid out. Other items that require to be paid out include stamp duty, insurance companies and occasionally patients. Regular monthly expenditure includes:

- income tax
- national insurance
- national housing trust
- education tax.

The term lodgement means the deposit of money into the bank account. There appears to be a long a gap between when each lodgement is made, this ranges from 10 to 30 days and it seems that large sums of money (mainly cash) must be retained on the hospital premises between the dates when lodgements are made.

SCS did not look into the security of money on the hospital premises but strongly recommends that lodgements are made into the account at the bank at much more frequent intervals. This should remove the motive for theft or attempted robbery and the associated possible injuries to staff.

Any payment by out of the Special Committee account is done by means of a cheque requires 3 signatures ie CEO, Dr Wilson and Mr Latchman (Hospital Board Member). While the security reasons for this may be appropriate there does appear to be a degree of overkill in this process.

If a designated manager with the clear and appropriate responsibilities and accountability were designated this task could easily be safely delgated.

The current financial system appears to show cash flow only as there is no evidence of any profit and loss account for the Private Patient Unit.

On a small sample "audit" taken for Obstetrics in May 1993, SCS were unable to reconcile the book containing fees charged with the Daily Census Sheet information. This appeared to indicate either an under-recovery of fees collected against those due or alternatively inaccurate book-keeping. It is recommended that a further review is pursued on this matter.

A recent audit report criticises the hospital and states that there has never been any permission given for this money to be in a separate account. This criticism conflicts very seriously with the requirements of the Special Committee for the Private Ward when it was agreed to re-open it in 1984. There is clearly a lack of communication and understanding on this issue between the Ministry and the Special Committee, which requires urgent attention as soon as the Special Committee is re-inaugurated. The present separate account is also a non interest bearing account which means the money which is believed to be in the region of half a million jamaican dollars is not realising its potential for the hospital. It is recommended that this money be moved to an interest bearing account as soon as possible and if necessary changes in legislation are brought about to allow this to happen.

We generally support the concept of maintaining a seperate account for the private patient activities as this makes it easier to keep an accurate record of cash flow and, where accurate costing information is available, profitability.

There appears to be no plans in existance to invest any of this money to provide benefits or realise improvements for the hospital in either the private or public facilities. Money in the bank on its own is of little use in improving the healthcare of the population and clear plans for invcstment within the hospital need to be developed. If the money was gaining interest the interest could be used to provide benefits leaving the capital as an investment for future use.

The only organisation which appears to be gaining from the earnings of the private ward is the bank with a large deposit of money for which it pays no interest and charges stamp duty.

With a sizeable balance of money in the bank it may appear that the PPU is doing well and making a profit but with the absence of any costs to check against prices (or fees) the unit is more likely to be making a loss in real business terms and being subsidised by the public sector. This thinking is based on similar experiences by SCS of private units in the UK.

Service Costing and Pricing

In the period spent at the hospital we attempted to identify upon what basis the overall charges for the ward were based. As regards the room rate we were told, as indicated above in the body of the report, that the costing had been undertaken by identifying the per diem charges made by hospitals in Kingston and then ameliorating these somewhat in order to appear competitive in the local market. This basis for calculating the fees is fundamentally flawed as SCS were informed that only one (or now possibly two) of the Islands private hospitals are making a profit, although the idea of market based pricing is laudable. A further point is that the per diem rate takes no account of the costs to provide the service.

We eventually discovered that the published tariff for operative procedures and paramedical services was published by the Ministry of Health although we were not given a contact point in the Ministry. Unfortunately during our visit we did not have the opportunity to pursue the matter with the MoH and determine the basis of the costs for the use of public services by private patients. We were however given a draft tariff which is soon to be published which revises the costs of private care significantly upwards (Appendix 2)

The lack of any costing information ensures that there is no way anyone can identify if the fee at least covers the cost of providing the service. The \$500 is for the cost of the room which is also intended to cover:

- staff (nurses, porters etc)
- catering
- cleaning
- linen
- water
- power
- television

The costs of other overheads such as indirect staffing (eg medical records, administrative and accounts staff) does not appear to have been considered at all in any financial assessment.

Out of the \$ 300 per patient day that the ward receives it is supposed to pay for the nursing staff. However it was noted above that at least one of the Ward Auxiliaries is paid for by the State, thus the system as currently operated does not even fully pay for the nursing input to the ward. Further, in discussions with Mrs Hamilton, we were informed that the costs of all utilities and food consumed on the ward were paid out of the Hospitals account and that there were no compensatory cross charges.

There does not appear however to be any information on costs of these services on which the fees have been based. The problem is therefore the the same as for the room fees where it is difficult to know the size of any profit that is being made (if any), if costs are being covered or if a loss is being made. When directly questioned on this point one of the accounting staff said that they did not think that the ward could be paying for itself to even the break-even point. Although no evidence could be provided on the subject this doubt, raised by someone familiar with the hospitals financial position is taken as being supportive of the thesis what we came to during the review that the Kaiser Ward was probably not making a profit.

In the absence of detailed budgetary information being available from St Annes Bay, we attempted to determine something about its financial position inductively using information from the HSIP Hospital Cost Study, prepared by Professors Shepard and Cumper in 1992, and from the Preliminary Output from the Cost Allocation and Unit Cost Model from Touche Ross Ogle & Co. December 1992.

Table 4.6 (Shepard & Cumper) indicates that 100% cost recovery of an in-patient at 1992 prices would be \$ 354. We are uncertain if this is for an entire episode or for a day. If for a day it would indicate that, considering the excess staff costs involved in running Kaiser Ward, that the \$ 500 per day would be unlikely to cover the costs.

A more detailed analysis of the cost per in-patient day are presented in Touche Ross's report where Table 7 for St Annes Bay (unfortunately the report pages are not numbered) indicates the range of costs per in-patient day by speciality. All of these are substantially above the \$ 200 per day which is the States share of the \$ 500 per day receivable from St Annes Bay, indicating that the state loses money (or subsidises) on each private patient day. Table 7 is reproduced in Appendix 3.

It might be argues that the majority of the nurse staffing costs on the ward are met by the Special Committee, which is correct, and thus the state costs for an average \$ 275 per day are an overestimate of the input. However as far as we can tell the Touche Ross report is only an analysis of the revenue cost of operation and seems to take no account of the capital or depreciation costs which proper, commercial, accounting would expect to be included in the cost of production of a service.

Conclusion

In drawing conclusions, a number of points need to be borne in mind. The first is that the environment for at least clerical and administrative staff at St Annes Bay is quite poor with extremely cramped working conditions, such conditions are not conducive to a high accuracy level even with diligent staff. Secondly, that there appears to have been little high level financial input to the Kaiser Ward operation which has not helped to identify its financial performance. Thirdly that the consultants are measuring the performance of the unit against the UK norms and fourthly that all of the finance systems appear to be paper driven with no IT input apparent. Finally it should be noted that the ward has not had any effective management at least since the dissolution of the Special Committee.

The established criteria for measuring a PPU's performance against in the UK are financial. In the model with which the consultants are familiar, the profitability of the treatment of private patients is the key concern. If a PPU is not, in its own right, profitable then it is assumed to be draining resources from the state sector. We have taken this as the basic approach in analysing the operation at St Annes Bay.

In Jamaica, there is a general opinion that there is a growing market for private healthcare for all specialties. To be successful a PPU would however need to demonstrate a better environment and hotel services (inc. more choice of food) as more qualified nurses if it is to attract more patients.

Kaiser Ward is at best providing some income for the hospital compared to the situation of there being no private wing when they would not receive such income. The problem at present is that the organisation is not receiving the full potential of a properly run private patients facility. In addition it would seem that the public sector is subsidising the treatment of private patients. If this is so it is unacceptable in any country, but even more so in Jamaica with its current scarce public resources and a section of the population which would appear willing and able to pay a higher rate for health care.

Poor or non-existent management and financial information systems make the calculation of the problem in real terms, difficult and disable management from taking any appropriate action.

The PPU should be seen as a small business and organised and managed as one is with rigour, precision and clarity of financial cost allocation. The alternative is to continue as at present with Kaiser Ward providing some additional income but unlikely to break even let alone make a profit in real business terms.

A question which is slightly outside the scope of this report, but one which needs to be asked, relates to the purpose for which a private patient unit is established? There can be many reasons, but in the UK experience the reasons for having a PPU in a state hospital tend to include:

- higher technical quality of care than in a private hospital and thus safer patient treatment and less likelihood of the state having to pay to put back together the "medical disasters" which occur in overambitious private hospitals

- convenience for the management and doctors in having a single main base of operations and thus most doctors present in the hospital most of the time
- achieveing extra income for use within the hospital, over and above that level of income which the public sector makes available to the hospital - thus giving the management the discrissionary funds to deploy as and where appropriate within the hospital. (In the UK this is the most common reason)
- ability to siphon-off the more economically well-off and reduce the demand for state funded care
- providing choice where there might otherwise be none (but generally the desire to exercise choice leads to a demand for private care resulting in the establishment of a private hospital).

We believe that the purpose of the existence of Kaiser Ward needs to be reviewed. If it is to make money for the betterment of the general hospital, such "profit" needs to be reallocated into St Annes Bay. At present there appears to be no mechanism for such reallocation to occur. If it is simply to provide a higher standard of care, but not make a profit, then the costing base and accounting procedures need to be reviewed and improved so that it can clearly demonstrate that it is not using state money by itemising and paying for all state provided inputs.

It may be that once a true costing exercise has been completed with cost centres from which pricing of services can be identified, that the market will not be able to stand prices that cover all costs. The at least the financial position will be clear and management can make the appropriate decisions on the organisation and future of the PPU such as market testing some of the support services to see if they can be provided more economically.

This follows the well used business maxim

"If you can't measure it - you can't manage it."

Good Practices at St Annes which should be replicated.

Although the foregoing report has been critical of some aspects of the operation at St Annes Bay, this should not overshadow the positive aspects of the operation. We believe that the following good practices should be implemented whenever a private patient facility is lodged in a public sector hospital :

Hospital staff having access to a private facility at a reduced rate. This not only can be offered as one of the few "perks" in the system, but also would ensure the PPU was well served by staff.

Payment of an honorarium for long service to staff seems a reasonable way of thanking staff for showing dedication to staff on a private ward, where there employment does not attract a pension.

The strict regulation of the levels of overtime which nursing staff work within a state hospital PPU is a good model for staff management in all disciplines

The offering of overtime within the organisation prior to looking outside is an example of good management as it tends to build a loyal workforce and can be used to create a Bank of nurses.

The extensive use of ward assistants / auxiliaries to support the qualified nurses is a good example of appropriate ward skill-mix and to be commended

The general organisation of support services such that the public patients are not disadvantaged in accessing hospital services by private patients must be a core value in the development of any PPU. The organisation of the services at St Annes Bay Hospital in such a way is to be commended.

We believe that separate accounts should be clearly identified for all income and expenditure related to PPUs, as is the situation at St Annes Bay, in order that the profitability of the unit can be clearly demonstrated.

Appendices

In the following appendices we present information collected during the visit to St Annes Bay Hospital as well as other materials supplied by the HSIP office.

- Appendix 1** Example of a private patient invoice for a tourist patient staying on Kaiser Ward.
- Appendix 2** Fee Tariff for Clinical Support Services at St Annes Bay Hospital
- Appendix 3** Fee Schedule for the use of the Operating Theatre giving examples of the differential charges for differing complexity of procedure.
- Appendix 4** Draft Fee Schedule proposed to update the scale of Private Patient Fees charged in Public Hospitals.
- Appendix 5** Table from Touche Ross Ogle report identifying average in-patient costs per case and per day

Appendix 1

Example of a private patient invoice for a tourist patient staying on Kaiser Ward.

August 12, 1993

TO WHOM IT MAY CONCERN

HOSPITAL BILL

RE:

Indianapolis, Indiana
c/o Majestic of the Sea

DATE OF ADMISSION: August 5, 1993

DATE OF DISCHARGE: August 12, 1993

Seven days @ \$1,800.00 per day	- \$12,600.00
Laboratory	- 200.00
X-ray	- 200.00
Drugs	- <u>480.00</u>
	<u>\$13,480.00</u>

Amount paid by patient on Official
Receipt #s 180 & 171016 AND
6/8/93

186 & 171144
12/8/93 - \$13,480.00

N.B. BILL IS QUOTED IN JAMAICAN CURRENCY

(US \$1 = JA \$24

.....
CHIEF EXECUTIVE OFFICER
+

Appendix 2

Fee Tariff for Clinical Support Services at St Annes Bay Hospital

ST ANNES BAY HOSPITAL
KAISER WARD

FEES FOR CLINICAL SUPPORT SERVICES

All fees in Jamaican Dollars

Registration	30
X Ray	60 - 400
Physiotherapy	100 for 6-15 minute sessions
Path. Lab. Tests	40 - 200
Obstetrics	200 for delivery of baby
Ultrasound	200
ECG	150
Blood Tranfusion	250 per unit of blood
Drugs	Cost plus 20% (handling charge)
Transfer of patient by Ambulance to Kingston or Montego Bay Airport	1000

Appendix 3

**Fee Schedule for the use of the Operating Theatre
giving examples of the differential charges for differing
complexity of procedure.**

BEST AVAILABLE COPY

HYSTERECTOMY
 C / SECTION O.T - ,1000.00
 MASTECTOMY SUT. - \$350.00
 PROSTATECTOMY
 AMPUTATION
 VASCOTOMY / PUROPLASTY (Peptic Ulcer)
 THYROIDECTOMY
 CHOLYSTRECTOMY

MAJOR B

APPENDICITIS
 LAPARATOMY
 ECSTOPIC/SALPINGECTOMY
 HAEMORRHOIDECTOMY O.T - ,1650.00
 MYOMECTOMY SUT - \$250.00
 OVARIAN CYST/OOPHOECTOMY
 VENTRO SUSPENSION
 FISTULA IN ANUS
 HYDROCELE

MAJOR C

CIRCUMCISION
 ORCHIDECTOMY/ORCHIDOPEXY
 TUBAL LIGATION O.T - ,500.00
 SUT. - \$150.00
 HERNIA
 SKIN GRAFT

MINOR

BIOPSY
 D/C O.T - \$350.00
 F.O.E. SUT. - \$100.00
 EXCISION

These fees exclude fees for :- ANAESTHESION, LABORATORY, X-RAY, PHYSIOTHERAPY, DRUGS, ULTRASOUND, I.C.C. etc.

Ambulance Transfer Kairi E 1000.00.

Appendix 4

**Draft Fee Schedule proposed to update the scale of Private
Patient Fees charged in Public Hospitals.**

DRAFT FEE SCHEDULE (IN JAMAICAN DOLLARS)

<u>Items/Services</u>	<u>Public</u> \$	<u>Private</u> \$
Registration:		
Outpatient/Casualty/Dental	50	250
General Inpatient Admission (including maternity) of up to 6 days	200	1400 - 3000
Each Additional Inpatient day	50	350 - 550
Major Operations	600	2000 - 3000
Minor Operations and Treatment Procedures eg. Nebulization	100	600 - 800
Laboratory Tests	50 per request form	150 per request form
Routine X-Rays	50 per film	150 per film
Pharmacy	50 per prescrip- tion	250 per prescrip- tion
Physio/Speech Therapy	100 up to 6 treatments	150 per treat- ment
* - Appliances		
Each Additional Treatment	25	
Emergency Ambulance Services	100 within 100 mile radius then \$10 per mile per person/ patient	300 within a 10 mile radius then \$20 per mile per patient
Morgue	100 per day	250 per day
Transfusions	50 per unit	250 per unit
Medical Report	150	500
Rates for non-residents should be private rates.		
* Appliances	50% of cost to a maximum of \$1,000	cost

Exemptions

- A. Food Aid Programme recipients on presentation of registration cards.
- B. Persons with high risk pregnancies as identified by the health team.
- C. Children on the school dental programme - for dental treatment only.
- D. Persons over 65 who are unemployed, or beneficiaries of N.I.S. pensions only. Other persons in this category to be charged 50% of scheduled rate for pharmaceuticals.
- E. Disabled servicemen.

Indexation

The Committee suggests the adoption of the formula given by Dr. Shepard but an annual review should occur. Cabinet would therefore be requested to approve indexation after annual review, if expedient, using the formula below:

For relevant (previous year)

$$[(60\% \text{ of the percentage increase in the government wage index}) + (40\% \text{ of the percentage increase in the consumer price index})] \times \text{Fee} = \text{New Fee}$$

This is to be applied at the beginning of the fiscal year.

Example

<u>Component & Indicator</u>	<u>Inflation (previous year)</u>	<u>Weight</u>	<u>Product</u>
Labour (Compensation of employees)	12%	60%	7.2%
Government wage index			
Non-Labour (drugs, food etc.)	25%	40%	10%
Consumer Price Index			
			<hr/>
			Sum =17.2%

Increased basic fee from \$50 to $(50 \times 117.2\%) = \$58.60$
(Could be rounded off to \$60.00)

Appendix 5

**Table from Touche Ross Ogle report identifying average
in-patient costs per case and per day**

MINISTRY OF HEALTH: INSTITUTIONAL STRENGTHENING PROJECT: UNIT COST MODEL

TABLE 7: SUMMARY OF INPATIENT UNIT COSTS BY SPECIALTY

File: HOSP04.wk1
08-Dec-92

HOSPITAL: ST. ANNS BAY

UNIT COST PER INPATIENT CASE

	General Medicine	General Surgery	Paediatrics	Obstetrics	Other	Average
Admin, Utilit & Security	\$140.33	\$101.63	\$99.37	\$45.78	\$0.00	\$90.24
Medical Records	\$34.51	\$24.99	\$24.43	\$11.26	\$0.00	\$22.19
Accounts	\$52.91	\$38.32	\$37.47	\$17.28	\$0.00	\$34.02
Security	\$55.21	\$39.99	\$39.09	\$18.01	\$0.00	\$35.50
Medical	\$565.91	\$409.87	\$400.72	\$184.84	\$0.00	\$383.92
Nursing and CSSD	\$558.28	\$404.34	\$395.32	\$182.15	\$0.00	\$359.01
Operating Theatre	\$0.00	\$23.49	\$23.49	\$23.49	\$0.00	\$18.34
Pharmacy	\$14.71	\$10.86	\$10.42	\$4.80	\$0.00	\$9.46
Radiology	\$7.57	\$7.57	\$7.57	\$7.57	\$0.00	\$7.57
Physiotherapy	\$3.55	\$3.55	\$3.55	\$3.55	\$0.00	\$3.55
Laboratory	\$12.22	\$12.22	\$12.22	\$12.22	\$0.00	\$12.22
Radiotherapy	\$1.36	\$1.36	\$1.36	\$1.36	\$0.00	\$1.36
Dietary	\$230.76	\$167.13	\$163.40	\$75.29	\$0.00	\$148.39
Linen & Laundry	\$48.67	\$33.80	\$33.05	\$15.23	\$0.00	\$30.01
Transport	\$17.32	\$17.32	\$17.32	\$17.32	\$0.00	\$17.32
Housekeeping	\$214.53	\$155.38	\$151.91	\$89.99	\$0.00	\$137.96
Sanitation	\$24.03	\$24.03	\$24.03	\$24.03	\$0.00	\$24.03
Maintenance and Fuel Oil	\$27.82	\$27.82	\$27.82	\$27.82	\$0.00	\$27.82
Portering Services	\$37.94	\$37.94	\$37.94	\$37.94	\$0.00	\$37.94
	\$2,045.62	\$1,541.40	\$1,510.47	\$779.69	\$0.00	\$1,380.85

UNIT COST PER INPATIENT DAY

	General Medicine	General Surgery	Paediatrics	Obstetrics	Other	Average
Admin, Utilit & Security	\$18.01	\$18.01	\$18.01	\$18.01	\$0.00	\$18.01
Medical Records	\$4.43	\$4.43	\$4.43	\$4.43	\$0.00	\$4.43
Accounts	\$6.79	\$6.79	\$6.79	\$6.79	\$0.00	\$6.79
Security	\$7.09	\$7.09	\$7.09	\$7.09	\$0.00	\$7.09
Medical	\$72.62	\$72.62	\$72.62	\$72.62	\$0.00	\$72.62
Nursing and CSSD	\$71.64	\$71.64	\$71.64	\$71.64	\$0.00	\$71.64
Operating Theatre	\$0.00	\$4.16	\$4.26	\$9.24	\$0.00	\$3.66
Pharmacy	\$1.89	\$1.89	\$1.89	\$1.89	\$0.00	\$1.89
Radiology	\$0.97	\$1.34	\$1.37	\$2.98	\$0.00	\$1.51
Physiotherapy	\$0.45	\$0.83	\$0.84	\$1.39	\$0.00	\$0.71
Laboratory	\$1.57	\$2.16	\$2.21	\$4.81	\$0.00	\$2.44
Radiotherapy	\$0.17	\$0.24	\$0.25	\$0.53	\$0.00	\$0.27
Dietary	\$29.61	\$29.61	\$29.61	\$29.61	\$0.00	\$29.61
Linen & Laundry	\$5.99	\$5.99	\$5.99	\$5.99	\$0.00	\$5.99
Transport	\$2.22	\$3.07	\$3.14	\$6.81	\$0.00	\$3.46
Housekeeping	\$27.53	\$27.53	\$27.53	\$27.53	\$0.00	\$27.53
Sanitation	\$3.08	\$4.26	\$4.35	\$9.45	\$0.00	\$4.79
Maintenance and Fuel Oil	\$3.57	\$4.93	\$5.04	\$10.94	\$0.00	\$5.55
Portering Services	\$4.87	\$6.72	\$6.88	\$14.92	\$0.00	\$7.57
	\$262.51	\$273.11	\$273.74	\$306.68	\$0.00	\$275.56

DRAFT FOR DISCUSSION

**Review of the feasibility of developing a private patient facility
at Bustamante Hospital for Children, New Kingston, Jamaica.**

This review was commissioned by the Health Sector Initiatives Project of the Jamaican Ministry of Health, under the sponsorship of the USAID programme and is based on a site visit undertaken in September 1993.

**Report prepared for : Dr Holding-Cobham
HSIP**

**Mrs Carlene Neugent
CEO, Bustamante Hospital.**

**Report prepared by : Ray Quinn and Nic Weston
Stanmore Consulting Services
RNOHT**

October 1993

The Next Steps

In order to take the project forward to a successful conclusion and to ensure that there is good communications within BHC regarding the development, it is important that a Project Group is established within the Hospital. The role of the group will be to co-ordinate the development and have oversight at a level which ensures that the necessary work is undertaken to an established time-table, slippage in any one area nearly always meaning that there is slippage in the overall project calendar.

We believe that the core Project Group should include input from the following service areas :

- Medical
- Nursing
- Management
- Finance
- Personnel.

In the course of the planning of the development particular issues will arise which require focussed input from one or several of the above disciplines. The representative on the group would then be expected to lead a small working party to analyse the issue and make recommendations back to the Project Group on the appropriate solution or policy. This group would in addition to undertaking the "in-house" activities required, would form the point of contact for all external liaison in the project. A nominated officer from the group would thus have to lead the contacts with the Ministry of Health, legal advisors and potential investors. We would expect that the group would have access to external support in addressing certain specialist areas, but that much of the detailed work should be undertaken by the staff from within the hospital. This would ensure that the development could be used as both a team building and a developmental exercise, as well as achieving the objective of a profitable development.

The agenda that the group would have to face would be the following, which are the key headings or milestones within the outline project plan. They include :

Detailed Service Planning

Based on the finalised report from SCS and the information provided by the hospitals clinicians regarding the volume of work which could reasonably be expected the Group will need to take a view on

- The services which they wish to offer to the market both type and volume
- What physical facilities are required to deliver the identified service
(this will include to some extent such operational decisions as :

will we feed the patients from the main kitchen or offer
some alternative

what space is required to deliver a GP / Doc in the Box service

what level of treatment might be given to patients on the ward as opposed to within the casualty department)

Based on this the group will be able to develop a planning brief for an architectural firm to undertake an outline design which will generate capital and equipping costs. It is worth noting that some architectural practices are able to generate projections of the revenue costs of operating the building that are designing (in terms of energy and utilities) and such projections can be very useful in the next phase.

Costing and Design

Based on the information made available by the architect in terms of capital costs to refurbish and equip, the next phase of the process is to establish the likely revenue costs of the operation in terms of both labour, service and consumable costs. This information is then used, combined with information on the charges which other private hospitals make for services and the rates of reimbursement which insurance companies will make to develop a relatively simple economic model of the unit. This model, based on the projected case-mix and length of stay of the patient population allows projections to be made on the income streams, associated costs at different levels of occupancy and thus the overall economic viability of the proposal.

It may well be that there has to be a degree of iteration at this stage developing different costed scenarios, requiring slightly different capital and revenue costs, until the optimum design is achieved which assures the economic viability of the development.

It will be important to obtain a commercial valuation of the proposed asset (land and building) so that the likely refurbishment costs can be judged against the extant capital values. If the development is likely to cost much more than the established value of assets which might be brought into a joint venture, then it will be more difficult, but not impossible, to attract appropriate partners for the scheme.

It is important that by this stage the in-house review of (and planning of how to deal with) the services which the proposed development will demand has been completed. These services range from the domestic / hotel service aspects such as linen and laundry through to how the operating theatres and other high-technology areas of the hospital will accommodate the load, knowing the prices that can be charged for the different services.

Once the viability of the proposal has been established, a variety of activities can begin, some can occur in parallel with each other, but first an investment proposal must be developed.

Business Plan Creation and Investor Screening

The most important document which the team will develop is the costed business plan, demonstrating markets and financial viability, so that investors can be attracted. This document will be the basis upon which a partner will take their decisions about investment and thus is the opportunity for the hospital to demonstrate its mastery of the subject to the market and identify itself as a competent and commercially minded organisation to do business with.

At the same time that the business plan is being pulled together work will have to take place with the Ministry of Health, either to take advantage of existing legislation or to obtain the appropriate legislation for the operation to move forward. The whole project would be fundamentally frustrated if a legislative block were not identified which prevented the development of a joint venture (or other appropriate) commercial vehicle for the project.

Potential investors will need to be identified and a process put in place to ensure their financial solidity to undertake partnership in the development. In all likelihood the Ministry of Health and the Ministry of Finance will need to be involved in some review of potential partners to assure that they are fit and proper business to become involved with the scheme.

Establishment of Joint Venture Company

After the vetting process a selection process will be required to identify the most suitable candidates to join the partnership and then after the conclusion of negotiations the Articles and Memorandum of Association drawn up and signed. Following this the transfers of land and finance can take place.

By this point the architects will have had to have drawn up and the Project Group have agreed (probably with some input from the identified partner(s)) the finalised plan for the physical development. It is then a matter of getting the refurbishment works in hand and ensuring that all of the other developments in and around the hospital are proceeding according to plan.

Operational Programme

The operational programme for the new development must include the issues of staffing, management, training, designing and implementing financial systems and marketing. These tasks can actually be begun at an earlier stage, once it is known that the project is likely to proceed, but will obviously need to have been finalised in detail (and for preference tested) prior to the completion of the physical works and the snagging and commissioning phased of the ward / facility. The operational programme can be considered complete when both the operational policy for the development - governing in detail how it interfaces with the hospital and the building are complete.

The final tasks, prior to running the business, is to ensure that as much publicity as possible is gained from the opening of the ward and that a suitable (newsworthy) ceremony is properly organised.

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Appendices.

In the following Appendices we present information collected during the site visit to BHC, as well as certain information regarding the UK experience of operating a private patient facility within a state hospital.

- Appendix 1 Bustamante Hospital for Children
Operational Statistics September 1992 to August 1993
- Appendix 2 Sketch Site Plan of Bustamante Hospital For Children
- Appendix 3 Architects rough plan for the development of Ward 8 into a six-bed private patient unit.
- Appendix 4 Example of marketing material produced to inform hospital staff of development.
- Appendix 5 Example of the Ian Monro Ward operating budget, showing the detailed breakdown of cost heads required for financial control of a private patient unit.
- Appendix 6 Example of the detail planning and costing required for a service to be provided to a private unit - Example is Linen Services which is purchased from an external supplier for the Ian Monro Ward, not from the in-house service.
- Appendix 7 Job Description for the Administrative Officer running the RNOHs Private Patient Unit.
- Appendix 8 Private Patient Questionnaire distributed to all Clinicians at BHC.
- Appendix 9 List of Consultant Clinicians providing services at BHC.

Appendix 1

**Bustamante Hospital for Children
Operational Statistics September 1992 to August 1993**

Operational statistics for Bustamante Hospital for Children September 1992 to August 1993									
	Medical Admissions		Surgical Admissions		Average Length of Stay (days)		Bed	Occupancy %	
	Male	Female	Male	Female	Medical	Surgical	Medical	Surgical	Total
Sept	294	193	122	76	6.06	8.71	74.10	64.60	74.10
Oct	309	289	132	67	12.00	7.30	78.00	57.00	70.00
Nov	303	224	113	76	4.80	8.80	73.00	70.00	72.00
Dec	239	168	110	79	6.27	9.11	62.48	62.54	62.51
Jan	232	167	136	90					
Feb	226	163	113	67	5.01	8.20	63.00	66.00	65.00
March	278	233	119	91	5.00	9.20	64.00	74.00	68.80
April	252	178	148	81	4.72	7.43	65.00	74.00	68.00
May	217	166	136	68	5.40	7.00	65.00	69.00	60.00
June	259	228	144	79	5.31	9.23	69.00	77.00	73.00
July	251	204	155	97	5.10	9.00	60.00	80.00	70.00
August	234	168	169	109	5.50	7.50			
Average LoS					5.92	8.32	74.10	64.60	74.10
Totals	3094.00	2381.00	1597.00	980.00					
Total Admissions	8052.00								

	Orthopaedic Operations				
	Emergency		Listed		
	Major	Minor	Major	Minor	Day
Sept	5.00	0.00	6.00	2.00	0.00
Oct	2.00	0.00	8.00	2.00	0.00
Nov	5.00	0.00	4.00	0.00	1.00
Dec	3.00	0.00	1.00	0.00	1.00
Jan 93	5.00	0.00	5.00	9.00	5.00
Feb	3.00	0.00	2.00	5.00	0.00
Mar	4.00	0.00	5.00	7.00	4.00
Apr	5.00	0.00	6.00	8.00	1.00
May	4.00	0.00	6.00	8.00	1.00
June	4.00	0.00	7.00	9.00	2.00
July	0.00	0.00	6.00	9.00	0.00
August	4.00	0.00	11.00	10.00	1.00

	ENT Operations				
	Emergency		Listed		
	Major	Minor	Major	Minor	Day Case
Sept. 92	3.00	0.00	17.00	27.00	4.00
Oct	4.00	0.00	8.00	19.00	11.00
Nov	8.00	0.00	6.00	9.00	0.00
Dec	7.00	0.00	2.00	17.00	3.00
Jan 93	10.00	0.00	9.00	15.00	2.00
Feb	3.00	0.00	15.00	14.00	6.00
Mar	8.00	0.00	17.00	16.00	6.00
Apr	4.00	0.00	10.00	26.00	3.00
May	2.00	0.00	10.00	21.00	6.00
June	3.00	0.00	21.00	27.00	2.00
July	5.00	0.00	15.00	25.00	8.00
August 93	4.00	0.00	14.00	18.00	1.00
Total	61	0	144	234	52

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General Surgery Operations					
Emergency			Listed		
Major	Minor	Major	Minor	Day Case	
Sept. 92	6.00	0.00	15.00	60.00	59.00
Oct	7.00	0.00	9.00	53.00	54.00
Nov	8.00	0.00	7.00	32.00	32.00
Dec	7.00	0.00	6.00	29.00	17.00
Jan 93	8.00	0.00	12.00	35.00	18.00
Feb	3.00	0.00	16.00	21.00	37.00
Mar	10.00	0.00	20.00	43.00	57.00
Apr	10.00	0.00	17.00	23.00	41.00
May	7.00	0.00	18.00	23.00	37.00
June	9.00	0.00	24.00	30.00	45.00
July	9.00	0.00	27.00	53.00	73.00
August 93	10.00	0.00	5.00	64.00	64.00
Total	94	0	176	466	534

Out-Patient Attendances Bustamante Childrens Hospital												
September 1992 to August 1993												
General				General			Urology			Orthopedics		
Medicine				Surgery								
No. Clinics	New Cases	Total Cs.	No. Clinics	New Cases	Total Cs.	No. Clinics	New Cases	Total Cs.	No. Clinics	New Cases	Total Cs.	
Sept 92	25	32	537	9	160	400	2	4	32	8	83	388
Oct	24	29	523	9	161	357	3	4	39	9	86	352
Nov	24	23	571	8	136	316	2	4	29	8	92	301
Dec	21	26	444	8	131	354	1	2	18	6	72	248
Jan	23	17	585	8	88	298	2	4	15	8	74	311
Feb	24	22	599	8	128	352	2	6	35	7	75	299
March	24	30	594	8	111	316	1	3	12	10	116	411
April	24	21	505	9	108	334	3	5	25	9	93	346
May	24	22	516	8	92	332	0	0	0	12	79	332
June	27	28	583	8	96	279	2	6	29	12	90	383
July	27	31	517	9	145	385	1	2	9	9	94	307
August 93	27	46	550	8	169	415	1	6	20	12	88	324

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Out-Patient Attendances Bustamante Childrens Hospital
September 1992 to August 1993

N.T.			Neurosurgery			Dermatology			Plastics			Dental		
No. Clinics	New Cases	Total Cs.	No. Clinics	New Cases	Total Cs.	No. Clinics	New Cases	Total Cs.	No. Clinics	New Cases	Total Cs.	No. Clinics	New Cases	Total Cs.
8	117	296	4	4	48	8	37	138	4	13	91	42	145	319
8	84	257	4	4	48	8	38	133	5	11	112	40	129	337
9	104	310	4	9	66	8	24	120	4	1	82	22	56	180
5	57	145	3	9	45	6	28	94	3	5	70	33	80	200
8	72	267	4	8	85	8	51	158	0	0	0	0	0	0
8	103	287	3	16	70	8	45	157	4	8	104	33	126	268
9	101	291	4	12	78	9	47	184	4	16	79	24	53	121
6	99	193	4	11	53	8	49	196	5	5	70	26	99	197
8	87	284	4	19	50	8	36	152	4	8	88	21	58	130
8	81	210	5	13	80	6	36	122	4	8	99	34	100	220
9	94	267	4	49	55	9	47	184	5	11	100	40	104	279
8	103	247	4	17	65	8	44	168	4	16	90	34	133	306

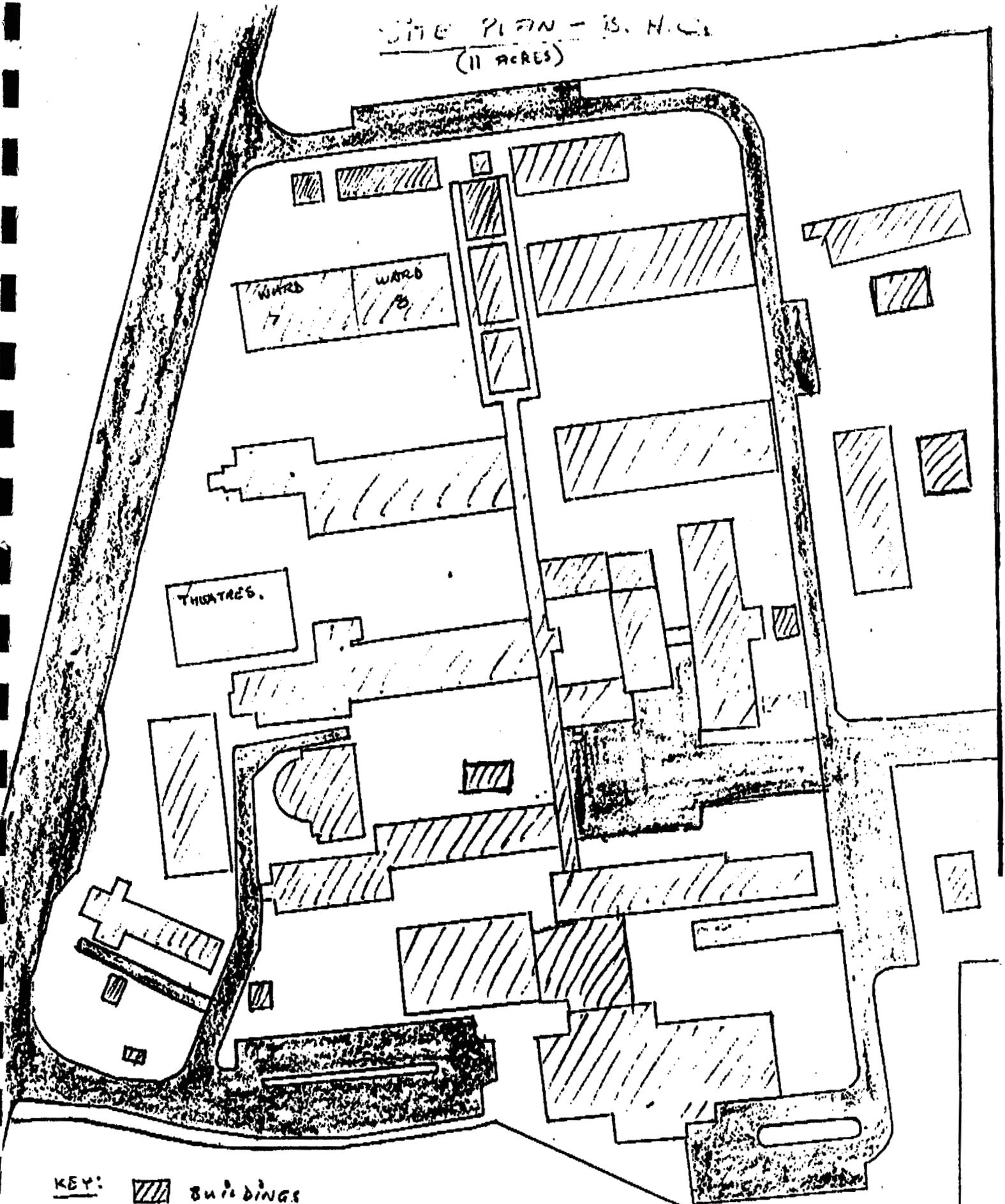
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Appendix 2

Sketch Site Plan of Bustamante Hospital For Children

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SITE PLAN - IS. H.C. (11 ACRES)



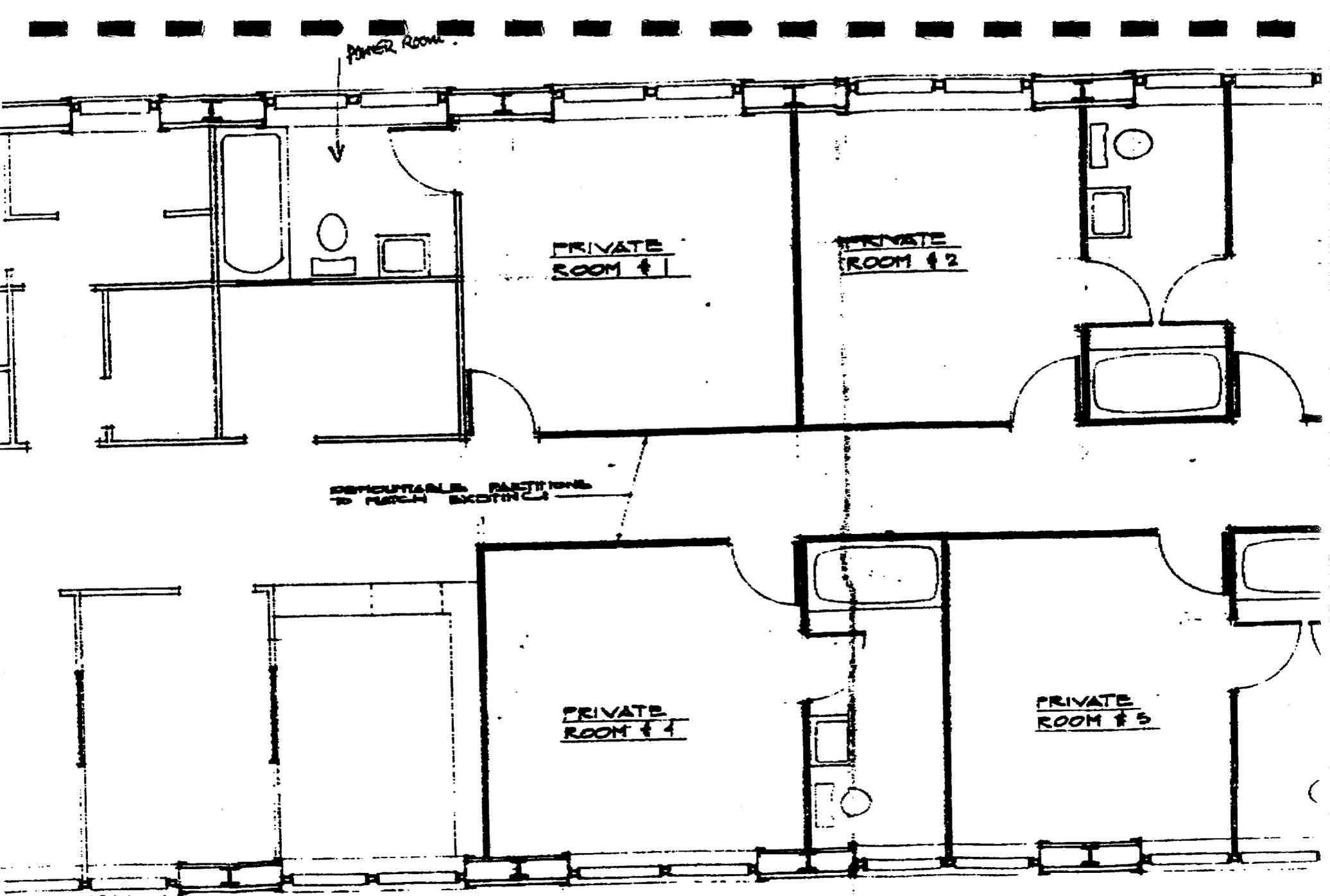
- KEY:
-  BUILDINGS
 -  PAVED AREAS
 -  "GREEN" AREAS

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Appendix 3

Architects rough plan for the development of Ward 8 into a six-bed private patient unit.

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Appendix 4

Example of marketing material produced to inform hospital staff of development.

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**THE ROYAL NATIONAL ORTHOPAEDIC HOSPITAL
NHS TRUST**

IAN MONRO WARD



A PRESTIGIOUS NEW FACILITY FOR PRIVATE PATIENTS

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IAN MONRO WARD, the privacy and comfort of home - in a leading specialist hospital.

Ian Monro Ward has been created to give private patients an environment of the highest quality and one which is appropriate to the international standing of a hospital with the reputation of the Royal National Orthopaedic Hospital.

The ward is composed of eight spacious single en-suite rooms furnished and equipped to a standard which will satisfy the most discerning. Seven of the rooms have walk-in showers to facilitate bathing for patients whose operation makes it difficult for them to use a bath, this is particularly practical for patients in wheelchairs. The eighth room, in addition to being substantially larger, has a mechanically aided bath to assist patients who are immobile.

Each room is tastefully decorated with its own colour television, direct dial telephone, nurse call system and all the other facilities expected by today's private patient. For the businessman who wants to stay in contact we can provide a full secretarial and facsimile service.

The ward has its own permanent nursing staff so that every patient can receive individual care and attention. All of our staff undertake regular training updates to ensure that the excellence of patient care is maintained.

To help make your stay as comfortable as possible you have the choice of any daily newspaper or periodical and tea, coffee or other beverages are served at any time on request. The choice of meals is varied, the quality of the food excellent and given our international clientele we cater for special religious, national or medically directed diets.

If you prefer something which is not on the menu this can usually be arranged after discussion with our staff and the Chef and there is a special menu available for children. A wine list is available, subject to your Consultant's approval.

The visiting hours for all patients are unrestricted and parents are welcome to stay overnight with their children; should a visitor wish to join you for a meal we will be happy to arrange this. An additional charge is made for these services.

A private consulting room is incorporated into the ward for private out-patient consultations.

THE FULL RANGE OF SERVICES AVAILABLE

As you would expect the RNOH is equipped with the most up to date facilities and equipment including :

- **MRI Magnetic Resonance Imaging**
- **Gamma Camera for Isotope Imaging**
- **Osteodensitometry**
- **Gait Analysis Equipment.**
- **Isokinetic Systems**

as well as the full range of more usual diagnostic and therapeutic services including

- **Radiology**
- **Physiotherapy which is available 7 days a week**
- **Occupational Therapy**
- **Psychology**
- **Orthotics**
- **Dietetics**
- **Medical Physics**

and in conjunction with the Institute of Orthopaedics the specialist services of

- **Biomedical Engineering**

In addition the facilities of the Mike Heaffey Sports and Rehabilitation Centre, which is the first in Europe to have been purpose designed with the aim of integrating the able bodied and disabled in a wide range of leisure activities, is available to private patients during their stay.

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Appendix 5

Example of the Ian Monro Ward operating budget, showing the detailed breakdown of cost heads required for financial control of a private patient unit.

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ROYAL NATIONAL ORTHOPAEDIC
DEPARTMENTAL REPORTS DECEMBER 1992

	[-----THIS PERIOD-----]			[-----YEAR TO DATE-----]			LAST YTD
	ACTUAL	BUDGET	VARIANCE	ACTUAL	BUDGET	VARIANCE	
PATIENT DAYS	6	0	6	79	0	79	149
MUNRO WARD							
ES							
03 INPATIENT REVENUE - OTHER	66,421	56,291	10,130	608,830	506,619	102,211	0
06 OUTPATIENT REVENUE	0	0	0	103	0	103	0
80 OTHER INCOME	777	0	777	5,623	0	5,623	0
	<u>67,198</u>	<u>56,291</u>	<u>10,907</u>	<u>614,556</u>	<u>506,619</u>	<u>107,937</u>	<u>0</u>
TOTAL COSTS	67,198	56,291	10,907-	614,556	506,619	107,937-	0
00 MONTHLY PAID STAFF	18,357	19,983	1,626	167,608	179,847	12,239	0
300 AGENCY STAFF	267	0	267-	5,124	0	5,124-	0
700 BANK NURSES	1,479	0	1,479-	22,820	0	22,820-	0
035 BOOKS AND PERIODICALS	27	0	27-	416	0	416-	0
037 CATERING RECHARGE	2,000	2,000	0	18,000	18,000	0	0
045 CLEANING EQUIPMENT	0	0	0	20	0	20-	0
050 CLEANING MATERIALS	254	166	88-	437	1,494	1,057	0
055 COMPUTER HARDWARE	0	0	0	1,674	0	1,674-	0
060 COMPUTER SOFTWARE	68	0	68-	237	0	237-	0
065 CONSULTANTS FEES	300	0	300-	10,415	0	10,415-	0
067 CREDIT CARD CHARGES	48	0	48-	571	0	571-	0
070 CSSD	9	166	157	917	1,494	577	0
080 DRESSINGS	0	50	50	0	450	450	0
112 EQUIPMENT OTHER	0	0	0	972	0	972-	0
130 FURNITURE AND FITTINGS	0	0	0	1,581	0	1,581-	0
148 HOTEL SERVICES RECHARGE	0	0	0	23,994	23,994	0	0
150 INSURANCE PREMIUMS	2,666	2,666	0	1,041	3,294	2,253	0
155 KITCHEN EQUIPMENT	0	0	0	505	0	505-	0
180 LINEN SERVICE	979	491	488-	4,999	4,419	580-	0
185 MAINTENANCE CONTRACTS	0	166	166	717	1,494	777	0
188 MARKETING	0	833	833	78	7,497	7,419	0
222 MISCELLANEOUS	291	700	409	1,060	6,300	5,240	0
255 NETRHA STORES	116	0	116-	2,247	0	2,247-	0
315 ORTHOTICS READY MADE	0	0	0	1,274	0	1,274-	0
320 OTHER ACCRUALS (FINANCE USE)	1,000-	0	1,000	109	0	109-	0
325 PATHOLOGY CHARGES	0	0	0	66	0	66-	0
340 PLANTS AND SEEDS	16	0	16-	72	0	72-	0
350 POSTAGE	0	0	0	2	0	2-	0
400 PROVISIONS NETRHA STORES	0	0	0	3	0	3-	0
2405 PROVISIONS OTHER	97	0	97-	380	0	380	0
700 STATIONARY	301	83	218-	2,010	747	1,263-	0
2800 STUDY LEAVE	10	466	456	1,679	4,194	2,515	0
7801 STUDY LEAVE AMENITY ACCOUNT	60-	0	60	1,003-	0	1,003-	0
3000 TELEPHONE RENTAL	97	416	319	918	3,744	2,826	0
3152 THEATRE CHARGE	8,500	8,500	0	76,500	76,500	0	0

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ROYAL NATIONAL ORTHOPAEDIC
DEPARTMENTAL REPORTS DECEMBER 1992

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Page 002

300 TRAVEL PATIENTS
310 TRAVEL STAFF

[-----THIS PERIOD-----]		
ACTUAL	BUDGET	VARIANCE
0	0	0
10	0	10-
<u>34,832</u>	<u>37,052</u>	<u>2,220</u>
<u>34,832</u>	<u>37,052</u>	<u>2,220</u>

[-----YEAR TO DATE-----]		
ACTUAL	BUDGET	VARIANCE
619	0	619-
347	0	347-
<u>348,411</u>	<u>333,468</u>	<u>14,943-</u>
<u>348,411</u>	<u>333,468</u>	<u>14,943-</u>

LAST YTD
0
0
0
0
0

TOTAL COSTS

NET REVENUE

<u>32,366</u>	<u>19,239</u>	<u>13,127</u>
---------------	---------------	---------------

<u>266,145</u>	<u>173,151</u>	<u>92,994</u>
----------------	----------------	---------------

patient Day :

REVENUES
COSTS
NET REVENUE

11,200	0	11,200
5,805	0	5,805-
<u>5,394</u>	<u>0</u>	<u>5,394</u>

7,779	0	7,779
4,410	0	4,410-
<u>3,369</u>	<u>0</u>	<u>3,369</u>

0
0
0

END OF REPORT

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Appendix 6

Example of the detail planning and costing required for a service to be provided to a private unit - Example is Linen Services which is purchased from an external supplier for the Ian Monro Ward, not from the in-house service.

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SUNLIGHT HOSPITAL SERVICES

STOCK AND USE CALCULATIONS

WARD: RNOHT Stanmore

No. OF BEDS: 8

No. OF OCCUPIED
BEDS, AVERAGE: 6/75%

BED ASSEMBLY	USE P.P DAY	DAILY USE	5 PAR TOTAL	BED STOCK TOTAL	TOTAL STOCK REQUIREMENT	DAILY WARD STOCK	WEEKEND WARD STOCK
Sheets Bone	1.25	7.5	38	16	54	15	30
Pillowcase Bone	1.00	6.0	30	24	54	20	40
Bath Towel White	.80	4.8	24	8	32	10	20
Hand Towel White	.80	4.8	24	16	40	10	20
Bath Mat White	.35	2.1	11	8	19	5	10
Patient Gown	.30	1.8	9	—	9	5	10
Childrens Gown	.30	1.8	9	—	9	5	10
Dressing Gown	.10	.6	3	—	3	5	10
Linen Bag	.10	.6	3	—	3	2	4
Blanket Ivory	.35	2.1	11	8	19	6	12
Duro Pad	.35	2.1	11	8	19	6	12

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SUNLIGHT HOSPITAL SERVICES

ESTIMATED TEXTILE USE AND COST

HOSPITAL: RNOHT Stanmore

No. OF BEDS: 8

Based on 6 beds.

No. OF OCCUPIED
BEDS, AVERAGE: 6/75%

WARD:

BED ASSEMBLY	USE P.P DAY	PRICE PER USE	COST P.P DAY	PATIENT DAYS PER WEEK	ESTIMATED COST PER WK (EX vat)
Sheets	1.25	.56	0.07	42	29.40
Pillowcase	1.00	.30	0.03	42	12.60
Bath Towel	.80	.43	0.34	42	14.28
Hand Towel	.80	.33	0.26	42	10.92
Bath Mat	.35	.37	0.12	42	5.04
Patient Gown	.30	.55	0.16	42	6.72
Childrens Gown	.30	.43	0.12	42	5.04
Dressing Gown	.10	.78	0.07	42	2.94
Linen Bag	.10	.16	0.01	42	0.42
Blanket Ivory	.35	.88	.30	42	12.60
Duro Pad	.35	.84	.29	42	12.18
Total less Blankets & Duro Pads	.05	3.91	2.08	42	87.36
TOTAL	5.70	5.63	2.67	42	112.14

Appendix 7

Job Description for the Administrative Officer running the RNOHs Private Patient Unit.

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ROYAL NATIONAL ORTHOPAEDIC HOSPITAL TRUST

Post: Private Patients Administrator
Grade: A & C Grade 3
Reports To: Private Patients Sister
Accountable To: Senior Nurse, Adult Directorate
Responsible For: Administration of Private Patient Service,

JOB SUMMARY:

The post is a key role within the Private Patients Service. The function of the administrator is to establish and maintain the administration systems for both inpatient stays and outpatient visits.

To ensure the effectiveness and smooth running of the system and to maintain its efficiency. The post holder will be responsible for pricing and raising invoices for all Private Patient activities within the hospital and also receiving and recording all monetary transactions. To work in close co-operation with the Finance Department and comply with guidelines set by the auditors.

GENERAL OFFICE MANAGEMENT:

1. 1 Responsible for the organisation and effectiveness of private patients' administration systems.
1. 2 Setting up and maintaining computerised systems for private patient administration and billing systems.
1. 3 Ensuring that reception areas are constantly staffed, for answering telephone enquiries and receiving admissions and outpatients.
1. 4 Ensuring that case notes and X-Rays if appropriate are available for all admissions and any other clinical need and that new case notes are raised for all new patient admissions.
1. 5 Dealing with enquiries from the public and GP's about the Private Patients' Service and providing information about costs of procedures and treatments.

RESERVATIONS AND FINANCE:

2. 1 Accepting and co-ordinating all reservations for inpatients stays, day patients, consulting rooms and theatre sessions if required.
2. 2 Contacting all patients by telephone or by letter to confirm admission arrangements.
2. 3 Raising 'agreement to pay' contracts for signature at time of admission.
2. 4 Arranging for collection of deposits or recording of insurance details.
2. 5 Pricing inpatient stays (accommodation, theatre charges, prostheses, investigations, etc) for all private patients. Raising and processing invoices.
2. 6 Pricing outpatient investigations and collection of payment at time of visit.
2. 7 Issuing receipts for deposits taken and payments received and recording same.
2. 8 Collation of all information for preparation of computerised invoices and for prompt despatch of invoices to patients and insurance companies.
2. 9 Accepting and processing invoice queries in conjunction with the Finance Department as necessary.
- 2.10 Receiving payments and relaying payment information and payments to Finance Department - including contacting the poor or slow payers before referral to debt collection agency. Ensuring costs are ready for billing within an agreed time, discharge date being known. Furnishing Finance with the information to bill and solving invoicing problems.

STATISTICS:

3. 1 Providing information required by Senior Nurse, Finance Department and auditors.
3. 2 Providing Finance Department with information for departmental recharges to be made.
3. 3 Providing information about private patient activity, providing weekly, monthly and quarterly returns.
3. 4 Providing a PAS computerised system of admissions, discharges and transfers.

3. 5 Providing Korner information if required.

COMMUNICATION:

4. 1 Maintaining effective communication with nursing and all other staff.
4. 2 Providing information to prospective customers and consumers of the Private Patient Service.
4. 3 Communicating with all Service Departments concerning pricing information.
4. 4 Communicating with main theatres to arrange operating sessions.

Appendix 8

Private Patient Questionnaire distributed to all Clinicians at BHC.

Private Patient Questionnaire

ALL INFORMATION PROVIDED WILL BE TREATED IN THE STRICTEST CONFIDENCE

In order to assist the Hospital in establishing the feasibility and viability, as well as the appropriate size for a Private Patient Unit on site, please provide the fullest information possible in your answers. All information provided in the response will be treated in the strictest confidence and the questionnaires destroyed once an analysis of all responses has been made.

- 1. Name
- 2. Specialty
- 3. Do you have particular special interests within the specialty? Please detail

.....
.....
.....

4. Surgical Workload

4.1 Please give below details of the annual volume of private surgical in-patient workload. If possible please provide actual figures for the most recent 12 month period.

	Number of cases	Average length of stay (days)
Minor
Intermediate
Major / Complex

4.2 Day Cases

Surgical - General anaesthetic

Surgical - Local anaesthetic

Endoscopic

4.3 Please tick those days and session times on which you prefer to operate

	Morning	Afternoon	Evening
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

5. Medical Workload

Please note below the private general paediatric medical caseload you admit to a private hospital per year

Number of patients

Average length of stay

6. General Practice workload

Please note below the private general practice caseload (if any) you admit to hospital

Number of patients

Average length of stay

7. Future Development.

WHAT PROPORTION OF YOUR PRIVATE IN-PATIENT WORKLOAD WOULD YOU WANT TO ADMIT TO A PRIVATE PATIENT FACILITY ESTABLISHED AT BUSTAMANTE HOSPITAL ?

.....

.....

8. Out-patient

Please give details of the annual private out-patient workload

8.1 How many patients do you see each year

8.2 Where do you currently see these patients ? Please tick each that applies.

Own rooms / office

Shared or rented rooms / office

Private hospital consulting rooms

8.3 Would you want to have private consulting facilities in a private patient development at Bustamante Hospital.

Yes No

Particular conditions that would make you consider moving your office to Bustamante. Please detail.

.....

.....

8.4 If yes (or possibly if special requirements were met) please tick those sessions you would require.

	Morning	Afternoon	Evening
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

9 Age Group of patients

Please indicate the percentage of you patients which fall into the following age ranges.

12

- 0 - 2 years of age%
- 2 - 5 years of age%
- 5 - 10 years of age%
- Over 10 years of age%

10. Where are your patients currently admitted

- Nuttall
- Andrews Memorial
- St. Josephs
- Medical Associates
- Other please detail

10.1 On what basis do you decide the hospital to admit patients to

11. How do your patients pay for their treatment

Estimated percentage.

- Completely funded by insurance
- Insurance with top-up payments
- Self - pay
- Employers
- Other

Total 100%

12. How many pathology tests do you order each month for your private patients

13. How many x-ray investigations do you require each month for your private patients

14. Please specify any special procedures that you require from x-ray

Procedure

Numbers per year

.....
.....
.....

15 Intensive treatment/care unit. Please estimate the number of patients likely to require ITU/ICU care per year

.....

16 Lastly, please tell us what particular facilities or services you think a private patient centre should have in order to be successful and any characteristics that you would want to see in order to undertake your private practice there.

Thank you very much for taking the time to complete this questionnaire. Please now seal it into an envelope and pass this to Dr Johnson, SMO Bustamante Hospital by September 30th 1993, She will act as the central collection point and pass the completed forms to SCS

Thank you once again

Yours sincerely.

Appendix 9

List of Consultant Clinicians providing services at BHC.

Example of the Ian Monro Ward operating budget, showing the detailed breakdown of cost heads required for financial control of a private patient unit.

**LIST OF RESIDENT CONSULTANTS AT
BUSTAMANTE HOSPITAL FOR CHILDREN**

- | | |
|----------------------------|--------------------------------------|
| 1. Dr. Barbara E. Johnson | - Senior Paediatrician |
| 2. Dr. Hazel Chung-Knight | - Consultant Anaesthetist |
| 3. Dr. William W. Dennis | - Consultant Paediatric Surgeon |
| 4. Dr. Karlene Neita | - Consultant Radiologist |
| 5. Dr. Beverly Reid | - Consultant Paediatrician |
| 6. Dr. Sonia Henry-Heywood | - Consultant Paediatrician |
| 7. Dr. Joy Williams | - Consultant Paediatrician |
| 8. Dr. Charmaine Scott | - Consultant Paediatric Cardiologist |
| 9. Dr. Margaret MacAlpine | - Dental Surgeon |
| 10. Dr. Y. Sujathamma | - Consultant Paediatric Surgeon |

**LIST OF PART TIME CONSULTANT AT
BUSTAMANTE HOSPITAL FOR CHILDREN**

- | | |
|--------------------------|----------------------------------|
| 1. Robert Wan | - Consultant Urologist |
| 2. Dr. John McHardy | - Consultant Neurosurgeon |
| 3. Dr. R. Cheeks | - Consultant Neurosurgeon |
| 4. Dr. G. Arcott | - Plastic Surgeon |
| 5. Dr. Leighton Logan | - Plastic Surgeon |
| 6. Dr. Angella Clare | - Dermatologist |
| 7. Dr. Hal Shaw | - E.N.T. Surgeon |
| 8 Professor John Golding | - Consultant Orthopaedic Surgeon |
| 9. Dr. Christopher Rose | - Consultant Orthopaedic Surgeon |
| 10. Dr. Chutkhan | - Consultant Orthopaedic Surgeon |
| 11. Dr. I. Ali | - Consultant Orthopaedic Surgeon |
| 12. Dr. Warren Blake | - Consultant Orthopaedic surgeon |