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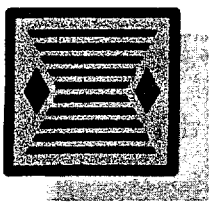

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REVIEW OF THE FEASIBILITY OF DEVELOPING A PRIVATE PATIENT FACILITY AT BUSTAMANTE HOSPITAL FOR CHILDREN NEW KINGSTON, JAMAICA

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October 1993

Stanmore
Consulting
Services

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.

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October 1993

Building the Business of Public Service

Executive Summary

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Acknowledgements

Stanmore Consulting Services would like to take this opportunity to thank the numerous individuals and organisations who generously gave of their time and wilingly shared their experience and views on the proposed development.

We are indebted to the HSIP team for their assistance in preparing the way for our visit and in particular we thank Mr Donald Prince for organising the meeting schedule which helped to make the visit so worthwhile. In addition we thank the management and clinicians of BCH who gave up precious time to talk with us and finally a special mention should be made of the invaluable assistance of Dr Palamino-Lue, President of the Paediatric Association of Jamaica.

Introduction

Background

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 feasability of developing a private patient ward at Bustamante Hospital for Children (BHC).

The senior management of BHC, responding to market pressures, exemplified by requests from patients and clinical colleagues for access to private patient facilities, are in the initial planning stages of developing a private patient facility. It was felt by HSIP that SCS could contibute to the development in terms of both their management consultancy experience in planning private health-care facilities and their practical experience in the development of private patient facilities within a national health service hospital. This experience includes the recent development at both the RNOHs' Central London and Stanmore hospital sites, of private in-patient wards and out-patient consultation facilities.

Terms of Reference

The objective of the review was to address the following issues for a private ward development :

- the size of the potential market
- analysis of the competitors in the marketplace
- facilities required to accomodate the identified/projected demand
- availability of potential accomodation within the current hospital
- outline of the facilities required in the potential unit
- identification of cost heads associated with a facilities operation
- impact of such a development on the regular workload of the hospital

The review was intended to act as the pilot phase of the project to develop a private patient unit, in that it would identify in detail the information that is required to undertake a full economic appraisal of the concept and evaluate, at the outline stages, the likely feasability of such a project being successful.

In addition to the quantitative, task-orientated points noted above, the consultancy assignment had the secondary aim of sharing the UK experience with the senior management of BHC in order to develop their understanding of the full range of commercial opportunities potentially available to them.

Consultancy Approach

In order to obtain a fuller understanding of the background to the project and also to establish the degree of support for the proposal within BCH, a series of meeting were undertaken. These included meeting :

The Senior Hospital Management group, comprising

Mrs Carlene Neugent	Chief Executive Officer
Dr Barbara Johnson	Senior Medical Officer
Mr Henry Anglin	Hospital Administrator
Mrs Gwendolyn Francis	Hospital Matron

to discuss the thinking on the project so far and the stage which the planning had reached.

A cross section of the Consultant medical, surgical and diagnostic services clinical staff were met to test certain ideas and to guage the clinical support for the proposed development

Selected Heads of Department from paramedical, information and support services were interviewed to attempt to establish the availablity of services to support a private facility.

Dr Palamino-Lue, President of the Paediatric Association and Dr Johnson in her role as a paediatrician, to obtain a broader understanding of the context within which BHC operated. Following this meeting the privilidge was extended to the consultants to accompany Dr Palamino-Lue to visit both her own consulting rooms, as well as to the facilities available within two of the private sector hospitals in Kingston, Nuttall Memorial Hospital and Andrews Memorial Hospital.

A variety of recent statistical data was obtained from the Medical Records Officer at BHC to place the impact of the potential workload, which a private facility might create, in proper context.

A visit was made to the ward area which had been identified as the proposed location for the private patient facility and detailed discussions undertaken with the Hospital Administrator regarding technical building constraints on the development and also the opportunites for other developments in the site.

The Statistical Institute of Jamaica was visited and a variety of statistical data and information was obtained in order to support the analysis of the potential market which the development might serve.

A questionnaire was prepared and distributed to all the clinical staff at BHC requesting details of the volume of private practice that they undertook and their views on a potential development, in particular the services that they would require in order to undertake private practice in a new facility.

A meeting was held with representatives of the insurance companies currently involved in the health insurance market, to establish their views on the expansion of private health care facilities in State hospitals generally, current trends in the health care insurance market and finally to gauge their potential support for the development of a paediatric facility within BHC.

Lastly a meeting was held with Dr Ashley at the Ministry of Health in order to obtain both her views on a development (her clinical specialty being paediatrics) and to give feedback on progress over the period on-site. At this meeing certain epidemiological data was made available on the usage of paediatric in-patient facilities.

Current Position

In order to establish the feasability of the proposed development it is important that the context within which it will operate is reasonably clearly understood. For this reason we present below our understanding of both BHCs' position in the current health care market place. The general market for private health including both the current providers of care with which the new facility will have to compete and also the insurers and the payment mechanisms are also reviewed.

Bustamante Hospital for Children

BHC is a busy, 244 (nominal) bedded paediatric hospital, located in New Kingston, which provides both secondary and some tertiary level services. The hospital was opened in 1963 and is the Islands only dedicated paediatric hospital. The facility was originally a British Army barracks and the buildings which date from this period are predominantly single story brick built units, based on the Pavillion type of design. The complex of pavillions is connected by covered walkways. In the late 1980s a variety of additions were made to the hospital. These include both single and double story system-built buildings supplied by an Italian company. The new buildings are linked into the system of covered walkways and include out-patient and office facilities, clinical facilities and ward space. The entire hospital occupies a compound are of some 11. acres. An important point to note is that currently BHC does not accept children who are older than 10 years of age.

The hospital has its own laboratory and x-ray facilities but relies on the laboratories at Kingston Public Hospital for some support services. The hospital has a consultant population of 10 full time consultants and 12 part time consultants covering all of the genral specialties and most of the sub-specialties.

We understand that although the hospital has a nation-wide catchment, the majority of the patients treated in the unit come from the metropolitain Kingston area comprising the parish of Kingston and the urban parts of the parish of St Andrew as well as parts of the parish of St Catherines which abutts Kingston Parish.

Hospital Based Health Care

Jamaica has always had coexisting public and private health-care sectors. By the middle of the 1980s it was estimated (Lalta 1991) that the private health care market accounted for about 32% of the nations total health expenditure, even though private in-patient facilities consituted less that 6% of the nations hospital bed stock.

There are 24 public hospitals in Jamaica, and 7 private hospitals. The state hospitals vary in size and range of services provided and are classified type A, B or C according to the level of service provided and the catchment population served. The type C hospitals are the smaller units which interface with the primary health care system at the Parish level. In-patient and out-patient services are provided in general medicine, child and maternity care. Some of these hospitals, but not all, provide the services of a specialist surgeon.

Type C hospitals are normally staffed by 2 or 3 doctors and provide basic x-ray and laboratory services, not only for hospital patients but also for the primary health care services in both public and private sectors.

The type B hospitals are mostly situated in the larger urban centres and provide in-patient as well as out-patient services in at least the 4 basic specialities of general surgery, general medicine (internal medicine), obstetrics and gynaecology and paediatrics. The government recognises that the support services in such units may not have been either maintained or upgraded to the appropriate standard to support the role of being a secondary referral centre for the type C units.

Type A hospitals include the teaching hospitals such as UHWI (University Hospital of the West Indies), Kingston Public Hospital and Cornwall Regional Hospital in Montego Bay. These multi-disciplinary hospitals provide both secondary and tertiary level services for the whole Island. In addition to the type A hospitals there are 6 specialised hospitals including :

Victoria Jubilee	229 bed maternity hospital
Mona Rehabilitation Centre	111 bed rehabilitation hospital
BCH	244 bed paediatric hospital
The Hope Institute	52 bed hospice (terminal care) unit
The National Chest Hospital	116 bed thoracic medicine unit and
The Bellevue Hospital	1600 bed psychiatric unit

There are approximately 350 state health centres within the Island of various which act as the base for the delivery of primary, preventative and community health care.

Over the period 1987 to 1991there appears to have been a reduction in the bed complement in the type A, B & C hospitals from 3126 (1987) to 2630 (1991), although several hospitals did not submit figures for the most recent years, which may be the reason for the apparent reduction. (Source : Statistical Yearbook of Jamaica 1992)

Private Sector Hospital Facilties

Private medical care is provided at all levels from private general practitioners (family doctors) through to complex tertiary in-patient care. In the past, as indicated by the figures above, the majority of the expenditure in private health care was associated with primary health care and the purchase of pharmaceuticals, however we are informed (by the health insurers) that hospitalisation is seen as playing an increasingly important part in the costs of private health care. The 7 private hospitals include the following :

Community Medical Associates Hospital - Kingston

This unit was founded in 1959 by Dr T J Burrowes and a group of colleagues but was roeorganised by Dr S Suite in 1975, following a period of financial difficulties. The statistical yearbook states that it has 44 beds whilst Lalta states that it has 64. The unit is noted by the statistical yearbook as having 19 doctors on its staff with full supporting laboratory, x-ray and pharmacy services. We were informed that this hospital has a policy of not admitting children although in exceptional circumstances this rule may be bent.

Nuttall Memorial Hospital - Kingston

This hospital was built in 1923 as a memorial to the late Rt. Rev. Enos Nuttall, Archbishop of the West Indies and Bishop of Jamaica. There is some divergence of view within the statistical Yearbook regarding the hospitals bed complement. At one point it states that the unit has 65 beds for general medicine and surgery, together with a further 24 beds for maternity cases and a nursery for 24 babies, another entry in the Yearbook states a total of 65 beds and Lalta also notes a total complement of 65 beds.

This unit operates under the auspices of the Anglican Church and we were informed that it had a number of financial difficulties with its overall operation being viewed as "not-for-profit" rather than a private for profit organisation.

St Joseph's Hospital - Kingston

This hospital is owned and operated by the Roman Catholic Archdiocese of Kingston and when opened in 1916 had 25 beds but now has increased to 66 beds. The unit provides medical and surgical facilities and has a maternity department. Its work is supported by in house x-ray and laboratory services.

The Andrews Memorial Hospital - Kingston

This 45 bed hospital is operated by the Seventh Day Adventists and provides private and semi-private rooms with resident doctors providing 24 hour emergency medical cover. The unit has its own x-ray and laboratory services and includes medical, surgical and obstetric and maternity services. During the visit of SCS to the unit we were informed that the childrens ward has been closed due to problems in obtaining the appropriately trained staff, however children were neverthless admitted to the hospital at the rate of between 6 and 10 per week.

Hargreaves Memorial - Mandeville

This 40 bedded unit located in Mandeville is reported to be staffed by private doctors operating in that area and to provide medical, surgical and maternity services.

Maxfield Medical Centre - Ocho Rios

The only information available is that this unit has 12 beds for in-patient care.

Doctors Hospital - Montego Bay

The only information available is that this unit has 10 beds for in-patient care.

The Tony Thwaites Wing - University Hospital of the West Indies - Kingston / Mona

A recent entrant to the private medical market is the 30 bedded private wing of UHWI. Unfortunately the SCS consultants did not have the opportunity to visit this unit, but were informed by both clinicians and a recent patient that the wing offers a quality of hotel environment which may be considered sumptuous in comparison to the other private hospitals. It should be noted that this unit is not really a private hospital, as it is part of the University Hospital. We understand that some investment was made in this development by one of the health care insureres, Life of Jamaica.

Other Facilities

In addition to the beds noted above we understand that there are facilities for approximately a further 46 private patients, in private wards located within State hospitals. An example of this being the 12 bed unit located at St Annes Bay Hospital on the north coast. We were informed that a number of these units were non-functional for various reasons and thus the total potential private bed complement cannot be established with clarity.

Lalta (1991) notes that the private hospital sector in general faces quite major problems, with only 1 private unit operating at a profit, a proposition which was repeated to the SCS consultants by a number of individuals during thier visit. This unit was believed to be Community Medical Associates although the Tony Thwaites wing, being a new market entrant may additionally be operating at a profit.

<u>Payment Mechanisms for Private Health Care.</u>

Acording to Lalta (1991) about 50% of all contacts with the private general-practice health sector are covered by health insurances of one form or another, 45% are paid directly by the consumer (or family) and the remaining 5% are "gratis". These figures are not dissimilar to those presented by Cumper (1990) in his review of the Investment Climate for Private Health Care where the following figures are presented :

Source of Private General Practitioners Income

Fee for Service (Direct Payments)	60%
Third party payments (Health insurances)	25 - 30%
Employer-provider negotioations	5 - 8%
Capitation schemes (OAPs & Schools)	3 - 5%

Unfortunately data could not be located which gave insight into the source of payments for private in-patient care within hospitals. Anecdotally the SCS consultants were informed by several clinicians that about 50% of those patient treated in private hospitals had insurance and that where these were not in place the extended family network would often make arrangements to pay for the treatment.

Private Health Insurance

In order to determine the coverage of insurance within the population two sources in particular have been reviewed in detail, these are the work of Joseph Kutzin under the auspices of PAHO and George Cumper in his paper on the private health care investment climate. In addition some information was was obtained from the Survey of Living Conditions jointly published by The Planning Institute and the Statistical Institute of Jamaica.

There are five carriers of health care insurance in Jamaica, these being

American Life Insurance Company (ALICO), Jamaica
Blue Cross of Jamaica
First Life Insurance Company Ltd
Life of Jamaica Ltd
Mutual Life

The largest Health Insurance Company, Blue Cross of Jamaica, accounts for over 60% of the insured population and is the only business exclusively conducting health insurance, the other providers being part of general insurance companies which also conduct health business. It is interesting to note that Life of Jamaica also operates an HMO (health maintenance organisation) . Most policies are group insurances with the coverage extending (or extendable) to individuals or dependants.

In general the policies offered are basic indemnity plans with co-insurance or co-payment provisions and a defined annual or per use maxima. In the past private health insurance has been predominantly used for ambulatory (out-patient and doctor consultations) care and from the purchasde of pharmaceuticals, with just over 10% of the total claims paid out relating to private hospital in-patient stays. (data from various sources 1986 and 1987)

By far the largest type of health care insurances offered are those related to "Group" insurance, generally through an employer organised group insurance scheme with the minimum number of employees for entry being as low as 4 in some cases. Such insurance accounted for over 90% of the insurance cover carried in 1987 (Kutzin 1989) with individual or family "commercial" insurances being far less common.

The Health Insurance Industry as currently observed, developed through the 1980s with a fairly rapid expansion in group memberships particularly during the early -mid 1980s and then what appears to have been a decline in membership numbers through the late 80s and early 90s.

It is worth noting that in the "round-table" discussions held with representatives of the insurers, the current level of population coverage was tested. The figures indicated by various researchers and also from statistical sources were quoted (these are presented below) and the response was that these figures were too low and that a more realistic figure was in the order of 15% of the population being covered by some form of insurance. In addition it was noted that there has been an increase in the number of personal policies being taken out.

Table 1 below shows the growth in employment based group health insurance coverage in Jamaica 1980 to 1986

Table 1

Year	No of employed persons with group health insurance
1980	69,202
1981	75,803
1982	83,077
1983	98,022
1984	106,636
1985	110,360
1986	119,922

Source : Kutzin 1989

Table 2 shows details of the coverage of Health Insurance as at July 1987

Table 2

Group Insurances		Non-Group Insurances		Total
Employees	Dependents	Enrollees	Dependents	
108,848	190,375	10,312	15,810	325,345

Source : Kutzin 1989

Since 1987 Cumper reported that there had been a decline in the number of lives covered by private health insurances and an estimate made in 1989, based on questionnaires and claims experience put employee membership at between only 70,000 and 80,000 with a total national coverage (including dependents, individual coverage and the Kingston HMO) at approximately 214,000 or roughly 9% of the Islands population.

The percentage of the population covered by insurances has been reported in the results of the Survey of Living Conditions (SLC). The survey carried out in 1989 is reported to show an overall average across the Island of 8% of the population covered, varying between 16% in the Kingstom Metropolitain Area to 5% in rural areas.

The figures quoted are consonant with Cumpers estimate of 9% and accords well with the SLC results for the two reviews in 1989 as well as the 1990 and 1991 results, which are as follows :

Table 3

Survey Date	Percentage with health insurance
1989 - 1	8.2
1989 - 2	8.1
1990	9.0
1991	8.6

The results of the 1991 survey of living conditions, the most recent publication available, indicate that in the Kingston Metroplitain Area 16.6% of the population held insurance, other urban populations held insurance at the rate of 10.9% of the population and in rural areas only 3.8% had health insurance. Of particular importance, the 1991 SLC showed that in the survey the population of children between 0 and 13 covered by insurances was as follows :

Table 4

Age Group	Percentage with health insurance
Under 1 year of age	6.1%
1 to 4 years of age	6.4%
5 to 13 years of age	7.1%

The above figures are for the Island as a whole and no indication was made in the survey report of differential rates of paediatric coverage in different geographical locations.

In the limited time available for the research these figures have been used as the basis for the calculation of the potentially insured populations which might use a private patient facility at Bustamante Hospital.

Definition of the Hospitals' Potential Market.

BHC has a number of different markets open to it, if it wishes to generate income from activities within the private health care sector. These obviously include, but are not limited to, the provision of private (fee paying) in-patient accomodation. Other opportunities which could be explored from within the hospital premises include :

provision of private day-surgery facilities utilising the hospitals operating theatres

provision of specialist services such as developmental monitoring clinics

provision of paediatric primary care / general practice services available without appointment (the Doc in a Box concept) as a first point of access into the private services to be provided at BHC.

servicing the clinicians as a seperate market by selling them private consultation / office facilities with access to better diagnostic services than they would normally have in their own practices

development of on-site retailing outlets aimed at the paediatric / child market

In discussions with the management and clinical staff, interest was expressed in all of these as potential areas to be explored.

As regards the core issue of developing a private ward in the hospital, given the key decision making/influencing role of the clinicians as to where a patient is admitted, the hospital has two "in-patient" markets to address. The first being those patients who are under the care of clinicians attached to BCH and the second patients of those paediatric doctors who undertake their practice elswhere.

It was the feeling of a number of the clinicians interviewed, that the main market which the Hospital should address was really that based in the local geographical area. We were told that the majority of the private practice originated within the Kingston Metropolitain area although some work would be referred from further away for the more specialised services which BHC offered. As with all private health-care developments, once established a facility creates its own "gravitational pull" which attracts further work, but in the first instance there has to be a sufficiently large local market to justify the initial investment.

At the initial meeting with the senior management of the hospital, we were informed that the concept was for a six-bed unit to be developed within a currently unopened ward, located in one of the newly built pavillions. When challenged as to the basis for a six-bed unit we were told that an architect who had been engaged to undertake preliminary design work could only fit six seperate rooms into the space and that there was feeling within the clinicians that "about six beds was the correct size". Whilst we recognise the importance of obtaining the views, and more importantly engaging the enthusiasm, of clinicians who are potential users of a facility, we believe that it is important to establish the potential size of the market, entry to which is being contemplated, in a slightly more rigorous manner.

Presented below are the calculations which we have undertaken in attempting to establish the size of the potential private paediatric in-patient market and the size of facility required to meet the likely demand. In the calculations we make explicit the assumptions made in order that they can be **rigorously reviewed and actively challenged** by, in particular, the local management and clinicians who are far more familiar with the realities of paediatric care in Jamaica than SCS.

Our experience indicates that time spent at the initial planning stages of a private ward project is time well spent, if expensive mistakes are to be avoided which might otherwise jeapordise the profitability of the venture. We thus welcome the opportunity to present this draft report and look forward to recasting it in the light of comments made. It should be noted that the majority of the assumptions made in the following calculations are minimalist in nature and will thus err towards an underestimation of the market, this being far safer than an overestimation. Further the calculations relate to in-patient care only. It should be noted that many surgical proceedures are undertaken on a day-case or ambulatory basis with a child attending the hospital in the morning and returning home in the afternoon or evening. No account of the potential size of this market has been taken in defining the market size and the physical facilities required to address the market.

Calculation of the size of the Private Paediatric In-Patient Market.

The basis of the following theoretical calculations is that, having defined the population that a private facility will serve, application of epidemiological data to the target population will reveral the potential case load which might be expected. The potential case-load calculation is then subjected to further modification in terms of the populations' insurance coverage or other indicators of ability to pay, in order to determine the pool of potential private work which clinicians will be competing for. In estimating the size of the resulting facility we have made some assumptions regarding how much of the target market might be captured by a development at BHC.

Definition of the Target Population

From the discussions we undertook with clinicians it would appear that the main population from within which patients will be drawn, is that resident within the Kingston Metropolitain Area, which we understand comprises both the Parish of Kingston itself and the urban areas of the Parish of St. Andrew. For simplicity we have not included any allowance for patients who might live in the Parish of St Catherine, although we know that some of these patients will look towards the Kingston area for private medical care, rather than towards Spanish Town Hospital.

Unfortunately detailed analysis of the 1991 Census results were not available to us and so we have used the 1991 Population Census, Preliminary Report as the basis of our calculations, adjusted (as described) on the basis of other demographic information available from the Statistical Institute of Jamaica.

The size of the population of the Kinston and St Andrew Metropolitain Area is estimated as being 587,798 in 1991, compared with 524,638 in 1982 (the previous census). No breakdown into age/sex cohorts is presented in the Preliminary Report. These figures however indicate an increase in the population of 12.0388 % over the period.

A breakdown of the urban populations of Kingston and St Andrew into age cohorts is published in Demographic Statistics 1992 (Pages 14 & 15) for the 1982 census.

1982 Census Data

	Age Groups (in years)		
	0 to 4	**5 to 9**	**10 to 14**
Urban area of Kingston	12,670	12,105	12,030
Urban area of St Andrew	46,613	47413	47,027
Total in urban area	59,283	59,518	59,057

Assumption : That the increase in population size between 1982 and 1991 has been reflected by an equal increase in size of all age cohorts.

Applying the inflator of 12.0388 % to each age cohort gives us the following estimations of the population as at 1991.

	Age Groups (in years)		
	0 to 4	**5 to 9**	**10 to 14**
Estimated total urban paediatric population	66,420	66,683	66,167

Unfortunately the epidemiological data is presented for different age cohorts, including the under 1 year of age group, the 1 to 4 years of age and then the 5 to 14 age group.

From the population estimates for 1991 (Page 30 & 31of Demographic Statistics) we estimate that the under 1 year age group constituted 21.464 % of the 0 to 4 age cohort.

Assumption : That the 1991 estimates are reliable and that the age make-up of the urban population under consideration had similar characteristics to the total estimated population.

From the above we derive the following age make up for the urban target population in 1991

	Age Groups (in years)		
	Under 1	**1 to 4**	**5 to 14**
Derived population	14,269.66	52,150.3	132,850

From the 1990 epidemiological data from the Health Information Unit we know the age specific hospitalisation rates for paediatric cases presenting at Bustamante Hospital for Children. These are :

Hospitalisation rates per 10,000 population in given age ranges for all presenting conditions

Age Groups (in years)

Under 1	**1 to 4**	**5 to 14**
1119.7	395.8	151.5

It is then a simple matter of multiplication to derive the case load that this paediatric population would generate. Note as the epidemiological data relates to first-listed diagnosis rather than treatment we have to take a further step to derive even a simple case mix of patients.

Assumption : That 1990 was a typical year and that the population of patients at BHC from which the data was derived were truly representative of general paediatric morbidity requiring hospitalisation.

Age Groups (in years)

	Under 1	**1 to 4**	**5 to 14**
Derived caseload	1597.78	2064.11	2012.68

Total caseload = 5,674.56 in-patient episodes

We know from an analysis of the BHC medical records data that in the past 12 months, September 1992 to August 1993, that of the over 8,000 admissions, 68% were for medical conditions and 32% were for surgical admissions. Also that the average medical length of stay was 5.92 days and that the average surgical length of stay was 8.32 days during the reference period.

Assumption : That the most recent 12 months admission data at BHC is representative data. in terms of case mix and length of stay

Application of the known rates of insurance coverage in the different age groups starts to define the private patient population size which can be expected to present themselves as requiring in-patient care per annum.

Rates of Health Insurance coverage from SLC 1991

Age Groups (in years)

	Under 1	**1 to 4**	**5 to 13**
	6.1%	6.4%	7.1%

	Under 1	**1 to 4**	**5 to 14**
Derived In-patient Population	1597.78	2064.11	2012.68

Resulting in a population of insured patients requiring in-patient care of the following composition :

	Under 1	1 to 4	5 to 14
Private Patient Population	97.47	132.1	142.9
Total	372.47 in patients		

From the analysis of the most recent 12 months of data at BHC we know that the in-patient case-mix composition is roughly 68% Medical cases at 5.92 days average length of stay, which equals a requirement for 1499.42 bed days of care and 32% Surgical cases at 8.32 days average length of stay, which equals a requirement for 991.67 bed days of care. Thus in total 2491.02 bed days will be required to serve the predicted private in patient population.

The number of beds required to serve this population is calculated by dividing the bed-day requirement by the number of days of the year that any proposed ward is to be open. Given the normal requirement for a closure of at least 5 days during the year for maintenance and five days for holidays the denominator used is 355. This results in a projected bed demand of **7.017** beds.

It should be noted that this is the demand calculated as follows :

- only for the insured urban population of Kingston and St Andrew
- for the age group 1 to 14, which is currently not serviced at BHC, the current maximum age of patient accepted into the State sector being 10 years of age
- Assumes that the insurance coverage of 14 year olds is the same as the 13 year olds
- Assumes that the case mix for private patients will be the same as for public sector patients which may not be realistic
- Assumes a zero turn-over interval between patients
- Assumes that the length of stay for private patients will be the same as for public sector patients, whilst in reality it is often shorter

A couple of important points which bear upon the calculation of the minimum demand for beds relate to the "national characteristics" for the use of private health care.

In Western Europe empiric evidence suggests that the most affluent 1 to 1.5% of the population will not bother to purchase health insurance. These individuals and families are of such economic means that health care is simply purchased as required, as with any other good or service. If this situation pertains in Jamaica, and families of such economic means have children whose health care characteristics are similar to the rest of the population, then in addition to the approximately 7 beds required for the Kinston and St Andrew insured populations a further 1 bed will be required to accomodate this element of the population. Of course, as Kingston is the capital city, the size of the population in the top 1% of economic means may be disproportionately large. We unfortunately have no socio-economic data available upon which to base a judgement and thus have used a simple 1% calculation.

A further point which needs to be made is that the calculations above specifically excludes any population from outside Kingston and Urban St Andrew and also only relates to the indigenous, Jamaican market and makes no assessment of the potential for care of patients from the rest of the Carribean or from the Tourist markets.

Given all of the caveats above the "minimalist" demand for private paediatric care can be estimated at approximately 8 beds. Based on the assumption that BHC and its consultants would be unlikely to capture more that 70% of the existing market, a bed complement of 6 beds (5.6 beds rounded up) would seem eminently reasonable as the starting point for designing a ward.

The above figure is, however, only a starting point as given that the capital costs of creating a slightly larger ward would not, in all probability, be significantly greater than a smaller ward; it seems appropriate to attempt to analyse the **likely** demand which a facility at BHC could expect.

As the basis of the calculations has been laid out in some detail above, the commentary on the calculations will be abridged in the following section.

The estimated age-cohort breakdown for the population of Jamaica in 1992 was as follows :

Whole Island 1992 Estimate

Age Groups (in years)

	Under 1	**1 to 4**	**5 to 14**
	58,040	224,540	517,650

Applying the hospitalisation rates noted above to the whole island populations as follows results in the following estimation of total likely hospitalisation by age group :

Hospitalisation rate	1119.7	395.8	151.5
In-Patient case load	6,498.7	8,887.3	7,842.4
Total	**23,228.4**		

Applying the age specific insurance rates to these figures results in the following expected annual populations of in-patients capable of paying for private health care :

Insurance rate	6.1%	6.4%	7.1%
Private In-patients case load	396.4	568.8	556.8
Total	**1522**		

From previous calculations we estimate that 372.5 of these cases will be in Kingston and St Andrew. Thus across the rest of the Island there will be 1149.5 cases which are insured.
Further there will in all probability be a total of 232 cases which fall into the "top 1%" self pay category. If we assume that a ward at BHC was capable of capturing 70% of the insured cases in Kingston and St Andrew, just 10% of the insured cases from the rest of the Island and 40% of the "Top 1%" self pay cases, the case load would be

Kingston and St Andrew	372.5 x 70%	260.75
Rest of Island	1149.5 x 10%	114.95
"Top 1%"	232.3 x 40%	92.92
Total		**468.62**

Of this 468.62, the medical cases, numbering 318.66, would require 1886.47 bed days and the 149.96 surgical cases would require 1247.66 bed days, totaling 3143.13 bed days, which equates to **9 (8.82 rounded up) beds** noting that this figure is arrived at making the same assumptions as above.

All of the above theoretical analysis and calculation ignores points which were raised with us by the clinicians. These include that several clinicians noted that up to 50% of the patients seen by them were in the self-pay category, which would tend towards a doubling of the figures and that we cannot be certain of the rate at which children are insured in the Kingston and St Andrew urban area.

The calculations have applied the rates of insurance found across the Island, as reported by the SLC 1991. But this noted that the rate of adult health insurance in Kinston was roughly double that found in the rest of the Island. If the same doubling effect held good for children then the results of the above calculations would need to be doubled for the Kingston and St Andrew areas, raising the minimum size from 6 to 12 and the likely size of ward required from 9 to at least 15.

Until the questionnaires distributed to the BHC Doctors have been completed, collected and analyses to determine the scale of the work which they would be prepared to bring to a private ward at BHC, the above can only be seen as a theoretical analysis of the demand and likely size of a ward.

What the above section does is to establish, from an analytical point of view, the existance of a demand for private paediatric in-patient care of such magnitude that the proposed development of a ward to address the market appears entirely appropriate.

Given that the case appears proven for the existence of a sizeable market and that it would be feasible to create a private ward to address the market, it is necessary to consider the service characteristics which would be required to compete effectively for the treatment of private patients.

Competitive Position of a Development at BHC

As noted above in the Current Position section, there are 7 private hospitals on the Island, 5 being located in Kingston. In addition the Tony Thwaites wing of University Hospital is also located so as to be easily accessible from Kingston.

Currently none of the Islands' private hospitals have facilities specifically designed for paediatric care and the one hospital which did have an area set aside for paediatric cases has been forced to close the unit because of staff shortages. We were informed that UH has two paediatric wards for public patients, but that one of these was closed. Thus BHC is the only facility which is specifically designed for the care of children which is generally available.

Thus there is no single particular competitor for paediatric private care on the Island. That said the private hospitals do take paediatric cases, but some clinicians informed us that because of the acknowledged quality of BHC, when they saw patients with particular conditions they referred them to BHC to be treated in the public sector, as the hospital would be best able to provide the clincial care that was required.

It would thus appear that there is a niche market with little clearly defined competition which were BHC to enter, it could quickly come to dominate.

An absolutely imperative element in modern thinking about paediatric care is the ability for parents or guardians to stay in the hospital with a child during part or all of their in-patient stay. Unfortunately BHC is not able to offer this facility to parents of children staying on the public wards. It is however an absolute pre-requisite (as noted by the management and clinicians at BHC) if a private ward is to be able to compete effectively with the other private hospitals. Currently BHC is unable to take children over the age of 10 years old and thus children above this age have to be cared for, at least within the state system, on adult wards. This factor alone was related to us as a driver for some parents to arrange for their adolescent children to be cared for in a private hospital.

In considering what makes people turn to private health care in preference to that provided by the state sector, it is worth considering the issues of :

Accessibility
Privacy
Facilities.
Staffing

A key driver for using private health care is the speed with which a patient or parent can obtain a "satisfactory" response from clinicians and their supporting clinical services. A further aspect of the accessibility criteria relates to arranging in-patient care for elective admissions at times which are convenient to the patient. In the case of paediatric care the convenience factor may relate to parental convenience, particularly if there are other children to be cared for.

Another important point for consideration, which weights heavily in the favour of a development at BHC is the issue of accessibility viewed from the point of view of user

clinicians. We understand that the majority of clincians at BHC have contracts which allow them to undertake private practice sessions.

As these sessions are currently undertaken at other hospitals and offices / consultation rooms the clincians have to travel to and from a number of locations. Were facilities of the appropriate quality developed on site it would have considerable advantages for the doctors as they would have less travelling to undertake, a simpler life being able to concentrate on only one or two main location for work and the full facilities of a paediatric hospital to call on for the investigation and care of their patients.

Privacy is, for many of the younger children, not a particularly important aspect. However where parents wish to stay with their children this does become an important issue and the ability to have a "single" room shared by parent and child can only be afforded within the private sector.

Generally the hotel facilities available within the private hospitals are not of a particularly high standard. In the two hospitals which were visited the quality of room finish and the equipment and furniture was not of a particularly high standard. Many of the buildings looked somewhat "tired" and somewhat cramped.

Having visited the proposed location of the private ward in BHC we were extremely impressed with the finish and fitting out of the ward space. By comparison to the private facilites that were visited the proposed ward would be excellent, being located in a ground floor pavillioned building, seperate from the rest of the hospital in an "uncluttered" area. The building is very modern and well equipped from the clinical point of view with piped gas and vacume outlets at each "bed/cot head". Properly developed/refurbished into seperate rooms the ward space identified to us would be of a standard far above that able to be offered by the current private hospitals.

A particular competative advantage of BHC is its posessions of an Intensive Care Unit, which would be both attractive to parents as a "comfort factor" and also allow the clinicians to undertake the care of more seriously ill patients that they could in the current private hospitals, also to undertake more complex surgical proceedures than they might contemplate in a less well equipped environment.

The visual impact of a private ward has a tremendous impact on patient satisfaction. Research has shown that as pateints are unable to consciously judge the quality of the professional services they receive, they subconsciously judge the quality on the basis of the tangible environment within which they stay. Simply put the higher the quality of the environment, the higher the perception of the service quality. Thus the ability to develop a ward in a new and purpose designed building would be of inestimable value to attracting business.

Some of the issues of staffing a proposed ward are discussed below, of particular importance in terms of competative advantage for BHC is the fact that the hospital operates on a 24 hour basis (Lalta notes that only two private hospitals are capable of doing this at present) and has a complement of resident paediatric trained doctors on site out of hours. This unique feature would be a definate competative advantage in "selling" the concept to both parents and consultant clinicians.

As regards the parents, they would know that the best possible clinical care was on hand 24 hours a day, and from the consultants point of view, that they would not necessarily have to respond to night call-outs at several locations. Further as most of the private hospitals do not have a medical resident consultants have to respond to the concerns of nursing staff whome they do not necessarily regularly work with.

By operating the ward as a part of the BHC out-of-hours on-call team within the hospital would be able to screen out some of the vexatious requests for a consultant to attend during the night and a consultant would know with confidence that if they were called, it was for a serious reason rather than something simple such as re-sighting a drip which had either stopped running or was tissuing.

It is worth noting as regards the size of the potential ward, that roughly the same nursing staff input would be required for either 6 patients or 10 patients. The precise level of staff input will depend on the acuity/ severity of illness of the patients together with their associated level of dependence.

In conclusion we see that there is little in the market-place which could compete with the services that a well designed system at BHC could offer. Of vital importance to the success of the proposed venture would be the development of a private facility which truly met the clinicians needs, as well as those of the private patient market. As we were informed than many of the paediatric specialists or specialists with an interest in the paediatric element of their field, are already linked into BHC it would appear that the opportunity exists to become the dominant player in the market in short order.

Facilities required to meet the market opportunities

As noted in the section defining the hospitals potential market, it is probable that between 6 and 9 in-patient beds will be required to service the market. In the ward space that we were shown, Ward 8 it would be feasible to create 6 private rooms in a way similar to the architects drawing (Appendix 1). During the course of our visit it became apparent that the hospital team had not had the opportunity to consider what other facilities might be offered to the private market from within a private patient development.

During our visit to Ward 8 we also visited the other ward No 7 occupying the pavillion. We noted that it had a very low bed occupancy with only 4 or 5 cots full on the ward. Having reviewed the bed occupancy statistics (reproduced in Appendix C) for the whole hospital, it occured to us that Ward Z might be condensed into the other wards, raising their bed occupancy and effectively clearing the whole pavillion for a private patient development.

Physically the ward is located at the extreme north of the hospital site, with the wards long axis orientated roughly west - east. We noted that there was a car park adjacent to the pavillion, as well as a perimeter gate leading onto the street for vehicular access. The main ward entrance faced South into the hospital site and is approached through a pleasant garden area. Unfortunately the car park is effectively at the rear of the building however, unlike so many hospital buildings, the rear aspect is neat and tidy and free of the normally encountered plethora of engineering and utility pipework and is not in the least "offputting".

Because of the pavillion design it would be a relatively easy task to make a private patient development at one and the same time both an integral part of the operation of the hospital and also a seperate entitiy with its own distinct identity. In other words to create a semi stand-alone "hospital within a hospital".

Were a development to take place in the pavillion to cater for up to 9 or perhaps even 10 in-patients, there would still be space for a number of the facilities which although necessary, were not included in the architects initial design. Such facilities would need to include :

A play area for the children in order that, condition permitting, their socialisation and skill development could continue.

A quite area for parents and other relatives to be able to "retreat" to to obtain some respite from contact with their children.

A private area for doctors to consult with parents when poor prognoses had to be delivered and for parents / relatives to be able to greave in.

Such facilities would be an absolute necessity if the type of high quality service which will ensure market domination is to be provided. On the basis of the architects sketch plan it would appear that both of the wards would be required as it would appear that only 6 single rooms could be fitted into one of the existing ward spaces.

will have to be of a sufficient size to allow both parent and child to sleep in the room.

It may be that a number of rooms could be equipped with the Parker Knoll type of fully reclinable armchair which could be used for ad hoc sleep. Such rooms, being smaller than the room requiring a bed for both parent and patient, could be priced differentially in order that there is a spectrum of cost so that the facility could attract patients from a wider spectrum than if all were pitched only at the premium price market.

Other facilities which might be considered could, were there sufficient demand, include consulting rooms with either seperate or shared examination rooms and possibly a minor treatment room so that children did not have to leave the ward. Obviously one would not wish to turn highly engineered and thus expensive capital assets such as a ward block into offices if these could be provided elsewhere within the hospital.

The Hospital Administrator indicated to us that there was the possibility of leasing to doctors some underused office space near the main entrance to the hospital, should there be a demand for private consulting rooms. In many ways these would be preferable to having an office on the ward as by design the level of traffic through or into such a clinical area as a ward should be minimal. This apart from any other reason, helps to maintain the security of the ward. However having a "Doc in the Box" service operating from the ward might well help to promote the services offered by exposing the maximum number of potential customers to it.

The precise requirements of the ward cannot be determined as the SCS Consultants have not yet obtained the responses to the questionnaires regaring the clinicians particular requirements.

Conclusions regarding the feasability of a Private Patient development at BHC

To conclude we believe that it would be entirely feasible to develop a private patient unit at BHC. From our analysis of the likely demand we believe that there is an extant, but as yet, unexploited market for high quality private paediatric and particularly adolescent care.

Given the stresses on the public health sector it is unlikely that in the near future the public services will develop to the extent that they undermine the opportunity and further it appears that BHC would be in the prime position to exploit the market because of its reputation for clinical excellence, availability and obvious commitment of clinical staff and the general level of enthusiasm amongst the managerial and clinical staff to develop a successful venture.

Assuming that appropriate space can in fact be made available within the hospital and that the cooperation and enthusiasm of the staff and management of the hospital can be harnessed, we are certain that the development could be successful.

It is important to note that this report does not include an analysis of the investment and operational costs or the potential income streams associated with a development. These must be the subject of further investigation.

Prior to any detailed work on the project it will be necessary to perform an outline review of the financial viability. In our experience, an iterative process which extends over a number of months has to be undertaken. This, through a process of definition and clarification of how the service might operate, makes clear the likely scale of costs, income streams and thus viability and level of profitability.

Issues requiring clarification.

During the course of our review a variety of topics were raised which we believe need to be carefully considered and potential solutions tested prior to moving forward. Many of these topics were raised by the management at BHC in the course of our discussions, but some arise out of our visit to the private unit at St Annes Bay Hospital, which is an example of a private patient facility operating within a state hospital.

Staffing

By far the most important concern of both the hospital management and the clinicians was how a private unit could be staffed, particularly with nurses. In the course of our visit we regularly encountered concerns over the ability of the health service to adequately staff wards with trained and experienced nurses.

We were informed that because of both the relatively poor position of nursing pay in Jamaica and the financial attraction once qualified of migrating to work in the United States, it was found to be increasingly difficult to attract and retain experienced nurses.

The clinicians in particular informed us that the biggest single differentiator between the public and private health care sectors related to the availability of nursing staff and the improved quality of care that the better motivated staff gave in the private sector. Further it was noted that in many cases the pay in the private sector, whilst better, was not enormously greater than that in the public sector.

The concerns regarding pay were a twofold conundrum. The first problem is that the creation of a two-tier pay system with higher salaries being paid for work on the private ward would lead to industrial relations and morale problems. The second problem is how nursing staff could be encouraged to firstly work on the ward and then give of their best and deliver the standard of service required in a private unit without paying above the standard rates of pay. The final part of the conundrum was that if other staff groups saw extra pay being made available for nurses on a private unit that they too would expect extra pay for involvement with it.

Some of the managers and clinicians thought that because of the sense of affiliation for the hospital felt by many staff the problem could be overcome, but only if it was obvious that the overall hospital was gaining from the work performed on the ward. A number of other staff felt that a private unit would only work if all of the staff clearly understood its purpose and saw this as being beneficial to the hospital. It would thus seem that a transparent system would need to be created which demonstrated tangible benefit back to the hospital and some level of "personal" benefit back to the staff, through a non-financial mechanism.

Whilst this is a serious problem we feel that it could potentially be overcome by some creative mechanism such a reinvesting some money generated by a private patient unit into such things as improved staff facilities, a swimming pool or the development of a subsidised staff creche.

A number of quite important issues were raised regarding the physical ability of the hospital to operate sufficiently well to provide the standard of service required for private patients without compromising already stretched resources for the delivery of public health care.

Examples were raised regarding the status of some diagnostic equipment such as x-ray where two out of the three rooms were unserviceable due to non-availablity of spare parts. It was felt that unless the hospital was operating properly to start with, that the imposition of excess workload into the system would compromise the standard of care currently provided.

It is obviously essential that the hospital is capable of dealing effectively with its baseline public sector workload before any excess load is placed on it. Any development which was seen to damage the service currently offered would, we believe, fail to gain the necessary support of the general hospital staff. A further and possibly more important point as regards the operation of a private ward in a business-like manner relates to attracting and retaining the goodwill of consultant clinical staff. Unless these individuals are confident that they will be able to do their private business better, or at least as well, in a private unit at BCH as they currently do elsewhere, they will have no reason to transfer their aleigences from the hospitals which they are already using.

An important early stage in planning for a private patient development will include an analysis of how the hospitals clinical infrastructure would either stand up to an increase in workload of something like 450 (or hopefully more) new cases per annum, or the areas which were likely to fail and would need reinforcement in order to continue to operate.

Some concerns were expressed regarding, for example, how out of hours pathology tests might operate and also how support staff used to operating with the current clinicians might react to demands being made by outside consultants if they were given admitting privelidges.

From the consultant clinicians point of view the development of a ward within the hospital would be attractive as they would know that there would be proper medical cover out of hours. However an issue which would need to be addressed would relate to how junior medical staff might be compensated for excess work on private patients during their on-call period when they were supposed to be attending to public sector patients. Further there would be the issue of how such junior staff might relate to "external" consultants should such be given admitting rights.

We believe that in the first instance, should there be sufficient workload brought be indigenous consutlant staff, that external admiting rights be denied. Once a workable system had developed within the hospital then the Medical Executive / Advisory Committee of the hospital might entertain the grant of admitting privelidges to external consultants, but this would have to be after the development of clear policy statements and written protocols such that external consultants did not abuse the system and "unload" difficult patient or excess work into the private ward.

An extremely important area, which was raised by the clinicians, relates to the age group of patients who are to be admitted. As noted elsewhere in this report BHC has a cut-off age for admission of 10 years of age. In discussion the clinicians were concerned that the age for admission was at least up to 12 years of age as there is a singular absence of adolescent

facilities on the Island. The calculations undertaken above include the population up to 14 years of age which from the UK experience is the likely maximum for admission to a paediatric / adolescent unit. Given that all of the proposed rooms within the unit would be private single rooms, we do not see that there would be a problem in admitting from the whole age range and in fact, as this appears to be an unadressed market, would recommend that the service is offered.

Financial and Managerial Issues

The most fundamental concern over the proposition to develop a private patient facility at BHC must be financially based, this being in turn intimately linked with the sound management of the development and the overall hospital. We have to express some reservations about the level of sophistication of the financial systems we have been exposed to, to operate what must essentially be a cost centre approach and the maintenance of proper trading accounts for the venture.

During our visit to St Annes Bay Hospital it became apparent that the Hospital was subsidising the private unit to at least the cost of utilities and food. Further that the charges which were levied for diagnostic and operating theatre services were centrally dictated by the Ministry of Health with the local management unable to determine if these charges were really covering the costs of the services provided let alone making some level of profit.

We counsel most strongly against such an approach being replicate in the case of a development at BHC. We believe that it is absolutley imperative that charges made for services provided to the private sector are determined locally and that they can be demonstrated with absolute clarity and certainty to have not just covered the costs of provision of a service but also to have achieved an agreed level of profitability. If the charges which the hospital would have to levy to achieve its objective are non-competitive then it should not enter the market and it should certainly not engage in a commercial activity subsidised by tax-payers money.

Without authority and responsibility being vested at the local level it will be impossible for management to develop either the business skills which are essential to the development of the practice of public service management, or to be held truly responsible for the success or failure of a given venture.

Part of the problem which we identified at St Annes Bay related to the way in which the private unit had been set up. Although the development demonstrated great resourcefulness and a sense of great local spirit in the way in which it brought together the public and private sectors, it appeared to us that there was a lack of shared understanding between the local unit and the Ministry of Health over how the ward would operate.

In the St Annes' model the patients of the private unit were charged at the approved Ministry of Health rates for certain services such as x-ray and pathology services and then charged at a rate in excess of the normal daily fee rate for public in-patient accomodation. The normal daily fee rate is remited to the Ministry of Health and the excess portion lodged in a bank account to pay for some of the running costs and maintenance of the ward. However because of the rather "fuzzy" split over costs and income it has proved impossible to establish the level of profitability or otherwise for the ward operation.

In the UKs' NHS, to take the RNOHTs' own private patient ward as an example, the Directors of the Trust are responsible for the profitability of the operation and also its impact on the overall financial position of the Hospital. Having accurately established the revenue and capital costs for the operation it is then their duty to establish an appropriate set of charges such that not only is there a completely recover the costs of the operation (including the management and financial services overhead costs associated with its operation and the necessary reserve for maintenance of the assets) but also a profit. That profit retained within the Hospital can be used for any purpose, as determined by the Hospital, save only that it complies with all audit and standing financial instructions governing the conduct of the Hospitals business.

As such we strongly recommend that the development of a private patient facility be treated as though it were a commercial business, with **all** of the input (revenue and capital) costs clearly identified and fees charged so that a proper, true and clear profit can be generated.

Another area of concern relates to the initial investment capital needed to pump prime the scheme. There was, we felt, an expectation that these monies would be made available either by the Ministry of Health, HSIP or some other central funding source. Such funds are obviously not likely to be available from central resources, given the scarcity of capital within the public health sector generally.

The situation may be summarised that BHC is asset-rich but cash-poor, in that it cannot find the resources to invest into a money-making scheme. It appears to us that a way out of the problem would be for the Hospital to enter into a joint venture partnership with the commercial sector and operate the ward on a fully commercial basis using a Limited Liability Company vehicle.

Possible mechanism to develop a private patient facility at BHC.

Based on the assumption that when the responses of the clinicans have been analysed, they show a high degree of support for the overall proposal of creating a private unit, we believe that the following may be a mechanism for starting and then running the unit.

If an entire pavillion is to be given over to the development, we believe that this could easily be considered as a substantial equity stake to put foward to the creation of a commercial company. The capital costs of refurbishing the ward and creating an appropriately finished and furnished ward are small in relation to the capital value of a modern building and some small tract of land surrounding it. The precise value will have to be determined by the Government Valuation Office. It would be possible for either a lease to be granted on the land and buildings or for these assets to be passed into a joint venture company entirely.

A business partner or partners would then be required to make cash payment into the joint venture company, which would be used to refurbish the ward and also to provide the working capital to operate the company. How much investment would be both required and then allowed are outside the scope of this report, but obviously would depend upon the degree of control which the State partner wished to exert over the Company and the level of dividends required.

By having either the Ministry of Health, or for preference the Board of BHC, being the entity in partnership with the investors, they would receive the appropriate portion of dividends as declared and would be able to exert control over the operation through having appropriate persons nominated as Directors to sit on the Board of the Joint Venture (JV) Company.

This approach would mean that there was a very clear legal separation between BHC and the JV Company and that the Company would be a clear legal entity required to operate in accordance with company law, including payment of taxes, preparation and lodgement of annual accounts etc.

Whilst the JV Company could hire its own clinical staff, we would see it as being more sensible that staff from BHC were used in the ward and that appropriate payments were returned to the Hospital for such services rendered. This would be a model for all of the exchanges between the Hospital and the Private Unit and would be a mechanisms which forced the development of a clear (transparent) financial relationship between the organisations. Such a fiancial relationship would also be useful as a stimulus to improve the accounting function within the Hospital and to help the management obtain a better understanding of the costs of their own activities within BHC. This is an area we know that the senior management at BHC are anxious to see improved. Such an approach would ensure that public resources were not being diverted into some sort of muzzy subsidy of activities which by definition should be fully paid for by the private sector.

We discussed the possibility of such a development, in broad outline only, with the group of insurance company representatives and tested wether they thought that their companies might be interested in partnership in such a venture. Our sense of this meeting was that the proposal was warmly received around the table and that in particular one or two companies would be keen to become involved.

The benefits and disbenefits of having the health insurers involved are roughly balanced. If all insurers had a stake in the venture then apart from the obvious risk sharing, we do not believe that there would be a problem in charging premium rates for the facility. If only one insurer were involved then there might be the opportunity for the other insurers to refuse to meet a premium cost knowing that a competitor was benefiting in particular.

The Insurance Sector is an obvious area to look at for potential investors as it gives the companies an opportunity of vertical integration in a market that they are reasonably familiar with. They are however far from the only investors who might be interested. There are presidents within the UK and the USA of groups of doctors wishing to become involved in such investments and we believe that with the venture being underpinned with a substantial property base that it might be attractive to institutional investors such as banks, pension funds etc. where the opportunity for positive publicity might be as attractive a proposition as the underlying business.

Mr Peter Bunting, the Parliamentary Secretary, gave a positive response to the proposition when it was outlined to him and agreed to support the project, assuming of course that the business case was justified.

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 calender.

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" activties required, would form the point of contact for all external liason 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 :

<u>Detailed Service Planning</u>

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 notibng 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 an 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 whioch 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 throught to how the operating theatres and other high-technology areas of the hospital will accomodate 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 likelyhood 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 candiates 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 fiancial 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

	General Surgery Operations				
	Emergency		Listed		
	Major	Minor	Majo	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 Medicine			General Surgery			Urology			Orthopaedics		
	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	93	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	9	88	298	2	4	15	8	74	311
Feb	24	22	599	8	126	362	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	8	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

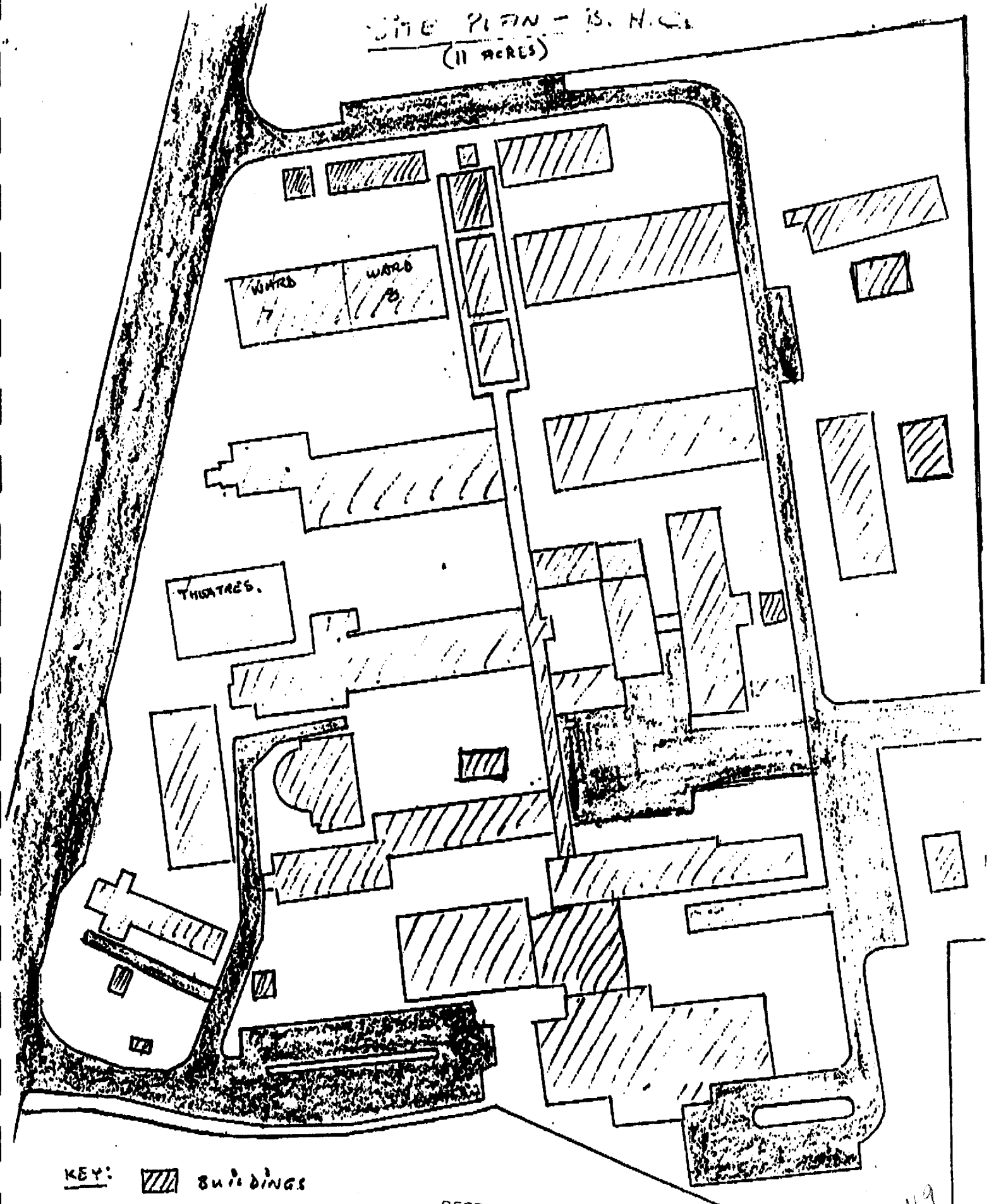
Out-Patient Attendances Bustamante Childrens Hospital

September 1992 to August 1993

E.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	146	31
8	84	257	4	4	48	8	38	133	5	11	112	40	129	33
9	104	310	4	9	66	8	24	120	4	1	82	22	56	18
5	57	145	3	9	45	6	28	94	3	5	70	33	80	20
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	26
9	101	291	4	12	78	9	47	184	4	16	79	24	53	12
6	99	193	4	11	53	8	49	196	5	5	70	26	99	19
8	87	264	4	19	50	8	36	152	4	8	88	21	58	13
8	81	210	5	13	80	6	36	122	4	8	99	34	100	22
9	94	267	4	49	55	9	47	184	5	11	100	40	104	27
8	103	247	4	17	65	8	44	168	4	16	90	34	133	30

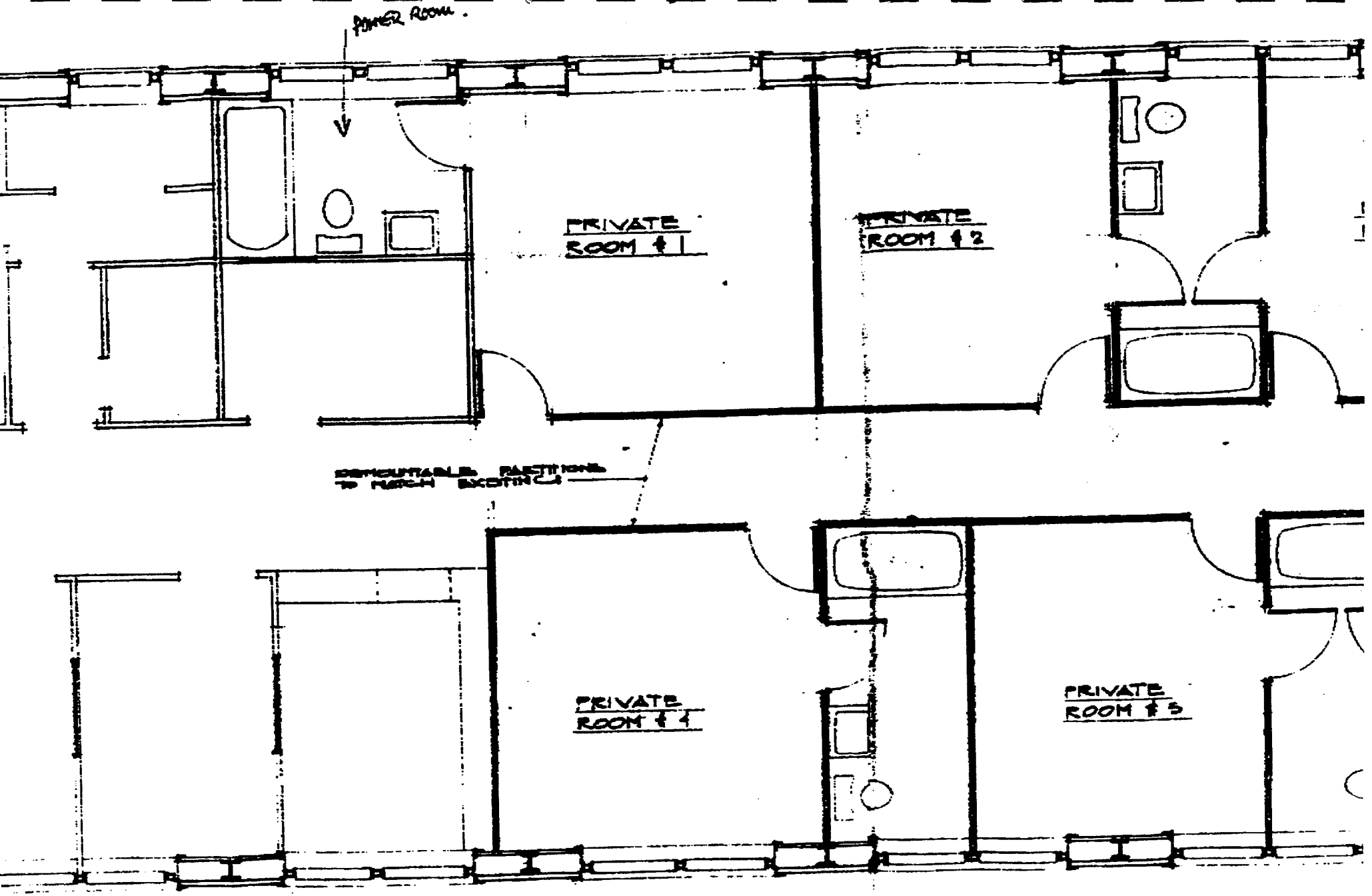
Appendix 2

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.


POWER ROOM
PRIVATE ROOM # 1
PRIVATE ROOM # 2
PRIVATE ROOM # 4
PRIVATE ROOM # 5

Appendix 4

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

THE ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST

IAN MONRO WARD

A PRESTIGIOUS NEW FACILITY FOR PRIVATE PATIENTS

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 todays 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 recieve 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 clientel 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 Consultants 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
- Osteodensitometery
- Gait Analysis Equipment.
- Isokinetic Systems

as well as the full range of more usual diagnostic and theraputic 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.

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.

		THIS PERIOD ACTUAL	THIS PERIOD BUDGET	THIS PERIOD VARIANCE	YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VARIANCE	LAST YTD
PATIENT DAYS		6	0	6	79	0	79	149
MUNRO WARD								
KS								
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
		67,198	56,291	10,907	614,556	506,619	107,937	0
	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
00	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	2,666	2,666	0	23,994	23,994	0	0
150	INSURANCE PREMIUMS	0	366	366	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
405	PROVISIONS OTHER	97	0	97-	380	0	380-	0
700	STATIONARY	301	83	218-	2,010	747	1,263-	0
800	STUDY LEAVE	10	466	456	1,679	4,194	2,515	0
801	STUDY LEAVE AMENITY ACCOUNT	60-	0	60	1,003-	0	1,003	0
000	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

		THIS PERIOD			YEAR TO DATE			LAST YTD
		ACTUAL	BUDGET	VARIANCE	ACTUAL	BUDGET	VARIANCE	
00	TRAVEL PATIENTS	0	0	0	619	0	619-	0
10	TRAVEL STAFF	10	0	10-	347	0	347-	0
		34,832	37,052	2,220	348,411	333,468	14,943-	0
	TOTAL COSTS	34,832	37,052	2,220	348,411	333,468	14,943-	0
:T	REVENUE	32,366	19,239	13,127	266,145	173,151	92,994	0
.tient	Day :							
	REVENUES	11,200	0	11,200	7,779	0	7,779	0
	COSTS	5,805	0	5,805-	4,410	0	4,410-	0
	NET REVENUE	5,394	0	5,394	3,369	0	3,369	0

E N D O F R E P O R T

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.

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

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.

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 feasability 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 peadiatric 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.

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 proceedures that you require from x-ray

Proccedure	Numbers per year
.....	.....
.....	.....
.....	.....

15 Intensive treatment/carc 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 oder 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 HOSPTIAL FOR CHILDREN

1.	Robert Wan	- Consultant Urologist
2.	Dr. John McHardy	- Consultant Neurosurgeon
3.	Dr. R. Cheeks	- Consultant Neurosurgeon
4.	Dr. G. Arscott	- 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