

# Private Medicine

## Building a private hospital

BY A SPECIAL CORRESPONDENT

As I cautiously concluded in the last article, the wind seems set fair for a limited expansion of private medicine. More people have medical insurance cover now than ever before, the consultant contract allows full-timers to do a little private practice, and the Government in power is enthusiastic about private care. But to set against this, interest rates are exceedingly high, Government requirements for private hospitals are increasingly stringent, competition is keen, and the future—with Tony Benn donning his warpaint—is uncertain. So what are the things that a group of doctors in a small provincial town must consider before trying to get themselves a private hospital?

Throughout the country there is considerable activity in the private sector. At one end of the scale a new luxury hospital is about to be built close to the Wellington (a luxury hospital in London), and AMI (American Medical International) are building new top-grade hospitals. In the middle, BUPA (British United Provident Association)—or rather a subsidiary, BUPA Hospitals Limited—is building and planning new hospitals, while at the lower end all kinds of local groups and small consortiums are trying, succeeding, and sometimes failing to build private hospitals. This article is concerned with the problems of this last group.

The first question a consortium of local doctors must consider, obviously, is whether a private hospital is needed? The local doctors are usually the ones to take the initiative in calling for a private hospital—particularly the consultants (especially surgeons), who stand to gain the most. But they should quickly involve local general practitioners and local businessmen. The problem whether there is enough local demand for private practice to pay for a hospital is hard. Almost certainly the group will have to employ professional hospital planning consultants to answer the question. The professionals will have to consider the size of the population, its socioeconomic structure, the number of people with medical insurance (likely to be small if there is no private care readily available, but also likely to rise if a new hospital is built), the extent of local consultants' existing private work, the distance to other private hospitals, the local NHS facilities, and other variables.

### Money is hard to find

These complicated considerations have got to be set alongside the problems of raising money. If the local doctors want things done their way then they will have to raise the money themselves. There are companies that will attempt to provide the money, do the work, and take the risks, but they will want considerable control; and they are unlikely to be enthusiastic about the poorer or more sparsely populated parts of the country. These days (when a 30-bed acute hospital is likely to cost about £1m) the local doctors and businessmen are most unlikely to have enough money themselves, and so they must raise the money. They have two possible routes: charitable or commercial.

A charitable trust will usually command more local support than a purely commercial venture but £1m is a great deal to

raise quickly in a small community where many of the people will have no interest in or aspirations towards private medicine. Support may, however, be forthcoming from local large companies or from the private medical insurance companies.

New Hall Hospital in Salisbury, a well-equipped 24-bed acute hospital that opened on 30 April 1980, cost just over £1m, and £750 000 came by a special arrangement from UK Provident, a large mutual life assurance company that has its national headquarters in Salisbury. BUPA had also provided an interest-free loan of £40 000, and PPP (Private Patients Plan) £125 000 at 1%. When the hospital opened only £200 000 had been raised from the local community (36 000 people in Salisbury, but 200 000 in the catchment area) in 16 months. Clearly it is almost impossible to raise enough money fast enough by gifts, deeds of covenant, and the like. The directors of the hospital in Salisbury imagine, however, that a similar arrangement—of substantial support from a large company—might be arranged in other small towns.

Another potential problem with such charitable trusts is that their charitable status might be removed by a future Labour Government. This might be part of a two-pronged attack on public schools and private medicine, and public opinion might be sympathetic to the politicians' arguments that educating children privately and removing businessmen's gall bladders were not really charitable pursuits.

Raising the money commercially is also difficult. The problem is, firstly, to find the money (and when the hospital is simply a plan in a few heads there is inevitably great risk for any financier) and, secondly, to achieve an income as quickly as possible. C R Sandison has argued that if £1m must be borrowed to build a 30-bed acute hospital then with commercial interest rates currently at 20%, enough profit can never be generated ever to pay the interest, let alone the capital.<sup>1</sup> He goes on to say that cheaper money may be found through the Stock Exchange's unlisted securities.

### Alternative of cost control

The financial complexities of this are frightening, however, and an alternative many doctors may find more attractive is to do things more cheaply. This is the line taken by the doctors and others who have erected the Sussex Private Clinic. It opened in 1976, when the national economic problems were not nearly as severe as they are now, but the originators managed to do it cheaply by watching their costs closely. They decided carefully what they needed, did much of the decorating themselves, drove hard bargains with local builders, and searched around for ways to equip the hospital. The administrator in the hospital believes that too often the NHS is insufficiently cost conscious, and that excellent small hospitals can be put up cheaply by being cost-conscious and ingenious.

This delightful hospital also defeats conventional economic wisdom in that it runs with an average bed occupancy of about 65-70%—and at one stage of only 55%. The hospital followed

the classic pattern of starting with a high occupancy rate immediately after opening, as work that had built up over preceding months was dealt with. Then bed occupancy dropped, and now, as the reputation of the hospital is spreading, bed occupancy is steadily climbing again. But, as everybody knows, the costs of a bed lie mostly in the staff who must support the patient in the bed, and therefore if there is flexibility in staffing arrangements an empty bed is not a great expense. This flexibility in staffing is achieved in two ways: firstly, because of the spirit prevailing in the hospital, nurses whose nursing duties are light on a particular day are willing to do non-nursing work; and, secondly, the hospital has a close relationship with local nursing agencies—close enough to ensure that the nurses the agencies send are of a high quality. The administrator of the clinic is proud, too, of the adaptability of the rest of his staff: if the phone is not ringing and the grass is long he thinks nothing of mowing the large lawn himself. He also observes that running a hospital in such a way is fun: there is a great sense of achievement in building and running a high-quality and friendly hospital from limited resources.

### Reasons for failure

The people at the Sussex Private Clinic have also been co-operating with consultants who want to build a hospital in another town. The plans for their new hospital, however, have had to be abandoned—at least temporarily—and we can learn from the failure of these plans. The main reason, the people from Sussex think, is that the consultants in the other town wanted everything immediately. They wanted the hospital, which was to be built new, to open with fully equipped x-ray, pathology, and physiotherapy departments. Not only would an enormous amount of capital be needed for such facilities, but probably they would not be well used, mainly because a small hospital

does not generate enough work, and partly because most sizable towns already contain private radiology and physiotherapy facilities. Also the doctors were unrealistic in their staffing requirements. They estimated that they needed 23 nurses for a 30-bed unit, whereas the Sussex Private Clinic needs considerably more nurses for a hospital that is roughly 25% smaller—and they are by no means overstuffed.

Finance and feasibility are thus the major problems, which must be solved early, and if they are not solved then nothing can proceed. But they are not the only problems: once it is clear that a hospital is needed and money is available then things must proceed as fast as possible—to produce a return on the money.

Many of the problems will be in satisfying government requirements (both national and local). These requirements, which cover things such as planning, fire precautions, staff facilities, safety—particularly with any radiological or radioactive activities—are increasingly stringent, and perhaps rightly so. Other problems are in finding a site that is convenient for doctors and patients, deciding whether to build from scratch or convert an existing building, and finding equipment.

Politically, with the Conservative Government, the increasing demand for private medicine, and the shrinking number of pay-beds, these are encouraging times for building small private hospitals, but economically times are hard. But ingenuity in raising money, realistic objectives, and care in controlling costs should allow most small groups of doctors to put up a private hospital.

### References

- 1 Sandison CR. Using the stock market to fund private hospital projects. *Br J Hosp Med* 1980;23:400-2.

This is the last in a series of three articles.

### What are the possible complications of a Stanmore hip prosthesis?

The complications of a Stanmore hip prosthesis are the complications of any total hip prosthesis. They are, firstly, the immediate risk, which is infection that may occur as a result of theatre infection and is unlikely to happen if the operation is done in an enclosure; secondly, the early late infection due to secondary infection of a haematoma a week or ten days after the operation. This may be avoided by adequate suction and continuous drainage in the first two or three days; and, thirdly, late infection, which occurs often as a result of a deep infection in the hip joint related to the cement or the prosthesis, and has been known to come on a year or more after operation.

### I am considering replacing long-term phenytoin and barbiturate treatment with sodium valproate in an epileptic patient. How should this change be effected?

The wisdom of making the change should be carefully considered. Phenytoin and phenobarbitone (which is presumably the barbiturate referred to) are two of the most effective drugs available for tonic-clonic (grand mal) and partial (focal) seizures, and sodium valproate may not be an adequate substitute, particularly in the latter type of seizures. Possibly carbamazepine might be a better choice.<sup>1</sup> If the attacks are primary generalised tonic-clonic fits, however, sodium valproate may be satisfactory, in which case a suitable regimen for changing is as follows: slowly tail off the phenobarbitone, no more rapidly than 60 mg a month because of the risk of withdrawal fits. Meanwhile substitute sodium valproate 200 mg nightly, increasing in stages to 400 mg twice daily (given that the patient is adult). As sodium valproate can potentiate the sedative effects of phenobarbitone the dose of the former should not be increased too rapidly. When this substitution is complete, and given that all is going well, the phenytoin should then be tailed off over four to six weeks while the dose of sodium valproate is adjusted to 1000-1500 mg daily, divided into two doses, although a single night-time administration may be

as good.<sup>2</sup> Enteric-coated 200 mg or 500 mg tablets are more convenient to the patient than uncoated tablets, and cause fewer gastrointestinal adverse effects. The dose may be increased to 2500 mg or 3000 mg if necessary, but this dose should not be exceeded. If full doses are used liver function tests and the platelet count should be monitored at monthly intervals until the dose is stabilised. Weight gain is sometimes encountered, and hair loss is a rare but fortunately reversible adverse effect.

<sup>1</sup> Laidlaw J, Richens A. *A textbook of epilepsy*. Edinburgh: Churchill Livingstone, 1976.

<sup>2</sup> Covanis A, Jeavons PM. Once-daily sodium valproate in the treatment of epilepsy. *Dev Med Child Neurol* 1980;22:202-4.

### What is the minimum time between a child having a course of antibiotics for, say, an upper respiratory tract infection and then being able to have one of its routine immunisations?

The use of antibiotics is no contraindication in itself that immunisation should be withheld, or that one should wait a specified time after discontinuing the antibiotics before immunising. But the condition for which the antibiotic is being given may make it desirable to postpone immunisation. For instance, one does not give poliomyelitis immunisation when a child has diarrhoea, because the diarrhoea may make the vaccine ineffective: some may (usually unwisely) be treating the diarrhoea with an antibiotic. But the antibiotic does not affect the immunisation. In the case of other infections being treated with an antibiotic, the infection does not increase the risk of an adverse reaction to the vaccine, but any complication or exacerbation of the infection would be blamed on the vaccine if immunisation had been performed. For instance, it is unwise to immunise a child when he has a cold (whether or not he is being foolishly treated by an antibiotic) because on the day of the immunisation he might develop a complication of the cold, such as otitis media, and if he does it will be blamed (wrongly) on the vaccine. The cold itself does not increase the risk of an untoward side effect of the vaccine—for instance DPT.