

DO HOSPITALS NEED TO OWN THEIR BUILDINGS?

Nigel Edwards and Richard Darch

INTRODUCTION¹

Group Health Co-operative (GHC) in Seattle has sold its last hospital. In future, GHC will provide healthcare to over 600,000 people by using hospitals belonging to other organisations. Outside healthcare this would not be seen as a radical idea – airlines often do not own the aircraft they use and department stores lease space to other retailers. But in hospital care the buildings and the history associated with them have been seen as inseparable from the service itself. However, if we could break the link between the organisation that delivers the service and the buildings that it occupies, there might be some very significant advantages.

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We propose a system in which some trusts would choose to operate as clinical groups that use assets provided by a property management organisation. This would deal with a number of problems associated with misaligned incentives in the current market. It would also create opportunities for much more imaginative models of commissioning, provision and the design of health buildings.

The model is described in more detail below, but in outline we assume that the property management companies would have the following characteristics:

- A public purpose – creating high quality healthcare, rather than the primary purpose being related to rates of return
- A very large portfolio of healthcare related property, to allow risks to be managed
- Access to capital markets
- A joint venture structure bringing health and private sector expertise together
- A focus on maximising value from assets (land and buildings) and generating development gain that can be reinvested into healthcare
- Healthcare organisations would lease space and therefore

¹ This paper is very much an early exploration of a very complex area, which is littered with technical rules about risk, control and VAT. The paper is intended to spark debate and to help us identify the shortcomings and unanswered

questions and we hope that readers will provide feedback to help us refine the ideas. It is also important to point out that the proposals would not be suitable for all circumstances in the NHS.

hospital (and other) buildings could be made available to a number of providers or put to other uses with the approval of local commissioners.

WHAT IS THE PROBLEM?

Buildings can be an obstacle to reforming services for patients

The design of the payment by results (PBR) system, particularly the fact that it is based on full costs, means that any loss of income creates a significant problem for trusts. Not only does income fall faster than costs can be reduced, there are a number of costs – particularly those associated with the estate – that cannot be shed at all without a major reconfiguration of the site. This gives hospitals an incentive to ensure that the assets are fully utilised. Whilst this may appear efficient, it may well mean that even more efficient options for delivering care are discouraged and this may be at the expense of the clinically best options for patients. For example, rather than being admitted to hospital, patients with heart failure might be better served by having their care either self-managed at home or managed by their GP with the support of specialist staff from the hospital and technology to remotely monitor their condition. This is clinically the right thing to do and more cost-effective for the NHS generally, but it is potentially financially ruinous for the individual hospital. The absence of a good method for sharing the risks and benefits of these models, and the need to keep assets fully utilised, creates perverse incentives which run counter to the overall direction of policy to reduce the use of hospitals.

There is a problem with how capital is dealt with in Payment by Results

Including capital in the payment by results system has some potential problems. Including it in the tariff gives excess windfall gains to

providers with low overheads or very old buildings that are fully depreciated. The most logical solution, basing payment on what the value of a functionally suitable estate should be, would require a large one-off injection of money and then lead to the accumulation of this in reserves until providers were ready to replace their assets.

Hospitals focused on buildings create monopolies

A significant difficulty in implementing quasi-market based approaches to reform is that hospitals in their current form represent significant geographical monopolies. Practice based commissioning offers some solutions to this, but even in outpatient care setting up alternative services that require back up from diagnostics or other hospital-based care may be difficult and can require expensive duplication.

Hospitals are changing rapidly

The basic design and purpose of hospitals has remained unchanged from the Middle Ages until the early nineteenth-century. A well-constructed hospital built in the 1500s could have 300 years life with little need for significant modification. The pace of change in medicine, the development of new technology and changes in society have meant that the design and function of the hospital has changed more in the last fifty years than in the whole of the previous 1000. Even thirty years now seems a long time to expect to see a hospital exist without being subject to major changes. Indeed, in many cases, hospitals are frequently modified to accommodate new services and technologies while they are still being built.

Changes in technology, the need to centralise some functions to improve quality and the opportunity to take work out of the hospital are leading to a major reconfiguration of many hospital services. The existing procurement routes do not fit easily with the scale of change associated with reconfiguration. PFI in the NHS has been used to deliver many of the whole-hospital developments that were required.

Most of the major conurbations of the UK have benefited from PFI schemes and are now served by modern hospital facilities. However, the need for additional whole-hospital developments in the UK is now limited. Many trusts are voicing caution over the use of the standard PFI model to support estate development, as the model can be very constraining and is not considered flexible enough to respond to longer-term estate strategy and developments phased in over time.

The need for new approaches to development and disposal

Many trusts are now turning their attention to a programme of estate development and rationalisation that is leading to more campus style developments, e.g. developing a new diagnostic centre or urgent care centre. Often these plans are to be delivered over a long timescale with a phased approach dependent on affordability and the support of patient choice. PFI does not suit this strategy well for either the public or the private sector providing the buildings. The schemes are smaller, which makes it difficult to support the critical mass of bidding costs, and a series of twenty-five or thirty year concessions procured by a single NHS Trust is a costly and inflexible way of managing change.

PCT provider functions also have significant estate and although they are less subject to some of the problems of inflexibility that apply to hospitals, there may also be advantages in adopting new approaches to development. NHS LIFT presents a more flexible vehicle on the development side but LIFT Companies are not structured to manage the large-scale disposal of assets and the realisation of development gain as, unlike PFI, in the LIFT model the property transferred by the NHS represents its equity in the LIFT Company. Furthermore, LIFT remains focused on individual buildings and assets rather than providing a mechanism to deliver value from wholesale estate rationalisation. Often there is not the organisational structure in place to manage that estate effectively and address the strategic reconfiguration required to support service reconfiguration. LIFT

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is supporting the modernisation of the estate in some areas but remains focused on delivering individual building schemes, and LIFT Companies have found it difficult to take on responsibility for wider estate management. However, the separation of services from assets, and a willingness of PCTs to divest themselves of estate as they focus on commissioning, will provide the impetus for LIFT Companies and their shareholders to gear up and develop the capability to acquire and actively manage PCT estate.

It is likely that large parts of the NHS Estate will become redundant or unfit for purpose. The value of the NHS Estate now stands at more than £30 billion at existing use value. Although the NHS has adopted much good practice in terms of the sale of surplus estate, the development gain that is achieved following the sale through change of use or redevelopment has, historically, been largely taken by the private sector developer.

It is probable that managing the retraction and disposal of estate will be more of a challenge than procuring new buildings in the NHS. Furthermore, ensuring that best value is achieved through disposals will require skill sets which are not core to NHS management.

HOW MIGHT THE MODEL WORK?

Our proposal is for a new type of partnership, which brings private sector knowledge and skills into the management, development and disposal of NHS Estate and uses that expertise to deliver value back into the NHS.

- NHS Assets would be transferred to a joint venture (JV) between the NHS Trust (PCT or Hospital Foundation Trust) and a private sector partner. Equity would be split, with the public sector equity stake being financed through a value placed on part of the assets to be managed and the private sector putting in risk capital to finance the set-up and operational costs of the JV. In areas where there is scope for joint work with education, social care or agencies involved in regeneration, it might also be sensible to extend ownership options to local government. Indeed, they may wish to put parts of their estate into the portfolio.
- The Company can be structured as a Community Venture with agreed sharing of development gain where land is released and developed for alternative use – once it is clear that the asset is not required for a health purpose. There is a tension here that a better return is likely to be available if there is a long-term contract. However, it is likely that any disposals of this sort will be made on the basis that the property is no longer required.
- Healthcare providers would have contracts based on the use of the assets and the level of activity with the JV, which would take responsibility for the operation and maintenance of the buildings, new building and development of surplus land.
- Where land and/or buildings are surplus to NHS needs, they may be

developed commercially by the JV, e.g. for residential or retail use, and the development gain shared amongst the JV partners.

- Any development would have an initial focus on social infrastructure use (such as affordable housing, elderly care villages, etc.).
- The NHS Trust would have a guaranteed ability to buy back the healthcare buildings and land at the end of the lease term and/or pre-emption to be able to renew the lease. Alternatively, first refusal for an extension of the lease could be built into the contract and may be a better option in some cases. This will provide protection to the NHS to continue to provide healthcare from the site and be able to buy out the private sector partner.
- Operation of the building would include 'hard FM' but could also include hotel services and some other support services, such as decontamination or even laboratories. This function might be outsourced to specialist consortia similar to those found in PFIs.
- Because the JV would have a public purpose – supporting the provision of high quality healthcare – it could assume some of the risks associated with the reduced use of hospitals resulting from improved chronic disease management, the development of out of hospital care or successful practice based commissioning demand management. These risks are currently carried by individual hospitals. In this model these could be offset by the ability of the private sector partner in the JV to manage a very large portfolio over a longer period than the annual fluctuations of the payment by results regime – much more conducive to managing programmes of strategic change.
- Because of the incentives to increase often small open market values on health property, the JV would have incentives to build in ways that are more flexible and therefore more suited to the changing healthcare environment.

The property management and development industry in the UK is well developed, with significant levels of expertise. Many sectors in the UK economy have seen the value of releasing assets to be managed by joint ventures or private sector partners who focus on delivering value from property, leaving firms to focus on their core business. Banking, retail, hotel and leisure are all sectors of the UK economy that have moved away from owning property and have released value for re-investment into the core business. In the UK private healthcare sector it is no different, with the best example being Capiro Healthcare, which agreed a sale and leaseback of all of its UK hospital sites that raised £200 million to fund its UK expansion.²

² In June 2002, NPIL (Nikko Investments) completed the first UK private hospital sale-and-leaseback. The £250m transaction involved the sale of twenty UK private hospital properties owned by the Swedish-listed healthcare group Capiro AB to a special-purpose property partnership now owned by Nikko (80%) and Capiro (20%). The properties

were then leased back to Capiro on a 30-year full repairing and insuring lease, with an agreed annual rent escalation; as quoted in 'Nikko acquires UK hospital property assets for £250m' (*PR Newswire*, 12 June 2002) (<http://www.prnewswire.co.uk/cgi/news/release?id=86560>).

There are also many international examples of healthcare organisations and hospital groups in the public and not-for-profit sectors that have funded development of their operational business through the sale and leaseback of facilities to private sector property companies or specially created joint ventures. A number of such examples can be found in Scandinavia, Canada, Australia, New Zealand and the US.³

The opportunity exists to take this model and develop it further to create a new type of public-private partnership that benefits from the wealth of private sector expertise in property management and development whilst allowing NHS partners to focus on the delivery or commissioning of healthcare. This would not be a sale and leaseback; rather it is the creation of social ventures. The focus of this social or community venture would be to manage existing estate effectively whilst maximising value through estate management, disposals and development, in order to deliver development gain back into the NHS, which can be invested in additional or new services.

Such a model could also encourage the private sector to create supply chains designed to maximise value from estate disposals. For instance, the inclusion of specialist developers of elderly care villages can allow for site development with residential level returns whilst maintaining a healthcare-related use of the site. The private sector can also use its expertise through the planning process to construct a supply chain that will deliver appropriate development for sites, whether residential, retail or commercial, in order to enhance value and drive up returns for investment back into the NHS.

³ F D Campobasso, 'Off Balance Sheet Financing' (*Journal of Healthcare Financial Management*, 2000, 54), pp.37-9 and G H Pink and S H Hudson, 'Sale and Leaseback by Canadian Hospitals. Theory and Practice' (*Healthcare Management Forum*, 1998, 1), pp.16-23.

The opportunity exists to take this model and develop it further to create a new type of public-private partnership.

The inclusion of day-to-day estate and facilities management would be determined on a 'venture by venture' basis in terms of whether such services are provided by the NHS or the private sector supply chain. Such a decision should be based on local circumstances, availability of current workforce and meeting value for money criteria. The best arrangement might be a true public-private partnership with clear delineation of expertise. This would create the potential to deliver significant value back to the NHS for investment in healthcare: as well as an up-front cash injection through asset sales there would be the ongoing returns derived through property development following disposal. Such ventures would also allow the NHS to concentrate on what it does best, which is to deliver and commission healthcare, in the knowledge that the infrastructure required for such delivery is being effectively managed and developed according to future healthcare needs.

SETTING UP THE JOINT VENTURE

The choice of the Private Sector Partner in the JV would need to be made through a mechanism of open procurement, which ensures value for money is being achieved for the NHS and the public sector as a whole. Selection would be made on agreed Value for Money criteria, such as valuation cost of capital and operational costs of the JV as well as a proposed mechanism for gain share between the JV partners. These criteria would sit alongside 'softer' issues such as quality of the supply chain and ideas for future development of the healthcare estate. These criteria are not dissimilar to the NHS LIFT procurement process.

The right of the NHS to continue to operate from sites at the end of any lease would need to be protected through pre-emption agreements. The NHS would continue to be a significant property

owner through its stake in any joint venture, and other protections to ensure continuity of healthcare delivery on any particular site may be put in place through the guaranteed buy-back option. There are tried and tested approaches for estate valuation, which have been adopted elsewhere, that will provide safeguards and would support this. An example of such an approach in the public sector is when the then Department of Social Security transferred the ownership and management of its estate to a private sector company, Trillium, now Land Securities Trillium (LST), in a £1.2 billion deal. Since the initial deal the amount of estate managed by LST has been expanded and both the initial deal and its expansion have been found by the National Audit Office to offer value for money to the public sector.⁴

Obviously a single deal of this type for the NHS would be far too large and unwieldy and there would be advantages to there being more than one operator of this sort. However, each operator would need to be sufficiently large to be able to take on some of the short-term risks associated with the provider's fluctuating use of facilities, as well as having the resources to undertake an up-front purchase of the estate and the technical capabilities to manage a large leaseback programme.

This represents an attractive model to the private sector, which is demonstrating a strong appetite for infrastructure investment and managing assets that are supported by

⁴ *Accommodation Services for the Department for Work and Pensions: Transfer of Property to the private sector under the expansion of the PRIME Contract*, Report by the Comptroller and Auditor General (National Audit Office, HC 181, 26 January 2005) (http://www.nao.org.uk/publications/nao_reports/04-05/0405181.pdf).

clear future cashflows. There is an incentive for the private sector to build robust supply chains that demonstrate value for money and maximise shared development gain, as it is these successful consortia that will be rewarded with the opportunity to manage more assets, thus delivering value back to both their shareholders and the NHS through further development gains.

ADVANTAGES OF THE MODEL

The model we are proposing would have a number of significant advantages and deal with the issues we set out at the beginning of the paper that have the potential to hold back reform. The advantages include:

- Patients would get access to the most appropriate facilities, which would be much better able to adapt to meet changes in medicine.
- Increased contestability – commissioners could have alternative services run in existing hospital buildings similar to the way that retail concessions are let in department stores or shopping malls.
- Providers could reduce their use of assets where income fell. A number of fixed costs would remain to be dealt with but the problem of fixed costs associated with the estate would be reduced. The property management company would manage this risk over time and across the whole portfolio.
- The change would significantly increase the incentive for hospital

staff to work closely with primary care, particularly in the management of long-term conditions, as keeping the hospital full would be a much lower priority.

- As with PFI, the potential to fail to properly maintain the building would be avoided.
- A large property fund of this type would allow money to be raised on financial markets at very advantageous rates. This might provide a line of private finance that could be much more flexible than PFI and lend itself to more flexible and modular forms of development, more appropriate to a more volatile health market.
- More of the financial benefits of property disposal and development would be retained by the NHS.
- Bringing primary care and other health and social care property into the portfolio could create opportunities for highly creative ways of integrating the delivery of health and social care.
- The model would bring a number of the advantages of PFI in terms of delivering purpose-designed, well maintained infrastructure, but would be far more flexible, with the ability to respond to changing infrastructure needs over time rather than (as with PFI) providing an up-front solution that is difficult and costly to change over the 25 or 30 year concession period.

For a PCT, collaborating in a joint venture of this type would provide a partner who could concentrate on delivering the estate strategy to support their service and commissioning strategy whilst delivering value back into the PCT and the NHS through maximising the value of any surplus estate. For the Hospital Trust it would allow them to focus on the delivery of healthcare in the knowledge that they have an expert partner delivering the infrastructure required to support change and delivering value through the development of any surplus estate. Furthermore, there is the benefit of the initial purchase of the estate following formal valuation, which would provide immediate cash benefit to support reconfiguration and service re-design proposals.

OTHER IMPLICATIONS

Once liberated from the constraints of operating buildings, the clinical group would be able to think about new, more radical approaches to how their work is organised and the degree of integration primary care. One very radical option would be to integrate with practices (there are some issues about how monopolies are avoided so that patients can be offered choices of provider, but in many urban areas there is likely to be sufficient choice and contestability and, in any case, not all practices would wish to integrate). This model would create a provider that held a capitation budget for its patients and had incentives to provide the most cost-effective and responsive model of care. This is similar to the Kaiser Permanente Medical Group model, which seems to produce high quality results and to offer the prospect of more integrated services than the more contract-based and adversarial approach that underpins some of the current reforms.⁵

In addition to being able to explore vertical integration in this way, clinical groups might also be able to take new approaches to how some services are integrated. For example, laboratory services, specialist imaging functions and the services of AHPs (allied health professionals) might be externally procured. For anaesthesia to support operations, and some specialist surgery, it might make sense to contract out or procure these services on a fee-for-service basis.

⁵ R G Feachem, N K Sekhri and K L White, 'Getting more for their dollar: A comparison of the NHS with California's Kaiser Permanente' (*BMJ*, 2002, 324), pp.135-41 (<http://www.bmj.com/cgi/content/full/324/7330/135#art>) and C Ham, N York, S Sutch and R Shaw, 'Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme:

Analysis of routine data' (*BMJ*, 2003, 327), pp.1257-1260 (<http://www.bmj.com/cgi/reprint/327/7426/1257.pdf>).

THE RECONFIGURATION DEBATE

The model has some interesting implications for the debate on reconfiguration. Clinical providers with more freedom to use buildings in different ways would be better able to create networks with other providers. Networks for a range of functions – such as emergency surgery, specialist care and paediatrics – were identified in the National Leadership Network's report on the future of the local hospital as a key way of preventing the trend towards increasingly centralised services. Specialist providers considering an expansion of their services would be able to assess the option of using existing, cheaper estate in other hospital sites closer to their patients and investing the difference in additional staff, as an alternative to building new and more expensive central facilities.

The more hospitals are understood in terms of patterns of services rather than bricks and mortar, the easier it will be to have conversations with the public about the services available to them.

FINAL ISSUES

The model is not without some disadvantages and issues that would need some thought.

There is an inevitable tension between the goal of getting the most value out of the property portfolio and that of providing the best healthcare, and there would need to be careful attention given to the rules governing how these potentially competing goals are reconciled. The governance of the organisation will need to be structured in a way that allows these tensions to be managed.

There are some issues about how risks related to the operation of hospital services should be dealt with. For example, who would take responsibility for costs or penalties associated with healthcare acquired infection? Methods would need to be developed to ensure that these risks were appropriately shared without the need for a large industry of investigation and blame shifting.

There are some potential perverse incentives that could emerge if the incentives and regulation framework is not properly designed and there could be a conflict of interest between the property operator and the clinical organisation using the buildings.

Methods would need to be developed to ensure that these risks were appropriately shared without the need for a large industry of investigation and blame shifting.

CONCLUSIONS

Healthcare needs high quality buildings operated professionally and located in the best place for patients. The model we propose here seems radical for the health sector but would be unsurprising elsewhere. Technology and new models of care offer the opportunity to develop healthcare that is much less dependent on very high cost estate. Breaking the link between owning the buildings and providing the service is not free of unintended consequences and has some disadvantages. However, many providers would be well suited to this model and would be able use it to create new and imaginative ways of providing care. Like most policy in this area no single change is likely to be sufficient on its own and a range of complementary changes to payment systems, incentives and commissioning approaches would be required.

ABOUT THE AUTHORS

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Nigel is director of policy for the NHS Confederation, the membership organisation that represents over 90 per cent of NHS organisations in the UK. His role is to influence health policy on behalf of members, develop policy positions on areas of key interest and speak on behalf of NHS organisations, particularly in the media.

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Throughout his career Richard has focused on his principle interest of supporting investment decisions in healthcare.

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