

The evolution of primary care: financing and providing facilities



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Changing demographics, particularly an ageing population, make the effective delivery of healthcare a global issue. Primary healthcare is at the centre of this.

One thing is for certain: in the UK what we do over the next decade or so will have a profound effect on the generations to come.

Primary care has always been and will always be the cornerstone of healthcare. It must be remembered that throughout history the bulk of healthcare has been delivered by or on behalf of the local medical practitioner. Hospitals were relatively clean places where the poor were sent. The rich were cared for in their homes. Before the formation of the NHS in 1948 most family doctors worked single-handedly out of their own homes, managed care in the local cottage hospital and provided a 24/7 service.

Since 1948 there has been a slow progressive change to multiple partner GP practices delivering an increasing range of services out of purpose built premises. A further impact of multiple partner GP practices is that it has become more difficult and complex for the partners to take on their traditional

role as owner/occupier of the property, thereby creating the opportunity for the third party developer/investor.

We have also seen an increasing dominance of the hospital since the formation of the NHS and a consequent direction of capital funding towards secondary care, notwithstanding the fact that the vast majority of patient episodes have been carried out in primary care.

The lack of basic diagnostic and other services at a local level has resulted in many people being referred to hospitals for simple procedures. These facilities should be in place, making treatment quicker and more effective. Primary healthcare has to be moved in the direction of being able to deliver these basic services to support the GPs and the other locally based clinical staff. Premises and the installed kit have to be created to meet this task.

Table A (over the page) was produced by NHS Estates in 2000 and shows that 79 per cent of primary care facilities were below required size and 14 per cent in "cramped conditions". Since then a higher standard for room sizes and so on has been introduced, plus there was no consideration in 2000

for DDA compliance.

The Wanless Report published in October 2002 reinforced these statistics and suggested the cost of the necessary upgrading of the primary care estate over the following 10 years would be nearly £6 billion.

The Lift initiative in England has had, to date, mixed reviews. Although there has been the successful progression of many of the first-tranche schemes there is speculation that many Lifts are having difficulty in advancing further and that the initial projects are rather more expensive than they need to have been.

Recent Government announcements on increased funding for primary care are to be welcomed even though it remains unclear how this funding is to be deployed and over what timescale. In any event, the amounts are relatively small in relation to the perceived overall need. This suggests an ever increasing role for the private sector - which has anyway always supplied the bulk of the capital funding requirement for primary care facilities.

The reorganisations of the primary care trusts and their well publicised financial deficits have not helped. This is despite the fact that the NHS

► has received record funding over the past few years. The conclusion that has to be drawn is that these deficits will continue and possibly deteriorate over coming years.

Developers/investors and their institutional funders will have to think ‘outside the box’ in order to deliver the required property solutions and become an even closer integral part of the process of determining those services that are to be delivered. There must be recognition of the increasing involvement of private sector providers of specialist clinical support services bringing not only a mixed economy of healthcare provision but also multiple tenancies within primary care buildings. All this will mean more complex and time consuming development assembly with greater space allowances and the built-in capacity for future change. It also means becoming an integral part of a long-term partnership with the doctors and their NHS clients, with the knock-on effect in terms of the ability to trade in the real estate and consequent property values.

Clearly the needs of the community must be met in terms of primary healthcare provision, both now and for the future. This includes the delivery of services that are better provided locally but have traditionally been hospital centred. Various NHS organisations produce detailed strategies in this respect but it is the developer/investor, together with the doctors and the PCTs, that has to deliver the practical solutions.

Medical centre complexes will, in future, increasingly offer a much

broader range of local healthcare services, many of which will be provided by the private sector. The ageing population and the increasing incidence of chronic disease, combined with increasing overall demand for healthcare services, will put further pressure on local services and their delivery. This raises the notion of bringing together a mixed economy of provision to address these needs. This could be described as a ‘medical mall’. This form of development is not uncommon in North America and northern Europe and it is predicted that this model be introduced to the UK in the relatively near future.

So, where do the developers and investors in primary care real estate sit in all this?

They now not only translate the aspirations of the GPs, NHS organisations, local authorities and so on into practical real-estate reality, but also must do so in the most economic way, ensuring that the property is looked after in the long term and can be adapted for future needs. This requires a long-term partnering approach and fully deploys our development skills including the need to assemble the required development and long term funding. One of the biggest challenges the developer and, more particularly, its bankers have to face in this changing world of primary healthcare property investment is how to structure the financing. This is because the traditional approach has been pretty much a ‘no brainer’ for the funding banks. They too now have to think ‘outside the box’. Of course, all things are possible if



the pricing addresses the risks and accounts for the rewards, but there needs to be a balance.

Table B below illustrates the changing commercial considerations. The major change to be addressed is that the GP tenancy, effectively underwritten by the state, will become a much smaller component of the whole development and that even the level of rent reimbursement will decrease relative to the market rent of the GP space.

GPs have, historically, had their

TABLE A: CONDITION OF THE PRIMARY CARE ESTATE

	% of practices within types of premises	% below required size	% in cramped conditions	Proportion in age band (yrs)		
				< 10	10–30	30 +
Owner occupied: notional rent	33	79	13	14	24	62
Owner occupied: cost rent	30	Not available, but generally newer build than other premises type				
Actual commercial rent	21	78	19	14	28	58
Health centres	16	88	12	18	52	30
Total	100	79	14	14	25	61

*Below current recommended size as given in premises schedule of Statement of Fees and Allowances

Source: Departmental Investment Strategy (2000)



property-related costs reimbursed on a pound-for-pound basis. PCT funding deficits and other factors mean that this is no longer necessarily the case. This will be very difficult for the GPs to come to terms with. What was a cast iron bankable proposition is becoming much less so if viewed in isolation.

What there will be are multiple tenancies with rents reflecting both demand and covenant strength, probably on shorter term leases with the associated risk of voids. In other

words, we are moving closer to a commercial property model and the funding arrangements will need to accommodate this.

There will also need to be an element, in some projects, for non-medical development in order to make the project financially viable. Projects are already being progressed with both residential and retail elements, but where the medical centre is the catalyst for the overall development.

All this has an impact on

valuation. The sector has enjoyed unprecedented increases in valuations coming off ever-hardening capital yields. Wider economic conditions permitting, these values will continue if all the components of the developments ensure its long-term clinical and economic viability.

So, the challenges in terms of the future delivery and financing of primary care facilities are a more flexible approach to senior debt packages, with higher residuals and interest cover and a requirement for significantly higher levels of equity. Therefore the developers/investors will need deeper pockets to make schemes work and, with the funders, to reach solutions that strike a balance between the increased risk, while not pricing at a level that makes the development uneconomic because we cannot attract or retain tenants. This is a new phenomenon in this sector and a nettle that must be grasped. ■

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TABLE B: CHANGING COMMERCIAL CONSIDERATIONS

The traditional approach	The future
25 / 30 year lease/mortgage term	Shorter term leases
FRI lease	TIR leases
3/5 yr market based rent reviews	RPI-linked reviews
Minimum specification	No / limited reimbursement
100% (or close to it) debt funding	Multiple tenancies
Fully amortized over term	High level of private sector service providers relative to GP provision
Full interest cost / rent reimbursement by NHS	Flexibility / space for the future
Minimum specification	Valuation

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