Capital Investment in Primary Care—The Funding and Ownership of Primary Care Premises

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The authors describe the complexity of the financing arrangements of primary care premises. They explain how the early vision of an integrated primary care service of primary care and health and social services in health centres failed to be realized, with GP-owned practice premises remaining as the dominant model. There was a switch to private finance when the government loan body (General Practice Finance Corporation) was privatized in 1989. Although capital can now be freely raised by the private sector for investment in the National Health Service (NHS), these debts have to be repaid through NHS funds or user charges. The complexity, combined with demographic factors, makes it likely that as GPs opt for the Personal Medical Services (PMS) scheme and a salaried service, the trend towards for-profit corporations owning and buying out GP premises will accelerate.

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The 1997 NHS white paper shifted primary care centre-stage, with the establishment of primary care groups and primary care trusts in England (NHS, 1997). But the concept of a primary care-led health service is not new. It was embodied in the Dawson Report of 1920, which launched the idea of a comprehensive health service, hierarchically structured and under local authority responsibility. The vision for primary care was the compulsory organization of general practice in 'primary health centres', where adequate equipment, nursing and auxiliary staff would be available to the general practitioner (GP) and which would be visited regularly by specialists, thereby bringing together preventive and curative services (Eckstein, 1964). Although the report was shelved, it prompted pioneering models of buildings for integrating community health and social care, such as the Peckham Health Centre (1935) and Finsbury Health Centre (1938). Health centres formed the locus of progressive thinking regarding positive health and came to dominate the wartime Medical Planning Commission Report of 1942, and the Labour Government's White Paper of 1946 (Webster, 1995). A British Medical Association (BMA) poll, conducted in 1944, revealed that 83% of armed services GPs had supported the concept of a health centre-led salaried service (Hall *et al.*, 1975), and 89% of medical students in a 1948 survey (Eckstein, 1964).

By 1948, the health centre was no longer central to the plans for the NHS. It had come to be too closely associated with GPs' opposition to a state service and distrust of municipal control. Moreover, six months before the launch of the NHS, the Ministry of Health stated that, because of building difficulties and uncertainties over the best model to adopt, the general development of health centres was not appropriate. This was certainly related to the costs of buying out the capital infrastructure of existing primary care premises. As Charles Webster noted, the absence of health centres increased dependence on acute services and an opportunity was missed whereby 'the disparate elements within the new health service could be brought into meaningful co-operation' (Webster, 1995).

From the outset, the provision of primary care services in the NHS was grounded in an ideological struggle over ownership and control. When the NHS was established, GPs, unlike their hospital counterparts, were allowed to retain their independent contractor status—owning and operating their practice premises, for which since 1966 the NHS has paid them rent. In a sense, the NHS has thus always had public–private partnerships in the provision and delivery of primary care (Pollock *et al.*, 1999). In 1948, almost all of the 18,000 GPs in the UK were male and most were practising from their own homes. Almost half were single-handed. Models of ownership, rather than models of service provision, are a recurring theme in primary care, with the health centre model coming to be identified with local health authority (state) ownership and control in the 1974 reorganization. The practice premise model, on the other hand, embodied private ownership under GP control. Among the aims of the NHS Plan is the integration of primary care with other NHS and local authority

services (Secretary of State for Health, 2000). To this end, the health centre model is undergoing a renaissance, but is now rapidly becoming identified with private finance and company ownership. This article explores the financing mechanisms which underpin the forms of ownership of primary care premises in the NHS and shows how the switch to private finance facilitates the entry of for-profit corporations.

Funding of Primary Care Premises in the UK

GP premises are funded either by government grant or by a combination of grant and debt or loan finance, the latter is repaid from NHS revenue through the rental reimbursement schemes.

Government Grant: Health Centres under Local Authority Control

Although local health authorities (LHAs)—which until 1974 were part of local authorities—were charged with the provision of health centres in the 1946 National Health Service Act, an absence of public capital precluded developments in primary care in the first decade of the NHS. Indeed, it was not until 1966, with the relaxation in public expenditure controls and public capital becoming available for the first time, that health centre construction took off, with just 28 health centres built from 1948–67, compared with over 700 in the following decade (Loudon *et al*., 1998). In the early years of the NHS, capital expenditure did not fare well compared to other sectors of social services. From 1949 to 1959, local authority expenditure for health services remained static at £3M until reaching £4M in 1959, whereas expenditure on education and childcare rose from £38M to £123M in the same period. Local health service capital expenditure began to rise in the 1960s from £5M in 1960 to £14M in 1967 (Hall, 1975).

LHAs had responsibility for community nursing and the development of preventive and social support services, such as home helps, the after care of the mentally ill or handicapped, ambulance services and child and school health clinics under a medical officer for health. Local authorities needed to build health centres to accommodate their own staff, nurses, health visitors and dentists and, by renting space to family doctors, the concept of an integrated health centre came closer to being realized. By 1974, 15% of GPs worked out of such centres, with numbers increasing at about 2.5% per year and GP support for health centres growing.

The 1974 NHS reorganization should have provided a golden opportunity for re-fashioning primary care when LHAs and associated community health services were transferred from local authority control to the direct control of the Secretary of State for Health. However, the economic crisis in 1973–74, culminating in 1976 with the UK applying to the International Monetary Fund for a £4 billion loan and interest rates rising to 15%, resulted in draconian cuts in public expenditure. Capital investment and health centre development ground to a halt. With the exception of *ad hoc* improvement grants for inner city areas, and loans, the only alternative source of public funding for capital investment in primary care was the debt-financing system which had been set up in 1966 to promote GP ownership model of primary care premises.

Group Premises in the Ascendancy: The Creation of the GPFC

The health centre model under state ownership posed a serious threat to the independence of the GP contract. In 1954, the Cohen Committee, in their review of general practice within the NHS, focused on group practice premises as an alternative model to health centres under local authority control, seeing them as the natural focus for 'the various domiciliary arms of the health service', and able to secure better staffing, accommodation and equipment more easily than health centres (Rivett, 1998). Although, in theory, NHS family doctors could design, build, operate and own premises for themselves, raising the investment required from public or private finance, there was little incentive to do so because there was no separate income stream to pay for investment. General practice had been under-capitalized, mainly because GPs had to pay for premises improvements themselves.

The Danckwerts pay award settlement of 1952 introduced interest-free loans from the General Medical Services (GMS) budget to group practices wishing to improve premises, but demand was greater than the number of applications which could be approved. The GP Charter of 1965, ratified in the Act of 1966, introduced the first real opportunities for GPs to invest in their own premises with the establishment of a Treasury loan scheme, the GPFC, and a mechanism for the repayment of capital rental reimbursement through the NHS revenue budgets. As Julian Tudor Hart said, the Charter 'gave the independent ideologies of general practice a material base' (Loudon *et al*., 1998).

This was the earliest form of debt financing in the NHS, and replaced public sector capital as the main source of primary care investment. But, although debt financing became the main route for funding and financing primary care premises, it is crucial to note that there were strict controls and regulations over GPs' allowances and rental income, which were set out in a Statement of Fees and Allowances.

In 1966, the Government established the General Practice Finance Corporation. GPs could borrow money from the GPFC to invest in premises by purchasing land, constructing new premises or converting existing premises. The GPFC was a statutory non-profit making company raising money by borrowing directly from the Treasury and lending to GPs at the current commercial rate against the security of their property.

However, loans were strictly controlled, with restrictions on the amounts that could be borrowed, as can be seen from the data in figure 1.

The Switch to Private Finance

In 1986, the Government sought powers 'to change the constitution of the General Practice Finance Corporation to allow the maximum use of private sector funds' with loans to GPs no longer counting against the Public Sector Borrowing Requirement. The GPFC was sold by the Government in March 1989 to Norwich Union Life Insurance Society for £145M (DoH, 1990). Before privatization, GPFC raised money in the form of a Treasury guarantee. After privatization, GPFC provided capital by private finance from Norwich Union's annuities (pension funds). The privatization of the GPFC was a switch from government loans to private finance for investment in primary care. The effect was to take the brakes off government expenditure limits and the result was first an escalation in the loans taken out by GPs (figure 1) and then the entry of for-profit corporations.

It was not until 1995, some three years after the launch of the Private Finance Initiative (PFI), that the commercial sector became actively involved in the direct ownership of premises. GPs, hit by negative equity and high interest rates, were increasingly reluctant to invest. The London Initiative Zone, a government initiative to improve primary care premises in the capital, actively sought commercial partners by offering grants (NHS Estates, 1995). Private property companies began to approach the GPFC for full development finance for anything from a site purchase loan to a £20M+ portfolio. In 1999, some 50–60% of loans provided by the GPFC were to companies involved in building primary care premises compared with none five years before. The GPFC provides up to 100% loan finance, compared with 80% from normal lending institutions. The average size of the loans increased from £200,000 in 1990 to £800,000 in 1999. In contrast to the public finance regimes, there are no restrictions on lending or borrowing.

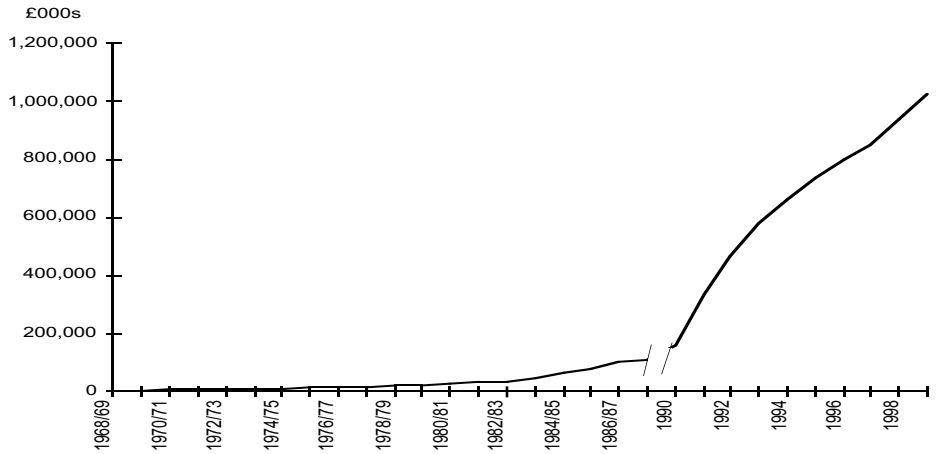
As figure 1 shows, the trends in loans from the GPFC to medical practitioners and companies involved in building primary care premises increased following privatization in 1989 from £158.8M in 1990 to £1 billion in 1999. Figure 2 shows a fourfold increase in turnover on 1990 levels from £21.3M in 1990 to £95M in 1999. This is a partial overview as the Government does not collect data on loans outstanding from other financial institutions.

Paying for Private Finance in Primary Care

Value of Primary Care Estate

Private finance is only a source of finance and not funding for new capital investment. Loans raised under private finance must be paid for out of NHS revenue or by generating new income streams such as user charges. Currently the total value of GP-occupied premises in England is estimated to be approximately £2.194 billion, of which £1.74 billion relates to owner-occupied

Figure 1. Loans to medical practitioners and private sector corporations (£'000s) from 1969 to 1999 by the GPFC.



Source: 'Loans to medical practitioners' presented in the balance sheet of the reports of the General Practice Finance Corporation 1969–1987 and 1990–1999.

Notes: 1988–89 is omitted as this was the first year of the GPFC Ltd and accounts were only presented from April 1989 to December 1989. The accounting reference date was changed to 31 December 1989 to coincide with that of the holding company.

Figure 2. Turnover (£'000s) for years 1990–1999 of the General Practice Finance Corporation Ltd (from company accounts)*.

*The accounts note that turnover represents income from loans and properties leased to medical practitioners and loans to staff. Interest and rental income are recognized on an accruals basis. Interest is calculated on the appropriate balance outstanding.

premises, £247M to premises rented from the private sector, and £207M to NHS-owned health centres (DoH, 2000). There are no data on loans outstanding.

Cost of Primary Care Premises

The revenue implications of servicing interest payments on loans for primary care investment can be estimated from the three NHS rental reimbursement schemes known as cost rent, notional rent and actual rent. These schemes reimburse GPs for the costs of providing NHS services from their premises:

- *Cost rent scheme*: Funded from the GMS discretionary budget, this enables GPs to reclaim all costs incurred in improving surgery premises, either for a new building or to purchase or modify existing buildings. The GP takes out a loan and is reimbursed by the health authority for the repayment of interest and principal. Only those premises that provide general medical services are eligible.
- *Notional rent scheme*: This is funded from GMS non-discretionary sources and paid from the national budget. After three years, a practice can opt to switch to pay current market rent as assessed by the District Valuer and thereafter receive notional rent rather than interest, but cannot then switch back. District valuers tend to relate notional rent to capital value. Rent is reviewed every three years.
- *Actual rent scheme*: This is funded from non-discretionary GMS central funds. GPs renting premises from private landlords can claim reimbursement based on the lease or the current market rent assessed by the District Valuer, whichever is the lower. Since April 1997, the actual rent scheme has been extended to GPs leasing or renting premises in health centres.

Overall expenditure on primary care premises by each of the health authorities in England are recorded on Finance Information Returns. Prior to 1989–90, expenditure was recorded annually in the NHS Summarised Accounts of Family Practitioner Committees, and in the Department of Health and Social Security's Annual Report. Due to changing definitions, it is not possible to construct a consistent time trend for accommodation payments.

In 1998–99, total expenditure in England for spend on GMS practice premises was more than £319M (including £28M in improvement grants). Figure 3 describes expenditure from 1990–1999 and shows how reimbursement through the actual and notional schemes has increased since the mid-1990s. The discretionary cost rent scheme has levelled out in recent years. The reason for the upturn in actual rent is the requirement that was introduced for GPs to pay actual rent to NHS health centre landlords. GPs also switched to notional and actual rent schemes because market based rents proved more lucrative than real rents based on interest rates.

It was possible for GP fundholders to reduce capital outlay on practice premises improvements by using fundholding savings against the cost. However this was only available up until the end of March 1999, after which time unused savings were to be passed to the primary care group (Kehoe, 1999).

Are GP-owned Practice Premises a Thing of the Past?

The entry of corporations into primary care premises is part of a wider trend across the NHS and the rest of the public services. The NHS Plan (Secretary of State for Health, 2000) states that:

> *…there will be £7 billion of new capital investment through an extended role for PFI by 2010…up to £1 billion will be invested in primary care facilities [and] up to 3,000 family doctors' premises will be substantially refurbished or replaced by 2004…New one-stop primary care centres will include GPs, dentists, opticians, health visitors, pharmacists and social workers. As a result of this NHS Plan there will be 500 one-stop primary care centres by 2004.*

However, the Government has indicated that, with the exception of the Treasury Capital Modernization Fund, there will be almost no up-front government capital for capital investment. The total capital in the Modernization Fund is only £360M for the NHS over the three years 1999–2002, with only £20–30M earmarked in 1999–2000 for improving primary care premises (DoH, 1999), the bulk of which will go to walk-in centres (letter from the NHS Executive). Instead most new investment will be undertaken using private sector finance.

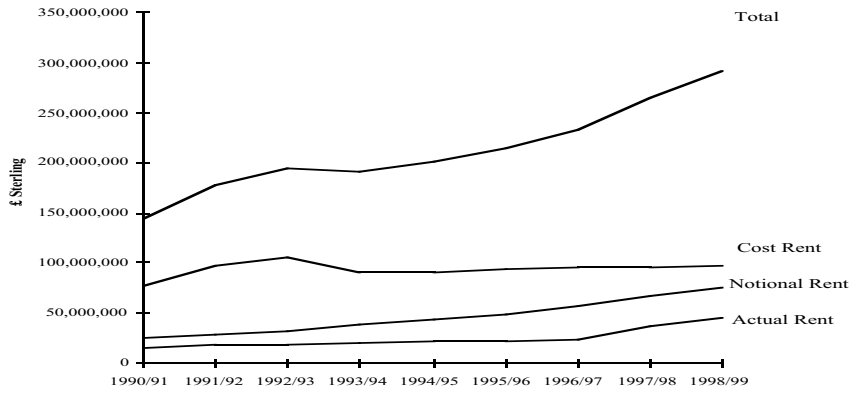
NHS Lift for Primary Care

A recent development has been the introduction of the NHS Local Improvement Finance Trust (Lift) to drive the process of channelling private finance into primary care. This was announced in the NHS Plan as a joint venture between the NHS and Partnerships UK (PUK) to invest £1 billion to refurbish and replace up to 3,000 GP premises and develop 500 new primary care centres. This joint venture will be allowed to own, lease or rent properties to GPs and to maximize third-party revenues from ancillary commercial activities. Lift will build and refurbish primary care premises to rent to GPs on a lease basis (as well as to chemists, opticians and dentists), focusing on deprived inner city areas with large numbers of sub-standard premises. Therefore such premises will be under the management of Lift as opposed to the clinicians. It is likely that these new premises would predominantly house PMS practices. Also, with the development of Care Trusts it is likely that the Government will want to see the development of contractual arrangements, so that the Care Team in a building is managed by the same health-care company that mortgages the building and its facilities. There is an absence of transparency on the financing of Lift and its accountability.

The Risks of Private Finance are too High for GPs?

Until recently the traditional use of notional and cost rent schemes to reimburse GPs' investment in premises was considered a low risk, high return capital investment for GPs. However, many GPs have been adversely affected by the imposition of redemption penalties on long term fixed-rate

Figure 3. Trends in expenditure by reimbursement scheme for primary care premises from 1991 to 1999 for England.



Source: Department of Health, Unaudited FIS (FHS) 4, Part B & C returns.

Notes: If the actual, notional and cost rents were added together, this would not account for the 'total' presented; the difference is accounted for by items such as rates, water, sewerage and refuse. In 1990–91, only 76 out of 90 FHSAs reported figures, so the England total is lower than would be expected. Since April 1997, the actual rent scheme has been extended to GPs leasing or renting premises in health centres.

loans taken out after 1989. Many GPs still pay high interest rates for the mortgage on their premises but cannot afford the redemption fees to remortgage or switch lenders. This is because GPFC offered mainly long-term fixed-rate mortgages linked to the yield on government bonds (gilts). The GPFC loans differ from most mortgage lenders by linking the penalty to the level of gilt yields. These collapsed in the last decade pushing up the level of penalties at the same time as the fixed-rate loan became highly uncompetitive. Thus a loan arrangement through the GPFC increased risks for many GPs (Miles, 2000). Also, the risks and the scale of investment required in building new premises under the PFI are proving prohibitive to many GPs—the GPFC's average loan size has increased from £200,000 in 1990 to £800,000 in 1999.

Salaried GPs

In any case, demographic changes in the workforce will accelerate the shift away from GP owned practice premises. Part-time employment has continued to rise from 5% of unrestricted principals in 1990 to 17% in 1999. Of the 27,591 unrestricted principals/equivalents working in 1999, 6.3% or 1,740 GPs are over 60 and approaching retirement and looking to sell their share in premises (DoH, 2000).

The Government has put in place the provision and incentives for GPs to switch to a salaried service with the introduction of Personal Medical Services (essentially the same as General Medical Services) through the National Health Service (Primary Care) Act 1997. Under this arrangement, health authorities fund services from their cash-limited allocation. An important feature of PMS is the access to new forms of employment including salaried general practice. The NHS Plan states:

> *By April 2002, we expect nearly a third of all GPs to be working to Personal Medical Services contracts. And we expect the number to grow steadily over the next four years to form a majority of GPs. Salaried GPs will come to form a growing number of family doctors providing that is what they choose to do* (DoH, 1999).

The content and conditions of services are based on a local agreement with practices. The Government's current reluctance to concede national negotiating rights for the core PMS contract is consistent with its subsequent desire to allow the option of privatizing provision of primary care services to the new companies. This is consistent with attempts by the Government to allow private companies, instead of local education authorities to run schools, where they are seen to be failing. No PFI company would want to be bound by a nationally-negotiated contract.

The complexity of property negotiations and project bundling under private finance are deterring many GPs, already overladen with administrative duties, from ownership. This is part of the explanation for the trend which has seen 60% of private finance raised by the GPFC being accessed by commercial property developers and for-profit health care companies rather than GPs.

The combined and sustained use of private finance indicates that the transfer of ownership to for-profit corporations is likely to accelerate, with GP-owned practice premises rapidly becoming a thing of the past. Currently there is an escalation of health-care companies and property developers entering into the provision and ownership of primary care premises (Pollock *et al.,* 2001).

Conclusion

The early vision of integrating health and social care in health centres failed to be realized for a variety of reasons, both ideological and economic, which resulted in the GP-owned health centre as the prevailing model.

The switch to private finance after the privatization of the GPFC in 1989 relaxed restrictions on raising capital—although all debts using private finance still need to be repaid, either through NHS funds or user charges. Today, the complexity, risks and scale of investment, combined with changes in demographic factors and the opportunity to opt for a salaried service under the PMS scheme, are likely to accelerate the trend to for-profit companies buying-out and owning GP premises.

The strategy for new investment focuses on maximizing the investment opportunity of the commercial sector. There is little evidence of population and public health needs informing the process. However, questions are raised about the appropriateness of arrangements for the provision and planning of NHS facilities. It remains to be seen whether the Government can safeguard the public interest when health care is provided on a purely commercial basis.

Summary Points

- The three methods of financing and funding capital investment in primary care premises are: government grant; government loans repaid from NHS revenue; and private finance repaid from NHS revenue.
- From 1948 to 1974 grant funding came to be associated with building of health centres under state ownership and control.
- From 1966 to 1989, government loan finance facilitated the group practice premises model under GP control and ownership.
- Since 1989, private finance has been the main way of financing GP premises.
- There are no detailed or systematic data collected centrally on the current value, loans outstanding or debts incurred by GPs and for-profit corporations in acquiring practice premises. Limited data are available on the GPFC, which was privatized in 1989. Average loans from the GPFC have increased from

£200,000 in 1990 to £800,000 in 1999, and up to 60% of all loans are made to private corporations.

- Data on the public expenditure implications of primary care premises are incomplete and there is poor central monitoring. In 1998/99 £319M (including improvement grants) of the NHS General Medical Services budget was spent on reimbursing private providers (mainly GPs) for rent and expenses related to practice premises. The amount given as grant or subsidy is unknown. ■

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