# Primary Care Premises Forum

## Building Progress - 2

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# Dr Peter Holden

- GPC UK negotiating team – 15 years to July 2014
- GPC UK – 33 years
- BMA Council , voting member and Director
- Lead member, Technical Steering Committee, NHSIC/DDRB 1999-2014
- Emergency Preparedness Lead, British Medical Association
- Member, Emergency Preparedness Resilience & Response CRG DH UK
- External Advisor, The Health Service Ombudsman
- Examiner, Royal College of Surgeons of Edinburgh
- Chairman BASICS Education Ltd – The British Association for Immediate Care
- Medical Aircrew Lincs. & Notts. Air Ambulance and East Anglian Air Ambulance
- HEMS Physician East Anglian Pre-Hospital Critical Care & Retrieval Team
- Regional Major Incident Advisor, East Midlands Ambulance Service NHS Trust
- Senior partner Dr PJP Holden & partners, Matlock

# Dr Peter Holden

- Until 17 July 2014 GPC UK Executive Policy Lead and now
- Special Advisor on
  - Finance, VAT, TSC
  - New Contract Infrastructure
  - Rural practice and community hospitals
  - Practice premises
  - Dispensing , P.A., Stock order
  - “Special services”
  - Urgent, Unscheduled and Emergency Care
  - Emergency Preparedness
- STILL a WORKING GP 6 sessions per week +OOH shifts!
- The only person left from either side who negotiated the new 2004 GP contract

# Disclaimer

Any remark made in this presentation is a personal observation and may not necessarily reflect BMA or GPC policy. However my observations are informed by the offices which I hold or have recently held.

# Premises – the background

- Understand the past
- Understand the present
- Develop reasonable assumptions for the future
- NO apologies for stating the obvious as it is frequently forgotten

# General Practices in theory

- Are small businesses
- Must operate within a budget like other businesses
- Consequently should accept normal business risks
- Alleged not to have taken all steps to maximise efficiency or increase turnover such as
  - Seeking extra work streams
  - Taking up work from hospitals
  - Streamlining staffing levels
  - Working smarter

- Therefore should be a simple proposition?

# General Practice the reality

- Unlimited services for  fixed block of money (well under £100/pt year)
- 4 generations not used to paying for medicine
- Political cannon fodder
- 19 fold jeopardy
- Micromanagement of an intensity no small business would tolerate
- Interference from managers having
  - no stake in the business
  - no experience other than a salary
  - No comprehension of the INDEPENDENT contractor status
  - No understanding that they have no locus managing GPs
  - Little, if any, knowledge of the rules
- The more work you do the less you earn
- The average GP is too nice for his/her own business good
- GPs regarded as a free good with infinite elasticity of capacity

# General Practice financial reality

- 23% drop in income in 5 years
- No rise in gross turnover for 8 years. Huge rise in workload (40%)
- Population drag alone has generated 3% per annum rise
- Carried inflation
- Hamster wheel economics
- “Cost Plus” depends upon functioning DDRB/TSC mechanism
- “Cost Plus” militates AGAINST ability to invest or be entrepreneurial
- Results in drip feed economics
- Treasury philosophical aversion to GP owned premises
- Treasury don’t give a toss
- Surgeries have to be located where patients live We cannot outsource
- Premises now highly specialised- they used to be toti-potential

# IF General Practices were truly small businesses

- Then
  - My prices rise 23% TONIGHT
  - My opening hours will reduce to match demand TONIGHT
  - No patient may have more than 40 minutes of my time per annum either F2F,administratively or by remote consultation under the NHS
  - **177 high work (elderly) uneconomic patients will be delisted <u>immediately</u>**
  - Nursing and residential homes will be told to pay a supplement
  - Services unavailable under the terms of the NHS WILL BECOME available to listed patients at an economic **<u>supplementary</u>** charge payable to the practice
  - Late night and weekend convenience appointments become available at **<u>supplementary</u>** charge

- **BUT WE ARE NOT AND WE CANNOT AND WE DON'T! so HMG takes unfair advantage of this every time.**
- **It is why we have a Doctors'and Dentists' Pay Review Body**

# Government and GP overheads

- As
  - GPs are not small businesses
  - GPs are on a cost plus contract
  - it was established in 1952 that the NHS expenses of the profession must be returned to the profession in full
- Then costs must be returned in full to the profession
  - Broad brush approach for general costs built into remuneration structure
  - Reimbursement for idiosynchratic “bespoke”costs such as
    - Business rates
    - Water rates
    - Trade waste
    - Premises borrowing costs or agreed rent

  by submission of individual receipted invoices

# Funding GP developments

- Because GPs are
  - on a cost plus contract
  - unable to charge for extra services
  - Have to locate surgeries where patients live
- there has to be a dedicated investment funding stream for premises developments capable of covering
  - Borrowing costs as a minimum
  - Some FM costs in less secure areas
- There needs to be a proper return on capital
- Issues of Cost, Price and Value - subjects badly understood by doctors and NHS managers

# Investment in GP premises

- 1947-1966 effectively none
- 1966-76 Health centres (Govt and never maintained properly)
- 1966-1995 GPs contributed £4Bn (2002 estimate)

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- 1996 the end of ring fenced monies.
- Start of requirement for 3PD quotes

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- 1996-2014 NOTHING in volume except for
  - flagship ribbon cutting sound bite opportunities
  - Darzi irrelevancies

# Why GPs invested in premises

1. Hedge against inflation (remember 22% inflation and 15% bank rates?)
2. Interest underwritten by government in return for GPs taking long term capital risk and maintenance costs
3. Property was a one way bet  between 1945-2000
4. Merry go round fed by a steady stream of incoming partners (not assistants) willing to take over loans and liabilities
5. Doctors expected to stay the course until retirement so prepared for long term investment
6. The Independent Contractor Status was never questioned. Security of contract
7. Reasonable Project Cost : Practice turnover ratios
8. Totipotential premises easily converted to domestic use
9. Health bodies could meet the ongoing revenue consequences of BCR
10. EVERGREEN LOANS from the banks at competitive rates of interest

# The perfect storm

# Why GPs wont invest now?

1. Inflation is low, Gilt yields are low, there are better investments
2. Property no longer a one way bet
3. No longer a steady stream of incoming partners
   - General practice is not family friendly and is poorly remunerated
   - Last man standing issue
4. Doctors now expect to have a portfolio careers
   - dont stay the course until retirement
5. Independent Contractor Status now questioned. Security of contract reduced by AQP policy
6. Difficult Project Cost : Practice turnover ratios
7. Specialised premises not easily saleable
8. Health bodies cant meet the revenue consequences of BCR
9. Repayment loans, low inflation and high pension contribution rates (29%) reduce disposable income
10. Student loans of £100K normal for medicine

# The country has had it too cheaply!

- Inflation has masked the real cost of health care premises provision
- GPs accepted no (or minimal) real return on capital invested
- Politicians want the flexibility of AQP without accepting the consequential costs
- The Treasury wants it at both ends and in the middle
- The traditional financial checks and balances have gone
- Proper and appropriate capital sums earmarked for development have been used to balance the books
- The system has not kept up with changes in property taxation law
- The NHS/Treasury has sought to lay the tax at the providers door without the provider having any means of properly passing on the cost of provision
- Government and its agents have tried to “fix” the market by instructing the Valuation Office to act unprofessionally

# What has been done to encourage development?

- 20 years stagnation in projects
- Chronic lack of DH/PCT/FHSA capacity and real expertise in premises
- Hampered by different visions and specifications of what is required
- Over specification because of “expert” input from the hospital world without understanding relative risks
- In 1996 GPC indicated that premises availability would rate limit the nascent shift of locus of care from hospital to the community- NOTHING has changed
- In 2001-2004 £250m ***recurrent*** was identified and would in the 1 for 10 rule have initiated £2.5Bn GP premises development
- It was swallowed by MPIG

# 2004-2014

- Premises Costs Directions 2004 created in a 36 hour time slot
- Negotiating to a faulty parliamentary timetable

- 8 years of government procrastination to save money

- Premises Costs Directions 2013 were all but sorted then DH ran out of lawyer time so were nothing more than 2004 continued to make payments lawful following the demise of PCTs

- Premises Costs Directions 2014 will be 2015……they are dragging their heels again

# What GPs want now 1

- Recognition that premises provision is a legitimate healthcare cost
- Action to resource those costs in a manner fair to ALL parties

- Recognition that premises are a long term commitment
- Actions to build confidence in the systems of provision of health care

- Recognition that the political privilege of AQP and the constructive competitive tensions systems of AQP have costs
- Actions to fully cost AQP which must be borne by the taxpayer

# What GPs want now 2

- Recognition that costs AND REQUIREMENTS vary location by location
- Action to educate managers as to the difference between cost, value and price

- Recognition that  confidence in the valuation system has been questioned
- Action to ensure that Valuation professionals are under no pressure to deviate from RICS rules

- Recognition of the need for a level playing field and a fair return for capital employed
- Action the SAME costs and rents allowed to 3PD as to GP developers for any given project without cross subsidy or cross charging from FM Charges

# Actions Now

- Premises funding black hole NOT of GPs making
- GPs will NOT be paying for this from their pockets
- NHSPS problems are those of its shareholder the SoS
- SoS must sort it out for himself
- Meantime GPC has NOT approved the final standardised leases whatever the public rhetoric maybe
- GPC advice will publicly be DO NOT SIGN
- Possession is 9/10ths of the law and this is an election year!

# Premises Emergency Measures

- Meantime Rome is burning
- 28% of GPs are aged 59+
- 40% of GPs are over 50
- The GPVTS are not filled – combination of workload and reward issues
- The government is likely to have to rescue General Practice
- **The government needs to underwrite Last Man standing scenarios**
- Last man standing scenario could easily become a stampede
- Without General Practice the NHS will collapse within weeks

# Summary

1. A level playing field between 3PD and GP developers
2. Confidence in the valuation system
3. Government to recognise and understand economics!
4. A fair return for the capital invested
5. Crystal clear rules not open to interpretation or vexatious manipulation

# QUESTIONS

- Questions?
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- Questions?
- Questions?
- Questions?