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Impression from a Round Table Discussion

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Dilemmas in Health Care Real Estate Management – Impression from a Round Table Discussion

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Health care real estate in the urban context

On 24 April 2008 the Chair of Corporate Real Estate Management hosted the expert workshop Health Care Real Estate in the Urban Context ahead of the Corporations and Cities colloquium. The intention was to instigate the sharing of ideas and experience between practice and theory in real estate management and urban planning. Between them, the eight workshop participants represented all these fields.

As a consequence of increasing competition in the care sector, many health care organisations are currently repositioning their real estate. The question is whether this also has an impact on the position health care organisations wish to occupy in the urban context. Do health care organisations prefer a location close to the urban centre with facilities in the neighbourhood or a location on the outskirts with more opportunities for expansion? Will care facilities continue to be clustered in large hospital complexes or will care organisations undergo a Big Bang, forming small care centres at different locations? Will hospitals take on new functions, transforming themselves into health care boulevards?

The participants were presented with propositions on three issues: 1) the desired position in the urban context; 2) centralisation versus decentralisation; and 3) combination of functions. The main purpose of the propositions was to generate the debate. Three debating techniques were employed. The first round was devoted to free discussion. The second round took the form of a traditional debate with four (designated by the hosts) affirmative team members (the opponents) and four negative team members (the proponents), followed by a free discussion. In the final round all participants first formulated a maximum number of arguments in favour of comprehensive combination of care and non care-related facilities and then a maximum number of arguments against.

Position in the urban context

Proposition: the choice between a location in the city or on the outskirts is of secondary importance compared with the expansion possibilities at the potential locations.

BM[1] Can the limits of the urban environment be clearly established? Hospitals that were situated on the periphery in the 1970s are now integrated with the city. The establishment of new functions around the hospitals has created a new urban homogeneity. Is the quality of the environment not much more important than the location in the city?

LK[2] The product the care organisation delivers and what is offered where is more important. In our Big Bang concept, we advocate the fragmentation of large care organisations into smaller components for specific target groups. Each component looks for the location that best fits the delivered product.

IH[3] Care facilities that are dependent on each other form clusters. The care location must be accessible and be able to guarantee the care demanded. That is more difficult to sustain at smaller locations.

LK Ultimately, there will be a combination of large and small care centres, partly clustered, partly in small units in a finely woven urban network, depending on the target group and the degree of dependence on other care facilities. The combination of functions now being contemplated in a health care boulevard spontaneously comes into existence when small care organisations locate strategically in the urban environment. How people find those small organisations is comparable to a train station. Everyone goes there for a different reason, but they all get on the train. Just like everyone finds their way in the station, the same can also happen in a care process with a personal roadmap and planning.

BM There is actually a regrouping of the parts of the hospital in the urban context. It is extremely important to properly fit together the different functions of the hospital to enable division. Flexibility is often already embedded in the city biotope. Onze Lieve Vrouwe Gasthuis in Amsterdam can absorb the desired growth and shrinkage by leasing or selling space in the direct environment. There has been a great deal of debate about this with respect to the plans for the new development of Erasmus MC in Rotterdam[4]. Should Erasmus MC looks for a site outside the city or not? Ultimately, the decision was taken to stay at the current site due to the good accessibility and the presence of shops and restaurants in the close vicinity. If a lecture hall is needed for the students a nearby cinema will be hired. This option is not available on the outskirts.

GD[5] Urban development considerations also play a role. We always look for intensive use of space. We prefer integration in the city above swallowing up even more scarce space in the landscape. The master plan must be an intelligent body that is flexible in use and not mono-functional. There are various models in the history of urban development. You have to look for a particle size that offers possibilities for alternative use and the hiving off of certain parts. A master plan must have this flexibility.

HV[6] It is important to distinguish between the type of care, for instance between Care and Cure. Which care does the organisation provide? Who are the patients? Every form of care has its own location preferences. Psychiatric

Participants (practical)
Johan Kips
Harry in 't Veld
Bodes de Vries
Ingrid Hulshoff

Participants (theory/design)
Bas Molenaar
Cor Wagenaar
Geert Driesen
Laura Kaper,

1 Bas Molenaar, professor of Bouw Gezondheidszorg at Eindhoven University of Technology and architect at egm architecten

2 Laura Kaper, director/owner of MedSync and prize-winner of The Dutch Board of Hospital Buildings' international competition "Healthcare 2025, buildings for the future" Motto: Big Bang.

3 Ingrid Hulshoff, portfolio manager Healthcare, ING Real Estate Investment. ING Real Estate views the care industry as a new opportunity to invest in real estate. A new investment fund will be set up to this end in the near future.

4 EGM architecten have designed a large number of buildings in health care at various sites in the urban context. At the moment their firm is involved with Erasmus MC in Rotterdam, the Dordrecht care park and Reinier de Graaf Gasthuis in Delft, among other projects.

5 Geert Driesen, teacher architectonic designs at Henry van de Velde Academie Antwerpen and urban development architect at AWG architecten. AWG architecten is responsible for the master plan of University Hospital Leuven's Gasthuisberg site and together with EGM-architecten winner of the competition for Reinier de Graaf Gasthuis in Delft.

6 Harry in 't Veld, building director of Diakonessehuis in Utrecht

From the left front clockwise: Johan van der Zwart, Cor Wagenaar, Bas Molenaar, Ingrid Hulshoff, Harry in 't Veld, Johan Kips, Bodes de Vries, Geert Driesen, Laura Kaper, Theo van der Voordt.

care and rehabilitation have different site demands than a hospital. What's more, hospitals are expanding less and less nowadays. The possibilities for renewal at the site are more important.

IH Expandability is often integrated with the adaptability of the care building.

BV[7] Accessibility is more important. Patients go to the care organisation that is accessible from their housing situation.

Centralization versus decentralization

JK[8] University Hospital Leuven at Gasthuisberg has a special position vis-à-vis the city of Leuven. The city of Leuven has around 35,000 inhabitants. Around 15,000 people come to the campus on a weekday. The status of university hospital means that University Hospital Leuven has a double role in society: a local function for the city of Leuven and environs, and a regional role for people from the whole of Flanders. The choice of a site between the motorway and the city means the hospital is accessible from the city and from the motorway. The site also offers good possibilities for expansion. Having three different sites on the campus is a problem that produces high transport costs between the departments. How is this arranged in the Big Bang idea? Cost-reduction through concentration is lost if the organisation is not centralised.

Big Bang

LK University hospitals remain intact under the Big Bang. Preferably at sites with high-quality public transport which are accessible by motorway. In addition, there are independent clinics focused on a specific type of clinical assessment. The university hospitals are specifically for top-notch care.

Urban context

CW[9] The university hospitals fear to loose routine procedures; it costs them money. Furthermore, a university hospital needs sufficient volume to fulfil their research and education role. The complexity of the processes necessitates a certain scale.

JK It is a fundamental question whether research laboratories belong on the campus or could work remotely with digital information sharing. For clinical research a spatial link between care and research is very important. That's why in Leuven there was a conscious decision to establish research labs on the campus. This is contrary to chemical laboratories, which do not have to be linked to the care.

Health care real estate

BM Why do shops form concentrations? The same integration is visible in care. If a patient suffers from one complaint a specialised clinic is an option. But most people have several disorders at the same time and are happy when all expertise is present in the same building, which makes referral between them possible.

IH The one-counter function is also important here: where can I find which type of care?

CW In health care, everything relating to acute care must be accessible, and so there are at least "counters". And if there are, there is no reason for not making them into crystallisation cores that more things can grow on. The neighbourhood hospital accordingly gets a new significance.

Centralization versus decentralization

BV This is a thorny issue. Acute care must be well managed. But sentiment is also a factor. After a study, Tergooi hospitals were split between the different sites in Hilversum and Blaricum and a system of mutual referral was introduced. Accessibility was given due consideration there. Blaricum was to become a high-tech hospital and Hilversum a day centre with an outpatients' unit. But residents collected 15,000 signatures to maintain a full-fledged hospital in Hilversum, despite the fact that the site in Blaricum is much easier to reach even from Hilversum.

Big Bang

BM Two international studies into accessibility are interesting in this context. In Finland, local stations across the country have diagnostic equipment and good means for communicating with the specialised clinics. That is obviously entirely due to the distances and accessibility in terms of time. Around 100 hospitals are located in the Paris agglomeration, as many as the whole of the Netherlands. Even so, due to the formidable traffic in the city branches are built between the hospitals for acute care and diagnosis. These branches are often combined with other care facilities, such as assistance units for diabetics.

Urban context

HV In acute cases the hospital is chosen in the ambulance. But is there sufficient critical mass when sites are fragmented? It is already difficult to guarantee permanent class I care with three sites. For Diakonessehuis[10] in Utrecht the site in Zeist can only be maintained through conscious steering in the patient groups and doing certain operations only in Zeist.

Health care real estate

BV KBCZ – De Trappenberg[11] has various sites that have ended up in a single organisation due to mergers. Now that the partners want to start building it turns out that if all related parts will be located on the same site, everything will ultimately be brought together.

JK Another question is how does the patient evaluate? As a result of

7
Bodes de Vries, director of building, KBCZ-De Trappenberg, Hilversum

8
Johan Kips, professor and general director of University Hospital Leuven,

9
Cor Wagenaar, assistant professor architectural history at the faculty of Architecture, Delft University of Technology and editor in chief of "Architecture of Hospitals"

10
Diakonessenhuis in Utrecht is looking for opportunities to expand at existing sites. More effective use of outpatients' departments in Zeist and Doorn and the partnership with University Hospital Utrecht is an integral part of this real estate strategy.

11
De Trappenberg is a rehabilitation centre and KBCZ has two asthma centres. The foundation has branches in Hilversum, Huizen and Davos (Switzerland) and a dependent unit at Flevoziekenhuis in Almere. KBCZ-De Trappenberg offers outpatient and clinical (lung) rehabilitation care to adults and children. KBCZ-De Trappenberg is currently considering a plan to house its Het Gooi sites together with a neighbouring hospital.

demographic developments (ageing), multi-pathologies are more and more common. Medical techniques are increasingly expensive. Does the patient choose a hospital close by or a hospital that provides the best care for that specific complaint? How far is a patient prepared to travel? This is important for the positioning of the hospital and whether the choice of the location is important.

BM Health care has become part of the public debate. Whereas the doctor used to be God in a white coat, nowadays people first search online for possible treatments or the best doctor that can prescribe a specific treatment from America. People also increasingly look at the operations a hospital has already done. How often has a hospital performed a specific surgical procedure? For a high-risk operation you go to the best specialist, even if you have to travel further.

JK The location and urban facilities are less important for Cure patients than for Care customers. Combining functions is important for staff however[12]. Due to the workforce scarcity in care, it is a good idea to combine functions. The possibility of quickly doing the shopping before or after work is an interesting perk to attract staff.

IH What about the visitors? Should you offer them facilities too? People will not go to the hospital to do their shopping.

CW They will if there are care-related facilities in a health care boulevard. In addition, investments in the building could attract staff. People find the atmosphere and ambiance around a hospital important.

12
The campus of University Hospital Leuven is on the outskirts of the original city. There is an ongoing study into which urban facilities need to be accommodated on the campus.

Decentralisation or concentration at a single site?
Proposition: a campus model can more easily be adapted to the primary business processes than a network of different sites in the city.

This theme was touched on to a degree by the participants in the first round, but it was explored in greater depth in the second round of debate. The arguments pro and contra centralisation are summarised below.

Con A network of sites in a decentralised model produces more flexibility and leads to faster decisions. Small organisations are able to sustain some investments more easily and faster and are able to adapt to changing circumstances faster. They are better able to gear care strategy, care processes and logistics to each other. It is just like small ships, which are faster and more manoeuvrable than big super tankers.

Social interdependence in the urban context is essential. This is easier to achieve with small units. In small organisations there is also greater alertness to change in society.

Pro For patients, it is reassuring to have all care present in the building as well as other facilities that are important to the health process. Compare that to a department store, where it is warm and dry, you can have a meal or buy a book. The bigger the better. Furthermore, a campus is adaptable; you can always renovate another part of the site. You can also deploy a campus in the marketing of the care organisation. This promotes recognisability compared with competitor hospitals.

A big hospital has more possibilities to treat exceptions too. The patient volume is greater, which makes research possible. Expertise is brought together in large organisations, creating the possibility of knowledge sharing between different disciplines.

Con Acquiring knowledge does not really require co-location. Doctors mainly acquire knowledge from professional literature and not so much through direct knowledge sharing with colleagues outside their department.

Pro In the case of decentralisation, the word hospital has to be debated. Clusters of multidisciplinary concentrations are created versus specialisations that wish to set up business outside the hospital. The risk of this is that the hospital is left only with expensive, complicated care. The private clinics will do the cherry-pick.

Con In Finland decentralisation has resulted in clinics that are specially designed for a specific process. This has improved efficiency enormously. By organising patient groups it is possible to spread the care facilities over several sites.

Pro How can you retain command in a Big Bang Network? What are you director of? Why would a care organisation want to have command over a collection of sites? A network of organisations produces a lot of problems in the process. The controllability is difficult and the interaction between the different facilities expensive.

Con Every site can be a separate business unit under a holding company, profit-making or otherwise. Small buildings are more adaptable. They are easier to

renovate, with less disruption to ongoing business processes.

Pro What types of care are provided at the various sites? Is it feasible to have a surgery department at every site?

Combining functions

Proposition: the introduction of a wide mix of care and non care-related functions in a health care complex supports the care organisation's proper functioning.

Con Experience from Dordrecht shows that medical staff feels this development is a threat. The hospital is not a site for non care-related facilities. The owner of the building has an extra concern: is there sufficient demand among patients and visitors?

Health care is sensitive to infection. So you have to ask whether you want more people than necessary in the hospital. If infection occurs, there will be the devil to pay. Also, people come into the building the care organisation perhaps does not want, like loitering pensioners. In an university hospital early on the restaurant functioned as a neighbourhood restaurant, due to the low prices. That had to stop at a certain moment.

More functions also mean more people and so more traffic and more parking problems. You also run the risk of damaging your image if poor products are traded that are associated with the care organisation. The anti-quackery union for instance opposes the sale of certain homeopathic products in pharmacies. How do you control what is sold in the building? You are bringing people in that have different goals after all. And if a care insurer opens an office in the hospital, does that not imply that the hospital is connected with that care insurer? Does a pharmacy brand in the hospital say something about the quality of the care?

There is also an ethical consideration. Integrating beauty and wellness leads to the commercialisation of health care and creates the impression that everything is for sale.

Pro A mix of functions can be supplementary to the provision of care, for instance when wellness functions or independent treatment centres open in the vicinity of the hospital. Shops and restaurants can also supply products to patients, visitors and staff. This can generate service provision from outside to inside. For patients for instance it's nice to be able to buy a pair of pyjamas and a toothbrush if they are admitted unexpectedly.

Shops can benefit from the flow of hospital users. An average hospital has about 10,000 people coming in every week, just as many as an average neighbourhood shopping centre. High profitability is possible if there is a link to the primary process. The economic basis is greater when the facilities are linked to the hospital. In Dordrecht the health park is no longer borne exclusively by the hospital, but also by other facilities in the neighbourhood, such as a police station. In Berlin's Spandau hospital rehabilitation is integrated into the hospital. The rehabilitation swimming pool opens for the neighbourhood at four in the afternoon, which contributes to the hospital's positive image. Combining rehabilitation and fitness can contribute to "normalising" care: a sick person is doing less well for a time but he is working on getting better. A hospital needs a lot of parking spaces. If you can share the parking spaces with other facilities the result is a win-win situation.

Concluding remarks

The workshop made clear that care organisations are faced with some tough choices, partly due to the dynamic political and economic context. The most sensible choice depends on the type of care offered – cure or care – but also on the organisation's mission, goals and possibilities. In the many considerations, it is important to always involve the perspectives of all stakeholders in decision making, including management, staff, patients and visitors and society as a whole. The accessibility of the site, the approachability, quality and affordability of the care, and the flexibility of the building and the organisation all play an important role in the decision.

Clearly, a workshop like this one does not permit discussion of the entire spectrum of important issues. Such themes as sustainability, healing environments, the impact of increasing market forces versus care organisations as social enterprises and the question of what makes hospital real estate different from other real estate remained somewhat underexposed. The same goes for how new concepts can be implemented in existing organisational and physical structures. All participants agreed that a sequel to the debate would be very worthwhile.

Centralization versus decentralization
Big Bang
Urban context
Health care real estate