



Healthcare Real Estate: Not Immune to Capital Crunch

By Gordon Soderlund

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THE CRISIS IN THE CREDIT MARKETS has affected every sector of the economy, including healthcare. In particular, the tightening of the bond markets has curtailed many hospitals' capital projects, especially construction of new facilities or additions to existing ones. On many hospital campuses, even construction projects that had started have now halted, while the hospital systems await a thaw of the capital markets.

For medical office developers, the crisis in the capital markets has also had an impact, as hospitals have delayed construction on these types of facilities as well. Because medical office buildings (MOBs) are increasingly used to deliver less expensive procedures and care than the traditional hospital setting, medical office development has boomed in the last decade. With substantially lower construction and operating costs than acute-care hospitals, medical office buildings have helped to address a number of crucial healthcare needs. Extending delivery of care to patients across a larger and more geographically diverse area via a hub-and-spoke facility strategy allows hospitals to reach the broader market at significantly lower costs. Given the attractive economics of medical office buildings and ambulatory surgery centers (ASCs), some industry experts expect that MOB development will pick up relatively quickly once the capital markets return to normalcy.

Rehab Challenges

In the interim, existing MOBs may be candidates for rehabbing and adaptive reuse, but both options present their own challenges. Adapting existing MOBs (particularly older ones) for new uses may not be easy or cost-effective, in part because older buildings may not have the floor plates to accommodate innovations in medical technologies. Innovations in diagnostic imaging equipment (such as MRI, CAT and PET scanners, which are large, energy-demanding and sophisticated systems) may hamstring a renovation strategy because not every building can accommodate them. Their presence in MOBs continues to increase, however, providing benefit to patients who desire convenient access all in one location and to physicians who can generate referrals within the same building.

Older MOBs also may not accommodate the designs of more sophisticated specialty healthcare practices, such as neurology and oncology. In addition to the challenges of accommodating the equipment needed for these types of physician practices, these facilities also have to be reworked to accommodate the unique patient flow demands of these specialties.

Finally, many healthcare systems—thanks to government incentives—are foraying into electronic health records (EHRs). Electronic health records essentially store all patient records in a central database and allow physicians to access patient history and current treatments via laptop computers and PDAs, which accompany them into the exam room. Frequently lauded as tools for improving patient safety and treatments—because

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Saint Joseph East Medical Center, Lexington, Ky.





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physicians will not have to rely on patients to share information about their current conditions or medical history—EHRs require technology infrastructure in order to work properly. Skeptics have already raised the issue of how patient records will comply with HIPAA (patient privacy legislation), and whether EHRs will, in fact, save time and money for physician practices. Accommodating the technology infrastructure requirements to support EHRs in older MOB may not be feasible from either a design or a cost perspective.

Despite these challenges, healthcare systems and MOB owners may nevertheless be forced to become ever more creative about rehabbing existing facilities, particularly if the capital markets continue to struggle. Further exacerbating the problem are flat or decreasing patient volumes, as consumers defer both elective and non-elective surgeries and other procedures due to job loss, high deductible insurance coverage or increasing COBRA premiums following layoffs. Industry experts also expect an increase in the numbers of uninsured and underinsured, which will create further pressure on hospital systems' financial performance.

Banking on Monetization

Beyond its impacts on development of new MOB or rehabbing of existing ones, the credit crisis is also having an impact on MOB monetization activities. Here, too, it's unclear precisely how far-reaching the impact will be. In the past decade, many hospital systems have elected to monetize their MOB and other non-core assets in order to generate additional capital that can be deployed directly to provide healthcare services. Often, large portfolios were monetized. The constriction in the capital markets has certainly cooled monetization activity, as lenders have been unwilling to finance the large transactions that were common in the past.


Despite the slowdown over the last six months, many in the industry expect that monetization activity will begin to rise. As hospital systems wrestle with their own financial fortunes, many may revisit monetization as an effective tool to improve their capital positions.

A Return to the Hospital?

Other trends in healthcare may also have significant impact on the development and leasing of MOB. Chief among them is the renaissance of hospital-employed physicians. Hospital administrators note that many physicians currently in private practices continue to face significant economic pressures. Shrinking Medicare and Medicaid reimbursements have contributed to a steady decline in private-practice physicians' earning power. For nearly 20 years, these reimbursements have not even kept pace with inflation, while physicians' practice costs (such as malpractice insurance)

have risen. These practice economics have created pressures on MOB rents.

While practice acquisitions by hospitals were in vogue 15 years ago, flaws in that strategy, such as improperly structured incentives post-acquisition, caused substantial financial failures leading to an unraveling of these acquisitions. That trend is now reversing in favor of the closed-physician model, whereby physicians are becoming hospital employees again. The deal structures are improved with appropriate incentives negotiated. Though physicians may earn less than they might have in private practice, there is greater security in a consistent flow of income; hospitals assume greater burdens of practice administration; and the hospitals gain built-in loyalty and patient volume. It's unclear what impact the closed-physician models might have on MOB rents—though one could expect tougher negotiations during lease renewals, since hospitals have a stronger credit position than the physician practice tenant. The hospital could also exercise its right to purchase the facility if its combined tenancy gives it majority occupancy in the MOB.

Ultimately, the most significant trends affecting healthcare and its real estate may be on the horizon. The Obama Administration has pledged to undertake healthcare reform. Though no formal plans have been issued to date, most healthcare experts expect the administration to move quickly with the outlines of a reform plan. But, until they do, both healthcare and real estate industry experts decline to speculate about what the implications of healthcare reform may be. Seasoned healthcare real estate experts, however, are watching carefully as the larger trends in healthcare often result in changes in real estate strategy, development and leasing. 

For more information on these and other trends in healthcare, attend BOMA's Medical Office Building and Healthcare Facilities Conference, June 25-26, 2009, at the Marriott Philadelphia Downtown.

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