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Value Adding Management of Hospital Real Estate: Balancing Different Stakeholder Perspectives

Real estate is one of the resources that organisations can use to attain organisational goals and to add value to the organisation. Due to a move towards less governmental support in favour of increasing entrepreneurship, Dutch hospitals are becoming more responsible for their own building investment decisions. This is happening in other European countries as well and is visible in the third wave of healthcare reform (Cutler, 2002) in which market incentives play an important role to reduce medical expenses. Integral pricing of diagnosis-treatment combinations including building costs is an important part of the new Dutch healthcare system to stimulate cost-effectiveness and to create market incentives. This changing context creates opportunities for the institutions but also new risks. As a consequence, Corporate Real Estate Management (CREM) of Dutch hospitals shifts to managing real estate as a strategic asset that should add value to the organisation like other resources such as budgets, human resources and technology. This requires a building strategy that is aligned to the organisational strategy.

Balancing Different Stakeholder Perspectives

Adding Value by Real Estate

Value as a concept originates from economy, with financial value being the tradeoff between costs and revenues. Within economic literature, value for a customer is also defined as the preference of a customer for a product or service and the extent to which (the use of) the product meets the targets set by the customer (Woodruff, 1997).This definition presents value as subjective perception by a specific stakeholder, the customer.

In a broader sense, added value of real estate can be defined as the perceived contribution of the building to achieving the goals set by all stakeholders. Added value of real estate is as such a subjective concept related to different stakeholders such as policy makers, controllers, users, and technical managers, and their different perspectives on real estate. According to Den Heijer and De Jonge (2012) these perspectives on real estate can be classified into four categories (Figure 1).

Jensen, van der Voordt, and Coenen (2012) traced six different types of added value: use value (quality in relation to the needs and preferences of the users), customer/ consumer/user value (the tradeoff between benefits and costs for these stakeholders), economic/financial/exchange value (the economic trade-off between costs and benefits), social value (e.g. supporting positive social interaction or reinforcing social identity), environmental value (Green FM, environmental impact of FM), and relationship value (e.g. getting high-quality services or experiencing a special treatment) (Jensen et al., 2012b). This clearly shows the multi-dimensionality of the added value concept.

Aligning Real Estate with Organisational Strategy

As value depends on the perception of stakeholders, stakeholders should be able to define the desired values and assess whether the goals are attained. This process can be managed by using principles from healthcare quality management. Quality management is a cyclic process of defining, achieving and testing the pre-set goals. Important principles of quality management in healthcare are the plan-do-checkact cycle (Deming, 1950) and managing quality of care in connection to organisational structure, process and outcome criteria (Donabedian, 1988).

Both principles have been combined into a model for adding value management to align real estate strategy to organisational strategy and care processes (Figure 2). This model consists of four steps (context, value, managing and design) regarding both the primary process of the organisation and the building. The cycle starts with an evaluation of the organisation and its real estate based on an assessment of the internal and external context and stakeholders' outcome criteria derived from stakeholders' objectives. Successes and failures define plans for improvement. Implementation aims to result in an improved organisational structure and more effective and efficient primary processes, and real estate interventions that add value to the organisation and supports its performance. The final step is to check if the decisions regarding organisation and real estate result in improved outcomes for the stakeholders. When the context and/or stakeholders' objectives change, it can be necessary to conduct this quality assessment again. Important steps are firstly defining the desired values and checking whether these values are achieved in the building by design research and by Post-Occupancy Evaluation (POE) of the building-in-use.

Opportunities and Constraints

As part of a wider study into hospital real estate management in a changing context (Van der Zwart, 2011; Van der Zwart, Arekesteijn, & Van der Voordt, 2009; Van der Zwart, Van der Voordt, & De Jonge, 2010), fifteen interviews were conductedwith CEOs and real estate project managers on opportunities and constraints of adding value by hospital real estate. All interviewees are involved in management of hospitals that constructed a new building in the period 2004 - 2012. Key points for discussion were the accommodation strategies of these hospitals and the role of added value of real estate during the life-cycle of the building. Three main questions in the interviews were:

• What are the key strategic objectives for the accommodation of your hospital?

• Which added values of real estate are prioritised?

• How are these values incorporated into the design of the hospital building?

Based on a literature review, nine added values of (hospital) real estate can be defined (Figure 3). These values were used as a reference for discussing the perception of added values of real estate in the building management and design of the interviewed hospitals.

According to the interviewees, the first priority of hospitals is to deliver good healthcare in a cost-efficient way. Real estate is secondary but at the same time an important resource to attain the organisational objectives and to optimally facilitate healthcare processes, effectively and efficiently. Being a resource for production, real estate is always examined upon its facilitating role of care processes and its impact on business economics. Supporting the primary process requires that the building is functional, attractive and comfortable. On the one hand the building has to support patient's needs and wellbeing. On the other hand the building has to be a pleasant and productive working environment for healthcare staff. Therefore, the building should support multidisciplinary and patient focussed working processes. Remarkably, although sustainability is being perceived as important and linked to corporate social responsibility, it is mainly assessed on the impact on investment and running costs. Five other main lessons emerged from the interviews are described below.

a. People are Key

Supporting innovation, patient and employee satisfaction and culture were highly prioritised by CEOs and real estate project managers. These values are related to the experience of the building by its users. Measures to stimulate innovation and improve organisational culture were linked to social interaction and communication by creating meeting places where healthcare professionals can exchange information and ideas. References were made to the use of innovative office concepts and creating a back-office for medical specialists. Patient satisfaction was often linked to hospitality, healing environment and the Planetree concept (www.planetree.nl) with the ultimate aim of contributing to the health and wellbeing of the patients.

b. Alignment of the Building to Primary Processes

A general value is to provide optimal healthcare for a reasonable price. Related real estate values are increasing productivity and reducing costs. Reducing capital charges of real estate lowers the price of healthcare products and services. Optimising the flexibility and adaptability of the building are often applied to be able to continuously align the building to changing healthcare processes and to increase productivity in a changing context.

c. Priorities Depend on Building Phase

A number of added values of real estate such as the image of the building are difficult to customise after completion of the building and for this reason are highly prioritised in the initial phase and during the design of the building. Due to the static character of real estate, importance decreases once the building is finished. Controlling risk and using real estate as an asset are closely related to the physical appearance of the building and the location. These real estate characteristics determine largely the futurevalue of real estate and opportunities to facilitate changing user requirements and adaptive re-use.

d. Sector Dependent Definitions

The respondents interpreted user satisfaction as patient and employee satisfaction. Apparently, patient satisfaction and employee satisfaction are perceived as two distinct added values of real estate. The use of real estate to get a high return on investment – now and even more in the future - was not recognised as an important issue in the context of hospitals. Real estate choices as a means to increase finance possibilities appeared to be comparable with measures to controlling risk. Application of functional 'layers' by division of the building in a hot floor (operating theatres), office, hotel (bedrooms) and factory (laboratories) was often mentioned as a means to improve the marketability and future disposal of hospital real estate at the end of the functional life cycle.

e. Value for Different Stakeholders

The respondents were asked how added values of real estate were visible in the design of the hospital building. The responses varied from associations with regard to the concept of value adding, abstract visions on building to concrete design interventions. All these different responses are linked by the authors to four perspectives on real estate (Den Heijer & De Jonge, 2012): strategic, financial, functional and physical. In this way Figure 4 summarises the perception of added values of hospital real estate by the interviewees.

Concluding Remarks

The framework of nine added values linked to four stakeholder perspectives can be used as a reference in decision-making about hospital buildings at strategic and tactical levels. As such it provides input to the development and implementation of a professional building strategy and briefing, design and management of hospital buildings and other health facilities. The huge variety in associations regarding building solutions shows the need for a clear conceptual framework on added values of hospital real estate. Besides, the explorations of adding value by real

estate might be applicable in other sectors as well.

A next step could be to operationalise the added values in depth and to develop measurement tools on different scales: a real estate portfolio, buildings, departments and places. A first step has already been made with the development of a design assessment tool for newly built hospitals. This “research by drawing” explores how different added values of real estate can be made visible in the floor plans and cross-sections of a hospital building in the design phase. This study will be published in December 2013 in the PhD-thesis of the first author on value adding management of hospital real estate in a changing context.

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