

Guidance notes - Medical Partnership Agreements

Guidance Note on the approach to the valuation of surgery premises in Partnership Agreements.

1. NHS Act 1977, Schedule 10 (as amended in 1997), provides:-

“... a disposal of premises previously used for the purposes of a medical practice shall be deemed to be a sale of the goodwill of a medical practice if:-

- (a) the person disposing of the premises did so knowing that another person (“A”) intended to use them for the purposes of A’s medical practice; and
- (b) the consideration for the disposal substantially exceeded the consideration that might reasonably have been expected if the premises had not previously been used for the purposes of a medical practice.”

2. The wording of Schedule 10 is very strong. The “deeming” provision has the effect of creating a payment for goodwill even though in fact none exists.

3. In 1988 MPC gave guidance as follows (inter alia):-

“A question of sale of goodwill would arise if premises, or a share in them, were being sold for a price substantially above the market value of the property. The basis of valuation used by the MPC is the market value of the property with the benefit of vacant possession **excluding** any element of goodwill attaching to the premises by reason of the fact that a medical practice has previously been established therein but reflecting the value of any adaptations, alterations and extensions and their value not only to an incoming doctor but also competing users such as dentists, veterinary surgeons and other professionals.”

This was not very helpful. What available market is there for purpose built medical surgeries, especially adapted for that purpose? How many veterinary surgeons practices are there who would take over a large modern purpose built GPs surgery?

4. In practice, from 1988 the MPC were prepared to acknowledge that transfers of interests in surgery premises on the basis of “cost” or “book value” was not unreasonable. Informally, they were prepared to confirm that they would not consider taking any action in such cases, and there appeared to be a clear recognition that such arrangements were practicable and sensible. Nevertheless, in about 1992, they decided they would take Counsel’s opinion to clarify a point.

5. It was not until 1994 that they were prepared to issue further “clarification”, and they then declared (inter alia):-

“In the opinion of the MPC, the sale of a property for anything substantially above the market price has to be deemed a sale of goodwill in the context of the current legislation.

The clear legal advice the MPC have received is that they have no latitude to interpret the current legislation in any wider way, which might have been hoped to reflect what is going on in the field.

In the final analysis it would be for the Courts to decide whether the sale of the goodwill of a medical practice had taken place in any particular case or whether the parties involved had throughout acted in a reasonable manner in the light of the legislation. There has to MPC knowledge never been a prosecution under the Goodwill provisions so there are no authoritative pronouncements by the Courts.

In the particular circumstances of an individual practice it must be for the partners to proceed as they see fit.”

6. In February 1996 the case of **Blackmore and others -v- Timberlake** came before the High Court (Ms Cherrie Booth QC appearing for the Defendant!). Here an arbitrator made a decision on the valuation of surgery premises. It was alleged that the arbitrators wrongly took into account the fact that a cost rent scheme was in operation for the surgery premises, and as a consequence determined that the consideration payable for the premises in question was substantially in excess of the consideration which might reasonably have been expected had the premises not previously been used for the purposes of a medical practice. The Judge made the following observations:-

“It seems to me that the cost rent ... is paid because the premises are going to be used for the purposes of a medical practice. It may well be arranged before the premises

even come into use as a medical practice. It may be made in some circumstances where the premises are previously in use as a medical practice, but if it is paid, it is not paid because the premises had previously been used for the purposes of a medical practice. ... any excess is not due to the medical practice; it is due to the cost rent.”

[My underlining]

7. In Medeconomics August 1996 Mary Leigh of MPC responded with her view of the decision in Blackmore -v- Timberlake as follows:-

“It is clear from the judgment that all the legal and public interest arguments were not presented to the judge. The hearing was purely about leave to appeal and the judge’s words were not a ruling in law.

In the circumstances and taking account of legal advice, there will be no change in the Medical Practices Committee policy: premises funded under cost rent may not change hands at a price substantially in excess of the market value. I remain confident our legal advice is correct.

Many problems are created by the cost rent scheme. Either doctors lose capital when leaving a partnership, or other doctors have to pay far more than the premises are, or may ever be worth. The problem arises because of the flaws in the scheme and lack of proper valuation and investment advice to participants in the first place.”

8. In July 1997, judgement was given in the case of **Martin, Luder -v- Alcock & Ors**. In this case three practices constructed a new surgery (without the aid of any kind of partnership agreement!) and carried on practice as partners therein. Subsequently, there was a fall-out. Long running (and expensive!) litigation ensued, particularly over the valuation of the surgery. After much argument, the Judge determined that the price payable should be “the higher of:-

- (i) the sum due to TSB [the Partnership’s banker and representing the amount of the loan used to carry out the development] ...
- (ii) the open market value of the ... Medical Centre”.

9. In May 1999, the General Practitioners Committee of the BMA issued their “Guidance on Surgery Premises” valuation, which gave cautious approval to the concept of “cost or market value, whichever is the greater” as the basis for valuing surgery premises, at least in the case of premises carrying the benefit of a cost rent.

10. The case of **Rodway -v- Landy** was decided in April 2001. Here, two GPs formed a medical partnership (again without an agreement) and built new surgery premises. They duly fell out and litigation ensued. Here the Judge determined that he could not order a sale of the surgery from one partner to the other because “it was common ground that a valuation ... which disregarded cost rent would produce significant negative equity.” He also “found that there would probably be negative equity even if cost rent were taken into account, therefore an offer for purchase in an amount significant to repay the loan principal would entail the giving of excessive consideration ... and ... this deemed the transaction to be a sale of goodwill and so unlawful”. Instead, the Judge used the power conferred under the then recently enacted Trusts of Land [etc] Act 1996 to order a partition of the surgery, with each partner occupying part and excluded from any rights to occupancy or of access to the other part.
11. Many surgeries were built in the ‘80s and early ‘90s with the benefit of Cost Rents. In many cases, the amount of such cost rent covered all, or virtually all, the “borrowing cost” incurred in connection with the construction of the new surgery. Experienced lenders in the sector (eg GPFC and TSB) had no difficulty in lending monies to GPs in these circumstances - they look to the “capacity to repay”, rather than notional “alternative use” capital valuations.
12. In many circumstances, however, a retiring partner found that “market value” was no more than 50%, or at best, 75% of the original “cost”. These valuations merely reflected what had happened generally in the commercial property sector and it came as a nasty surprise to a retiring GP to discover that he could owe perhaps £50,000 to the Continuing Partners as his share of the “negative equity” on his retiring from the practice. There has also been considerable reluctance on the part of an existing body of Partners to allow a new Partner to buy in at a market value substantially less than cost thereby crystallising loss.
13. By the late 90’s, the position had materially improved to the extent that market values generally had increased so the “gap” between original “cost” and current market value had in most cases, all but disappeared. In many cases, cost rents have been replaced by well-negotiated notional rent allowances. Valuers (if appropriately authorised by the Partnership Agreement) have felt able to reflect these notional rent levels in enhanced values applicable to transactions between Partners.
14. Nevertheless many GPs are still very cautious about developing surgery premises at considerable cost and risk. Why should they (particularly those close to retirement) take the risk of participating in new development save in terms that on retirement, they would, at least be indemnified against their share of outstanding borrowing. Could they also persuade new Partners to join the Partnership and take their due proportion of that risk?

15. A new Partner, on the other hand, would be very concerned about:-

“... the last person out of the room, switch off the light ...”

ie they “bail out” existing Partners, who all in turn retire and they are then left with premises which are by then a liability.

16. Many practice agreements have been entered into which basically “lock” the price at which transactions relating to interests in the surgery take place to certain minimum benchmarks eg

- a specified “agreed” value
- original acquisition and construction “cost”
- the particular partner’s acquisition cost
- the relevant proportion of the loan secured on the surgery for which the particular partner is personally responsible.

In most cases, a formula will be included enabling “market value” or “open market value” to be taken “if higher” than the stipulated benchmark.

17. It has to be acknowledged that there is a possibility that such an arrangement could be regarded as an attempt to evade, or circumvent, Schedule 10. On the other hand, if doctors are expected to take the risk involved in developing new surgeries - the better to provide patient care - then they should be allowed, like “consenting adults”, to reach practical and sensible agreements between themselves as to how they deal with that risk. There is little prospect of the Government bringing in amending legislation.

18. What practical guidance can be given in the light of this background?

19. It is important that the Partners take experienced property valuation advice. The RICS have issued guidance on the valuation of surgery premises, and if it is necessary to engage a valuer, then the Partners should ensure that such valuer is experienced in this kind of work.

20. The issue differently affects new partners, continuing partners, and retiring partners. Where a partner has say five years or less to go before retirement, there would appear to be little point in his joining in with the others in making a surgery development. It is better that the other partners do so, with his continued occupation as a practising partner protected by authority by way of licence contained in the Partnership Agreement.

21. Where “cost or market value, whichever is the higher” arrangements have been agreed and are in place, then it is generally not desirable or necessary to engage a valuer to ascertain market value, unless there is a reasonable expectation that such market value would be higher than “cost”. The Agreement should direct the valuer, in any event, to find that market value should not in any event be less than cost.
22. Would any partner challenge such an arrangement? It is certainly arguable that if such an arrangement is unlawful, then no partner is bound by it. A Court would not enforce an illegal contract. A retiring partner, however, is hardly likely to take the point, because he will generally be a beneficiary. A continuing partner might be tempted, but he would have to realise that he could be the next retiring partner! As far as incoming partners are concerned, they can either accept a proposal to buy into the surgery on the terms offered, or not, as the case may be. In those circumstances, it might be better for the existing partners to be selective in their choice of new partners. A practice with a modern, purpose built, surgery should, after all, be an attractive proposition to a new GP, with a long future ahead of him, during which time it should be possible to anticipate that “market value” will float up to equal, and then exceed, the original cost.
23. No prosecution has ever been brought by the MPC for breach of the goodwill rules. If it were, such a prosecution would be met with the arguments put forward in Blackmore -v- Timberlake, namely that it is the cost rent that creates the value not any notional goodwill. There would also be practical difficulties in assessing the meaning of “substantially” in Schedule 10. There are relatively few legal definitions of the word “substantial”, but it would certainly mean “a material amount”, perhaps even “more than half”. Nevertheless. If a prosecution were brought, and a conviction obtained, a fine or even imprisonment could be imposed.
24. At worst, the Agreement could provide that a retiring partner should not be **required** to sell his or her interest in the surgery at less than the relevant proportion of original cost. For a period (say five years) at least, the retired partner can receive by way of “rent” the amount that he or she had previously been receiving by way of share of the cost or notional rent with a subsequent sale being “triggered” when market value had reached a value equivalent to cost.
25. In the last resort, practices are advised to be aware of the possible risks but otherwise they should follow the 1994 MPC guidance “to proceed as they see fit”!

26. Consideration will need to be given to the issue of whether account should be taken in any valuation of the additional value attributable to surgery premises in consequence of additions extensions improvements generated out of improvement grants, or (where historically that has been the case) fund holding savings. It is generally desirable for a retiring partner not to be paid for his share of them, but it is for each partnership to take their own view about this.
27. Care should also be taken in the treatment of loans. Are they partnership liabilities, or the individual liabilities of the particular Partners? The point is particularly relevant where the Partners (or a particular Partner) are contemplating taking out long term fixed interest rate loans. Will the Continuing Partners be expected to take over these loans, even if current interest rates are much lower? The point has to be addressed.
28. Finally, **Rodway -v- Landy** determined that that particular surgery was not partnership property. The judgement gives no indication as to how this decision of fact was reached but it is suggested that every partnership agreement should put the point beyond argument.

It should be understood that the above notes are given by way of guidance only. No responsibility is accepted by veale wasbrough for their application to any particular circumstances and each partner must take individual advice as appropriate.

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