How capital is allocated and managed has a high impact on the cost structure and performance of hospitals and the sector as a whole. Even though capital costs make up a relatively small portion of total hospital costs (5-10% on average), decision making on capital investments drives the efficiency of use of other inputs, influencing the location of facilities (and hence access) as well as the setting where care is delivered and the medical equipment available. The processes by which capital is allocated and paid for in many health systems generate poor incentives in all these areas – seriously undermining hospital and health system performance.

WHAT IS CURRENT PRACTICE FOR ALLOCATING CAPITAL TO HOSPITALS IN WELL-PERFORMING HEALTH SYSTEMS?

Essentially there are two models: a “traditional model” where operational expenses (or services costs) are allocated to hospitals separately from capital; and, the “integrated model” where these two funding streams are unified. The two approaches are described below.

Box 1. Key Features of Traditional Capital Funding Model
- Two-tiered
- Cost based funding
- Project-based allocation

“Traditional” capital funding model
Traditionally, capital funding of both public and publicly-funded private hospitals has been “two-tiered”, that is, operational costs are covered from one revenue stream and capital costs are funded from a separate one. Further, capital allocations are set based on the cost of an investment; the allocation mechanism is usually “project-based”, meaning funds are distributed from a predetermined pool of funds in response to proposals for a one-time need. Technical criteria for selecting projects are generated by priorities set out in a medium to long-term plan for development of sector capacity (e.g. geographical shifts; service-setting shifts; care coordination). Under the traditional model, the allocation of funds based on these criteria is an important tool for guiding sector development (planning) – and is all the more important in systems where alternative mechanisms for guiding sector development are weak (as in systems with autonomous public hospitals, or substantial private hospitals).

Criticisms of the “traditional” model.

Box 2. What makes the traditional capital funding approach work?
- Technically derived criteria for project selection (task taken seriously; full multi-year costs taken into account)
- Project selection de-politicized (transparency, low stakeholder involvement)
- Project selection criteria directly based on sector planning priorities (sector planning is effective and well connected to capital funding process)
Capital allocation is politicized—Most countries that have used this model of capital allocation have found it to be very susceptible to politicization of capital funding flows. It is commonly perceived that project selection has more to do with a “community’s political persuasion” or with the presence of an influential local politician than with any government criteria for capital replacement or expansion.\(^1\)

Hospitals invest and use capital badly—Even when political influence isn’t leading to poor allocations of capital, the separation of capital funding from operational (recurrent) costs encourages poor investment decisions. Since the capital allocation amount is set based on cost, and the funds are allocated from an external actor, there is no incentive to use the appropriate level of capital nor to use capital well. Capital may be hard to get, but to the degree that it is obtained it is a “free good” from the perspective of hospital management. The structure creates adverse incentives leading to hospital management requesting excessive amounts of capital. Funding capital for hospitals based on cost has been shown to lead to higher use of capital as well as higher levels of “organizational slack” (unused capacity) and relatively rapid deterioration of capital stock.

Government budget situation determines capital availability—Under the traditional system of capital funding, the total envelope is determined by the overall fiscal situation, as well as competing (other sector) priorities. This de-links capital allocation from important factors such as: need, demand and availability of productive investment projects.

Integrated capital funding model
While the traditional model for capital funding has historically been widespread, a number of countries have long funded their hospitals via a single payment stream covering both operational and capital costs (Netherlands). Others, have recently changed their capital funding mechanisms to address the weaknesses noted above (UK). The common features of these alternative approaches are listed here.

Integrating capital costs into services payment—Under an integrated capital funding mechanism, charges to payers cover operating AND capital costs (including depreciation and interest payments). They can use their revenue (whether from service charges or loans) however they like – and hence have the incentive to invest sensibly in and maintain capital investments. If they can keep an investment project low cost, they keep the savings and can use them how they please. This integration also strengthens the “power” of whatever incentives are constituted in the services payment system – as that is where all their revenue is coming from.

Sector neutrality (or the “level playing field”)—Under this integrated system, hospitals cover their costs of capital from self-generated funds. This is so even when the hospitals and their assets are publicly-owned. For public hospitals, the system of covering the cost of current and future capital is known as

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“capital charging” – emphasizing the fact that public hospitals are being charged for the use of public assets. In health systems where both public and private hospitals deliver publicly funded services, this requirement that public hospitals fully cover the cost of their capital is critical. Where public hospitals benefit (either in terms of installed capacity or on-going public funding) from subsidized capital – private operators or investors will not invest. They simply cannot compete with such a disadvantage in terms of costs.

Box 3. What makes the integrated capital funding approach work?
- Supply or purchasing-based planning instruments in place and working
- Service prices constrain “gold plating” (e.g. not cost - plus reimbursement)
- Service prices motivate investment (fully cover costs of capital)
- “Level playing field” for providers (no input subsidies to “special groups”)
- Payment system is predictable (attract investors; reduce cost of borrowing)

Self-funding and private borrowing—
When services payments include the costs of capital – the hospital take its own capital funding decisions. For smaller investments, these purchases are made out of retained earnings. For larger investments, hospitals often seek loans. In the Netherlands, for example, all major capital investment projects are financed through loans from private banks. The banks’ review processes for loan approval is one of the hospital accountability mechanisms in such a system – both in terms of the soundness of the proposed investment, and, in terms of the overall financial soundness of the hospital.

Self-funding and private investment—
Until 1991, the UK Government funded all capital in its public hospital system (the NHS) on a project basis. They have now established an integrated system of funding (including capital charging). A significant amount of capital investment in the UK is based on private equity investment. Once a capital project has been identified, NHS hospitals seek private equity investors to fund and deliver the project. It is believed that the private funds are only slightly more expensive than public funds (interest rate) and that there are significant cost savings in the private management of the capital development project (on-time, under budget, delivery of quality facilities) and subsequent operation of the facility.

Planning tools—Under the “integrated” model for capital funding, capital investment decisions take place in the hospital itself – subject to the discipline of being able to pay for the investment (including interest on any loans taken). Under such a system, it is no longer
possible for the government to guide sector development (engage in hospital sector planning) via approvals for capital projects. In systems where government is the primary payer, or has control over the payer(s), hospital sector development (planning) is implemented via eligibility requirements for services reimbursement related to criteria or approval for capital investment – especially capacity expansion. For example, in the Netherlands and Germany, sickness funds may not pay for hospital services where the related capacity or equipment was not approved. Using this mechanism for guiding the development of the hospital sector has the advantage that it applies equally well to both public and private hospitals.

In health systems, such as the US, where government does not have strong influence over payers, capital funding is constrained on the supply-side via either a requirement for a “certificate of need” (again buttressed by public funding programs requirements); or, for non-profit hospitals – requirements related to access to subsidized local (bond) markets.

**Issues with the integrated approach**

*Harder to Implement and Administer*—It is difficult both politically and logistically to move from one regime to the other. The government and payer tasks are substantially more complex (new price setting mechanisms, valuing installed capital; identifying funds for necessary increase in prices to cover capital).

*Big job for the payer vis a vis private investment*—For private capital to flow to the hospital sector requires that service prices are fully, fairly and transparently set to cover the costs of capital. It also requires the public hospitals get no special treatment – in terms of supply side subsidies (including free capital). The services payment regime of the payer, plus the system for public hospitals to cover the cost of their capital determine the “business case” for investing in the hospital sector. It is very hard for government or quasi-government monolithic payers to administer contracts and payments sufficiently well to reduce the perceived risk enough to motivate private capital to flow into hospitals.

*Planning*—All countries actively guide and constrain the development of the hospital sector. When capital costs are integrated into services payments, selection of capital projects cannot be used to implement policy priorities in terms of sector development. Hence, the alternative instruments mentioned above are critical. If an alternative instrument for hospital sector planning isn’t in place or isn’t working well, low levels of sectoral efficiency and access problems in the hospital sector result.