A new approach to capital payment in a competitive era

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Prologue: One important item on the health agenda of the new Congress will be the formulation of a policy to prospectively pay hospitals for the Medicare portion of their capital costs. When the Medicare prospective payment system was signed into law in 1983, Congress delayed its decision on how to fund capital costs until it could research the issue more fully. Now, with the October 1987 deadline for determining a capital payment policy around the corner, discussion of capital issues has been active among the health policy community. In this article, Jonathan Betz Brown analyzes the thought behind the various flat-rate capital payment proposals under consideration, asserting that while they look simple and effective, they probably are not. Additionally, they “will get us into deep trouble in the long run,” he argues. The author then presents a new approach to capital payment that has emerged from a three-and-a-half year study by the Harvard Health Capital Project. This proposal of “planned payment” looks at the long-range implications of designing capital policy and attempts to build in the flexibility that is so necessary in our rapidly changing health care environment. Brown, an assistant professor of public policy and health planning at the Harvard School of Public Health, emphasizes the need to recognize capital payment—beyond Medicare—as a fundamental health policy issue “Present capital decisions cast a long shadow. Long-term commitments based on short-term thinking or mistaken forecasts could have tragic consequences.” Also, Brown asks, How can we design community and governmental institutions that really work in a competitive era? He suggests that this question of integrating public policy and community planning into a competitive market needs to be addressed as seriously as are questions surrounding financial reimbursement. Brown, who holds both a master’s degree and doctorate in public policy from Harvard’s John F. Kennedy School of Government, has studied capital issues for the past five years and has been closely involved in the Health Capital Project.
Historical cost-based reimbursement of hospital capital expenses has not worked well. Like cost-based reimbursement of operating expenses, it rewards inefficient management and encourages excessive spending. The nation's current excess of hospital beds and its overreliance on medical technology is at least partly due to the past availability of historical cost-based reimbursement of capital expense. In addition, continued use of cost-based capital reimbursement by the newer hospital rate regulation systems, such as Medicare's diagnosis-related group (DRG)-based prospective payment system (PPS), creates a large and inviting loophole which may further distort the balance between capital and noncapital hospital expenditures. Yet historical cost-based reimbursement has not allowed many essential facilities serving poor neighborhoods to maintain a safe and efficient physical environment. The cash flow problems brought on by poorly insured and uninsured patients have prevented some hospitals from investing freely in plant and equipment.

It is easier to criticize cost-based capital reimbursement than to design a better alternative. By far the most popular alternative proposals are those that rely on some form of flat-rate payment. Examples include several proposals to reimburse capital requirements under Medicare by using a percentage add-on to DRG prices or by eliminating separate capital payments altogether. Such policies break the connection between capital needs and capital expenditures, on the one hand, and capital reimbursement, on the other. They also fit easily into hospital cost control arrangements that rely on price regulation, as does the Medicare DRG system, and into selective contracting and capitation environments. In addition, flat-rate payment mimics the way unregulated business receives revenues. Many proponents therefore believe that flat-rate capital payment of hospitals will promote efficient management, produce a more efficiently structured medical service delivery system, and be simple to design and administer.

A second alternative to historical cost-reimbursement is planned payment of capital, which allocates capital funds to institutions for specific projects and uses. Cost-based and flat-rate capital payments create institutional entitlements, leave investment decision making primarily to institutions, and govern allocation with formulas that for the most part ignore local circumstances and priorities. By contrast, planned payment systems operate more like the head office of a decentralized multidivisional corporation. Large private corporations allocate limited corporate capital by evaluating divisional proposals and negotiating with division executives. Both the merits of specific divisional proposals and the overall structure and strategy of the larger entity are considered during the negotiation-allocation process.

Varieties of the planned payment approach operated in the United
States in the past. The Hill-Burton program and successful early “business coalition” efforts to coordinate philanthropy provide well-known examples. \(^4\) “Capital pooling” proposals were discussed when Medicare was enacted. \(^5\) President Carter included a capital pool in his unsuccessful program to impose hospital rate setting nationwide. \(^6\) The recent Commission on Health Capital also analyzed pooling. \(^7\)

**Terms of the debate.** The current debate about health capital policy in the United States proceeds, or should proceed, on two levels. The question of programmatic efficiency—whether or not a particular policy will work in a narrow operational sense—occupies one level of discourse. Most of what is published and said adopts the narrow, technical approach appropriate to this question.

Behind the programmatic issue lies another, more important, debate—a debate about the evolution of the nation’s health care system and strategies to guide its development. Health capital policy plays a much stronger strategic role in health system development than is generally recognized. \(^8\) Capital funds comprise the resources available to support institutional renovation, innovation, expansion, and competition. The desire for access to capital funds drives management behavior to a surprising degree, and capital access explains much of the current attractiveness of for-profit medicine, multi-institutional systems, vertical integration, and corporate restructuring. These facts remain largely unspoken and unheeded in current capital policy deliberations.

The following analyses of flat-rate payment and planned payment evaluate both narrow programmatic efficiency and long-run strategic impact on health system development. I analyze flat-rate capital allowances first, finding fatal flaws, especially in the long run. I then consider a generic form of planned capital payment that has particular promise, an arrangement I and my colleagues at Harvard’s Health Capital Project call a Community Health Infrastructure Bank.

### Flat-Rate Capital Allowances

In abstract terms, for any capital payment system to be successful, it must be feasible to administer (be practical), provide fair institutional and community access to funds (be equitable), and allocate capital funds to their highest and best uses (be efficient). In addition, capital payments should help produce over the long run a health care delivery system that society will be happy with. This latter consideration might be termed its **strategic efficiency and equity**.

**Practicality.** Ease of administration is an apparent strength of flat-rate payment. Nothing could be simpler than to increase existing reimbursement payments for operating costs by a percentage amount. The bureaucratic and legal mechanisms are in place and the necessary information is
at hand. Simplicity has its side effects, however.

One of these side effects is "mismatch." Hospitals vary widely in the percentage of total expenditures they devote to capital. Proprietary hospitals and hospitals that have recently added beds are well above average, while large urban public hospitals, teaching hospitals, and hospitals serving large Medicaid populations are below.

Far wider differences separate individual institutions. A recent econometric study by the American Hospital Association (AHA) introduced nineteen explanatory variables but left more than 70 percent of this variation unexplained. A fair and efficient policy ought to recognize much of this variation, explained and unexplained. Yet no formulaic system can hope to do even as well as the AHA model, and even an inadequate set of adjustments sacrifices much of the simplicity that is the most attractive feature of flat-rate payment. Ease of design and administration will evaporate as the formula becomes complex.

One group of hospitals that will fare especially poorly under flat-rate payment are those that because of recent renovation or other factors are obligated to make high annual loan principal and interest payments. Three options exist to accommodate such hospitals: cost-based coverage of historical obligations, borrowing forward from future formulaic payments, or a gradual blending of cost-based and formula-based capital reimbursement. Borrowing forward against future capital reimbursement payments is unrealistic because the future revenue environment, for most hospitals, is too uncertain to attract lenders. Cost-based reimbursement is feasible, but it would be cumbersome to administer because of the regulations and hospital-specific data analysis that would be required for decades into the future. Supporters of flat-rate payment therefore favor blending.

Blending would phase in percentage payment by gradually decreasing the share of total capital reimbursement calculated on a cost basis. If only expenditures for major plant and fixed equipment are allowed to enter the cost-based portion of the blend, then overinvestment due to continued cost-based reimbursement can be controlled. However, if hospital revenues do not rise rapidly, hospital capital obligations will not decrease rapidly as a proportion of total revenues, and many hospitals may become insolvent.

Despite this risk, blending offers a feasible technical fix for the problem of accommodating hospitals carrying large capital repayment obligations. No equivalent fix can compensate for other perverse side effects of flat-rate payment, however, including other forms of mismatch. One of the latter is flat-rate payment's inability to address the needs of institutions that serve the poor, a failing that also violates a second criterion of payment system performance—equity.

**Equity.** Financial condition currently excludes 25 percent or more of
the nation’s hospitals from access to private capital markets for major projects. In most hospitals, severe financial distress appears to be caused primarily by the demographics of the neighborhoods they serve, not by poor management or lack of community need. Where patients lack sufficient insurance or depend on low-reimbursing Medicaid programs, hospital revenues suffer. Competition and intensified cost control will exacerbate this problem in the future. If flat-rate payment were set at the current average capital payment in the Medicare program (about 7 percent), it would increase reimbursement to distressed hospitals, because most of these institutions have not been able to invest at the 7 percent national average even under the old cost-based system. However, the extra 2 percent or so they would receive would not cover the annual operating deficit many of them have. Moreover, since their financial future is so threatening, few if any could enter the debt market on the strength of this small and uncertain additional revenue stream; even substantial extra payments are unlikely to make them creditworthy. Extra payments also will waste money on financially distressed hospitals for which no need exists, unless some planning mechanism to focus augmented rates were instituted.

**Efficiency.** The short-run efficiency of flat-rate payment is a function of two effects: the investment behavior it induces, and its ripple effects on institutional and clinical management.

Much of the support for flat-rate capital payment arises because of the discretion it gives hospital administrators in the selection and financing of capital purchases. Is it correct to assume that managerial discretion will ensure truly efficient hospital behavior? Hospital managers of the future, like those of today, will try to key their future investments to the constraints and incentives imposed by their internal and external operating environments. These environments are far from economically neutral. Often, perhaps characteristically, they fail to reward investment according to its productivity in fostering health.

Inside the hospital, the administrator must contend with a fractionated decision structure dominated by physicians who enjoy independent bases of economic and political influence. To maintain the flow of insured patients necessary for the hospital’s financial survival, the administrator must work actively to attract and keep physicians, in part by satisfying their often idiosyncratic demands for capital equipment. While community hospital administrators can expect to exert greater influence over physicians in the future (and flat-rate payment may stiffen their resolve), they may never be able to ignore the preferences of key fee-for-service physicians. And the power of eminent service chiefs (who command multimillion-dollar “dowries” when they join major teaching hospitals) seems even less likely to disappear.

The administrator’s external environment also will discourage effi-
cient allocation. The need to maintain institutional financial health, coupled with the active pursuit of profits in proprietary and aggressive voluntary hospitals, will lead administrators to concentrate investment in the most profitable services and, as previously discussed, the wealthier and better-insured geographic areas. Community-oriented services that cannot be successfully priced and/or sold, or that serve no marketing purpose, may be ignored entirely.

By lumping capital reimbursement with price-controlled operating cost reimbursement, the hospital’s ability to innovate, renovate, and survive depends entirely on its ability to extract surplus revenues from the pricing system. Flat-rate capital payment will greatly magnify the incentives presented by price control systems such as DRG payment and selective contracting.

Many of these incentives are perverse. In the Medicare DRG system, for example, flat-rate capital payment should strengthen existing incentives toward excess admissions, cost-shifting to nonregulated payers, reclassifying patients into more remunerative pricing categories (“DRG creep”), and shifting of assets and costs into nonregulated corporate entities and markets. Moreover, because real capital obligations change very little in the short run as a result of changes in capacity utilization, flat-rate payment authorizes extra payments when additional capital use is nearly costless. This is all to the good in normal businesses, where increased volume signifies a good product and a strong economy. In health care, however, it creates strong incentives toward unnecessary care, and penalizes hospitals that decrease utilization and costs.

Strategic efficiency and equity: the long run. The shorter-run problems identified above will continue to hurt poor and minority neighborhoods, promote inefficient investment, and stimulate excess admissions and other managerial inefficiencies as long as flat-rate payment of capital remains in effect. Over time, these patterns will create a national health care infrastructure that is dramatically less equitable and efficient. Simultaneously, other adverse medium- and long-run effects of flat-rate payment will begin to materialize.

One medium-range problem derives from another form of mismatch. Flat-rate payment contains no mechanism (short of grafting on a planned payment component) to provide capital access to hospitals that need to make big-ticket capital expenditures in the decade after flat-rates begin. This group includes institutions with pressing renovation needs, such as hospitals constructed during the early Hill-Burton program years and nearing the end of their capital cycle, as well as hospitals located in areas of rapid population growth, such as the sunbelt states. Capital-related outlays by these hospitals will need to double, triple, or quadruple to perhaps 15-30 percent of operating costs during the immediate post-investment years. Few if any hospitals can cover the difference between
these percentages and the 7 percent or less they will receive from flat-rate payment.

Flat-rate payment can accommodate such hospitals and retain its essential formulaic character only in rare cases. Borrowing forward to the time when flat-rate payments will exceed institutional repayment obligations seems ruled out by the uncertain future reimbursement environment and the large carrying costs of such borrowing. Saving up takes too long and, as we have seen, only very prosperous hospitals seem able to do it.

Therefore, any reform of flat-rate payment capable of accommodating most hospitals that face immediate major investment needs must include a planning mechanism. Planning is required to assess community need and programmatic efficiency, lest a blank check be issued to every interested hospital. Such judgments cannot be made by formula, nor can competitive payers act in concert to make them. They require intimate awareness of community needs and a coordinated local mechanism to negotiate affordable solutions.

In the longer run, most hospitals probably will come to face the same lack of capital access that poor hospitals, and hospitals facing immediate renovation and expansion needs, face now. Increasing competition among hospitals and increasing cost cutting by employers and insurers will eliminate access to private capital markets for nearly all hospitals. Predictable attempts to lower the level of flat-rate capital payments will accelerate this process, as will any attempt to accommodate the special needs of hospitals in poor or growing areas, or those with aged plants, from the existing payment stream. It is thus difficult to see any time in the future when flat-rate payment will permit major renovations or expansions to occur without additional subsidies. Ultimately, political pressure will build for subsidy programs for new construction. The nation’s public hospitals already call for a new grant program to finance their rebuilding needs.

**Does it matter?** The United States is, in the aggregate, over-bedded. Occupancy of existing beds is dropping rapidly. A contraction in capacity seems justified and, in fact, the same pressures that exclude most hospitals from capital markets should cause many hospitals to close their doors. Other hospitals will delay renovation and spend less when they do rebuild, in part to offer lower prices to the preferred provider organizations (PPOs), health maintenance organizations (HMOs), and other price-conscious care managers of the future. Does not flat-rate payment simply allow the market to bring much-needed efficiency to a heretofore undisciplined system?

Perhaps it will, but there must be fairer and more efficient ways to do it. Contraction and delay will occur first and fall most heavily on the very areas and institutions that—from a health point of view, in terms of
physical deterioration and potential for operating efficiencies, and for equity's sake—deserve more, not less, access to capital. If the process of reducing capacity can be likened to burning a candle, flat-rate payment lights the wrong end.

It also is far from clear that capacity contraction is such a desirable goal in the emerging competitive era. First, competition requires a certain degree of excess capacity. Otherwise, patients and purchasers cannot take their business elsewhere. Second, we no longer need fear the Roemer effect: the ability, under historical cost-reimbursed health insurance, of excess capacity to create its own demand. DRGs, global budget rate setting, and capitation—the reimbursement systems of the future—weaken the Roemer effect, as recent declines in hospital utilization and occupancy show. Third, the capital costs of excess capacity are sunk and unrecoverable, and the carrying costs are minimal under prudent management (which better reimbursement systems actively promote). Finally, the accelerating acquired immunodeficiency syndrome (AIDS) epidemic reminds us that there soon may be times when some vacant beds will come in handy, and save billions in new construction costs.

**Planned Capital Payment**

The alternative to flat-rate capital payment or a continuation of cost-based capital reimbursement is planned capital payment. Planned payment provides something that flat-rate and cost-based payment cannot, a mechanism that can conserve and sequentially focus the limited resources likely to be available in the future for priority investment needs. Planned payment also opens up the possibility of proactive capital distribution, stimulating the creation of innovative services and assisting entirely new institutions and forms of care.

Planned payment takes longer to describe than flat-rate and cost-based payment because many different policy designs are feasible. However, for reasons which subsequent discussion will make clear, planned payment design options are most promising when (1) they allocate actual funds, not licenses to use funds; (2) the amount of allocable funds is clearly limited; and (3) allocation is based on community-oriented plans and priorities. These three attributes define a generic class of planned payment designs that I and my colleagues at Harvard University’s Health Capital Project call a Community Health Infrastructure Bank, or CHIB.²²

**How a CHIB works.** CHIBs thus defined resemble several other institutions that receive and distribute capital funds, including commercial banks, venture capital funds, and philanthropic foundations. Like a bank, fund, or foundation, a CHIB’s pool of allocable funds is limited. On the funder’s side, limited funds discipline the evaluation of proposals, highlight tradeoffs, and force consideration of strategic priorities.
Applicants, on their side, are moved to develop funding proposals that respond to the funder’s priorities, to cooperate with the funder’s efforts to evaluate their proposals, to compete among themselves for approval, and to negotiate with the funder over proposal content.

A well-managed commercial bank or foundation develops a strategic plan to guide its acquisition and distribution of capital. Proactive foundations also publish requests for proposals (RFPs) that describe their strategic priorities in detail and show why they chose these priorities. In the process, they reveal the values and concerns that will motivate their award decisions. RFPs stimulate more responsive, creative proposals than otherwise might be received, and help-foundation leaders invest strategically.

A CHIB could imitate the RFP approach. In its strategic plan, a CHIB could decide how health capital subsidies should be spent to maximize their benefit to health system development, given the CHIB’s legal mandate and its assessment of future environmental changes. A CHIB could set aside subpools of resources and advertise its objectives for each subpool. It could compare the proposals it receives and select the combination that best advances its objectives, or it could reject them all and hold its subpool until better applications are in hand.

These similarities to successful private institutions are important, but the CHIB also differs because of its focus on community plans and priorities. A community orientation does not require governmental or even quasi-governmental auspices; the hospitals in Rochester, New York, for example, have banded together on the basis of private contracts to pool most of their capital reimbursement. Being community-oriented, however, does require political accountability in some form. In addition, it means that a CHIB’s mission will typically be more complex and less self-evident than the profit-making motives of the typical bank or venture capital firm.

Adaptations. CHIBs can be designed to serve a variety of possible missions. In addition to substituting it for flat-rate or cost-based capital reimbursement, policymakers could adapt the CHIB mechanism to allocate tax-exempt bonding authority, to distribute grant funds under a new Hill-Burton program, to allocate special capital subsidies to institutions serving the poor (drawn, perhaps, from a pool created by taxing health insurance premiums or hospital bills), or to manage an exceptions process within a flat-rate payment system.

The CHIB’s community mission also could be guided by any one of a variety of political and economic philosophies. It is easy to assume that any arrangement to pool funds for community use would implement a regulatory philosophy based on traditional notions of bed need, capacity restriction, regionalization, and protection of existing institutions and structures. But other, more market-oriented approaches could be taken,
approaches that will be much more feasible in the innovative and competitive economic environment of the future than they have been in the past. The CHIB, for example, could seek to promote and structure competition among institutions by ensuring sufficient capacity to allow freedom of choice to purchasers. They could encourage forms of managed care, particularly in areas where private capitalization is hard to attract, and they could act to maintain competition among managed care providers. CHIBs also could finance competing integrated systems rather than single institutions, updating the traditional goal of a single regionalized system across a given area. Conceivably, the CHIB could delegate some allocational authority to such systems.

Using the RFP mechanism and sequestered subpools of funds, a CHIB also could promote innovation, to the point of providing demonstration and start-up funds and perhaps even limited initial operating subsidies. Legislators could require that a certain portion of funds go to new institutions, in order to combat the natural tendency of existing beneficiaries to control the lion’s share of agency funds.

Each such adaptation requires a design that matches sources of funds with intended outlays. Possible sources of funds include the existing reimbursement stream, new governmental appropriations, tax expenditures (such as the tax exemption for state-issued hospital revenue bonds), and risk pooling and packaging. Risk pooling and packaging has the potential to draw new funds from private investors, but amounts will be small and only relatively well-off institutions can benefit. If a CHIB’s purpose is to replace the current cost-based capital reimbursement system, then the existing reimbursement stream offers the only realistic source of sufficient funds.

**Size of CHIB funds.** The magnitude of projected outlays depends on two primary variables: (1) intended coverage, and (2) the intended mechanism of distribution. Coverage defines the institutions and provider types eligible to receive funds. Will CHIB funds support the majority of institutions across a wide range of health subsectors, including HMOs, acute hospitals, health centers, and nursing homes? Or will coverage be limited to a subset of institutions within a given subsector, say hospitals serving the poor? Various mechanisms of distribution also are possible, including grants, loans, loan guarantees, and combinations thereof. Grants are the most expensive initially (to the CHIB), but loans and loan guarantees require continuing financial strength among recipient institutions, and drain substantial resources from the health care system in the form of interest and loan principal payments. Grants also enable the CHIB to direct funds more easily to innovate ventures and new institutions.

Mechanisms of distribution obviously depend on the job CHIBs are expected to do. A CHIB designed to replace traditional cost-based
reimbursement of hospital capital costs would need to assume control of a major portion of the stream of funds that now flows through the cost-reimbursement process, or that might flow through flat-rate payment systems in the future. Reimbursement for routine, “small-ticket” capital expenditures such as moveable equipment and limited renovation might best be delegated to a flat-rate arrangement. This would remove the overinvestment incentives of cost-based payment, give greater flexibility to institutional managers, and allow the CHIB to focus its planning and decision-making resources on investments of greater strategic importance.

Of the 7 to 8 percent of hospital operating costs that now go for capital, about 5 percent are devoted to “big-ticket” projects, expenditures for major new construction and renovation. Roughly half the cost of these projects is interest on indebtedness. Nearly all payers now reimburse hospitals for interest and depreciation (and for return on equity in proprietary hospitals). These payments permit hospitals to meet their legal obligations to repay loan interest and principal. Since much of the current reimbursement stream supports long-term obligations already in place, this stream could be transferred only gradually to a CHIB created to replace existing reimbursement mechanisms. (Alternatively, the CHIB itself could assume responsibility for repayment, and probably negotiate lower interest cost systemwide in the process.) Either way, the stream of new discretionary funds available for allocation by a broad-coverage CHIB to new projects would build up gradually over a decade or so.

How well could CHIBs perform? As the foregoing discussion indicates, CHIBs could be designed in many ways to serve a variety of purposes and economic philosophies. In addition, policymakers can select from several governance structures, ranging from private contracts, through various quasi-governmental forms such as independent boards, commissions, and authorities, to governmental agencies. Each potential mission and each state’s political culture require an institution tailored to their needs. Because the CHIB’s impact will depend on its plans and allocations, management systems as well as managerial competency also will be important. All of this potential diversity makes it difficult to predict the effectiveness of CHIBs in general.

One conclusion seems warranted: CHIBs have the capacity to perform much better than certificate of need (CON) programs have in the past. Federally mandated health planning and CON lacked the legal, economic, and political power to achieve the cost-control objectives against which their performance has been judged. The match between a CHIB its objectives, and its environment would be markedly better. CHIBs would operate in a more competitive economic environment that naturally stimulates innovation and cost control. They would dispense
money rather than try to tell institutions how to spend their own funds—
a change of relationship sure to increase the attention and cooperation of
the provider community. Because CHIB funds would be limited, the
problems of “logrolling” to increase federal payments and agencies’
inability to limit spending will disappear. Moreover, since providers will
be competing with each other for the bank’s limited funds, it should be
much easier to acquire needed information, stimulate truly innovative
and efficient proposals, and undertake productive negotiations with
applicants. Even the development of long-range agency plans may be
easier and more substantive, since every provider’s future access to funds
will depend on developing a sustainable long-range collective funding
strategy and on maintaining funding discipline.

Perhaps the question of CHIB effectiveness is best phrased in terms of
potential to perform a specific mission in a specific environment: Could a
CHIB, for example, do a better job than cost-based or flat-rate capital
payment at managing capital reimbursement in a given state? Given the
magnitude of the likely bad effects of cost-based and flat-rate payment
discussed earlier, planned payment seems potentially better, assuming it
is designed and implemented well.

One question that does arise is whether “politics” will unduly influ-
ence design and implementation. Social decisions about health infra-
structure investment are and ought to be political, in the best sense.
CHIBs can be designed to help create a political and economic environ-
ment that enables them to function fairly and effectively. For example, if
CHIBs are a source of funding for both hospital renovation projects and
programs outside hospitals, a wider than usual range of interests will
have important stakes in CHIB decision making. This will help prevent
capture by a single focused interest. In addition, unlike CON, because
each of these interests will have a stake in the bank’s long-run solvency
and fairness, each should be motivated to monitor all CHIB decisions,
not just those in which they are directly involved. The existence of many
affected attentive interests should be better able to create the environ-
ment of debate and information necessary to constructive political
accountability. The narrow and only episodically attentive constituents
created by CON and health planning were unable to do this.

Ultimately, responsible political institutions grow only from the soil of
real power and real responsibility. In situations where market solutions
cannot work, political solutions are essential. Like the town pump in
earlier times, health infrastructure banks could represent a resource that
everyone will come to rely upon. If so, like the town pump, it will be in ev-
ery state or region’s interest to keep its CHIB clean and constantly
flowing. Those who muddy or attempt to divert its flow can expect to be
opposed by a far larger number with an equally keen interest in preserv-
ing its integrity and accessibility.
Conclusion

In facing long-term uncertainty, we tend to rely on abstract theory or political philosophy. Thus, many assume that health care is a consumer good to be rationed according to personal wealth and income, and that the most promising policies are those that imitate classical economic markets. To analysts with this starting point, flat-rate capital payment looks very attractive. As the foregoing analysis shows, however, economic theory breaks down to a great extent on the rocks of real world health system structure and behavior.

The reality is that the health system is changing so rapidly that we do not know where it will end up, let alone whether we will like it. Presumably, twenty or even ten years from now, new philosophies and predictions will compete to control the policy agenda. Yet present capital decisions cast a long shadow. Long-term commitments based on short-term thinking or mistaken forecasts could have tragic consequences. It seems essential that capital policy preserve as much flexibility as possible so that it can adapt to future developments. Just as successful private corporations need planning systems, the nation needs a capital allocation mechanism that makes long-term plans that can be revised every year and does not destroy its infrastructure base in the pursuit of short-term administrative or budgetary objectives.28

Percentage payment provides little flexibility. It removes virtually all control over the details of system evolution from either Congress or local political structures, whether business coalitions, planning agencies, or government. It sets the system on what appears to be a radical developmental track. By effectively denying access to large project capital to many voluntary institutions, percentage payment may place the bulk of new system development in the hands of proprietary chains with enormously greater access to private equity and debt markets. Percentage payment thus sends the nation’s health system into dangerous uncharted waters, and leaves it on automatic pilot.

There is no reason for even ardent supporters of increased competition in health care to feel compelled to take this risk. Despite the natural affinity between competitive policies and flat-rate payment, flat rates are not necessary to achieve a competitive future. The very efficiency of HMOs and vertically integrated systems of care will assure their ultimate success on the basis of operating cost savings alone. It simply is not necessary to endure the costs of a technically inefficient and inequitable flat-rate capital payment system to enjoy the benefits of constructive economic competition.
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NOTES


11. Anderson and Ginsburg, “Medicare Payment and Hospital Capital.”
12. The long construction and repayment periods typical of major projects prevent a “feeding frenzy” because the blending period will attenuate and expire before a significant portion of such major expenditures can be recouped through cost-based payment. Alternatively, only repayment and interest obligations incurred prior to the blending period could be allowed, but that would penalize hospitals with low historical obligations.
13. Krystynak, “Prospective Payment for Capital.”
17. Even if very sizable increases in payment rates were channeled to financially distressed hospitals, these hospitals probably would not save the extra funds for major capital investment. In New York City, for example, where effective revenue controls have been in place since the mid-1970s, hospitals as a group have not responded by lowering operating expenditures sufficiently to maintain infrastructure. Approximately 75 percent of New York City’s voluntary hospitals do not meet the minimum bond rating standards required to issue long term debt, even though public hospitals assume the burden of caring for many of the city’s poor. See Kane, “New York City Hospitals.” Moreover, these hospitals have invested relatively little in plant and equipment in recent years and as a result they occupy facilities that are aged and presumably inefficient. See Kane, “New York City Hospitals;” Charles Brecher and Susan Nesbitt, “The Financial Condition of New York City Voluntary Hospitals” (New York: Commonwealth Fund, 1984); and D. McCarthy, “Capital Offense: New York’s Health Care in the Crunch,” Health/PAC Bulletin 14, no. 4 (1984): 5-15. Similar behavior was observed in voluntary hospitals before the passage of Medicare and Medicaid. See Eleanor D. Kinney and Bonnie Lefcowitz, “Capital Cost Reimbursement to Community Hospitals Under Federal Health Insurance Programs,” Journal of Health Politics, Policy and Law 7 (1982): 648-666.