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FIXING HEALTH CARE

How to Pay for Health Care

Bundled payments will finally unleash the competition that patients want.

BY MICHAEL E. PORTER AND ROBERT S. KAPLAN

The United States stands at a crossroads as it struggles with how to pay for health care. The fee-for-service system, the dominant payment model in the U.S. and many other countries, is now widely recognized as perhaps the single biggest obstacle to improving health care delivery.

PETER CROWTHER

Fee for service rewards the quantity but not the quality or efficiency of medical care. The most common alternative payment system today—fixed annual budgets for providers—is not much better, since the budgets are disconnected from the actual patient needs that arise during the year. Fixed budgets inevitably lead to long waits for nonemergency care and create pressure to increase budgets each year.

We need a better way to pay for health care, one that rewards providers for delivering superior value to patients: that is, for achieving better health outcomes at lower cost. The move toward "value-based reimbursement" is accelerating, which is an encouraging trend. And the Centers for Medicare & Medicaid Services (CMS), to its credit, is leading the charge in the United States.

That doesn't mean, however, that health care is converging on a solution. The broad phrase "value-based reimbursement" encompasses two radically different payment approaches: capitation and bundled payments. In capitation, the health care organization receives a fixed payment per year per covered life and must meet all the needs of a broad patient population. In a bundled payment system, by contrast, providers are paid for the care of a patient's medical condition across the entire care cycle—that is, all the services, procedures, tests, drugs, and devices used to treat a patient with, say, heart failure, an arthritic hip that needs replacement, or diabetes. If this sounds familiar, it's because it is the way we usually pay for other products and services we purchase.

> We need a better way to pay for health care—one that rewards providers for delivering superior value to patients.

A battle is raging, largely unbeknownst to the general public, between advocates of these two approaches. The stakes are high, and the outcome will define the shape of the health care system for many years to come, for better or for worse. While we recognize that capitation can achieve modest savings in the short run, we believe that it is not the right solution. It threatens patient choice and competition and will fail to fundamentally change the trajectory of a broken system. A bundled payment system, however, would truly transform the way we deliver care and finally put health care on the right path.

The Small Step: Capitation

Capitation, or population-based payment, is not a new idea. It was introduced in the United States with some fanfare in the 1990s but quickly ran into widespread criticism and was scaled back significantly. Today, a number of transitional approaches, including accountable care organizations (ACOs), shared savings plans, and alternative quality contracts, have been introduced as steps toward capitation. In the ACO model, the care organization earns bonuses or penalties on the basis of how the total fee-for-service charges for all the population's treatments during the year compare with historical charges. In full capitation, the care organization absorbs the difference between the sum of capitation payments and its actual cost.

Under capitation, unlike in the FFS model, the payer (insurer) no longer reimburses various providers for each service delivered. Rather, it makes a single payment for each subscriber (usually per patient per month) to a single delivery organization. The approach rewards providers for lowering the overall cost of treating the population, which is a step forward. However, under this system cost reduction gravitates toward population-level approaches targeting generic high-cost areas, such as limiting the use of expensive tests and drugs, reducing readmissions, shortening lengths of stay, and discharging patients to their homes rather than to higher-cost rehabilitation facilities. As a response to the failed experience with capitation in the 1990s, current capitation approaches include some provider accountability for quality. However, "quality" is measured by broad population-level metrics, such as patient satisfaction, process compliance, and overall outcomes such as complication and readmission rates.

This all seems good at first blush. The trouble is that, like the failed FFS payment system, capitation creates competition at the wrong level and on the wrong things, rather than on what really matters to patients and to the heath care system overall.

Providers are not accountable for patient-level value. Capitation and its variants reward improvement at the population level, but patients don't care about population outcomes such as overall infection rates; they care about the treatments they receive to address their particular needs. Outcomes

Idea in Brief

THE CHALLENGE

The United States stands at a crossroads as it struggles with how to pay for health care. Fee for service, the dominant model today, is widely recognized as the single biggest obstacle to improving health care delivery. The choice is between two fundamentally different approaches: capitation and bundled payments. The stakes are high, and the outcome will define the shape of the health care system for many years to come, for better or for worse.

THE DANGER

Although capitation may deliver modest savings in the short run, it is not the solution. It entrenches large existing systems, eliminates patient choice, promotes consolidation, limits competition, and perpetuates the lack of accountability for outcomes. Like fee for service, capitation will fail to drive true innovation in health care delivery.

THE OPPORTUNITY

Bundled payments trigger competition among providers to create value where it matters—at the individual patient level—and will finally put health care on the right path. Robust proof-of-concept initiatives in the U.S. and abroad demonstrate that the challenges of transitioning to bundled payments are already being overcome.

that matter to breast cancer patients are different from those that are important to patients with heart failure. Even for primary and preventive care, which the concept of population health rightly emphasizes, appropriate care depends heavily on each patient's circumstances—health status, comorbidities, disability, and so on. And managing the overall health of a diverse population with high turnover (as ACOs do) is extremely difficult.

Thus, capitated payments are not aligned with better or efficient care for each patient's particular condition. Instead, capitation puts the focus on limiting the overall amount of care delivered without tying the outcomes back to individual patients or providers. The wrong incentives are created, just as is the case for fee for service, which reimburses for the volume of services but not the value.

Providers bear the wrong risks. Because capitation pays providers a fee per person covered, it shifts the risk for the cost of the population's actual mix of medical needs—over which they have only limited control—to providers. Some large private insurers favor capitation for just this reason. But bearing the actuarial risk of a population's medical needs is what insurers should do, since they cover a far larger and more diverse patient population over which to spread this risk. Providers should bear only the risks related to the actual care they deliver, which they can directly affect.

A more fundamental problem is that capitation payments are extremely difficult to adjust to reflect each patient's overall health risk, not to mention to correctly adjust for this risk across a large, diverse population. Risks are much better understood and managed for a particular medical condition—for example, the probable effects of age or comorbidities on the costs and outcomes for joint replacement—as is the case in bundled payments.

Because population-level risk factors are so complex, health systems under capitation have an incentive to claim as many comorbidities as possible to bolster their revenue and profitability. A whole segment of health care IT providers has emerged to help providers "upcode" patients into higher-risk categories. Such gaming of risk adjustment first became a problem during the era of managed-care capitation in the 1990s, and it remains one today.

Patient choice is limited, and competition is threatened. Capitation creates strong incentives for a health system to deliver all the care within its system, because contracting for outside services reduces net revenue and results in underutilization of existing internal capacity. There is even a term for this in health care—"avoiding leakage"—and many systems explicitly monitor and control it. Capitated health systems encourage or require patients (and their referring doctors) to use in-house providers (the ultimate narrow network). Patients are often penalized with extra fees when they don't use services within the system, even if outside providers have greater experience and get better results for treating the patient's particular condition. Capitation creates, in essence, a monopoly provider for all the patients in the population. Consumers cannot choose the best provider for their particular needs.

Since providers now bear actuarial risk, they also have a strong incentive to amass the largest possible population. This will accelerate the recent trend of providers' buying up other hospitals and physician practices and merging systems, which reduces competition. To offset health systems' rising bargaining power, insurers will feel pressure to merge. The two dynamics will reinforce each other as provider consolidation begets even more insurer consolidation.

The end result will be the emergence of a few dominant systems—or even only one—in each region.

This would be bad for patients. No one organization can have all the skills and technologies needed to be the best in treating everything. We need multiple providers in each region to ensure enough choice and drive innovation in care delivery.

The bottom line is that capitation is the wrong way to pay for health care. It is a top-down approach that achieves some cost savings by targeting low-hanging fruit such as readmission rates, expensive drugs, and better management of post-acute care. But it does not really change health care delivery, nor does it hold providers accountable for efficiency and outcomes where they matter to patients—in the treatment of their particular condition. Capitation's savings also come at the high cost of restricting patient choice and inhibiting provider competition.

Let's consider the alternative.

> Bundled payments will empower and motivate providers—responsible for the overall treatment of a patient's condition—to coordinate and integrate all the specialists and facilities involved in the care.

Paying for Value: Bundled Payments

For virtually all types of products and services, customers pay a single price for the whole package that meets their needs. When purchasing a car, for example, consumers don't buy the motor from one supplier, the brakes from another, and so on; they buy the complete product from a single entity. It makes just as little sense for patients to buy their diagnostic tests from one provider, surgical services from another, and post-acute care from yet another. Bundled payments may sound complicated, but in setting a single price for all the care required to treat a patient's particular medical condition, they actually draw on the approach long used in virtually every other industry.

Bundled payments have existed in health care for some time in isolated fields such as organ transplantation. They are also common for services that patients pay for directly, such as Lasik eye surgery, plastic surgery, and in vitro fertilization.

To maximize value for the patient, a bundled payment must meet five conditions:

Payment covers the overall care required to treat a condition. The bundled payment should cover the full cost of treating a patient over the entire care cycle for a given condition or over time for chronic conditions or primary care. The scope of care should be defined from the patient's perspective ("Delivering a healthy child"). Care should include all needed services, including managing common comorbidities and related complications. In primary and preventive care, bundled payments should include all the needed care for each defined patient segment (such as healthy adults or low-income elderly).

Payment is contingent on delivering good outcomes. Bundled payments should be tied to achieving the outcomes that matter to patients for each condition and primary care patient segment. Important outcomes include maintaining or returning to normal function, reducing pain, and avoiding and reducing complications or recurrences.

Payment is adjusted for risk. Differences in patients' age and health status affect the complexity, outcomes, and cost of treating a particular condition, as do their social and living circumstances. These risk factors should be reflected in the bundled payment and in expectations for outcomes to reward providers for taking on hard cases.

Payment provides a fair profit for effective and efficient care. A bundled payment should cover the full costs of the necessary care, plus a margin, for providers that use effective and efficient clinical and administrative processes. It should not cover unnecessary services or inefficient care.

Providers are not responsible for unrelated care or catastrophic cases. Providers should be responsible only for care related to the condition—not for care such as emergency treatment after an accident or an unrelated cardiac event. The limits of provider responsibility should be specified in advance and subject to adjudication if disputes arise. Bundled payments should also include a "stop loss" provision to limit providers' exposure to unusually high costs from catastrophic or outlier cases. This reduces the need for providers to build such costs into the price for every patient (unlike in capitation).

How Bundled Payments Will Transform Patient Care

Decades of incremental efforts to cut costs in health care and impose practice guidelines on clinicians have failed. Bundled payments directly reward

How Fee for Service Destroys Value for Patients

Fee-for-service reimbursement, the dominant method used to pay for health care in the United States and elsewhere, has held back improvements in the quality of care and led to escalating costs. Overturning the status quo is not easy, but here's why doing so is essential.

Rewards Poor Outcomes: Because FFS reimburses providers on the basis of volume of care, providers are rewarded not just for performing unnecessary services but for poor outcomes. Complications, revisions, and recurrences all result in the need for additional services, for which providers get reimbursed again.

Fosters duplication and lack of coordination. FFS makes payments for individual procedures and services, rather than for the treatment of a patient's condition over the entire care cycle. In response, providers have organized around functional specialties (such as radiology). Today, multiple independent providers are involved in each patient's treatment, resulting in poorly coordinated care, duplicated services, and no accountability for health outcomes.

Perpetuates inefficiency. Today's FFS payments reflect historical reimbursements with arbitrary inflation adjustments, not true costs. Reimbursement levels vary widely, causing cross-subsidization across specialties and particular services. The misalignment means that inefficient providers can survive, and even thrive, despite high costs and poor outcomes.

Reduces focus. FFS motivates providers to offer full services for all types of conditions to grow overall revenue, even as internal fragmentation causes patients to be handed off from one specialty to another. By attempting to cater to a diverse population of patients, providers fail to develop the specialized capabilities and experience in any one condition necessary for the delivery of excellent care.

providers for delivering better value for the patient's condition and will unlock the restructuring of health care delivery in three crucial ways that capitation cannot.

Integrated, multidisciplinary care. Specialty silos have historically led to fragmented, uncoordinated, and inefficient care. With bundled payments, providers with overall responsibility for the full care cycle for a condition will be empowered and motivated to coordinate and integrate all the specialists and facilities involved in care. Clinical teams (the experts) have the freedom to decide how to spend the fixed bundled payment, rather than being required to deliver the services that are reimbursed by legacy FFS payments in order to receive revenue. Teams can choose to add services that are not currently covered by FFS but that provide value for patients.

Bundled payments are triggering a whole new level of care innovation. For example, hospital-based physicians are remaining involved in care after patients are discharged. Hospitalists are added to teams to coordinate all the inpatient specialists involved in the care cycle. Nurses make sure patients fill their prescriptions, take medications correctly, and actually see their primary care physician. (A recent study showed that 50% of readmitted patients did not see their primary care doctor in the first 30 days after discharge.) And navigators accompany patients through all phases of their care and act as first responders in quickly resolving problems. Bundled payments are also spurring innovation in the creation of tailored facilities, such as those of Twin Cities Orthopedics (Minneapolis), which performs joint-replacement care in outpatient surgery centers and nearby recovery centers, rather than in a traditional hospital.

Bundled payments will accelerate the formation of integrated practice units (IPUs), such as MD Anderson's Head and Neck Center and the Joslin Diabetes Center. IPUs combine all the relevant clinicians and support personnel in one team, working in dedicated facilities. Joslin, for example, brings together all the specialists (endocrinologists, nephrologists, internists, neurologists, ophthalmologists, and psychiatrists) and all the support personnel (nurses, educators, dieticians, and exercise physiologists) required to provide high-value diabetes care. IPUs concentrate volume of patients with a given condition in one place, allowing diagnosis and treatment by a highly experienced team. Numerous studies show that this approach leads to better outcomes and greater efficiency (including less wait time and fewer visits). Bundled payments also encourage the formation of "virtual" IPUs, where even separate practices and organizations actively collaborate across inpatient and outpatient settings to coordinate and integrate care—something that rarely happens today.

Accountability for outcomes. By definition, a bundled payment holds the entire provider team accountable for achieving the outcomes that matter to patients for their condition—unlike capitation, which involves only loose accountability for patient satisfaction or population-level quality targets.

Because bundled payments are adjusted for risk, providers are rewarded for taking on difficult cases. With a fixed single payment, they are penalized if they overtreat patients or perform care in unnecessarily high-cost locations. And because providers are accountable for outcomes covering the entire care cycle, they will move quickly to add new services, more-expensive interventions, or better diagnostic

tests if those will improve outcomes or lower the overall cost of care. Specialists operating under a bundled payment, for example, have added primary care physicians to their care teams to better manage the overall care cycle and deal with comorbidities.

Most important, the accountability built into bundled payments will finally bring to health care the systematic measurement of outcomes at the condition level, where it matters most. We know from every other field that measuring and being accountable for results is the most powerful driver of innovation and continuous improvement.

Cost reduction. There have been repeated efforts to control health costs for decades without success, and top-down cost reduction initiatives have sometimes increased costs rather than reduced them. The core problem is that legacy payment models such as FFS have given providers no incentive to cut costs or even to understand what their costs are for treating a given condition. Bundled payments, by contrast, directly reward and motivate cost reduction from the bottom up, team by team. At the same time, they encourage accurate cost measurement not only to inform price setting but to enable true cost reduction.

Bundled payments will be the catalyst that finally motivates provider teams to work together to understand the actual costs of each step in the entire care process, learn how to do things better, and get care right the first time. By encouraging competition for the treatment of individual conditions on the basis of quality and price, bundled payments also reward providers for standardizing care pathways, eliminating services and therapies that fail to improve outcomes, better utilizing staff to the top of their skills, and providing care in the right facilities. If providers use ineffective or unnecessary therapies or services, they will bear the cost, making bundled payments a check against overtreatment.

The result will be not just a downward "bend" in the cost curve—that is, a slower increase—but actual cost reduction. Our research suggests that savings of 20% to 30% are feasible in many conditions. And, because bundled payments are contingent on good outcomes, the right kind of cost reduction will take place, not cost cutting at the expense of quality.

The County of Stockholm's bundled payment for joint replacement yielded cost savings of 17% and a reduction in complications of 33%.

Overcoming the Transition Challenges

Despite the now proven benefits of well-designed bundled payments, many hospital systems, group purchasing organizations, private insurers, and some academics prefer capitation. Bundled payments, they argue, are too complicated to design, negotiate, and implement. (They ignore the fact that capitation models continue to rely on complex, expensive fee-for-service billing to pay clinicians and to set the baseline for calculating savings and penalties. Bundled payments are actually simpler to administer than the myriad of FFS payments for each patient over the care cycle.)

Skeptics raise a host of other objections: The scope of a condition and care cycle is hard to define; it is unrealistic to expect specialists to work together; the data on outcomes and costs needed to set prices are difficult to obtain; differences in risk across patients are hard to assess, which will lead to cherry-picking; and bundled payments won't rein in overtreatment.

If these objections represented serious barriers, we would expect to see little progress in implementing bundled payments and plenty of evidence that such programs were unsuccessful. To the contrary, bundled payments have a history of good results (see the sidebar "A History of Success") and are currently proliferating rapidly in a wide range of conditions, organizations, and countries.

In 2007, for example, the Netherlands introduced a successful bundled payment model for treating patients with type 2 diabetes, and, later, for chronic obstructive pulmonary disease (COPD). In 2009, the County of Stockholm, Sweden, introduced bundled payments for hip and knee replacements in healthy patients, achieving a 17% reduction in cost and a 33% reduction in complications over two years. More recently, Stockholm introduced bundled payments for all major spine diagnoses requiring surgery, and extensions to other conditions are under way there.

In 2011, Medicare introduced the voluntary Bundled Payments for Care Improvement (BPCI) program, which currently includes more than 14,000 bundles in 24 medical and 24 surgical conditions. Numerous physician practices have embraced the BPCI model, a transitional bundled payment

A History of Success

Bundled payments are not a new idea or a passing fad. Successful pilots date back for decades and include initiatives spearheaded by the Centers for Medicare & Medicaid Services.

Consider the Heart Bypass Demonstration, an initiative that ran from 1991 to 1996. CMS offered a bundled payment for coronary artery bypass graft surgery that covered all services delivered in the hospital, along with 90 days of post-discharge services. The pilot yielded savings to Medicare of $42.3 million, or roughly 10% of expected spending, at the seven participating hospitals. The inpatient mortality rate declined at all the hospitals, and patient satisfaction improved.

CMS also implemented the Acute Care Episode program (from 2009 to 2011), in which Medicare paid five participating organizations a flat fee to cover hospital and physician services for various cardiac conditions and orthopedic care. Over a total of 12,501 episodes, the initiative generated an average savings to Medicare of 3.1% of expected costs.

approach that covers acute-care episodes and often a post-acute period of up to 90 days to promote better management of post-discharge services. According to participating providers, BPCI bundles have achieved significant improvements and savings an order of magnitude greater than savings from ACOs. Building on that success, CMS launched a mandatory bundled payment program for joint replacements in 2016, which covers 800 hospitals in 67 U.S. metropolitan areas.

Bundled payment contracts involving private insurers are also finally beginning to proliferate. For example, Twin Cities Orthopedics offers a bundle for joint replacement with most of the region's major insurers at a price well below the traditional hospital models. The practice reports better outcomes and cost reductions of more than 30%.

To be sure, many existing bundled payment programs have yet to encompass all the components of an ideal structure. Most have made pragmatic compromises, such as covering only part of the care cycle, using important but incomplete risk adjustments, and incorporating limited outcome measures. But even these less-than-comprehensive efforts are resulting in major improvements, and the obstacles to bundled payments are being overcome.

Let's consider some of the main criticisms of bundled payments in more depth:

Only some conditions can be covered. Critics have suggested that bundled payments apply only to elective surgical care and other well-defined acute conditions, and not to nonsurgical conditions, chronic disease, or primary care. But this claim is inconsistent with actual experience. Of the 48 conditions designated for BPCI, only half were surgical. The other half were for care episodes in nonsurgical conditions, such as heart disease, kidney disease, diabetes, and COPD. Time-based bundled payments for chronic care are emerging in other countries and with private payers. Bundled payments work well for chronic conditions because of the huge benefits that result from coordinated longitudinal care by a multidisciplinary team.

Bundled payment models are also beginning to emerge for primary and preventive care for well-defined segments of patients with similar needs. Each primary care segment—such as healthy children, healthy adults, adults at risk for developing chronic disease, and the elderly—will need a very different mix of clinical, educational, and administrative services, and the appropriate outcomes will differ as well. Bundled payments reward integrated and efficient delivery of the right mix of primary and preventive services for each patient group.

Primary care bundles need not cover the cost of treating complex, acute conditions, which are best paid for with bundled payments to IPUs covering those conditions. Instead, primary care teams should be held accountable for their performance in primary care and prevention for each patient segment: maintaining health status, avoiding disease progression, and preventing relapses.

Defining and implementing bundled payments is too complicated. Critics argue that it will be hard to negotiate bundled payments across all conditions and to get agreement on the definition of a medical condition, the extent of the care cycle, and the included services. This objection is weak at best. A manageable number of conditions account for a large proportion of health care costs, and we can start there and expand over time. The care required for most medical conditions is well established, and experience in defining bundles is rapidly accumulating. Methodologies and commercial tools, such as the use of comprehensive claims data sets, are in widespread use. Service companies that help providers define conditions, form teams, and manage payments are emerging, as are software tools that handle billing and claims processing for bundles.

Initially, bundled payments may cover less than the full care cycle, focus on simpler patient groups

Why DRGs Are Not Bundled Payments

Critics of bundled payments point to Medicare's experience with a superficially similar approach: the diagnosis-related group, or DRG, payment model. DRGs, which date back to 1984 and were adopted in many countries, were a step forward, but they did not trigger the hoped-for innovations in care delivery.

Why have DRGs failed to bring about greater change? DRGs make a single payment for a set of services provided at a given location; however, the payment does not cover the full care cycle for treating the patient's condition. By continuing to make separate payments to each specialist physician, hospital, and post-acute care site involved in a patient's care, DRGs perpetuate a system of uncoordinated care.

Moreover, DRG payments are not contingent on achieving good patient outcomes. Indeed, many DRGs fail to cover many support services crucial to good outcomes and overall value, such as patient education and counseling, behavioral health, and systematic follow-up. Under the DRG system, therefore, specialty silos in health care delivery have remained largely intact. And providers continue to have no incentive to innovate to improve patient outcomes.

with a given condition, and require adjudication mechanisms for gray areas that arise. This is already happening. As experience grows, bundled payments will become more comprehensive and inclusive. And a large body of evidence shows that the effort involved in understanding full care cycles and moving to multidisciplinary care is well worth it.

Providers won't work together. Critics argue that bundled payments hold providers accountable for care by other providers that they don't control; skeptics also claim that it will be hard to divide up a single payment to fairly recognize each party's contribution. This is one reason many hospital systems have been slow to embrace the new payment model. We are selling doctors short. Many physician groups have enthusiastically embraced bundles, because they see how the model rewards great care, motivates collaboration, and brings clinicians together. As physicians form condition-based IPUs and develop mechanisms for sharing accountability, formulas for dividing revenues and risk are emerging that reflect each provider's role, rather than flawed legacy fee structures.

At UCLA's kidney transplant program, for example, a bundled payment was first negotiated with several insurers more than 20 years ago. An IPU was formed and has become one of the premier U.S. kidney transplantation programs with superior outcomes. To divide the bundled price, urologists and nephrologists—the specialists who have the greatest impact on care—pay negotiated fees to other specialists involved in care (such as anesthesiology) and bear the residual financial risk and share the gain. This structure has reinforced collaboration, not complicated it.

Another example is physician-owned OrthoCarolina's 2014 contract with Blue Cross and Blue Shield of North Carolina for bundled payment for joint replacement. OrthoCarolina provides care in several area hospitals and has negotiated a fixed payment with each of them for all the required inpatient care. Each participating hospital now has a designated team, including members of the nursing, quality, and administrative departments, that collaborates with OrthoCarolina surgeons in a virtual IPU. This ensures that everyone involved with the patient and the family fully understands the care pathway and expectations. The initial group of 220 patients in the plan experienced 0% readmissions, 0% reoperations, 0.45% deep venous thrombosis (versus 1% to 1.5% nationally), and substantial improvements in patient-reported quality-of-life outcomes. Average length of stay dropped from 2.4 days to 1.5 days, with 100% of patients discharged to their homes rather than a rehabilitation center. The cost per patient, as reported by Blue Cross and Blue Shield of North Carolina, fell an average of 20%.

Outcomes are difficult to measure. Critics claim that the outcome data at the medical condition level, an essential component of value-based bundled payments, doesn't exist or is too difficult and expensive to collect. While this may have been true a decade ago, today outcome measurement is rapidly expanding, including patient-reported outcomes covering functional results crucial to patients. Many providers are already systematically measuring outcomes. Martini-Klinik, a high-volume IPU for prostate cancer in Hamburg, Germany, has been measuring a broad set of outcomes since its founding, in 1994. This has enabled it to achieve complication rates for impotence and incontinence that are far lower than average for Germany. In congenital heart disease care, Texas Children's tracks not only risk-adjusted surgical and intensive care mortality rates but also metrics of patients' neurodevelopmental status and, increasingly, ongoing quality of life.

Advances in information technology are making outcome measurement better, easier, less costly, and more reliable. Greater standardization of the set

of outcomes to measure by condition will also make measurement more efficient and improve benchmarking. The International Consortium for Health Outcomes Measurement (ICHOM) has published global standard sets of outcomes and risk factors for 21 medical conditions that represent a significant portion of the disease burden, and the number is growing. Early bundled payment programs are already achieving significant outcome improvement. As provider experience grows, bundled payments will expand accountability and lead to even greater improvements.

Current cost information is inadequate. Critics argue that bundled payments require an understanding of costs that most providers lack, which puts them at unfair financial risk. Yet numerous bundled payment programs are already in place, using prices based on modest discounts from the sum of historical fee-for-service payments. New service companies are assisting providers in aggregating past charges and in reducing costs. Providers will learn to measure their actual costs, as organizations such as Mayo Clinic, MD Anderson, and the University of Utah are already doing. This will inform better price negotiations and accelerate cost reduction.

The failure of care delivery organizations to properly measure and manage costs is a crucial weakness in health care globally. Bundled payments will finally motivate providers to master proper costing and use cost data to drive efficiencies without sacrificing good patient outcomes.

Providers will cherry-pick patients. Critics charge that bundled payments will encourage providers to treat only the easiest and healthiest patients. But as we have already noted, proper bundled payments are risk-stratified or risk-adjusted. Even today's imperfect bundled payment contracts incorporate risk adjustments that are often better than those used in current FFS payment and beyond the crude risk adjustment used in capitation. Innovators are developing pragmatic approaches that adjust for risk, such as restricting initial bundles to groups of patients with similar risk profiles for a condition. The County of Stockholm did this with joint replacements. Its initial bundle covered the 60% to 70% of patients classified as ASA 1 (normally healthy) or 2 (mild systemic disease); more-complex patients remained in the old reimbursement system. Careful tracking showed no evidence of bias in the selection of patients. The county plans to extend the bundle to more-complex joint replacement patients as better data becomes available.

Recently, the county introduced bundled payments for nine spine diagnoses requiring surgery, with far more sophisticated risk adjustment. The bundled payment includes a base payment, a payment covering expected complications, and a performance payment based on pain reduction. All three elements are adjusted for multiple patient risk factors. Risk adjustment will only improve as experience with it grows.

Bundled payments will finally motivate providers to master proper costing practices and to drive efficiencies without sacrificing good patient outcomes.

Bundled payments will encourage overtreatment. Critics raise concerns that bundled payments, like FFS, will lead to overtreatment because payment is tied to performing care, incenting providers to manufacture demand. Note that capitation plans, which have limited accountability for individual patient outcomes, have the opposite incentive: motivating providers to deny or delay the treatments patients need.

While definitive results are not yet available, our conversations with payers and government authorities in the United States, Sweden, and elsewhere have revealed no evidence that bundled payments have resulted in unnecessary surgeries or other treatments. Bundled payments are risk-adjusted and introduce transparency on outcomes, and the fixed payment will discourage unnecessary procedures, tests, and other services. Bundled payments (and all care) should incorporate appropriate use criteria (AUC), which use scientific evidence to define qualifications for particular treatments.

Price competition will trigger a race to the bottom. Finally, some providers worry that bundled payments will result in excessive price competition, as payers demand discounts and low-quality providers emerge offering cheap prices. This concern is common among hospitals, which are wary of greater competition and want to sustain existing reimbursement levels. We believe this fear is overblown. Bundled payments include clear

accountability for outcomes and will penalize poor-quality providers. At the root of all these objections to bundled payments are critical failures that have held back health care for decades. Bundled payments will finally address these problems in ways that capitation cannot.

How Bundled Payments Will Transform Competition

As our multiple examples reveal, bundled payments are already transforming the way care is delivered. They unleash a new kind of competition that improves value for patients, informs and expands patient choice, lowers system cost, reshapes provider strategy, and alters industry structure for the better.

With bundled payments, patients are no longer locked into a single health system and can choose the provider that best meets their particular needs. Choice will expand dramatically as patients (and physicians) gain visibility into outcomes and prices of the providers that treat their condition. In a transparent bundled-payment world, patients will be able to decide whether to go to the hospital next door, travel across town, or venture even farther to a regional center of excellence for the care they need. This kind of choice, long overdue in health care, is what customers have in every other industry.

At the same time, the prices should fall. A bundled payment will usually be lower than the sum of current FFS reimbursements in today's inefficient and fragmented system. For conditions where legacy FFS payments failed to cover essential costs to achieve good outcomes, such as in mental health care or diagnostics that enable more targeted and successful treatments, prices may initially rise to support better care. But even these prices will fall as providers become more efficient.

In a world of bundled payments, market forces will determine provider prices and profitability, as they should. In today's system, FFS pricing allows inefficient or ineffective providers to be viable. With bundled payments, only providers that are effective and efficient will grow, earn attractive margins, and expand regionally and even nationally. The rest will see their margins decline, and those with poor outcomes will lose patients and bear the extra costs of dealing with avoidable complications, infections, readmissions, and repeat treatments.

Given today's hyperfragmentation of care, bundled payments should reduce the absolute number of providers treating each condition. But those that remain will be far stronger. And unlike the consolidation that would result from capitation, this winnowing of providers will create more-effective competition and greater accountability for results.

Providers will stop trying to do a little bit of everything and instead will target conditions where they can achieve good outcomes at low costs. Where they cannot, they will partner with more-effective providers or exit those service lines. The net result will be significantly better overall outcomes by condition and significantly lower average costs. No other payment model can produce such a transformation.

The shift to bundled payments will also spill over to drive positive change in pharmaceuticals, medical devices, diagnostic testing, imaging, and other suppliers. Today, suppliers compete to get on approved lists, curry favor with prescribing specialists through consulting and research payments, and advertise directly to patients so that they will ask their doctor for particular treatments. As a result, many patients receive therapies that are not the best option, deliver little benefit, or are unnecessary. With bundled payments, suppliers will have to demonstrate that their particular drug, device, diagnostic test, or imaging method actually improves outcomes, lowers the overall cost, or both. Suppliers that can demonstrate value will command fair prices and gain market share, and there will be substantial cost reduction in the system overall. Competition on value is the best way to control the costs of expensive drugs and therapies, not today's approach of restricting access or attacking high prices as unethical or evil regardless of the value products offer.

The Time Is Now

The biggest beneficiary of bundled payments will be patients, who will receive better care and have access to more choice. The best providers will also prosper. Many already recognize that bundled payments enable them to compete on value, transform care, and put the system on a sustainable health care path for the long run. Those already organized into IPUs for specific medical conditions are particularly well-positioned to move aggressively. Physician groups in particular have often moved the fastest.

Many health systems, however, have been reluctant to get behind bundled payments. They seem to believe that capitation better preserves the status quo—a top-down approach that leverages their clout

FURTHER READING

"The Strategy That Will Fix Health Care"
Michael E. Porter and Thomas H. Lee
HBR, October 2013

"What Is Value in Health Care?"
Michael E. Porter
New England Journal of Medicine, December 2010

"How to Solve the Cost Crisis in Health Care"
Robert S. Kaplan and Michael E. Porter
HBR, September 2011

"Redesigning Primary Care: A Strategic Vision to Improve Value by Organizing Around Patients' Needs"
Michael E. Porter, Erika A. Pabo, and Thomas H. Lee
Health Affairs, March 2013

"Getting Bundled Payments Right in Health Care"
Derek A. Haas, Robert S. Kaplan, Dereesa Reid, Jonathan Warsh, and Michael E. West
HBR.org, October 2015

and scale. They also see it as encouraging industry consolidation, which will ease reimbursement pressure and reduce competition. However, leading health systems are embracing bundled payments and the shift in competition to what really matters to patients.

Health systems with their own insurance plans, or those that self-insure care for their employees, can begin immediately to introduce bundled payments internally. Health systems that have adopted ACOs or other capitated models can also use condition-based bundled payments to pay internal units. Doing so will accelerate learning while motivating clinical units to improve outcomes and reduce costs in a way that existing departmental budgets or FFS can never match. Adopting bundles internally will be a stepping stone to contracting this way with payers and directly with employers.

> Providers will stop trying to do everything and will target conditions where they can achieve good outcomes at low cost.

Payers will reap huge benefits from bundled payments. Single-payer systems, such as those in Canada, Sweden, and the U.S. Veterans Administration, are well-positioned to transition to bundled payments for a growing number of medical conditions. Indeed, this is already happening in some countries and regions, with CMS leading the way in the United States.

But many private insurers, which have prospered under the status quo, have been disappointingly slow in moving to bundled payments. Many seem to favor capitation as less of a change; they believe it preserves payment infrastructure while shifting risk to providers. As an excuse, they cite their inability to process claims for bundled payments, even though bundled claims processing is inherently far simpler.

Improving the way they pay for health care, however, is the only means by which insurers can offer greater value to its customers. Insurers must do so, or they will have a diminished role in the system. We challenge the industry to shift from being the obstacle to bundled payment to becoming the driver. Recently, we've been heartened to see more private insurers moving toward bundled payments.

Employers, which actually pay for much of health insurance in the United States, should step up to lead the move to bundled payments. This will improve outcomes for their employees, bring down prices, and increase competition. Self-insured employer health plans need to direct their plan administrators to roll out bundles, starting with costly conditions for which employees experience uneven outcomes.

Should their insurers fail to move toward bundles, large employers have the clout to go directly to providers. Lowe's, Boeing, and Walmart are contracting directly with providers such as Mayo Clinic, Cleveland Clinic, Virginia Mason, and Geisinger on bundled payments for orthopedics and complex cardiac care. The Health Transformation Alliance, consisting of 20 large employers that account for 4 million lives, is pooling data and purchasing power to accelerate the implementation of bundled payments.

THE TIME has come to change the way we pay for health care, in the United States and around the world. Capitation is not the solution. It entrenches large existing systems, eliminates patient choice, promotes more consolidation, limits competition, and perpetuates the lack of provider accountability for outcomes. It will fail again to drive true innovation in health care delivery.

Capitation will also fail to stem the tide of the ever-rising costs of health care. ACOs, despite their strong advocates, have produced minimal cost savings (0.1%). By contrast, even the simplified bundled payment contracts under way today are achieving better results. Medicare is expected to save at least 2% ($250 million) in its program's first full year of operation. And experience in the United States and elsewhere shows that the savings can be far larger.

Capitation might seem simple, but given highly heterogeneous populations and continual turnover of patients and physicians, it is actually harder to implement, risk-adjust, and manage to deliver improved care. Bundled payments, in contrast, are a direct and intuitive way to pay clinical teams for delivering value, condition by condition. They put accountability where it should be—on outcomes that matter to patients. This way to pay for health care is working, and expanding rapidly.

Much remains to be done to put bundled payments into widespread practice, but the barriers are rapidly being overcome. Bundled payments are the only true value-based payment model for health care. The time is now.

HBR Reprint R1607G

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