

SPOTLIGHTING INTERNATIONAL INNOVATION

Bundling Payments to Promote Integration and Efficiency

High-quality care for patients with chronic and complex conditions often involves coordinating between multiple providers and sources of care. Fee-for-service payment, which reimburses providers for a particular service, fails to provide incentives to coordinate care and can encourage providers to work in silos. Bundled payments—also known as episode-based payment or case rates—have been proposed as a way to encourage coordination across providers and to promote more efficient care. Under a bundled payment, a single fee is paid for an entire episode of care; for example, a single fee for hip replacement would cover both the procedure itself and the rehabilitation and follow-up treatments. This fee would be divided among the providers along the care pathway, either prospectively or retroactively.

Bundled payments already exist in the U.S. in a number of systems, such as the [Geisinger Health System](#). The Affordable Care Act contains provisions advancing bundled payments in Medicare, including a large-scale pilot scheduled [to be rolled out by January 1, 2013](#). Other countries have also experimented with bundled payments, most notably the Netherlands and Germany. Their experiences can inform U.S. efforts to reform health system payment and drive improvement.

Bundling Payments for Chronic Conditions in the Netherlands

In 2007, a bundled payment system for diabetes care was introduced on an experimental basis in the Netherlands. This scheme created a new health care entity—“care groups”—to which insurers pay a single bundled fee to assume responsibility for a patient’s diabetes care for a defined time period. Care groups are made up of health care providers, often only general practitioners, and either provide the diabetes services themselves or subcontract them out to other providers. The services covered under the bundled payment are nationally defined and agreed on by all providers and patient associations, and must be offered free of charge to patients. Price negotiation occurs on two levels: between insurers and care groups on the bundled fee, and between care groups and any subcontracted providers.

A one-year evaluation of the bundled payment program found that almost all providers reported improved care delivery processes, including greater coordination and adherence to protocols. Transparency also increased as providers faced stricter reporting requirements, though outdated information technology systems meant this was accompanied by a greater administrative burden. Prices for the care bundle varied dramatically, suggesting that insurers had differing interpretations of the services included in the bundle. Also, some subcontracted providers reported that care groups had distortive market power. In particular, questions were raised about the potential conflict of interest for general practitioners, since they are both commissioning and providing care. Future evaluation will examine any effects the bundled payments may have had on patient outcomes and overall costs.

In 2010, the bundled payment program was approved for nationwide implementation for diabetes, chronic obstructive pulmonary disease, and vascular risk management, though participation is still voluntary: insurers and providers are free to operate under the bundled payment system or the traditional payment approach. In 2012, an evaluation committee appointed by the minister of health will recommend whether the system should be maintained, changed, or expanded.

Further reading:

- de Bakker DH, Struijs JN, Baan CB, et al., "[Early Results From Adoption of Bundled Payment for Diabetes Care in the Netherlands Show Improvement in Care Coordination](#)," *Health Affairs*, February 2012 31(2):426-33.
- J. N. Struijs, and C. A. Baan, "[Integrating Care Through Bundled Payments — Lessons from the Netherlands](#)," *New England Journal of Medicine* 2011, 364(11):990– 91.
- J. N. Struijs, J. T. van Til, and C. A. Baan, [Experimenting with a Bundled Payment System for Diabetes Care in the Netherlands: The First Tangible Effects](#), RIVM: National Institute for Public Health and the Environment, Bilthoven, the Netherlands, 2010.
- S. Thomson, R. Osborn, D. Squires et al., [International Profiles of Health Care Systems, 2011](#) (New York: The Commonwealth Fund, November 2011).

Integrated Care Contracts in Germany

Since 2000, German "sickness funds," or public insurers, have been allowed to negotiate integrated care contracts with providers from multiple sectors (e.g., family doctors and hospital-based specialists). Between 2004 and 2008, sickness funds were required to set aside 1 percent of their finances for hospital and ambulatory providers to subsidize these contracts, stimulating their use. Further reforms have since clarified and loosened criteria for integrated care contracts—including allowing them between different types of providers within the same sector—leading to over 6,000 such contracts by 2008.

Most integrated care contracts deal with a specific condition or treatment (e.g., hip surgery) and link two different health sectors (e.g., inpatient and rehabilitative care). However, some are far more ambitious. For example, *Gesundes Kinzigtal Integrated Care* in southwest Germany is a population-based integrated care system, covering all health care sectors for a given population—currently, roughly 30,000 people or half of the region's population. A health care management company (Gesundes Kinzigtal GmbH) works with two sickness funds to coordinate care for their enrollees. If the region succeeds in reducing costs for its population, the savings are shared between the management company and the sickness funds; if costs increase, the management company is liable for the loss. Since 2007, the program has achieved positive savings.

Further reading:

- [Evaluation of Gesundes Kinzigtal Integrated Care](#), Evaluations-Koordinierungsstelle Integrierte Versorgung (EKIV).
- "[Germany: Integrated Care](#)," in *Future-proofing Western Europe's Healthcare: A Study of Five Countries*, Economist Intelligence Unit Report, September 2011.
- S. Thomson, R. Osborn, D. Squires et al., [International Profiles of Health Care Systems, 2011](#) (New York: The Commonwealth Fund, November 2011).