



# *Bundled payment Pay-for-Performance in Taiwan*

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## **Pilot**

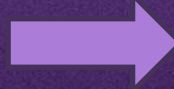
Details about main coordinator, Participants, Supporting partners, Core tasks, What & Who we test, Monitoring & Funding, Evaluation, Risks & Mitigation

## 01 *Introduction of Study*

### **Association of a Bundled-Payment Program With Cost and Outcomes in Full-Cycle Breast Cancer Care (Wang et al., 2017)**

#### *Cause for Action*

FFS incentives in Taiwan raised concerns about cost growth and variable quality.



***Does the bundled pay-for-performance model actually lead to better quality and cost control compared with the usual fee-for-service system?***

# 01 Introduction of Study

## Payment Model and Goals



01

# Organized care - better patient outcomes and cost control

## Take-away:

When hospitals followed the care steps better, more patients did well.  
At the same time, costs were better controlled over time.

### After 5 years

**84 / 100**

did well with organized care

Usual care: 81 / 100

### Biggest difference

Stage III patients

**62 / 100**

did well with organized care

Usual care: 53 / 100

## What improved in the care process?



Diagnosis & Confirmation before surgery



Enough lymph nodes checked



Radiotherapy given when needed

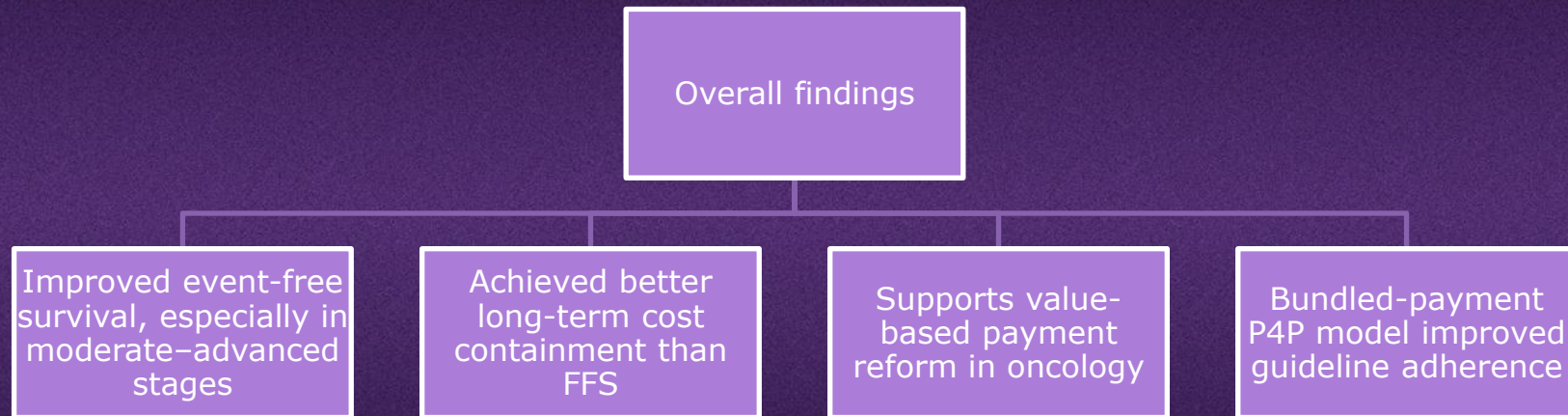


Recommended care steps followed

"Did well" = alive without a major cancer problem after treatment. Overall survival was mostly similar.

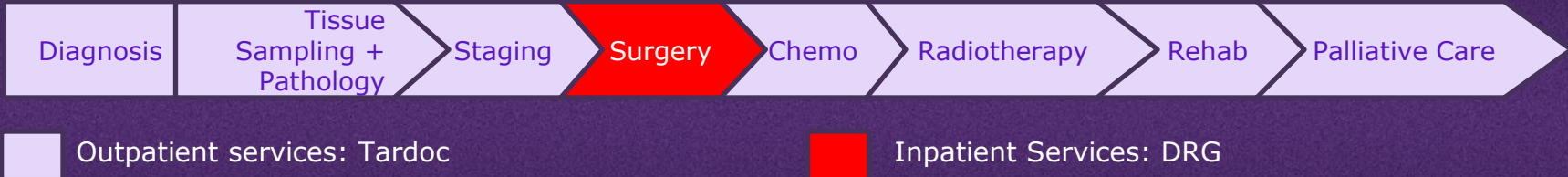
**Bottom line:** Good coordination + consistent care standards can make a difference.

# 01 Conclusion of the Study

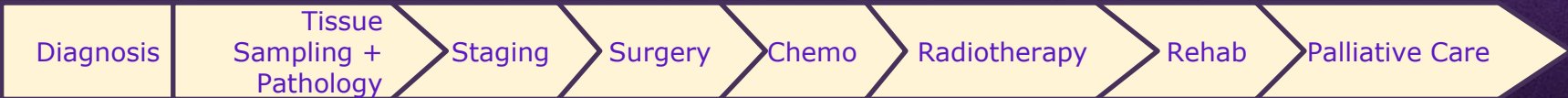


## 02 Breast Cancer Care: Switzerland vs. Taiwan

### Breast cancer care in Switzerland (COSA, 2025)



### Breast cancer care in Taiwan (Wang et al., 2017)



Different bundles for different cancer stages

Quality indicator for bonus payments (P4P): Overall and event-free survival rate at the end of the year

# 03 *Adaptation Potential & Implementation Considerations*

## **Adjustments to the Swiss Context**



Separate tariffs in DRG and Tardoc



Coordination of financial flows



Regulatory changes

## **Sustainability Factors**



Risk adjustment



Self-learning systems for quality measures



Patient education and safety



Implementation difficult, but E-GD and EFAS could act as facilitators

# 04 Why This Pilot Matters

*From fragmented oncology financing to a bundled value-based pilot*

## PROBLEM Cancer care in Switzerland

### Fragmented pathways

Care split across cantons, providers and tariff systems.

### Volume-driven payment

Fee-for-service rewards activity, not coordination.

### Quality variation

Outcomes and process adherence differ by canton.

### Rising burden

Incidence projected to grow through 2025 and beyond.



## PILOT ANSWER Bundled P4P for oncology

### Why breast & colorectal cancer

High prevalence, strong registry data (NICER) and clear clinical pathways — ideal for standardised monitoring.

### Episode-based payment

One risk-adjusted bundle covers diagnosis through follow-up; bonus tied to outcomes.

### Led by a coalition

Oncosuisse, NICER, major oncology centres, insurers and the FOPH.

Anchor partners: **Oncosuisse · NICER · Oncology Centres · Insurers · FOPH**

## 04 Pilot Design at a Glance

*Scope, sponsorship and stakeholders*

# 2

### tracer cancers

Breast & colorectal:  
high prevalence, strong  
NICER data, clear  
pathways

# 1

### episode tariff

Risk-adjusted bundle  
covering the full care  
cycle

# 5+

### core partners

Insurer-led with  
NICER, oncology  
centres and FOPH

### Pilot configuration

<b>LEAD</b>	Health insurer (sponsor) developing the bundle product
<b>SCOPE</b>	Breast & colorectal cancer, full-cycle episode, multi-year follow-up
<b>CO-DESIGNERS</b>	NICER (registry), oncology centres, FOPH
<b>MECHANISM</b>	Risk-adjusted bundle + P4P bonus on overall and event-free survival

Operating model - **monitoring, funding flows and risk protection**

## Monitoring

*Continuous oversight of process & outcomes*

- **Real-time dashboards**  
Episode costs, throughput and adherence visible to all partners.
- **Survival & adherence**  
Aligned with Wang et al. quality indicators.
- **PROMs**  
Patient-reported outcomes feed quality scores.
- **Independent review**  
External clinical oversight of bonus decisions.

## Funding sources

*Blended financing across the system*

- **Insurers**  
Primary payer for the bundle and bonus.
- **FOPH innovation support**  
Federal co-funding for the pilot phase.
- **Cantonal co-funding**  
Inpatient share, KVG Art. 49a logic.
- **Hospital infrastructure**  
In-kind contribution for registry and IT.

## Risk protection

*Keeping incentives aligned with patients*

- **Risk-adjusted payments**  
Higher bundles for advanced stage / comorbidities.
- **No cherry-picking**  
Audited case-mix monitoring.
- **Quality floor**  
Bonus withheld if minimum standards missed.
- **Stepwise rollout**  
Phased expansion to limit downside risk.

**Bottom line:** risk-adjusted payments protect complex patients; quality oversight keeps incentives aligned with outcomes.

## Evaluation design and risk mitigation

### EVALUATION

## How we will know it worked

### STUDY DESIGN

Pilot hospitals vs. matched FFS hospitals, using propensity-score matching.

### OUTCOMES TRACKED

#### Costs

Episode and 5-year total cost

#### Survival

Overall and event-free survival

#### Complications

Readmission and adverse events

#### Quality

Guideline adherence and PROMs

### MAIN RISKS

## Risks and mitigations

### Data fragmentation

*Data heterogeneous across cantons and providers*

**Mitigation:** NICER-led common dataset and national indicators

### Stakeholder resistance

*Hospitals fear revenue loss; payers fear budget risk*

**Mitigation:** Independent audits and transparent gain-/loss-sharing

### Cherry-picking

*Low-risk patient selection inflating quality scores*

**Mitigation:** Risk adjustment, case-mix audits, stepwise rollout

*Can Switzerland coordinate value-based cancer care despite its fragmented system?*



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*Thanks!*



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Do you have any questions?



# *Backup Slides*



# 01 Results: Financial Development

y-axis: Average 5-year total costs (US\$)

Cost development FFS / Bundled Payment  
(reconstructed according to Wang et al., 2017)



Values for 2005–2007 approximated from the original graph; values for 2004/2008 from textual information in the study

# 01 Results: Care Quality & Survival Outcomes

## Significant Improvements

Bundled-payment hospitals showed higher overall adherence (34.9% vs 27.5%)

Preoperative histologic confirmation

Adequate lymph node dissection ( $\geq 10$  nodes)

Radiotherapy after breast-conserving surgery

## 5-year Event-Free Survival (Stages 0–III)

Bundled: **84.48%** vs FFS: **80.88%**

## Stage-specific EFS (bundled vs FFS)

- Stage I: 92.1% vs 90.7%
- Stage II: 85.3% vs 80.5%
- Stage III: **61.5%** vs **53.0%** -> largest absolute gain (~8.5 percentage points; HR 0.80)

## Overall Survival

- Largely similar between groups overall
- Only Stage II shows a small but significant OS benefit (**91.9% vs 90.6%**; HR 0.82)