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Value-based Healthcare in Germany

From free price-setting to a regulated market

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About this report

Value-based healthcare in Germany: From free price-setting to a regulated market is a report by The Economist Intelligence Unit (EIU), commissioned by Gilead Sciences. It looks at the evolution of health technology assessment and pharmaceutical pricing reform in Germany and examines the new focus on providers and health outcomes.

In July-August 2015 The EIU conducted four interviews with experts on value-based healthcare in Germany, including senior healthcare executives and practitioners as well as academics. The insights from these in-depth interviews appear throughout the report. The EIU would like to thank the following individuals (listed alphabetically) for sharing their insight and experience:

- Dr Clemens Guth, executive director, Artemed
- Dr Günther Jonitz, president, Berlin Chamber of Physicians
- Dr Axel Mühlbacher, professor of health economics and healthcare management, Hochschule Neubrandenburg
- Dr Thorsten Schlomm, professor of urology and member of faculty, Martini-Klinik

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Introduction

Germany has one of the oldest national healthcare systems in Europe, and for the last 15 years it has had an infrastructure in place for assessing new medications, treatments and healthcare pathways. Yet despite its leadership in these areas, the German healthcare system has come relatively late to focusing on health outcomes.

In recent years, however, this has begun to change, spurred on partly by greater demand from patients and by a string of media stories that have drawn attention to the quality of healthcare.

At the same time, despite a series of reforms, most of these stories have been centred on the process of delivering care, rather than on measuring patient outcomes and experiences.

"The term 'value-based healthcare' doesn't translate well into German," says Dr Clemens Guth, executive director of Artemed, a private hospital and nursing-home operator in Germany, and co-author of a book on value-based healthcare in Germany with Michael Porter, a Harvard University professor who coined the term. Value-based healthcare looks at health outcomes of treatment relative to cost.

Nevertheless, there are signs that the government is trying to evaluate health outcomes. Some of the most controversial reforms in recent years have involved the assessment and pricing of pharmaceutical products, the reverberations of which are still being felt in the German drug market. In 2011 Germany imposed maximum reimbursement prices for all new reimbursable treatments following the assessment of their added therapeutic value. This put an end to the free pricing era in Germany.

The efficiency frontier is the approach chosen in Germany to assess costs and benefits of therapeutic alternatives within a therapy area. However, as will be discussed in Chapter 1, this approach is not yet used systematically, and the system will have to be adapted accordingly, because this methodology is relatively new.

The most recent set of healthcare legislation,[1] which is going through its final readings in the Bundestag (the German parliament) before coming into effect in January 2016, contains measures to carry out benefit assessments of medical devices and to evaluate the quality of healthcare, including the introduction of discounts and surcharges depending on the quality of the services provided. The new legislation will also aim to make the quality reports of hospitals more patient-friendly.

[1] Federal Ministry of Health, "Krankenhausversorgung zukunftsfest machen", July 2nd 2015. Available at http://www.bmg.bund.de/presse/pressemitteilungen/pressemitteilungen-2015-3/khsg-bundestag.html

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Meanwhile, a few hospitals around the country, notably the Martini-Klinik (a specialist centre for prostate surgery in Hamburg, northern Germany), already provide insightful lessons in how to improve the experience of patients (see case study in Chapter 2).

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1 Chapter 1: The evolution of health technology assessment and pharmaceutical pricing reform

Germany's healthcare system and health technology assessment (HTA) regime have been in place for more than a decade. Yet efforts to measure quality have largely emphasised cost savings in recent years, and the ultimate impact of initiatives involving the pharmaceutical industry are still being weighed up.

A venerable system...

Although Germany's health insurance system dates back to Bismarck's social legislation in the late 19th century, much of the country's current decision-making structure is considerably more recent.

Like other European countries, Germany guarantees healthcare to all citizens, but unlike many of its neighbours, which fund health coverage through general taxation, most Germans are covered by the Statutory Health Insurance (SHI) system (Gesetzliche Krankenversicherung, or GKV), which consists of 134 sickness funds financed by both employee and employer payroll taxes. Just 11% of Germans are covered by private health insurance.

While Germany's federal government has no role in healthcare delivery, it shares responsibility for public health and the management of hospital budgets as well as regulatory decision-making with the country's 16 Länder (states) and designated self-governing institutions.

The focal point for decision-making at the nexus of these government institutions is the Federal Joint Committee (Gemeinsamer Bundesausschuss, or G-BA), established in 2004 with responsibility for both appraisal and decision-making in the ambulatory and inpatient sectors. An independent, self-governing body with the ability to issue directives, the G-BA is the paramount decision-making body in the SHI system and co-ordinates HTA.[2]

The G-BA includes the Medical Evaluation Subcommittee, which prioritises technologies for evaluation, requests the submission of expert evidence and assesses its quality, and recommends whether technologies should be included in the SHI benefits package. A separate Valuation Committee, which includes representatives of physicians' associations and the SHI, determines which technologies will be reimbursed.

There are two main HTA agencies that help to co-ordinate the data on which the G-BA bases its decisions. First, the German Agency for Health Technology Assessment (Deutsche Agentur für Health Technology Assessment, or DAHTA) is charged with establishing and maintaining a

[2] Velasco-Garrido, M, A Zentner and R Busse, "Health systems, health policy and health technology assessment", in: Velasco-Garrido, M, R Borlum Kristensen et al (eds), *Health technology assessment and health policy-making in Europe–Current status, challenges and potential*. Copenhagen: WHO Regional Office for Europe, 2008, pp. 53-78.

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database system, including its own HTA reports as well as those produced by other national and international organisations. The DAHTA evaluates HTA reports for inclusion in the information system.

Second, the Institute for Quality and Efficiency in Health Care (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen, or IQWiG), now the leading HTA body compiling reports for the G-BA, produces evidence-based guidelines for epidemiologically important diseases, acts on requests for HTA from the G-BA and occasionally the Federal Ministry of Health, gives recommendations to the G-BA for drugs, operating procedures and medical devices, and produces reports. It currently has a budget of €30bn.

The IQWiG's initial remit was limited to the assessment of the benefits and harm of drug intervention and to preparing non-binding recommendations for the G-BA. It has gained new responsibilities through health reforms, allowing the agency to make cost-benefit assessments as well as evaluate clinical practice guidelines and submit recommendations on disease management programmes for chronic conditions such as heart disease and diabetes.[3]

Earlier this year the government established the Institute for Quality Assurance and Transparency in Health Care (Institut für Qualitätssicherung und Transparenz im Gesundheitswesen, or IQTiG), designed to develop and implement quality assurance measures in the healthcare system. The IQWiG and IQTiG have a complementary relationship, says Dr Günther Jonitz, president of the Berlin Chamber of Physicians. "The [IQWiG] looks at everything on its way into the system, and the [IQTiG] looks at all of the results of what is happening in the system," he explains.

...but with major economic limitations

Unlike other HTA agencies, such as the UK's National Institute for Health and Care Excellence (NICE), the IQWiG does not use the incremental cost-effectiveness ratio (ICER) approach, which measures the difference in costs between two possible interventions divided by the difference in outcomes. Instead, the IQWiG judges treatments according to their "efficiency frontier", in which all available compounds are compared using the total benefits in relation to their total costs. However, at the time of its introduction the efficiency frontier approach lacked real-life examples of its use in the healthcare space, not only in Germany but also everywhere else.[4]

"The theoretical idea of the efficiency frontier is that we take findings from clinical trials and, based on these clinical data, try to identify the best strategy within a disease class or treatment," says Axel Mühlbacher, professor of health economics and healthcare management at Hochschule Neubrandenburg, a university of applied sciences in northern Germany. In contrast to NICE, he adds, the G-BA does not use the IQWiG's efficiency frontier to make allocation decisions across disease classes. Rather than deciding, for example, between brain surgery and lung-cancer treatment, the system attempts to determine the most effective or efficient treatment within each category.

It is not just that the efficiency frontier is more a theoretical concept than a proven effective practical tool to assess value in healthcare. What is more, the German system is not perceived as using pharmacoeconomics systematically.[5] The approach has been criticised by health economists because "what interventions lie on the efficiency frontier will depend upon the method used to measure benefits", and without a commonly accepted method of measuring benefits, "it is difficult to draw judgments about efficient allocation of resources across therapeutic areas".[6]

The preference for the efficiency frontier approach may have cultural reasons. According to a 2013 paper[7] by academics at the London School of Economics, the development of the efficiency frontier was associated with cultural reluctance to frame healthcare decisions around cost-based

[3] "Pharmaceutical HTA and Reimbursement Process – Germany", ISPOR Global Health Systems Road Map. Available at http://www.ispor.org/htaroadmaps/germany.asp

[4] Ibid.

[5] Epstein, D, "The use of Comparative Effectiveness Research and Health Technology Assessment in European countries: current situation and prospects for the future", March 20th 2014. Available at www.ugr.es/~davidepstein/HTA%20in%20european%20countries.docx

[6] Vale, L, "Health Technology Assessment and Economic Evaluation: Arguments for a National Approach", *Value in Health*, Vol. 13, No. 6, pp. 859–861, September/October 2010.

[7] Klingler C *et al*, "Regulatory space and the contextual mediation of common functional pressures: Analyzing the factors that led to the German Efficiency Frontier approach", *Health Policy*, Vol. 109, No. 3, March 2013, pp. 270-280.

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valuations of human health. The authors found that the efficiency frontier approach "responds to an environment characterised by a need to deny, or to ignore, the need to ration healthcare, and a deep aversion to describing the benefits of health gains in monetary terms". The approach also "reduces any political risk that might be involved in a discussion of healthcare rationing and postpones the debate about what an acceptable threshold [for demonstrating cost-effectiveness] might be".[8]

The German system is therefore still in the process of being adapted to the new methodology, which is relatively new compared with cost-effectiveness approaches in the UK, for example, which have been in place for much longer.

The end of the free pricing era

Those therapies that the IQWiG determines to be innovative and those without any therapeutic equivalent are exempt from categorisation, and until 2011 Germany was one of the few countries where these therapies were fully reimbursed at manufacturer's prices on market entry.[9]

The G-BA can limit or exclude the prescription of pharmaceuticals if they have proved inadequate or if another, more efficient treatment option with comparable diagnostic or therapeutic benefits is available: excluded treatments end up on negative lists for drugs that are not reimbursed.[10] The G-BA is under no obligation to take the IQWiG's recommendations and has chosen not to follow the agency's advice on several occasions.

In December 2010 rising prices for new drug therapies and a stagnating European economy led Germany to push through the Act on the Law on the Reorganisation of the Pharmaceutical Market (Arzneimittelmarktneuordnungsgesetz, or AMNOG), which aims to limit the cost of pharmaceuticals, especially those that had previously been exempt from reference prices.

AMNOG requires the G-BA and the IQWiG to judge new treatments according to what they consider to be the best comparator. For drugs that are judged to be an improvement on the comparator, companies can negotiate a price in line with or even higher than what they had originally asked for, but if the level of innovation is not deemed sufficient, it is left to the government to set prices at a lower level with reference to the comparator.[11]

Under AMNOG, pharmaceutical companies set the initial price for new drugs after they are approved, but this price is only valid for a year. During this time the G-BA reviews the company's "value dossier"—the evidence demonstrating a drug's ability to shorten the period of illness, reduce side effects or improve quality of life—with help from the IQWiG and determines the level of added benefit of the new drug compared with the relevant comparator.[12]

As of May 2014 the G-BA had assessed 79 products and determined that 50% of them had no added benefit.[13] This compares with a reimbursement failure rate of 41% for NICE decisions during the 2000-13 period.[14]

Pharmaceuticals with a turnover of less than €1m a year or those that are only used in hospitals are excluded from the early benefit assessment. So-called "orphan drugs" for rare diseases are also exempt if their turnover with statutory health insurance is less than €50m; for orphan drugs with higher revenues, pharmaceutical companies also need to prove an additional benefit.[15] However, even those treatments that show added benefits may be subject to a minimum price reduction of 7%, unless this option is retracted during price negotiations.[16]

There has been a backlash from the industry. Japan's Eisai and Switzerland's Novartis have already withdrawn medicines from the German market owing to their inability to agree on a mutually beneficial price with payers. In July 2015 Denmark's Novo Nordisk said it would stop selling its Tresiba long-acting insulin in Germany because of a price dispute with the National Association of Statutory Health Insurance Funds,

[8] London School of Economics, "Why should the German approach to health economic evaluation differ so markedly from approaches in other EU Member States?" Health and Social Policy blog, February 27th 2013. Available at http://blogs.lse.ac.uk/healthandsocialcare/2013/02/27/why-should-the-german-approach-to-health-economic-evaluation-differ-so-markedly-from-approaches-in-other-eu-member-states/

[9] "Pharmaceutical HTA and Reimbursement Process – Germany", ISPOR Global Health Systems Road Map. Available at http://www.ispor.org/htaroadmaps/germany.asp

[10] Paris, V and Belloni, A, "Value in Pharmaceutical Pricing", *OECD Health Working Papers*, No. 63, 2013, p.18.

[11] "The evolution of IQWiG in Germany's drug pricing policy", PMlive.com, September 3rd 2013. Available at http://www.pmlive.com/pharma_intelligence/the_evolution_of_iqwig_in_germanys_drug_pricing_policy_493674

[12] Sackman, JE and M Kuchenreuther, "Germany Post AMNOG: Insights for BioPharma", *BioPharm International*, Vol. 27, Issue 11, p. 2.

[13] Ibid.

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which represents the statutory healthcare and long-term care insurers in Germany. The decision followed the IQWiG's conclusion that Tresiba did not represent added benefit on its own or in combination with other diabetes drugs for teenagers and children. Novo Nordisk officials said the agency had used as a price comparator "ordinary human insulin, a product that was launched in the 1980s".[17]

Dr Jonitz and other industry observers believe that such "opt-outs" could become more common; a recent update to the AMNOG legislation allows the government to publish the newly negotiated reimbursement amounts as the public source for referencing, rather than the product's original launch price, as has been the case in the past.[18]

With regard to the German hospital sector, a parallel reform process aimed at reducing costs and focusing more on outcomes and performance than previously has been under way in recent years. The next chapter will look at some of these reforms and present a case study of how German healthcare provision is moving more towards value-based healthcare.

[14] Grignolo, *A, Achieving Convergence In Global Regulatory Approvals And Market Access For True Innovation*. Presentation to the 26th Annual EuroMeeting, 25th-27th March 2014, Vienna, Austria. Available at http://www.epaccontrol.com/common/sitemedia/PrePost/PostPDFs/36710.pdf

[15] "AMNOG – evaluation of new pharmaceutical", GKV-Spitzenverband. Available at https://www.gkv-spitzenverband.de/english/statutory_health_insurance/amnog___evaluation_of_new_pharmaceutical/amnog___evaluation_of_new_pharmaceutical_1.jsp

[16] "Germany Post AMNOG", p. 2.

[17] "Novo Nordisk Halts Sale of Tresiba Insulin in Germany over Pricing Dispute", *The Wall Street Journal*, July 2nd 2015.

[18] "Germany Post AMNOG", p. 3

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2 Chapter 2: New focus on providers and outcomes

German healthcare provision has traditionally had a reputation for excellence, with many reform initiatives seeking to control costs and streamline the number of inpatient units.

Historically, there have been some efforts to collect data on healthcare outcomes in Germany. In the early 1970s efforts to implement the quality management of childbirth on a nationwide basis led doctors to collect information on survival rates to justify the closure of some very small units.

A 2000 healthcare reform law introduced diagnostic reimbursement groups (DRGs) and at the same time required hospitals to adopt quality management systems. Starting in 2005, the legislation also required hospitals to make publicly available biannual quality reports. While these quality reports initially focused on structural measures, such as diagnostic equipment, staff size and qualifications and processes, from 2007 hospitals were required to begin reporting limited data on outcome quality. Although these reforms fell short of the traditional definition of value-based healthcare, they provided a degree of transparency about hospital care that was accessible to patients.[19]

At the same time, an oversupply of hospitals in Germany has remained a central preoccupation for policymakers. In just one state, North Rhine-Westphalia, 300 hospitals serve a population of 18m, while in the Netherlands just 70 hospitals treat a population of nearly the same size. As it has introduced performance measures, the government has intensified efforts to encourage the closure of low-volume inpatient units or the merger of institutions into regionalised and more specialised centres of care, but rivalries within the system have made these efforts politically fraught.

"German healthcare politics have one goal, and that is shutting down hospitals, reducing the number of hospitals and the number of doctors," Dr Jonitz adds. "The real goal should be optimising rather than decimating care."

The struggle to rationalise healthcare provision

Because German healthcare provision has traditionally been perceived as high-quality, patients expect a superior standard of care from their local hospital.

However, that assumption has come under threat in recent years, according to Dr Guth, as reports of hospital mismanagement and poor outcomes have raised questions about the level of quality in the German hospital system.

[19] Jochem, M and S Klein, *Patient satisfaction in German hospitals: results of the biggest survey on hospital quality*. Presentation to the European Health Management Association annual conference, Innsbruck, June 26th 2009. Available at: http://www.ehma.org/files/Markus%20Jochem.pdf

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"Before, people thought care was expensive, but with high costs comes high quality. People now realise that neither spending a lot of money nor having an outpatient hospital or physician around the corner means you get excellent care," he says.

This realisation has in part been fuelled by greater transparency about outcomes available on the Internet, including published hospital rankings, and by increasing numbers of patients accessing these data.

One way in which German healthcare authorities are looking to improve quality is by increasing minimal volumes for procedures and creating centralised healthcare units that specialise in particular diseases or procedures.

The introduction of DRGs, a bundled payment system, was aimed both at reducing some costs by establishing a fixed fee for treatment categories independent of the length of stay (previously, hospitals were paid on a per-diem basis) and at directing care to centres with greater expertise. Under the DRG system, hospitals do not receive the full payment for some medical conditions if the care they provide is below a specified volume, based on evidence that higher volumes of care provided for a particular DRG can lead to better clinical outcomes. There have also been some efforts to provide quality-related incentives to outpatient doctors through the Disease Management Programmes; there are no comparable financial incentives for hospitals.[20]

The next step, according to Dr Guth, is a "pay for performance" (P4P) system to encourage high-quality outcomes and provide an assessment of the value of care. The IQTiG could potentially provide a foundation for the introduction of such a system, according to Dr Guth and also Professor Mühlbacher.

To a limited extent, P4P measures are already embedded in the current DRG system; if a patient undergoes a hip operation and is then readmitted to hospital within 30 days of being discharged, there is no additional payment for the physician or hospital, Dr Guth notes. At the same time, there is an incentive to hold off from a full launch of P4P until standards are raised.

The transition to more value-based healthcare provision in Germany has also been complicated by some of the anomalies within the system. For example, while all inpatient care is reimbursed, patients pay out-of-pocket for similar procedures in an outpatient setting. Because hospital care is based on the DRG system and outpatient care is invoiced according to physician fee schedules, the process of collecting data and evaluating outcomes and value across the system is potentially more challenging.[21]

There is also a greater effort being made to improve integrated care in Germany. Between 2004 and 2008 statutory health insurers (SHIs) held 1% of ambulatory and hospital care budgets to use as incentives for providers to develop integrated care. The majority of these cases involved both hospital care and rehabilitation services. Professor Mühlbacher notes that in one of the more successful programmes in south-west Germany, Gesundes Kinzigtal, a regional health management company, works with providers and SHIs to provide integrated care; the programme includes bundled payments to healthcare providers, with any profits from more efficient care distributed across providers.[22]

Despite the success of Gesundes Kinzigtal, the incentive system was discontinued in 2011, following renewed problems reconciling integrated care with Germany's fragmented health provision and insurance system, Professor Mühlbacher says.

"What we thought integration could be, and how it could very easily reorganise the healthcare system, didn't take place," he explains, adding that he was sceptical about the immediate future of integrated care in Germany if the system did not attempt to undergo radical change.

[20] Charlesworth, A *et al*, "Reforming payment for health care in Europe to achieve better value", The Nuffield Trust, August 2012, pp. 5 and 21. Available at http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/120823_reforming-payment-for-health-care-in-europev2.pdf

[21] Obermann, K *et al*, *Understanding the German Healthcare System*, pp. 186 and 202. Available at http://miph.umm.uni-heidelberg.de/miph/cms/upload/pdf/GHCS_Kap._1.pdf

[22] Charlesworth, *Reforming payment for health care in Europe*, pp. 25-26; and Busse, R, M Blümel et al, "Tackling Chronic Disease in Europe: strategies, interventions and challenges", European Observatory on Health Systems and Policies, *Observatory Studies Series*, No. 20, 2010, p. 37.

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Dr Jonitz argues that German healthcare still faces an inherent leadership dilemma. "The German healthcare system, according to the Basic Law, is the task of the Länder, but all the instruments to guide the healthcare system are on the national level. So those who are leaders by law don't have the instruments to carry out the process."

One way of solving this conundrum, he suggests, would be to create regionalised healthcare funds through which some of the SHI money is given to the Länder governments to promote their special goals.

Martini-Klinik: Providing a model for assessing outcomes

Martini-Klinik, part of the University of Hamburg-Eppendorf in northern Germany, is an example of a high-level specialty centre. The hospital, which specialises in prostate surgery, has been collecting data on outcomes for more than 20 years, making it unique in Germany and possibly in Europe, according to Thorsten Schlomm, a professor of urology and member of the Martini-Klinik faculty.

By having patients complete a detailed questionnaire before and after surgery, the Martini-Klinik has amassed a sizeable collection of real-world data that help its physicians to fine-tune their surgical methods and reduce complications.

Radical prostatectomies are characterised by particularly high rates of incontinence and impotence following surgery, side-effects that can markedly change a patient's quality of life. In 1992 the clinic started to measure oncological and function outcomes following surgery by asking patients to complete a 70-question survey prior to surgery, covering their quality of life and sexual and urinary function; several of these questions are repeated again one week after surgery, three months afterwards and then annually, with response rates of more than 90%. In some cases, the clinic has followed up patients for two decades.

The data are collected, stored and analysed by an independent statistician, and every surgeon attends two yearly meetings to examine the results. "We have a good relationship with our patients, and our patients are willing to give this information because we explain that this is key for their good experience," Professor Schlomm explains.

The existence of such comprehensive data has helped surgeons to modify their procedures with dramatic results. After noticing that one member of the team had particularly low incontinence rates in his patients following surgery, other Martini-Klinik colleagues looked at the data and found that the differences related to the amount of the urinary sphincter muscle preserved; because the shape of the muscle is different in every person, patients were losing different amounts of the muscle during surgery.

By following the lead of the surgeon in question and preserving a specific length of the sphincter in each patient, other Martini-Klinik colleagues were able to double early rates of continence. The clinic now has an incontinence rate of less than 5% in its prostatectomy patients, down from 8-10% in 2007, before the procedure was modified, and compared with an average of 20% elsewhere in Germany today.

The willingness of Martini-Klinik surgeons to learn from one another and submit to peer review would seem to fly in the face of conventional wisdom about the surgical profession, often viewed as one of the more competitive branches of medicine. According to Professor Schlomm, his colleagues recognise that their collaborative success benefits everyone.

While the Martini-Klinik model is rare, there are other examples of specialised care centres in Germany, including the Schön Klinik, a family-owned hospital group with clinics throughout the country, which focuses on orthopaedics and neurology.

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Professor Schlomm notes that the Martini-Klinik employs a team of six full-time data entry staff, an expensive model that not every hospital can afford to follow. In addition, he says, it is difficult to compel doctors to record their outcome data, and too tempting for them to be selective about the information they share. Patients, on the other hand, have a clear interest in documenting their disease history.

The Martini-Klinik provides a good case study of how value-based healthcare could be introduced on a wider basis in Germany within a specialised care context. The hospital's commitment to expanding its database of patient outcomes, and its willingness to share best practice among staff surgeons and revise its surgical methods accordingly, are likely to contribute to improved value—and these methods could be applied successfully to other parts of the country's healthcare system.

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Conclusion

While the concept of value-based healthcare appears to be spreading in Germany, physicians and analysts argue that the raft of healthcare reforms over the past couple of decades has provided the wrong incentives and failed to tackle the main problems facing the system, namely rising prices, uneven quality and a scarcity of specialised, high-volume centres for treating priority conditions such as chronic diseases.

"We've talked about healthcare costs for the past 40 years, and we're starting to talk about quality, but we won't solve it in the next five years," says Dr Guth.

Rising demands on the health system and budget constraints mean that policymakers will continue to look for ways to cut costs, and these pressures have the potential to influence the incentives built into the health system. However, there is continued reluctance in Germany to discuss the threshold for demonstrating cost-effectiveness and express the value of human health in monetary terms, reflected in the adoption of the efficiency frontier approach. The German system is still clearly in the process of being adapted to the new methodology, which has been in place for a much shorter period of time than the cost-effectiveness approaches in the UK, for example.

A number of possible strategies could help to alleviate the cost burden while still focusing on health outcomes. Pay for performance is one such example; giving the regions greater power to take charge of healthcare policy is another. The example of the Martini-Klinik shows how better data collection focused on the patient experience can improve results. By adopting such measures, the German system can move towards meaningful ways of measuring the value of the healthcare it provides.

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