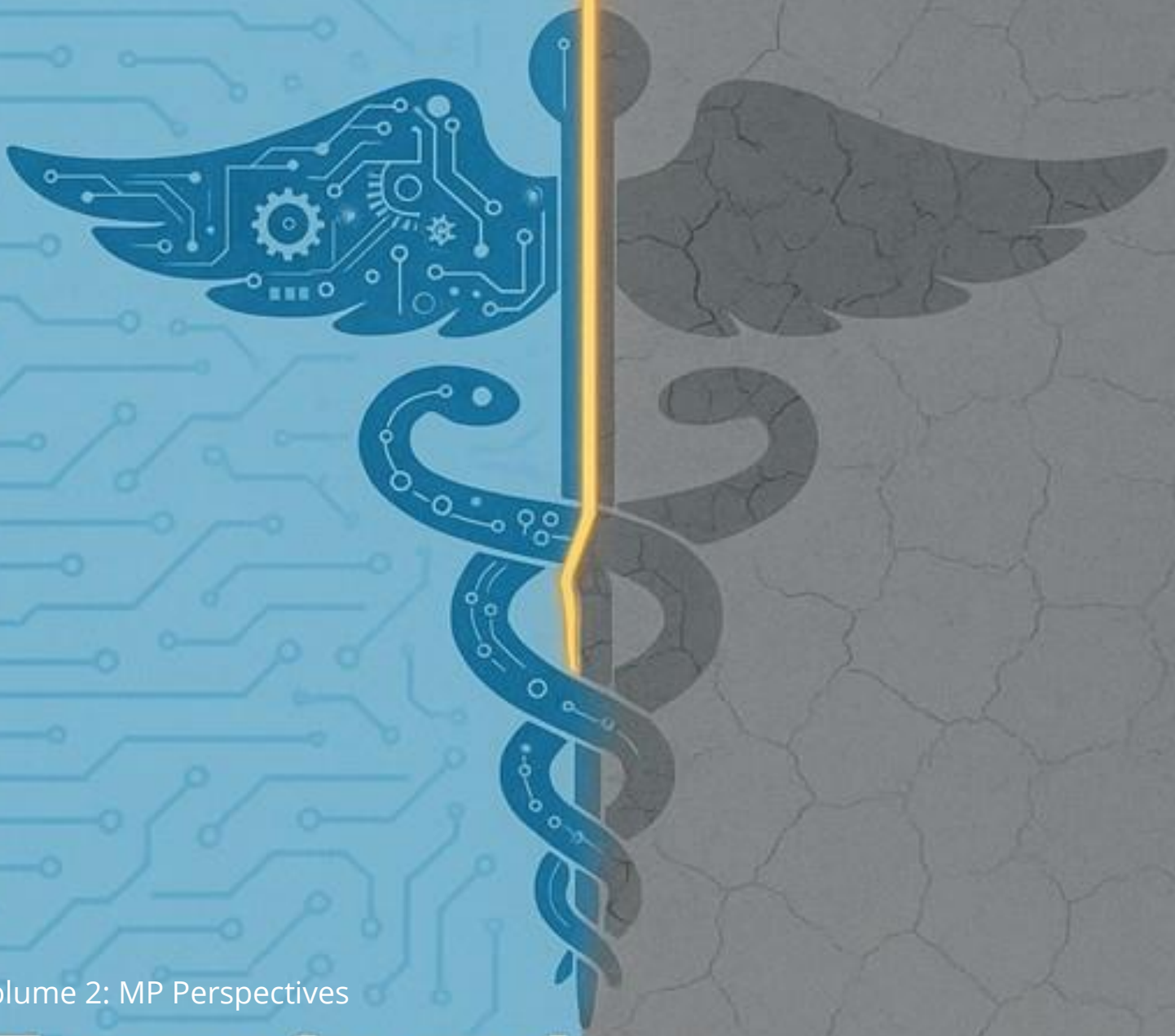
MANAGEMENT PARTNERS



Volume 2: MP Perspectives

Transforming Healthcare Delivery in the Gulf

Can Outsourcing Unlock Value-Based Excellence?

May 2025

Abstract

Gulf countries face rising chronic diseases, budget pressures, and bold national health goals that demand new approaches to healthcare delivery. This document redefines outsourcing from a cost-cutting tool into a strategic driver of value-based, patient-centered healthcare transformation.

Combining global best practices with the Gulf's unique context, it outlines how outcome-driven contracts, risk-sharing, integrated care models, and digital health ecosystems can build resilient, efficient, and equitable systems. Policymakers, providers, payers, technology innovators, and communities must collaborate to co-create a future-ready healthcare landscape.

This thought leadership piece offers a clear, practical roadmap to unlock outsourcing's full potential and position the Gulf as a pioneer in healthcare innovation. The time for bold leadership and collective action is now.

About MP Perspectives

This is Vol. 2 of the MP Perspective Series, focusing on the strategic transformation of healthcare outsourcing in the Gulf—redefining it as a key lever for value-based, patient-centered, and future-ready healthcare systems.

The MP Perspective Series curates insights from conversations with leading thinkers across Management Partners and MP-Connect's expert network. Rooted in real-world experience and strategic dialogue, the series explores the most pressing themes in economic development, corporate and public strategy, and business and technology transformation. From reimagining institutional roles in rapidly shifting economies to unlocking value through digital innovation and AI, each edition connects the dots between macro trends and actionable insights.

Designed for decision-makers and forward-thinkers, the MP Perspective Series provokes new ideas, challenges assumptions, and illuminates pathways toward more resilient and future-ready organizations.

About the Expert

Ahmed Al-Haidary is a Partner at Management Partners with over 20 years of experience driving strategic transformation across the MENA region, with a growing specialization in healthcare systems innovation. As head of the Financial Services Practice and co-lead of the Public Sector Practice, Ahmed leverages his deep expertise in financial leadership, project management, and digital transformation to help governments and healthcare organizations redesign care delivery models that are patient-centered, outcomes-driven, and financially sustainable.

Ahmed's work spans advising Gulf governments and key stakeholders on modernizing healthcare financing, embedding risk-sharing and value-based contracting, and deploying digital health ecosystems to enhance operational efficiency and equity. He brings a unique blend of public sector experience, financial acumen, and technology insight to guide multi-stakeholder collaborations essential for healthcare reform. Certified as a CFA charter holder, FRM licensed professional, and PMP, Ahmed combines rigorous analytical skills with practical innovation to support Gulf health systems confronting chronic disease burdens and ambitious national health goals.

Executive Summary

Healthcare systems across the Gulf region are under pressure. Aging populations, surging chronic diseases like obesity and diabetes, and the rising costs of medical infrastructure are testing the limits of traditional care models. Meanwhile, the ambitions outlined in national strategies—from Vision 2030 to Health Strategy 2050—call for healthcare that is not only universal and efficient, but also **patient-centric, outcomes-driven, and financially sustainable**.

In this context, **outsourcing emerges not as a cost-cutting measure, but as a lever for structural reform and value creation**.

Globally, healthcare outsourcing is undergoing a fundamental pivot—from isolated service delivery to **integrated partnerships focused on long-term impact**. Leading health systems are now using outsourcing to embed prevention, standardize care protocols, drive innovation through digital technologies, and enable multidisciplinary collaboration across the continuum of care. These models demonstrate that with the right governance, outsourcing can **enhance—not dilute—clinical quality, accountability, and equity**.

For the Gulf region, this shift is not theoretical—it is imperative. As governments diversify their economies and confront public health crises head-on, they must transition from fragmented, treatment-centric models toward **resilient ecosystems that reward prevention, personalize care, and track success based on health outcomes rather than activity volume**.

This transformation requires rethinking how outsourcing is structured and who it serves. It means:

- **Redesigning contracts** to reward long-term outcomes and penalize avoidable failures;
- **Embedding risk-sharing models** that align providers, payers, and regulators around common goals;
- **Organizing care delivery around conditions and patients**, not departments and processes;
- **Deploying digital platforms and AI-driven analytics** to enable real-time decision-making, patient engagement, and performance monitoring;
- **Cultivating a new class of outsourcing partners** who are technologically fluent, clinically collaborative, and culturally attuned;
- And most importantly, **building inclusive governance models** that empower patients and communities to shape the healthcare systems that serve them.

Success will require coordinated action across government agencies, healthcare providers, payers, digital innovators, and civil society. Each actor has a distinct role to play—but only by working in concert can they co-create a future-proof system capable of delivering health, equity, and economic value at scale.

The opportunity is clear, the stakes are high, and the tools are within reach.

What remains is bold leadership—and the courage to reimagine what healthcare in the Gulf can become. In the pages that follow, we explore the strategic pathways, operational blueprints, and ecosystem designs that can turn that vision into reality.

Dive deeper, and discover how outsourcing—when redefined with purpose—can unlock the next frontier of healthcare transformation in the Gulf.

Contents

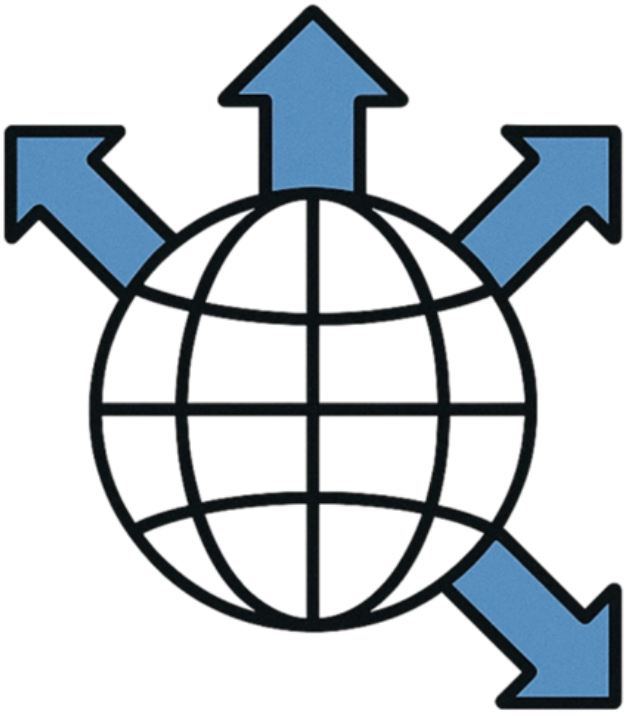
Chapter 1: The Global Pivot — From Cost Cutting to Value Partnerships

1.1 The Decline of Transactional Outsourcing Models

For decades, healthcare outsourcing—especially in developing and transitional markets—has been predominantly viewed through a narrow operational lens: a tool for lowering costs, optimizing back-office functions, or addressing staff shortages. This cost-first mindset, while initially effective for short-term fiscal relief, is now cracking under the pressure of rising chronic disease burdens, demographic shifts, and public dissatisfaction with fragmented, impersonal care.

Across global healthcare systems, a strategic shift is taking root. Outsourcing is being repurposed—not merely to cut costs, but to drive **value creation** across entire healthcare ecosystems. Under this reimagined model, outsourcing arrangements are designed not only to deliver services more efficiently, but to ensure **measurable improvements in patient outcomes, clinical quality, and system-wide performance.**

This evolution is largely driven by the global rise of **Value-Based Healthcare (VBHC)**—a framework that defines healthcare value as the health outcomes achieved per unit of cost. Under VBHC principles, outsourcing is no longer an adjunct; it becomes a structural enabler of transformation, capable of embedding accountability, fostering innovation, and realigning incentives toward long-term health impact.



> *"There is a big concern right now... outsourcing reduces cost but at the expense of worsening patient outcomes. That dilemma is now driving the rise of value-based care, which is reshaping the future of healthcare markets globally."*
>
> — Ahmed Al-Haidary

This dilemma is especially visible in fragmented systems where outsourced providers operate in silos, without alignment to national health goals or feedback mechanisms. When cost becomes the only driver, quality deteriorates. But when **outcome-based contracting, shared risk models,** and **technology integration** become foundational, outsourcing becomes a **partner in transformation**—not a substitute for it.

1.2 Global Trends Reshaping Healthcare Outsourcing

Globally, multiple converging trends are reshaping the healthcare outsourcing landscape and accelerating this pivot to value.

Rise of Digital Health and Automation

Technologies such as Artificial Intelligence (AI), robotic process automation (RPA), and telehealth are expanding what can be outsourced, while simultaneously demanding new standards of **accountability and data integration**. Outsourcing is no longer limited to logistics or billing; today, remote diagnostics, AI-supported triage, and virtual care pathways are being handled by third-party providers—often with **greater accuracy and reach** than traditional models.

> *"Digitalization, telehealth, and AI are significantly impacting the outsourcing landscape... these technologies enable scalability and precision, but they must be matched with patient outcome priorities."*
> — Ahmed Al-Haidary

However, digitization alone is not sufficient. Without embedded metrics, standardized care protocols, and seamless information flows, the proliferation of technology can exacerbate fragmentation rather than resolve it. Hence, forward-thinking outsourcing models are increasingly **bundled with data governance structures**, ensuring interoperability and outcome tracking.

Chronic Disease Management and Prevention as Core Functions

Countries across Europe and the Global South are experimenting with **outsourced disease management ecosystems**—especially for chronic conditions like diabetes, hypertension, and obesity. These are not narrow clinical interventions but comprehensive, **lifecycle-focused arrangements** involving prevention, treatment, behavioral health, and patient education—executed by specialized providers under performance-based contracts.

The **Diabeter network in the Netherlands**, for instance, represents a pioneering model where outsourced nonprofit clinics deliver person-centric care, demonstrating measurable improvements in glycemic control and reduced complications. This arrangement emphasizes not just clinical excellence, but **longitudinal tracking and prevention integration**—a leap beyond traditional episodic care.

> *"The Netherlands' Diabetes Network integrated person-centric care into outsourcing. It demonstrated measurable improvement in glycemic control and prevention outcomes."*
> — Ahmed Al-Haidary

These examples demonstrate the growing global recognition that prevention and personalization are not optional add-ons; they are central to healthcare resilience and long-term cost control.

1.3 Outsourcing as a Pillar of System Resilience

Value-based outsourcing is also proving essential in building health system resilience—the capacity to withstand shocks, scale services, and maintain continuity under crisis conditions.

The COVID-19 pandemic exposed critical gaps in many national healthcare systems, particularly in resource availability, data infrastructure, and surge capacity. In response, countries began outsourcing not just operations, but whole domains of care delivery—from vaccination programs to mental health support. In doing so, they relied on hybrid public-private networks, orchestrated around outcomes rather than ownership.

Notably, Germany's Martini Klinik for prostate cancer exemplifies this integrated approach. Instead of focusing solely on procedural throughput, the clinic organizes its care model around long-term, patient-reported outcomes—including at-home follow-ups and quality-of-life indicators. This outsourced specialty care model delivers higher consistency, lower recurrence, and greater patient satisfaction than comparable systems that emphasize throughput over outcomes.

> *"The Martini Clinic in Germany is a great example. They didn't stop at treatment—they focused on patient-reported outcomes and long-term quality of life, including home-based follow-ups."*
>
> — Ahmed Al-Haidary

These innovations reflect a broader truth: outsourcing is no longer a transactional contract—it is a co-managed platform for health impact. Future-ready systems do not treat outsourced providers as external entities, but as accountable nodes in an interconnected, outcomes-driven care network.

1.4 Strategic Implications for the GCC

For the Gulf region, which sits at the intersection of population growth, economic diversification, and healthcare reform, these global trends offer powerful strategic lessons.

Historically, outsourcing in the GCC has followed a **traditional procurement logic**—used to alleviate capacity shortages or improve non-core efficiency. But as GCC nations seek to implement the ambitions of **Vision 2030 (Saudi Arabia), UAE Healthcare Vision 2050**, and related reform agendas, outsourcing must be **reframed as a system design tool**.

Instead of merely offloading services, GCC governments can use outsourcing to:

- Embed **standardized care protocols** and reduce variation across providers.
- Accelerate **digital adoption** through tech-enabled partners.
- Create **accountability through outcome-based SLAs** and real-time data tracking.
- Enable **scalable disease prevention programs** through wellness operators and chronic care specialists.

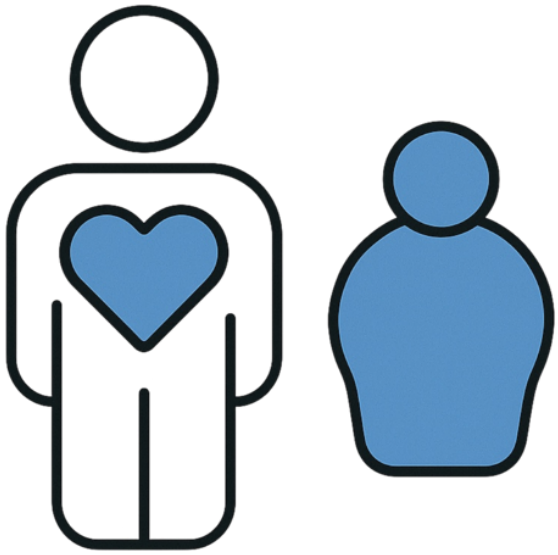
> *"Strategic outsourcing is a combination of scalability, quality, and sustainability. This formula must be foundational to evaluating outsourcing dynamics in the Gulf."*
>
> — Ahmed Al-Haidary

The strategic question is no longer "What can we outsource?" but rather: **"How can outsourcing be orchestrated to deliver patient-centered outcomes, population health goals, and future system resilience?"**

This reframing opens a pathway for the GCC to **lead globally** in redefining outsourcing as a platform for systemic transformation.

Chapter 2: The Gulf Inflection Point — Scaling Healthcare Amid Chronic Disease and Reform Pressures

2.1 A Region Under Pressure: Lifestyle Epidemics and Economic Imperatives



The Gulf Cooperation Council (GCC) region finds itself at a pivotal moment. While significant strides have been made in infrastructure development, medical workforce expansion, and digital health initiatives, the healthcare systems across these nations are increasingly strained under the dual weight of **chronic disease escalation** and **economic diversification mandates**.

As the Exhibit 1 starkly illustrates for the UAE, obesity rates are projected to exceed 80% of the population by 2050 while Saudi Arabia (KSA) exceeds 70%, both far outpacing global averages and diverging significantly from trends in the USA and Western Europe. The future health of the UAE and Saudi Arabia faces a critical challenge, with this projected obesity prevalence driving a corresponding rise in cancer incidence. These trends not only threaten individual health outcomes, but also place a substantial burden on national productivity and public expenditure.

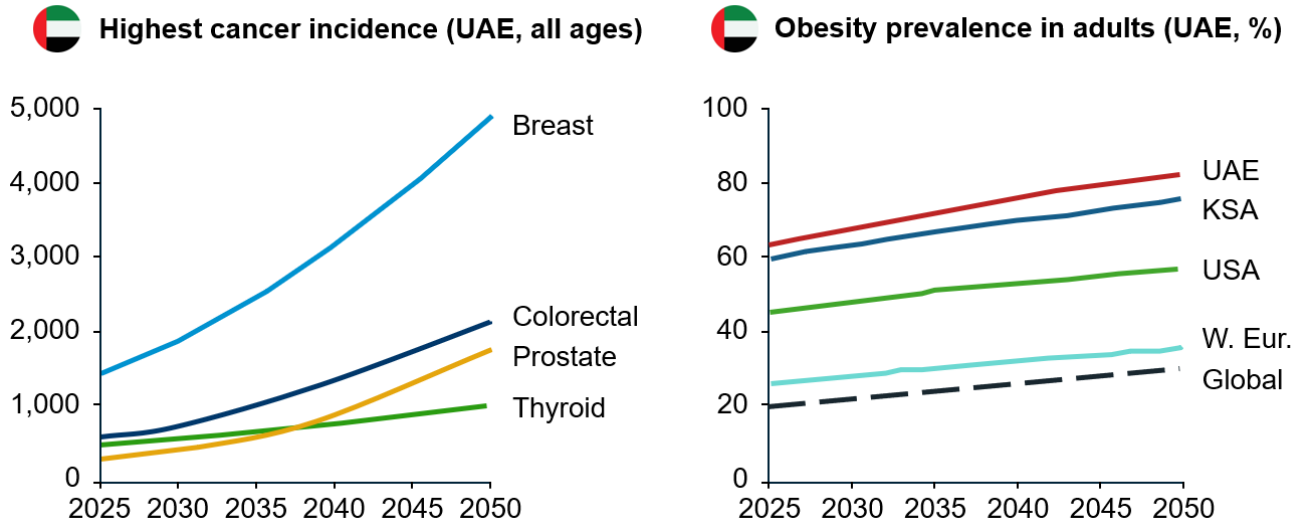


Exhibit 1: Projected obesity rates for the UAE and corresponding rise in cancer incidences[1]

Meanwhile, the GCC's ambitious transformation programs—**Saudi Vision 2030, UAE Healthcare Vision 2050**, and comparable frameworks in Bahrain, Oman, Kuwait, and Qatar—are pushing governments to rethink their healthcare delivery models. As oil revenues plateau and public sector budgets are rationalized, the pressure to deliver **more care, to more people, with better outcomes—using fewer resources—has become a strategic imperative.**

> *"Strategic outsourcing is a combination of scalability, quality, and sustainability. This formula must be foundational to evaluating outsourcing dynamics in the Gulf."*
>
> — Ahmed Al-Haidary

Against this backdrop, outsourcing emerges not just as an administrative option, but as a strategic lever to achieve scale, standardization, and sustainability in healthcare systems. Yet to unlock its true value, outsourcing must be re-engineered to do more than fill service gaps—it must become a vehicle for prevention, personalization, and performance.

2.2 From Episodic Treatment to Longitudinal Prevention

The GCC's current healthcare orientation remains largely treatment-centric—focused on managing acute episodes of care within hospital or clinical settings. This model, however, is increasingly ill-suited for the region's health challenges, which are **chronic, behavioral, and generational** in nature.

Obesity, for instance, cannot be addressed through isolated interventions or surgical procedures. It demands a comprehensive sustained lifestyle modification. This is where a paradigm shift in outsourcing logic is urgently needed procedures approach—starting with education, behavioral incentives, early risk identification, and. It demands a comprehensive approach—starting with education, behavioral incentives, early risk identification, and sustained lifestyle modification. This is where a **paradigm shift in outsourcing logic** is urgently needed.

> *"Treatment must feed into prevention. The story doesn't end at the hospital discharge—it starts there."*
>
> — Ahmed Al-Haidary

In leading systems, we now see the outsourcing of **entire disease pathways**—from primary prevention to post-treatment wellness. Chronic conditions such as diabetes, hypertension, and obesity are being managed by specialized third-party operators who are contracted not just for throughput, but for **longitudinal outcome improvements**.

This shift demands that outsourcing be aligned with new performance indicators: prevention rates, recurrence reduction, patient satisfaction, and long-term quality of life. Moreover, **technology integration becomes vital**—especially in areas like predictive analytics, wearable health monitoring, AI-based risk scoring, and digital coaching platforms.

The GCC's young, tech-savvy population presents an opportunity to **leapfrog legacy models** by embracing digital-first, outcomes-based outsourcing in wellness and preventive care.

2.3 Navigating Reform: Embedding Outsourcing in National Strategies

To scale health services effectively amid these pressures, GCC nations must position outsourcing as an **integrated pillar within their broader health reform agendas**.

Each Vision document in the region calls for expanding access, improving quality, and enhancing sustainability—objectives that **strategic outsourcing can operationalize if embedded properly**.

This requires a fundamental redefinition of outsourcing policy—one that links vendor selection and performance not only to input metrics (cost, coverage, timeliness), but to **impact indicators** (disease reduction, behavioral change, and social return on investment).

It also requires government agencies and regulators to **elevate their governance capabilities**. Rather than merely administering contracts, they must design ecosystems—complete with **data interoperability standards, accreditation frameworks, and outcome-linked SLAs**—that create the conditions for outsourced providers to deliver system-level value.

A parallel evolution is needed in the **public-private partnership (PPP)** model itself. Traditionally limited to infrastructure and service management, future PPPs must be **co-architected around shared health outcomes** and prevention milestones.

2.4 Harmonizing Standardization and Personalization

One of the perceived tensions in value-based outsourcing is between **standardization** (ensuring consistent care quality) and **personalization** (responding to individual patient needs). In reality, the two are not mutually exclusive—they are complementary when framed correctly.

Standardization provides the structural backbone: clinical protocols, treatment pathways, and metrics that reduce variability and improve reliability. Personalization adds the adaptive layer: tools like **Patient-Reported Outcome Measures (PROMs)** and **Patient-Reported Experience Measures (PREMs)** that capture what matters most to patients—recovery time, mobility, quality of life, and overall satisfaction.

> *"We need to rethink the model—not how many patients we treat, but how well we've treated them. Metrics like follow-up frequency and recovery quality are the new KPIs."*
>
> — Ahmed Al-Haidary

To operationalize both, outsourcing contracts must be designed to reward not just efficiency, but **care fidelity and person-centricity**. Incentives can be tied to both adherence to standardized pathways and improvements in patient-reported outcomes, creating a dual loop that enforces quality while fostering innovation.

Importantly, this balance enables scalability. By establishing **shared data platforms**, care quality dashboards, and AI-assisted personalization engines, governments and providers can achieve **mass customization**—a model that serves millions without sacrificing individual dignity or outcome accountability.

2.5 A New Generation of Outsourcing Partners

To meet these demands, a new class of outsourcing providers is emerging—entities that combine operational expertise with clinical insight, digital fluency, and prevention-oriented thinking. These are not traditional facilities management firms or call center operators; they are **strategic health partners** who offer bundled capabilities across patient engagement, digital therapeutics, behavioral change interventions, and longitudinal analytics.

The Gulf has a unique opportunity to **cultivate and scale this new vendor class**—through proactive policy support, ecosystem convening, and investment in health innovation clusters. Governments can act as market shapers, creating the regulatory clarity, procurement frameworks, and incentive structures that attract world-class operators and encourage local capacity development.

At the same time, **localization and cultural adaptation** are crucial. Outsourcing models that succeed in Germany or the Netherlands cannot be copy-pasted into Riyadh or Abu Dhabi. Religious norms, family structures, and social trust dynamics must be factored into the service design—especially in sensitive areas like mental health, end-of-life care, or adolescent wellness.

Chapter 3: From Service Provision to System Redesign — Reimagining Outsourcing for Value-Based Healthcare

3.1 The Evolution Imperative: Beyond Service Efficiency

As outsourcing in the Gulf healthcare sector matures, a clear inflection is taking shape—**one that moves the conversation from services rendered to systems reimagined**. Historically, outsourcing engagements have been judged by their ability to deliver on discrete, well-defined outputs: lab tests conducted, calls answered, or beds cleaned. But such transactional metrics fall dramatically short in a world where **the quality of care, continuity of experience, and health outcomes** define value.

The GCC's healthcare transformation goals—rooted in Vision 2030 and aligned public health strategies—demand a **deeper structural shift**: outsourcing must enable providers to function not as standalone service agents, but as embedded co-architects of value-based, integrated care systems.

This requires redesigning how care is delivered, tracked, and financed—not just what is delivered. It's a **paradigm shift** from cost-saving procurement to **strategic system design**.

> *"Outsourcing to providers who operate under a VBHC model can enhance—not dilute—quality while achieving financial efficiency. It's all about outcomes achieved per cost."*
>
> — Ahmed Al-Haidary

This reframing positions outsourcing as an accelerator of system resilience, a vessel for care integration, and a catalyst for patient empowerment.

3.2 Value-Based Healthcare as a Design Principle

At the core of this redesign lies the philosophy of **Value-Based Healthcare (VBHC)**—a model that defines success not by volume, but by value: **the outcomes that matter most to patients, divided by the cost to achieve them**.

In traditional fee-for-service models, providers are reimbursed based on activity—tests run, consultations made, medications prescribed. In contrast, VBHC demands a realignment of incentives, placing emphasis on:

- Health outcomes (e.g., remission rates, quality of life, functional mobility),
- Patient experience (e.g., timeliness, dignity, cultural sensitivity),
- System efficiency (e.g., cost per outcome, avoided hospitalizations).

This approach does not simply apply to hospitals—it permeates **all facets of the care continuum**, from diagnostics to mental health support, from remote monitoring to post-acute rehabilitation.

Critical to implementing this philosophy are innovative payment models like value-based contracts (VBCs), which fundamentally realign incentives across stakeholders. As detailed in the adjacent Exhibit 2, these risk-sharing agreements directly link reimbursement and coverage to a treatment's real-world performance. This creates powerful alignment between payers and biopharmaceutical innovators while delivering tangible benefits: Payers gain firsthand product experience and reduced financial risk, innovators demonstrate therapeutic effectiveness in real-world settings, and patients benefit from enhanced access to novel medications—particularly niche treatments with limited initial data.

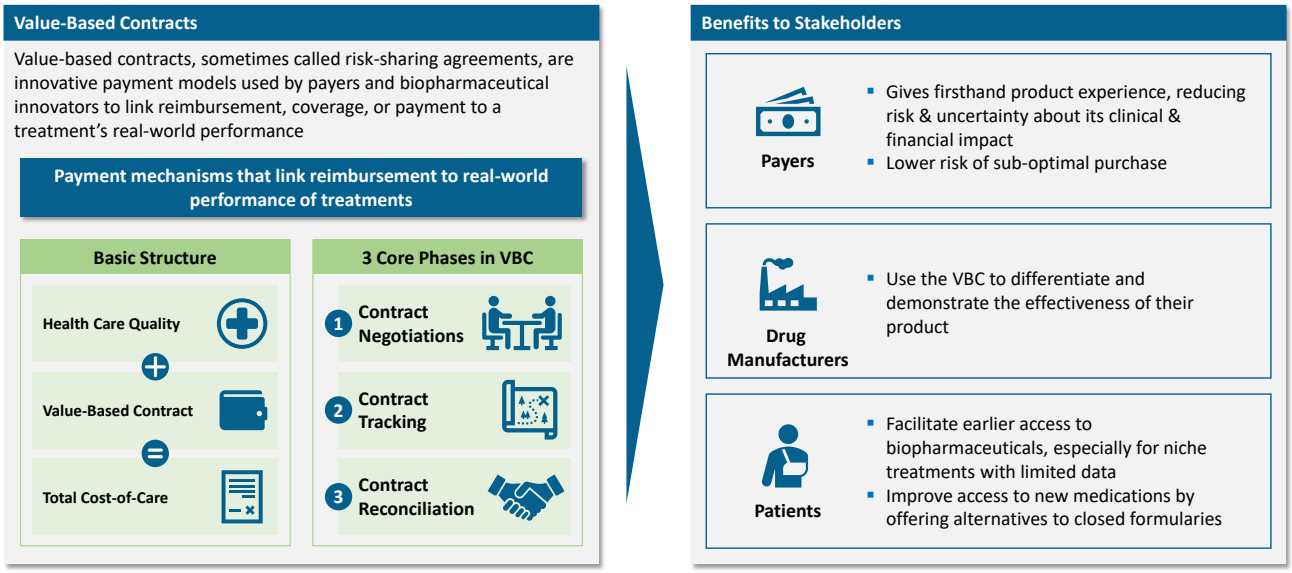


Exhibit 2: Aligning coverage with real-world outcomes trough value based contracts (own illustration)[2]

When outsourcing models are anchored in VBHC principles, they inherently encourage:

- **Preventive interventions** over reactive treatment,
- **Multidisciplinary team care** over siloed specializations,
- **Feedback loops** over one-time engagements.

Such reimagined outsourcing requires providers to take accountability not only for service delivery, but also for **longitudinal patient journeys and clinical outcomes**.

3.3 From Departments to Integrated Practice Units

Traditional hospital structures often mirror industrial-age logic—departments organized by function (cardiology, radiology, surgery), with limited coordination across units. But VBHC advocates for a new unit of organization: the **Integrated Practice Unit (IPU)**. These are care teams organized around specific medical conditions, responsible for the **full cycle of care**, including prevention, diagnosis, treatment, rehabilitation, and follow-up.

> *"Integrated Practice Units are key—care organized around conditions, not departments. With multidisciplinary teams and standardized pathways, we can track and benchmark outcomes effectively."*
>
> — Ahmed Al-Haidary

This design yields multiple advantages for outsourced care:

- **Continuity**: Patients are supported by the same team throughout their journey.
- **Clarity**: Each unit has clear goals, metrics, and ownership.
- **Coordination**: Data sharing and decision-making are integrated by default.
- **Customization**: Protocols can be tailored to patient segments while maintaining consistency in outcome measurement.

For Gulf countries, the IPU model—delivered through outsourced operators—offers a scalable and adaptable framework to manage chronic diseases, surgical care, mental health services, and wellness programs under a **single quality and outcome mandate**.

3.4 Embedding the Patient Voice: PROMs and PREMs

One of the defining elements of VBHC-enabled outsourcing is the incorporation of the **patient voice**—not as an anecdote, but as **quantifiable, contract-linked data**. This is achieved through:

- **Patient-Reported Outcome Measures (PROMs):** capturing how patients feel about their health status, functionality, and progress.
- **Patient-Reported Experience Measures (PREMs):** capturing their perception of care processes—communication, respect, responsiveness.

Together, these tools help reconcile the tension between **standardization and personalization**. While standard care pathways ensure consistency and efficiency, PROMs and PREMs surface the nuances of each individual's journey, offering insights into what works—and what doesn't.

> *"Payment must be tied to patient-reported outcomes—tools like PROMs and PREMs are essential to capture real value. In the GCC, this is a paradigm shift."*
>
> — Ahmed Al-Haidary

Implementing this shift requires investment in digital platforms, patient engagement strategies, and new reimbursement protocols. But the payoff is profound: providers are rewarded not for simply doing more, but for delivering **what matters more**.

3.5 Aligning Incentives Through Risk Sharing

A VBHC-aligned outsourcing model cannot succeed without a fundamental shift in how risk and reward are distributed.

Traditional contracts shield vendors from clinical risk: if a patient relapses, the payer absorbs the cost. In value-based arrangements, **risk-sharing mechanisms** ensure that providers are financially accountable for poor outcomes—and rewarded for exceptional performance.

Contracts must be structured around **shared targets**: reduction in re-admission rates, improved functional outcomes, or patient satisfaction benchmarks. Providers who meet or exceed these benchmarks receive bonus payments or extended contracts; those who underperform face penalties or renegotiation.

> *"Shift from pay-for-service to pay-for-outcome. Embed risk-sharing between providers and payers, and use SLAs to institutionalize performance-based accountability."*
>
> — Ahmed Al-Haidary

This incentivizes strategic thinking and continuous improvement. Providers invest in:

- **Proactive care management** to avoid complications,
- **Data systems** for outcome tracking and risk stratification,
- **Training and capacity building** for multidisciplinary teams.

For the GCC, where private sector engagement is still evolving in maturity, such models must be coupled with **regulatory guardrails**, including clear SLAs, dispute resolution pathways, and standardized metrics.

3.6 Outsourcing Beyond Hospitals: Building Health Ecosystems

A truly reimagined outsourcing model recognizes that value is created not just in hospitals, but across a **distributed health ecosystem**. This includes:

- **Schools and workplaces as platforms for preventive care,**
- **Home and community settings for chronic disease management,**
- **Digital interfaces (apps, wearables, telemedicine) as entry points for continuous engagement**.

In this context, outsourcing providers can deliver value by orchestrating cross-setting interventions—for example, managing a diabetes program that includes:

- School-based dietary education,
- At-home glucose monitoring,
- Clinic-based endocrinology consultations,
- Mobile-app-based coaching and peer support.

Such models require new levels of **interoperability, logistics coordination, and data governance**. But they also offer profound benefits: **decentralized access, reduced cost, and greater patient empowerment**.

Chapter 4: Building the Engine — Contracts, Risk Sharing, and RCM Models

4.1 The Operational Core of Transformation

Even the most visionary strategies are only as effective as their operational scaffolding. For outsourcing to serve as a true engine of value-based healthcare in the Gulf, it must be anchored in **robust contracting models, performance-linked incentives, and data-driven execution platforms**.

In too many settings, outsourcing still operates within outdated transactional frameworks: fee-for-service contracts with ambiguous KPIs, minimal oversight mechanisms, and limited integration with the broader health ecosystem. These legacy models are fundamentally incompatible with a value-based vision—one that hinges on outcomes, accountability, and sustained impact.

To support this evolution, the mechanics of outsourcing must be **reengineered around performance and prevention**. This means aligning contract design, payment structures, digital infrastructure, and compliance protocols to prioritize what truly matters: **better health, at better value**.

> *"Providers must share the risk of treatment success. That's when we move from service providers to partners in care."*
>
> *— Ahmed Al-Haidary*

4.2 Designing Outcome-Oriented Contracts

The shift from volume to value begins with how contracts are written. Traditional models often focus on **inputs** (hours worked, services delivered) or **outputs** (visits conducted, tests performed). In a value-based framework, contracts are instead linked to **impact indicators**—such as:

- Reduction in re-admissions,
- Improvements in patient-reported outcomes (PROMs),
- Adherence to evidence-based care pathways,
- Population-level prevention milestones (e.g., reduction in childhood obesity rates).

To achieve this, governments and health authorities must adopt a new class of **performance-based contracts**. These may include:

- **Bundled payments:** single payments covering the full episode of care across providers.
- **Capitation with quality bonuses:** fixed payments per patient, adjusted for performance.
- **Gain-sharing arrangements:** sharing of cost savings achieved through superior outcomes.

- **Withholds and penalties:** partial payment retention until key quality thresholds are met.
- **Pay-for-performance:** incentives for meeting benchmarks (patient-focused but administratively complex).
- **ACOs/shared savings:** provider groups assuming payment risks (improves coordination but limits patient choice).

Such models create mutual incentives: providers are rewarded for proactive, coordinated care and penalized for unnecessary interventions or preventable complications.

> *"Shift from pay-for-service to pay-for-outcome. Embed risk-sharing between providers and payers, and use SLAs to institutionalize performance-based accountability."*
>
> — Ahmed Al-Haidary

The in Exhibit 3 detailed comparison underscores that each model carries unique advantages and disadvantages—from administrative burdens and implementation challenges to varying risk distributions and patient choice implications. This makes contract selection critically dependent on a country's specific circumstances, risk tolerance, and population health priorities

		Pros	Cons
Pay-for-performance	They give financial incentives to hospitals, physicians, medical groups, and other healthcare providers for meeting certain performance benchmarks. They also penalize healthcare providers for medical errors, poor outcomes, and increased costs.	▪ Limited financial risk for payers ▪ Patient-focused care quality ▪ Enables healthcare providers to prioritize patient needs ▪ Compatible with existing payment methods	▪ Increased administrative complexities ▪ Potential compromise on quality commitment/ cherry picking ▪ Emphasis on clinical process measures ▪ Limited consideration for challenges in specific patient populations
Bundled Payments	Under this arrangement, providers receive a single, fixed payment for all services related to a specific treatment or condition over a defined period	▪ Low risk for providers ▪ Reduced healthcare costs for payers ▪ Encourages prudent care for both payers and patients ▪ Incentivizes prevention of readmissions and complications	▪ Complexities in defining chronic care episodes ▪ Opportunities for gaming the system by payers ▪ Implementation hurdles ▪ Risk of avoiding necessary specialty care ▪ Vulnerable hospitals may miss out on shared savings
Accountable Care Organizations (ACOs)/shared savings	They involve provider groups accepting payment risks for their assigned populations. In return, they receive the chance to share savings when costs fall below an adjusted benchmark	▪ Relatively high risks for providers ▪ Higher quality, coordinated care that reduces Medicare spending and improves patient health outcomes ▪ Improved focus on the patient	▪ Patients can't opt out without changing doctors ▪ Lack of privacy — everyone in a patient's ACO has access to their personal medical data ▪ No guarantee of better care ▪ Limited participation from providers serving marginalized populations
Capitation and Population-Based	Providers assume financial responsibility for the well-being & health of a given patient population. Under this contracts, members pay an annual premium, which a provider uses to care for the population	▪ Promotes reduction of unnecessary, costly medical services ▪ Predictable costs for payers and steady monthly income for providers ▪ Facilitates adoption of non-compensated services like telemedicine	▪ Highest financial risk among VBCs for providers ▪ May limit patient choices ▪ Incentive for practices to favor healthier, more profitable patients ▪ Possibility of reduced face time with doctors

Exhibit 3: Weighing the Pros and Cons of Value-Based Contracting (own illustration)[3]

However, as emphasized in the figure's conclusion, contracts must remain flexible. They should allow for dynamic renegotiation in light of new clinical evidence, regulatory shifts, or unforeseen public health events—as seen during the COVID-19 pandemic.

4.3 Institutionalizing Risk-Sharing Models

A key hallmark of a mature value-based outsourcing ecosystem is the presence of **codified risk-sharing arrangements** between payers, providers, and regulators. These arrangements create alignment across all stakeholders and help ensure that financial incentives reinforce—not undermine—clinical goals.

In the Gulf context, risk-sharing can be operationalized through:

- **Tiered outcome thresholds:** Providers receive payments based on performance bands (e.g., 90%+ target = full payment; 75–89% = reduced payment).
- **Stop-loss clauses:** Shared financial liability when costs exceed a certain threshold due to quality failure or non-compliance.
- **Clinical guarantees:** Providers commit to repeat or corrective care at no additional cost in cases of substandard outcomes**.**
- **Insurance integration:** Insurers co-develop KPIs and absorb a portion of clinical risk to drive smarter care utilization.

These mechanisms must be embedded within **service-level agreements (SLAs)** that outline:

- Clear definitions of success,
- Real-time reporting requirements,
- Remedies for underperformance,
- Dispute resolution pathways.

Such SLAs do more than enforce compliance—they **create a framework for continuous improvement and trust** between partners.

4.4 Redesigning Revenue Cycle Management (RCM) for Value

Value-based care requires a rethinking of not just what we pay for, but how we **track, verify, and manage payment processes**. This is the domain of **Revenue Cycle Management (RCM)**—an often-overlooked but critical infrastructure component.

Traditional RCM systems are geared toward **billing and collections**, focusing on transactional throughput. In a value-based system, RCM platforms must evolve to enable:

- **Outcome tracking:** Integration of clinical KPIs, PROMs, and quality metrics into billing workflows.
- **Real-time decision support:** Automated alerts for care gaps, non-compliance, or cost anomalies.
- **Claims adjudication based on value:** Payouts linked to evidence of outcome achievement.
- **Payer-provider-regulator integration:** Seamless data sharing between all ecosystem actors.

RCM must also become a vehicle for **data-driven resource allocation**. For example, if analytics reveal high post-operative complications for a particular procedure, funds can be reallocated toward prevention, retraining, or protocol revision.

In this sense, RCM is no longer a back-office tool; it becomes a **strategic lever for continuous system optimization**.

4.5 Embedding Digital Infrastructure and Interoperability

None of the above mechanisms can function without a **robust digital foundation**. For outsourcing to deliver value-based outcomes, every contract, SLA, and performance metric must be **digitally traceable, analyzable, and verifiable**.

Core digital enablers include:

- **Electronic Health Records (EHRs):** Standardized, interoperable records accessible across all care settings.
- **Clinical Decision Support Systems (CDSS):** AI-assisted tools embedded in provider workflows to guide adherence to best practices.
- **Health Information Exchanges (HIEs):** Shared platforms for cross-provider data sharing.

- **Dashboards and Benchmarking Tools:** Visualization platforms for tracking compliance, outcomes, and comparative performance.
- **Smart Contracts:** Blockchain-based systems that trigger payments automatically upon evidence-based KPI fulfillment.

> *"Data interoperability is a must...traditional independently operating providers won't succeed unless outcomes can be tracked, reported, and aligned with compensation models."*
>
> — Ahmed Al-Haidary

These digital systems also provide the basis for **regulatory oversight** and **public accountability**. With real-time data streams, health authorities can monitor systemic performance, respond to anomalies, and adjust policies based on empirical evidence.

4.6 Regulatory Maturity and Ecosystem Coordination

Finally, none of the above transformations can occur in a vacuum. They require **cohesive regulatory ecosystems** that provide clarity, consistency, and catalytic support. In the GCC, this means:

- Establishing **standardized contract templates and KPI taxonomies** for value-based outsourcing.
- Accrediting providers based on their **data capabilities, patient experience scores, and quality performance.**
- Training public officials to **design, monitor, and adapt performance-based outsourcing agreements.**
- Creating **national registries** for tracking health outcomes and benchmarking providers across the region.

Such institutional scaffolding is essential to **reduce transaction costs**, improve cross-border learning, and elevate overall system maturity.

Chapter 5: Future-Proofing Through Co-Creation — Building Resilient, Stakeholder-Aligned Ecosystems

5.1 The Limits of Transactional Thinking

Gulf healthcare systems are approaching a decisive frontier. While early waves of outsourcing delivered gains in efficiency and access, the next phase will demand much more: **resilience, adaptability, cultural alignment, and system-wide integration**. Achieving this will not come from more transactional contracts or vendor expansion alone—it will come from **co-creation**.

The future belongs to ecosystems—not entities. This means public health authorities, payers, outsourcing vendors, technology developers, academic institutions, and even patients must be aligned in a **shared architecture of care delivery and innovation**. Only by co-creating solutions—not merely procuring services—can GCC nations future-proof their healthcare systems against the demands of scale, cost control, digital disruption, and public expectation.

> *"Future-proof outsourcing equals agile, accountable, and augmented models—those that commit to outcomes, integrate with public systems, and invest in digital and clinical capacity."*
>
> — Ahmed Al-Haidary

5.2 The Co-Creation Model: From Contracting to Collaboration

Co-creation reframes the role of outsourcing from task execution to **system design participation**. In this model:

- **Governments** act as orchestrators, setting visions, standards, and incentives.

- **Providers and vendors** act as co-developers of delivery innovations and care models.
- **Insurers and payers** serve as outcome enablers through payment structuring and data sharing.
- **Technology partners** contribute platforms, analytics, and process automation tools.
- **Patients and communities** inform design with real-time feedback and behavioral insights.

This collaborative model introduces new expectations. Vendors are no longer passive executors—they are **co-accountable for system outcomes**. Governments shift from enforcing contracts to enabling ecosystems. And patients are engaged not just as recipients, but as partners in personal and population health.

5.3 Policy as a Platform: Enabling the Innovation Ecosystem

To support this transition, policy must evolve from **compliance enforcement to platform creation**. Ministries and regulatory authorities must act as:

- **Market stewards**: Shaping incentives to reward value creation over volume delivery.
- **Innovation enablers**: Funding pilot programs, sandboxes, and collaborative labs to test new care models.
- **Capability builders**: Investing in leadership development, data literacy, and procurement upskilling across institutions.
- **Data custodians**: Establishing national health registries, AI governance protocols, and data-sharing frameworks.

> *"Governments must revise incentive structures in outsourcing contracts, set up innovation hubs, and bring AI-driven healthcare to market via R&D clusters."*
>
> — Ahmed Al-Haidary

This platform approach allows for **decentralized innovation within a centralized accountability framework**. It catalyzes local entrepreneurship, accelerates localization of global best practices, and ensures interoperability across a diverse vendor ecosystem.

5.4 Strategic Capabilities of Next-Generation Vendors

The outsourcing partners of the future must build beyond operational scale—they must demonstrate **strategic, clinical, and technological fluency**. To remain relevant and impactful, vendors will need to evolve across three dimensions:

Technology

- Build **interoperable IT systems** capable of real-time data exchange.
- Invest in **AI and predictive analytics** for clinical decision support and population health forecasting.
- Deploy **automated RCM platforms** tied to outcome verification and SLA compliance.

Clinical Collaboration

- Integrate into **multidisciplinary care teams** (IPUs and beyond).
- Use **standardized protocols** while capturing PROMs and PREMs for adaptive care planning.
- Contribute to **protocol development and localization**, ensuring cultural relevance and compliance.

Operational Innovation

- Align services to **value-based contracts**, not just volume metrics.
- Manage **feedback loops** across clinical, financial, and experiential domains.
- Drive **continuous quality improvement** through embedded analytics and benchmarking.

> *"Outsourcing vendors must evolve across three fronts: IT interoperability, clinical collaboration via integrated practice units, and operational alignment with VBHC principles."*
>
> — Ahmed Al-Haidary

These capabilities distinguish vendors who deliver commodity services from those who enable transformation. As evidenced in the global examples above, vendors supporting value-based contracts actively deploy these competencies:

- Technology powers predictive analytics for outcome-linked drug pricing (UK/Australia)
- Clinical collaboration enables coordinated care in bundled episodes (U.S. BPCI)
- Operational innovation manages population risk in capitation models (U.S. managed care)

Exhibit 4 demonstrates how vendors worldwide align specific capabilities—from AI-driven cost-per-QALY calculations to multidisciplinary episode management—with contract structures that reward health outcomes over volume. This synergy between vendor competencies and value-based payment design is where true system transformation occurs.

VBC Model		Countries Used	HTA Example	VBC Contract Design	Real World Example	Contract Parties	Clinical Measures Used
Payment for Performance	Cost-effectiveness Models	UK, Australia	NICE (UK)	Sets thresholds for cost per QALY gained, determining if health benefits justify the drug's price.	Cancer drugs like pembrolizumab (Keytruda), where pricing is linked to therapeutic outcomes in the UK.	Pharma - Payer	QALYs, overall survival rates, progression-free survival
	Multi-attribute Models	France, Germany, Sweden, Spain, Italy	AMNOG (Germany)	Evaluates drugs based on multiple attributes including efficacy, cost-effectiveness, and societal benefits, with a discretionary approach to integrating these attributes.	Sovaldi (sofosbuvir) in Germany, evaluated for its high cure rates in Hepatitis C along with cost-efficiency.	Pharma - Payer	Cure rates, cost per treatment cycle, side effects
Shared Savings		U.S.	Medicare Shared Savings Program (MSSP)	Providers share in savings achieved under preset healthcare budgets if costs are kept below benchmarks without compromising care quality.	Diabetes management programs in the U.S. that reduce hospital admissions and complications.	Provider - Payer	Hospital admission rates, emergency room visit rates, HbA1c levels
Bundled Payments		U.S.	Bundled Payments for Care Improvement (BPCI)	A single payment covers all services provided during an episode of care, encouraging cost optimization and care coordination among providers.	Total knee replacements in the U.S., where all care from surgery to rehabilitation is bundled under a single price.	Provider - Payer	Post-operative recovery times, infection rates, readmission rates
Capitation and Population-Based		U.S.	Various Managed Care Organizations	Providers receive a set fee per patient to manage health, promoting preventive care and cost-effective treatment to avoid unnecessary services.	Kaiser Permanente in the U.S., using capitation for comprehensive health care services.	Provider - Payer	Patient satisfaction scores, preventive screening rates, chronic disease management effectiveness

Exhibit 4: Global success stories in value-based contracting[4]

5.5 Digital Health as the Unifying Fabric

Digital infrastructure serves as the backbone of future-proof outsourcing. As the ecosystem becomes more distributed and data-dependent, **interoperability, real-time analytics, and scalable platforms** are prerequisites for coordinated care.

GCC countries can lead by:

- Establishing **regional standards for health data exchange** and cybersecurity.
- Funding **healthtech accelerators** focused on AI diagnostics, remote monitoring, and digital therapeutics.
- Partnering with global and local firms to develop **LLM-powered education tools**, customized for regional needs.
- Embedding **patient engagement platforms** into public health infrastructure—combining telehealth, behavioral nudges, and PROM feedback loops.

> *"Large Language Models are starting to generate personalized patient education from case data. That's a huge step toward individualized care at scale."*
>
> — Ahmed Al-Haidary

In this way, technology is not just an enabler—it becomes a **medium for shared accountability and co-innovation**.

5.6 Localization and Cultural Relevance

Co-creation also demands **local intelligence and cultural adaptation**. In healthcare, trust and behavior are deeply embedded in religious norms, family structures, and societal expectations. Future-ready outsourcing models must integrate this layer—not as a footnote, but as a design principle.

This means:

- Training providers on **culturally sensitive communication and care planning,**
- Designing wellness programs that align with **religious practices and social norms**,
- Collaborating with **community leaders and influencers** to build acceptance and awareness,
- Ensuring **language, literacy, and accessibility** are embedded in digital tools.

Localization is not at odds with innovation. In fact, it is what enables **global technologies to achieve local impact**.

5.7 Building Resilience Through Distributed Accountability

Perhaps the most profound contribution of co-created outsourcing ecosystems is their ability to build **resilience**. In systems where outcomes are shared, data flows are real-time, and incentives are aligned, resilience becomes an emergent property—not an afterthought.

This resilience is visible in:

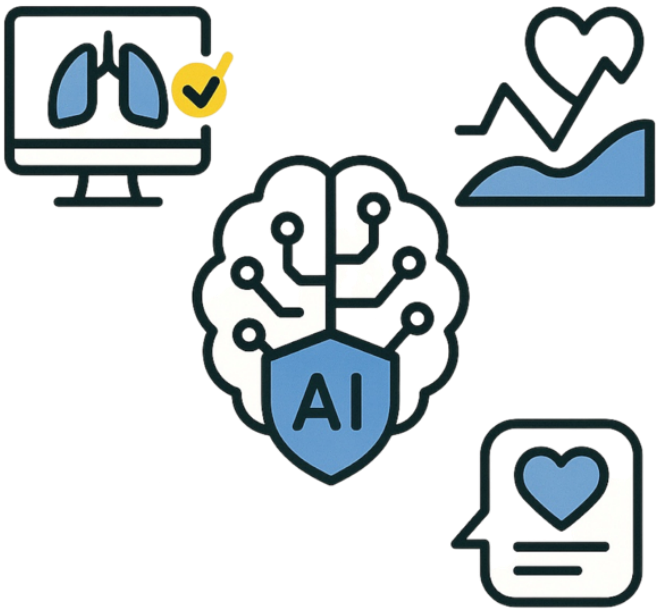
- Faster system adaptation to shocks (e.g., pandemics, policy changes),
- Greater continuity in chronic care and mental health services,
- Higher public trust through transparent performance reporting,
- Better talent retention through aligned professional incentives and shared success metrics.

These attributes are **not coincidental—they are architected**. And the architecture must begin today.

Chapter 6: Pathways Forward — Strategic Actions for the Healthcare Transformation in the Gulf

The promise of value-based, scalable, and future-proof healthcare in the Gulf hinges not only on strategic intent but on the **decisive alignment of actions across key system stakeholders**. From regulators and public authorities to private providers and technology partners, success will depend on how effectively these actors coalesce around shared goals, execute complementary roles, and remain responsive to the evolving needs of patients and populations.

Outlined below are the primary stakeholder groups whose collective actions will shape the trajectory of healthcare transformation through outsourcing. Each plays a distinct but inter-dependent role in building resilient, outcome-driven systems fit for the next generation of care.



6.1 Government Health Authorities & Policymakers

System Architects & Stewards of Long-Term Value

This group includes Ministries of Health, health regulators, and national health strategy units. Their primary mandate is to **design the foundational frameworks, regulatory scaffolds, and incentive systems** that enable a value-based transformation of care delivery. They must ensure that outsourcing aligns with national objectives of population health, economic diversification, and social wellbeing.

Strategic Actions:

- **Embed outcome-linked contracting mandates** into public outsourcing guidelines and procurement frameworks.
- **Define national KPI taxonomies** for clinical quality, patient experience, and health system performance.
- **Create innovation hubs and regulatory sandboxes** to test new outsourcing models, care pathways, and digital tools.
- **Localize global standards** to ensure cultural and societal relevance of outsourced care models.
- **Facilitate cross-border health data integration** to enable regional benchmarking and patient mobility.

6.2 Healthcare Providers & Outsourcing Vendors

Delivery Enablers & Value Creators on the Ground

This group spans public hospitals, private operators, specialized clinics, and outsourcing firms delivering clinical and non-clinical services. Their role is to **execute care models that achieve measurable outcomes** while embracing collaboration, transparency, and continuous

improvement. As frontline actors, they hold the key to operationalizing value-based healthcare through integrated, patient-centric service design.

Strategic Actions:

- **Adopt outcome-based care models** built around Integrated Practice Units (IPUs) and chronic disease pathways.
- **Invest in capabilities for PROM and PREM integration** into clinical workflows and reporting systems.
- **Align internal performance metrics and incentives** with contractual KPIs and value-based reimbursement.
- **Co-develop protocols with public authorities** to standardize care without losing clinical agility.
- **Build interoperable digital infrastructures** to support real-time data exchange and compliance tracking.

6.3 Payers & Health Insurance Ecosystem

Incentive Designers & Enforcers of Financial Accountability

This group includes national health insurance funds, private insurers, and third-party administrators (TPAs). Their influence stems from their role in **structuring payments and financial incentives** that shape care behavior across the system. They must evolve beyond claim adjudication to become **strategic partners in outcomes management and cost optimization**.

Strategic Actions:

- **Transition reimbursement frameworks** from fee-for-service to bundled, capitated, or performance-based models.
- **Integrate risk-sharing clauses and quality metrics** into payer–provider agreements and RCM systems.
- **Support the deployment of predictive analytics tools** to identify high-risk cohorts and optimize interventions.
- **Foster coordinated care programs** across primary, secondary, and wellness services through multi-vendor collaborations.
- **Invest in patient education platforms** to improve health literacy, benefit utilization, and treatment adherence.

6.4 Technology Providers & Digital Health Innovators

System Integrators & Drivers of Scalable Personalization

This group comprises EHR vendors, telehealth platforms, AI developers, analytics firms, and digital therapeutics companies. Their role is to **build and maintain the technological backbone** that supports data-driven care delivery, contract compliance, and patient engagement. Their solutions must enable scalability without compromising privacy, equity, or user experience.

Strategic Actions:

- **Co-develop outcome tracking dashboards and decision-support tools** embedded within provider workflows.
- **Ensure full interoperability with public health systems** and payer platforms through open APIs and shared standards.
- **Utilize AI/ML to power risk stratification, fraud detection, and personalized health education** across care pathways.
- **Partner with local health authorities and providers** to adapt tools for regional health priorities and cultural norms.
- **Prioritize cybersecurity and consent protocols** to protect sensitive patient information and uphold trust.

6.5 Patients, Communities & Civil Society

Beneficiaries of Care & Agents of Accountability

This group includes individual patients, advocacy groups, NGOs, and community leaders. Their centrality in the healthcare ecosystem lies not only in receiving care, but in **informing design, providing feedback, and demanding transparency**. Their active participation is essential to ensure **healthcare services remain aligned with real-world needs and values**.

Strategic Actions:

- **Participate in co-design processes** for public health programs, outsourced services, and digital health tools.
- **Provide structured feedback** through PROMs, PREMs, and community engagement forums to enhance service responsiveness.
- **Advocate for equitable access** and culturally competent care models, especially in underserved or vulnerable populations.
- **Promote preventative health behaviors and early screening** through grassroots campaigns and peer support.
- **Collaborate with public institutions** to improve health literacy and reduce barriers to engagement with new care models.

Conclusion: A Collective Leap Toward Health System Excellence

Healthcare in the Gulf is at a decisive juncture. The convergence of demographic pressures, lifestyle epidemics, economic diversification, and digital acceleration presents not just challenges—but a generational opportunity to **redefine the architecture of care**.

Outsourcing, when designed strategically and implemented collaboratively, is no longer a tool of efficiency—it becomes an engine of transformation. It enables governments to scale access without compromising quality, empowers providers to innovate around outcomes, and invites patients to take an active role in their health journeys.

But this transformation will only be realized if all system actors move in unison. It will demand **courageous leadership, rigorous execution, and shared accountability**. The choices made today—on how contracts are structured, how partnerships are governed, and how value is defined—will shape the region's health and prosperity for decades to come.

The pathway forward is not simple, but it is clear: Build systems that **reward outcomes**, **enable co-creation**, and **center the human experience** in every decision. With this vision, the Gulf can emerge not only as a model of regional excellence—but as a global pioneer in the future of healthcare delivery.

About Management Partners

Management Partners is a leading consultancy specializing in guiding organizations through complex transformations in rapidly evolving environments. With deep expertise in healthcare reform, digital transformation, AI integration, and organizational strategy, we empower public and private sector leaders across the Gulf and beyond to navigate disruption, optimize performance, and build resilient, value-driven systems.

Recognizing that strategic outsourcing and technology are pivotal to the future of healthcare, our teams bring extensive experience in designing innovative, patient-centered models that align people, processes, and technology to deliver measurable outcomes. We help governments, healthcare providers, payers, and innovators co-create sustainable ecosystems that balance quality, scalability, and cultural relevance.

As the GCC pursues ambitious national visions for health and economic diversification, Management Partners is committed to delivering insight-driven, actionable strategies that enable stakeholders to lead—not just adapt—in a transforming healthcare landscape.

If you are exploring how to leverage outsourcing, digital health, and AI to transform your healthcare system, connect with our experts at healthcare@m-partners.biz or call +971 4 3589 920 to start the conversation.

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Endnotes

1. *Projected obesity rates for the UAE and corresponding rise in cancer incidences; Iqvia, GLOBOCAN, IHME Obesity*

2. *Aligning coverage with real-world outcomes trough value based contracts; Npcnow, Physicians Advocacy Institute, Team Analysis; https://www.npcnow.org/topics/alternative-payment-models/value-based-contracts https://www.spectramedix.com/blog/navigating-the-key-components-of-value-based-contracting https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Value-Based-Arrangement-Resources/APM%20Guide%20to%20Value-Based%20Contracting.pdf?ver=pg0Pumym_gNRXmGGa43IEg%3D%3D*

3. *Weighing the Pros and Cons of Value-Based Contracting; Npcnow, Physicians Advocacy Institute, Management Partners Research and Analysis;*

4. *Global success stories in value-based contracting; Team Analysis, Experts*

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