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Transitioning To Value-Based Care

Delivering improved, clearly defined patient outcomes and experience-focused care for GCC nationals and residents while managing escalating healthcare costs and ensuring standardized, high-quality service delivery.



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Executive Summary

One of the biggest priorities for governments around the world today is how to deliver effective, efficient healthcare for citizens and residents. As populations grow and rapidly age, the burden of non-communicable diseases (NCDs) rises and the rising cost of care provision far exceeds the rate of GDP growth.

Value-based care (VBC) models address both challenges simultaneously by promoting a more holistic and outcome-based approach to healthcare. They consider the overall impact of entire care pathways on patients, while aligning the incentives of healthcare providers and payers through sustainable, predictable treatment costs.

While relatively new to GCC countries, VBC is more established in North America and parts of Europe, where it is having a positive impact on improving patient outcomes and the patient experience while curbing the growth in healthcare costs.

This paper discusses the principle and premise of VBC, its potential for ensuring sustainable, affordable healthcare, the significant developments and challenges encountered so far as VBC initiatives are rolled out, critical success factors – including the availability of high-quality data and recommended actions for GCC leaders and key stakeholders in their respective care systems. These include developing standardized metrics and reporting mechanisms for clinician-reported outcome measures (CROMs) and patient-reported outcome measures (PROMs), encouraging and driving system interoperability and robust data sharing, alignment of financial incentives and models, and provision of timely technical and financial support to patients, payers and providers.

Introduction

It is a basic tenet of business that to be able to improve something, you must first be able to measure it. Yet traditionally in healthcare, services have been evaluated and measured based on operational and process metrics such as the number of appointments or surgeries conducted. The longer-term cost of a person's journey through the healthcare system across their lifetime, its bearing on their overall wellbeing and quality of life, and their propensity to return for additional consultations and treatments, have not typically been measured, analyzed, or reported.

Linking clinician-reported outcome measures directly to quality-of-care delivery and patient-reported outcome and experience measures, and integrating them with reimbursement models and incentives, forms the foundation of value-based care.

However, currently, most health systems face challenges in understanding the cost of delivering health services and lack insights and data from patient-reported health outcomes and analytics to support and shape reimbursement mechanisms.

Across healthcare pathways and the broader service value chain, opportunities to improve outcomes through preventative services or early interventions are yet to be addressed and supported through reimbursement mechanisms. Without addressing this and supporting evidence-based, clinically led interventions that identify risks early and prevent complications, healthcare

systems face a disproportionate rise in costs due to overutilization of services, including repeated consultations, referrals, readmissions, additional tests new treatment plans and increased emergency room (ER) visits.

Value-based care (VBC) models look to refocus attention on patient experiences and outcomes by paying closer attention to the patient journey across each touch point, the impact and overall cost of VBC interventions and the quality of care delivered.

There is a greater focus and accountability by providers to achieve well established process and outcome measures related to the treatment pathways.

Linking care pathways, individual interactions and treatment plans with patient outcome and experience measures, as well as the associated cost, enables healthcare providers, payers/ insurance companies, and insured members (employers/ individuals) to correlate spending with outcomes. Value is delivered through healthier insured members who can live and work to their full potential and are less likely to re-enter the healthcare system with recurrent issues.

Unsurprisingly, governments and healthcare regulators worldwide are looking closely and purposefully at VBC models as a vehicle for delivering sustainable, patient-centric, quality and affordable healthcare and as a means of controlling increases in the cost of care provision as populations grow and age.



Section 1

The Financial Case For Value- Based Care In GCC Countries





Economic growth in GCC countries has been due to rebound to 2.8% and 4.7% in 2024 and 2025, according to World Bank forecasts¹. However, the region's healthcare cost is estimated to be growing at a rate of 5.4% annually since 2022, on course to total \$135.5 billion by 2027. The UAE is anticipated to have the highest growth rate at 7.4%². Less conservative estimates suggest an average growth rate of 8% or more³.

Either way, this trajectory is unsustainable in terms of individual countries' ability to provide standardized, high-quality care as demand for services increases. If the existing population trend in GCC countries continues, citizens aged over 50 will make up 18.5% of the region's population by 2025, up from 14.2% in 2020; by the end of the century, the median age is expected to have risen to 51, from 32 in 2022⁴. Aging populations bring more instances of disease and the interaction of more complex conditions, pushing up healthcare costs.

However, there is no escaping the fact that VBC represents a paradigm shift in traditional healthcare delivery and reimbursement practices. It requires stakeholders across the care ecosystem to actively embrace and support the concept of value-based care and value-based care payments. They must adopt new mindsets and behaviors, be more collaborative and transparent with other care ecosystem stakeholders, as well as invest in new technology infrastructure and skills for assessing, measuring, reporting on, and responding to information on patient outcomes and patient experiences. The right metrics also hold the key to assessing value based on patient outcomes and the cost of delivery, and how the interdependency might be optimized in future.

While not simple, the transition to value-based care offers tangible benefits to all stakeholders. The shift can be managed successfully by adopting emerging best practices and structured frameworks adapted to each country's national requirements.







Section 2

The Practical Problems That Value-Based Care Helps Solve

Beyond addressing the fundamental problem of the rising cost of healthcare delivery, value-based care approaches inherently target the fragmentation and lack of standardization that is commonplace in traditional care provision and target outcome measurement and improvement across the care pathways.

Within established fee-for-service models, which reimburse providers based on the volume of care delivered rather than the quality, there are limited incentives for providers to promote care coordination or standardization or to review performance in terms of meaningful patient outcomes. Without motivation to change, the care system has persisted in measuring volume based on activity rather than outcomes or improvements to the cost/outcomes ratio.

Population-level healthcare inequities cannot be overcome if care is provided and billed for using a volume-based/ activity-based model. Value-based care seeks to reduce structural and social barriers that drive health inequities by shifting incentives toward patient-centered care and improved outcomes for all. It paves the way for new emphasis on the social determinants of health, for implementing community health initiatives, and for maximizing population health.

EIT Health, a network of healthcare innovators backed by the EU, highlights the impact of value-based healthcare in Sweden. An ambulance unit reduced unnecessary dispatches by 17%, while a maternity care unit lowered the number of induced births, saving approximately 850 bed days per year (or 2.3 bed days per day). These improvements were achieved without compromising patient outcomes, ultimately enhancing population health and optimizing care delivery costs⁵

Such initiatives can be further supported by a reduction in waste. A lack of standardized care pathways across different providers has led to variation and duplication in care, resulting in over-treatment and over-consumption of services. This, in turn, has pushed up health insurance premiums.

Value-based care also drives care ecosystems to address the diverse, fragmented, and inefficient nature of existing IT environments. Up to now, stakeholders across the care value chain have followed their own respective paths in terms of the systems they have deployed, the data they have captured, and the formats they have followed. This lack of consistency has prevented easy visibility of care performance and how it is linked to spending. It also makes it harder for providers and payers to spot trends and issues and for data sharing between organizations (for example, to enable a more integrated care experience for patients that offers continuity as they move between different medical centers and hospitals).⁵

Value-based care encourages more standardized and readily integrated systems, which will foster the collection and analysis of more consistent and higher volume and quality data. This will be crucial to provide timely insights for regulators (at a macro level) and to guide providers and payers (at a micro/patient level) in making informed decisions on reimbursement, areas for improvement, and areas of excellence across the care continuum. All stakeholders stand to benefit from a more granular understanding of care delivery costs; in many health systems currently, providers and payers have limited transparency around the total clinical and non-clinical costs across different care domains.





Section 3

Challenges in Successfully Implementing Value-Based Care Models

Central to the VBC model is the patient-reported outcomes and experience measures, which play a pivotal role in ensuring care aligns with patient priorities and improves overall healthcare value. However, implementing VBC presents challenges such as aligning stakeholder incentives, integrating technology, managing costs and addressing care disparities.

● Stakeholder alignment and collaboration

Payers, providers, patients, and policymakers often have different goals and priorities. For instance, payers aim to reduce costs, providers focus on care quality and improving utilization of services and volume to support higher revenues, and patients prioritize accessibility, ease of service provision and patient outcomes. This makes alignment challenging.

● Infrastructure and technology integration

There are difficulties in aggregating and sharing patient data across different healthcare systems due to a lack of standardized platforms and interoperable electronic health records (EHRs). There is also a need for investment to transition to VBC, with technology requirements such as EHR systems, data analytics platforms, and telehealth capabilities.

● Reimbursement model adoption and adaptation

Payment reforms must drive delivery system transformation rather than being a goal themselves, emphasizing the link between payment and effective care delivery. Provider readiness and adoption of VBC are challenges, as each provider has a different level of readiness, appetite to absorb risks, value-based care capability, and ability to invest in technology innovations.

● Care delivery and patient engagement

There are challenges with patient awareness and understanding of VBC and ensuring adequate incentives to drive changes in patient behavior.

● Outcome measurement and stakeholder accountability

Some health systems continue to face challenges in defining relevant metrics, standardizing benchmarks, ensuring data accuracy, and attributing outcomes across diverse populations. Ambiguous roles, misaligned incentives, and difficulties in enforcing transparency and compliance among payers, providers, and patients hinder stakeholder accountability.

● Workforce development and change management

Challenges include reskilling staff to adapt to new workflows, technologies, and data-driven practices, often with limited training resources. Change management is hindered by resistance to shifting from fee-for-service models, provider burnout and the complexity of aligning teams with VBC goals and processes.

● Equity, access and sustainability

Sustainability is challenged by the need to balance cost control with maintaining high-quality care, especially when addressing social determinants of health and supporting long-term health improvements.



Section 4

Considerations When Planning a Move to Value-Based Care





When value-based care works well, all stakeholders are invested in playing their part to deliver the best possible patient outcomes within the established reimbursement frameworks.

The collective aim is to improve patient outcomes while providing care at a sustainable, standardized cost. Although no one wants to stymie innovation or inhibit clinicians' judgment and discretion, VBC approaches aim to standardize routine care pathways and avoid unjustified deviations from them. These include unwarranted referrals for CT or MRI scans or the over-prescription of medication.

Meanwhile, the patient risk assessment and stratification process would support the identification of cohorts that require more specialized pathways and those meeting eligibility criteria to be enrolled in VBC programs – such as members with chronic diseases (diabetes or hypertension, for example), those presenting for maternity care, or for common surgeries such as knee replacements or tonsillectomies.

Incentivizing stakeholders to uphold the agreed standards is essential to overcome hesitation or resistance to the inevitable changes to everyday practice by implementing VBC programs. There needs to be agreement about what constitutes the appropriate and agreed level of care and value and how this will be measured for patients.

EIT Health's research illustrates that Spire Health in the UK collects about 90% of completed baseline patient questionnaire data across its 39 hospitals, cascading this information to drive physician performance. This has led to significant improvement in patient outcomes and experience after hip and knee surgeries, for example.⁶ There is a need for early and continuous collaboration between all stakeholders – providers, payers, pharmaceutical and medical device companies, regulators, and patients – to ensure the successful adoption and implementation of VBC programs across the healthcare value chain.

To be fully effective, VBC initiatives should encompass a range of care settings – not just those provided to individuals in a medical center or hospital, but also care provided in the community, in day-care centers, home care, and virtual care (such as home or virtual care for patients with chronic diseases, support for new mothers virtually or in a community setting, or post-surgical support and rehabilitation for patients). Delivering early care in accessible settings ensures timely intervention, reduces the progression of chronic conditions, minimizes unnecessary hospitalizations, and aligns with value-based care principles by improving patient outcomes while lowering overall costs.

To date, optimal models have seen regulators set the agenda, with payers, care providers, and supporting technology and service suppliers playing critical roles in the rollout and implementation of VBC initiatives. We also see increasing involvement from pharmaceutical, medical device, and life sciences companies in value-based arrangements, with outcome-based or indication-based contracting becoming more common with payers and providers.⁷





Section 5

Data Infrastructure And Analytics As A Critical Enabler

At the heart of value-based care, besides the patient, are transparency and visibility – right across the patient journey – and an individual's experience at and beyond each touch point. This requires healthcare providers to capture and record data in a standardized way and make it securely accessible as appropriate to relevant stakeholders. That means anonymizing data if the purpose is for general performance reporting, trend analysis, and other such assessments. System/platform interoperability and agreed data formats are also essential.

There will need to be capabilities for tracking PROMs, patient-reported experience measures (PREMs), and CROMs, as well as financial metrics, operational metrics, and other quality measures to enable continuous monitoring and evaluation of outcomes. The standardization of PROM/ PREM measures by regulators and the adaptation of measures to local environments and cultures of care are essential and pivotal to the success of VBC implementation.⁸ We consider the challenges of achieving this later in this paper in the chapter 'Considerations as GCC Interest in Value-based Care Intensifies'.





Section 6

AI-Enabled Opportunities For Honing Value-Based Care

Artificial intelligence (AI) and machine learning can also significantly enhance analytics while supporting on-demand access to the latest performance metrics and trend snapshots, as detailed below.

A report from the US National Academy of Medicine has highlighted three high-potential benefits of AI in healthcare: improving outcomes for both patients and clinical teams, lowering healthcare costs, and benefitting population health⁹. All three are tenets of value-based care.

At a more granular level, AI offers encouraging support for VBC across a wide range of strategic areas:

● 1. Enhancement of risk stratification/predictive analytics

Specifically, AI can help with analyzing historical claims, clinical data, and social determinants of health, making it possible for payers to predict which patients are likely to incur higher healthcare costs, leading to more accurate and rigorous risk stratification of patients. This, in turn, could increase provider trust in VBC models and improve patient access to care. To prevent the risk of adverse selection of patients, VBC models have clear inclusion and exclusion criteria to ensure high-risk individuals get the care and attention needed for their condition and appropriate reimbursement mechanisms are deployed. This needs the appropriate clinical oversight mechanisms by regulators to assess and ensure that providers avoid cherry picking patients and including only low-risk patients in their VBC programs.

By helping payers estimate future healthcare costs for patients in VBC models and, by extension, adjust shared savings models based on these predictions, AI-powered predictive analytics could support the design of dynamic payment structures that meet the evolving needs of high-risk patients, ensuring that financial rewards align with patient outcomes.

● 2. Streamlining reimbursement

AI-powered tools can automate the bundling of payments, analyzing patient data and outcomes to simplify the management of bundled payment contracts. This could mean more efficient provider compensation for care episodes, lower administrative overheads, and increased payment accuracy, such as by using AI in revenue cycle management (RCM), thus supporting provider reimbursement. For example, automating administrative tasks such as eligibility verification, claims submission, and patient responsibility management enables RCM teams to adapt effectively to the evolving demands of value-based care. The Healthcare Financial Management Association (HFMA) in the US estimates that reworking a denied claim costs approximately \$48 for Medicare Advantage plans and \$64 for commercial plans. AI can address these challenges by automating processes, analyzing extensive datasets, and driving better collaboration between providers and payers.¹⁰

● 3. Supporting payment integrity

AI and machine learning are already transforming payment integrity by automating claims adjudication and reducing payment errors. AI can rapidly synthesize structured and unstructured data, such as medical records and claims, to improve payment accuracy and speed up reimbursements, ensuring payments align with care quality in VBC models. A leading national-level payer in the US used AI-enabled tools, including claim logic refinement and natural language processing (NLP) for medical record processing. This initiative increased the auto-adjudication rate from 87% to more than 92%, further streamlining the reimbursement process.¹¹

● 4. Optimizing incentive models

AI can help design and optimize incentive structures by analyzing the most effective care strategies and outcomes. This would allow payers to adjust performance-based payments, incentivizing providers to focus on high-quality, outcome-driven care – care that aligns with the goals of VBC and improves both patient outcomes and cost efficiency. Enabling providers to focus on outcome-based care will eventually help insured members get the highest quality of care at appropriate care settings and sustainable costs.

● 5. Enhancing the patient experience and engagement

AI can augment personalized patient management through predictive analytics, which can help identify at-risk individuals and optimize treatment plans. Additionally, AI enhances patient experience by streamlining care coordination, automating routine interactions, and providing real-time insights for more informed and efficient care delivery.





Section 7

AI Solutions Are Emerging At Pace



In California, the integrated care consortium Kaiser Permanente has partnered with ‘health cloud’ provider Innovaccer to implement AI-driven solutions within its VBC programs. Initiatives include an AI-powered population health-management solution that integrates data from electronic health records, health insurance claims, and lab results to predict health risks, identify care gaps, and enable early interventions to improve outcomes and reduce costs.

Also in California, health insurance company Humana uses AI to meet VBC targets by improving patient satisfaction and lowering costs, specifically by powering home health services under value-based care contracts. AI tools analyze patient data to identify those who could benefit from home-based interventions, improving care for high-risk patients while reducing hospital readmissions.

Meanwhile, numerous applications of AI are transforming radiology and diagnostic imaging performance. Among the published examples to date, Qure.AI has been shown to improve critical findings on head CTs by 20%; Zebra Medical Vision has flagged 10 times more pneumonia cases on chest X-rays than could be spotted by the human eye, and MaxQ AI has increased stroke detection on head scans by 35%. In cardiac care, AI can be used to automate ultrasound measurements, enhancing speed, accuracy, and patient outcomes. However, optimizing AI requires addressing key considerations, including ensuring access to adequate and diverse data to minimize biases, maintaining robust human oversight, achieving seamless system interoperability, and adhering to strict regulatory frameworks.

Section 8

An Evolution Of Healthcare Reimbursement

In the traditional fee-for-service model, healthcare providers are compensated for each specific service, procedure, or consultation they deliver. This model incentivizes the volume of care rather than the quality or outcomes of care provided. So, although they offer financial stability and incentives to providers for volume/ activity-based service provision, such systems do not drive collaboration between care teams, and patient outcomes and experience are not part of the assessment of performance or reimbursement mechanisms.

This system has some flexibility in service delivery and straightforward billing processes, but there are systemic challenges with the overuse of services and a limited focus on care coordination, patient outcomes, experience, and engagement.



In response to this model's rigidity and omissions, alternatives have emerged in the evolution toward value-based care and payment. **The main ones are set out below:**

Partial capitation

A lump sum is paid for a pre-defined population covering a limited set of services.

Advantages

- Promotes more efficient delivery of services in the pre-decided cost per capita
- Focus on provider collaboration aims to drive and improve patient outcomes
- Providers also take on considerably more risk, driving a shift in accountability.

Disadvantages

- Fixed budget with challenges in adjusting for risks for providers
- Can lead to rationalization of care, with potential longer wait times, prioritization of certain patient groups, and limitations in access.
- Difficulties with payer alignment
- Need for more member education and engagement
- Need for stronger clinical governance on referral mechanisms and appropriateness of care

Bundle payments

This model involves a risk-adjusted payment for all services needed for a patient over the care cycle for a defined procedure/condition, such as a total knee replacement or laparoscopic cholecystectomy.

Advantages

- Drives a culture of collaboration in care delivery between care teams and providers
- Increases cost and operational efficiencies across care delivery
- Strong focus on patient-centricity, with monitoring of patient-reported outcome and experience measures (PROMs and PREMs)

Disadvantages

- Lack of clarity in the definition of bundle components across all stakeholders
- Requires transparency and accountability from all stakeholders, challenging to design, implement, and operate.

Shared savings/losses

This involves risk-adjusted targets for providers, with providers receiving a portion of the savings generated if they meet quality and cost targets. In shared losses, risk-based arrangements may face reimbursement cuts or refunds to their payers if their spending exceeds the target.

Advantages

- Increased collaboration in care delivery, improved care coordination
- Clear understanding of the cost of care by providers
- Alignment of payer and provider incentives with active provider participation in risk-sharing arrangements.

Disadvantages

- Requires strong data capabilities, infrastructure, and investment
- Implementation must be done incrementally with multiple stakeholder involvement and engagement
- Could lead to underutilization of acute services.

Global capitation

Providers are reimbursed a set amount per month for each patient (PMPM – per member per month), and they accept full financial risk – upside and downside – to address all the care needs defined in the PMPM payment arrangement.

Advantages

- Increase in collaboration for care delivery and efficiency
- Incentives to focus on early detection and prevention, long-term health gains, population health outcomes.

Disadvantages

- Requires strong coordination of care and a view into the whole member treatment continuum
- Requires provider protections from catastrophic costs.
- Higher participation and engagement of provider stakeholders – clinical and non-clinical.
- Without complete alignment of payers and providers there is the risk of challenges in care delivery

Section 9

What Good Looks Like

Globally, value-based care payment models are being introduced and implemented successfully across developed and emerging health systems, with impact delivered on quality-of-care outcomes, cost containment and stabilization, improved patient experience and care coordination.

Although the GCC region is still relatively early in its planning and implementation for value-based care, appreciation is growing for such models' strategic importance in delivering sustainable, impactful care as efficiently as possible.

Over the last couple of years, we have seen regulators in the Kingdom of Saudi Arabia and the United Arab Emirates establish VBC agendas and teams, while over the last 12 months, we have seen several leading insurance organizations appoint VBC leads to explore the potential. (In a later section, we will discuss some initial programs being rolled out in GCC countries.)





Examples of Emerging Best Practice Globally

The table (see Figure 1) and case-based analysis below showcase emerging best practices. The associated critical success factors will provide a useful reference to help GCC governments as they start to formulate their own national plans to introduce value-based care and transition to new reimbursement models.

Globally, there are number of models focused on Value Based Care reimbursement aimed at delivering quality care with a focus on cost sustainability and efficiency.

North America	Europe	Worldwide
 1. USA: CMS': Bundle payment for care improvement, Medicare Advantage, Medicare Shared Savings Program	 Estonia: Estonian Health Insurance Fund - Quality Bonus System	 Australia: Department of Health - Diabetes quality improvement support, quality incentive model
 2. USA: Geisinger Health System: ProvenCare bundle payments for CABG? and Diabetes	 Germany: Federal Ministry of Health-Disease Management Program, Incentive based model for chronic disease management	 Kenya: Mom Care - Pregnancy and Childbirth bundle payment
 3. USA: Ohio: Ohio Medicaid Program - Laparoscopic cholecystectomy bundle payments	 Netherlands: Diabeter - Diabetes bundle payment	 New Zealand: Canterbury District Health Board - Integrated budget for health and social care
 4. USA: New England Baptist Hospital (NEBH) - Knee replacement - Bundle payment	 Spain: Ribera Salud - Capitation reimbursement model	 Singapore: Singapore General Hospital - Knee replacement - Bundled Payments
 5. USA: TennCare - Tennessee Medicaid Program - Knee arthroscopy bundle payment	 Sweden: Stockholm County Council - Bundled payment for hip & knee surgeries, spine surgeries	 Taiwan: National Health Insurance - DRG-based bundle payments
 6. USA: Texas Oncology: CMS Oncology care model pilot, performance-based payment incentive model	 Switzerland: Basel University Hospital - Knee replacement bundle payment	 India: Aravind Eye Hospital - VBC payments for ophthalmic surgeries, pay for quality model
 7. USA: Washington State Mental Health Integration Program: Pay for performance bonuses	 UK: NHS - Best practice tariffs for hospitals, primary care pay-for-performance scheme	
 8. Canada: Ontario: Pay for Quality based reimbursement for procedures		

Note: 1. CMS - Centers for Medicare and Medicaid Services, 2: CABG - Coronary Artery Bypass Graft Source: PwC Analysis PwC | Value Based Care Abstract

Figure 1: Emerging VBC Success Stories from Around The World

Some examples of specific early successes from the table are discussed here:

Knee replacements at New England Baptist Hospital in the US

New England Baptist Hospital (NEBH) is a not-for-profit hospital in the northeastern US, ranked among the region's top 15 orthopedic hospitals, with the highest share of elective surgical procedures.

Yet, despite the high quality of care and clinical performance, the hospital's reimbursements under the Centers for Medicaid and Medicare Services Bundle Payments for Care Improvement (CMS BPCI) scheme were lower than those of other providers.

NEBH physicians perform around 8,000 total joint replacements, 2,000 spine cases, and 3,500 outpatient procedures annually with superior clinical outcomes (reduced variability, controlled post-surgical complications, and 30-day readmission rates).

To overcome this, the hospital signed a bundled payment contract for hip and knee replacement with the Group Insurance Commission (provides and administers health insurance and other benefits to Massachusetts state and local government employees, retirees, and dependents), and the following NEBH outcomes were identified¹²:

- A complication rate of 1.4% compared to a national average of 2.5%
- 30-day admission rate of 2.7% compared to a national average of 4%
- A 95% likelihood of patients recommending the hospital compared to an average of 72% for other similar providers.

Lessons learned/ key takeaways:

Early involvement and buy-in from physicians on care pathways, cost, and outcomes will encourage healthy competition to drive change

Piloting bundles for select conditions/ procedures offers a way to capture learnings for adaptation in future pilots, reducing the administrative burden for payers and providers

Regulator to consider a lower financial barrier for providers to encourage participation. Payers to incentivize providers by supporting investment in system upgrades, digital technologies, and hiring and training care teams.

Type 1 diabetes management in the Netherlands

Diabeter, introduced in 2006, is a group of certified clinics that provides personalized care for children and young adults with Type 1 diabetes.

The incidence rate of Type 1 diabetes is increasing by 3.8% per year, and today, patient outcomes across providers in the Netherlands vary significantly, with less than 30% of pediatric patients able to achieve optimal HbA1c levels. Diabetes has a significant health system impact in terms of healthcare spending, with the risk of long-term complications for patients.

To manage the risks associated with Type 1 diabetes, a unique care model was built on value-based principles, providing e-health solutions and a unique patient experience. In 2015, Medtronic acquired Diabeter as part of its strategy to transform diabetes care by focusing on technology and outcomes. The measured impact includes¹³:

- No diabetes-related deaths to date for Diabeter patients
- A hospitalization rate of just 3% for Diabeter clinics compared with an 8% national average
- 55% of pediatric Diabeter patients are below the glycemic threshold level for avoidable death, compared to just 28% in other clinics/hospitals
- An annual 8.6% reduction in direct costs due to controlled and lower hospitalization compared to other clinics.

Lessons learned/ key takeaways:

Regulators should consider pilot testing with providers that offer the full care cycle through their integrated network

Effective use of primary care-led care coordination and use of virtual health and remote monitoring technologies to identify risks early, improve patient experience and outcomes

Maternity and childbirth in Kenya

Expectant mothers were experiencing gaps in their care journey and the availability of care in the form of excessive waiting times and a lack of equipment or products. There was a high risk of poor pregnancy-related outcomes, including a maternal mortality rate of 253 per 100,000 live births. There was a perceived financial burden on patients due to a lack of clarity around care coverage, leading to insufficient care. Meanwhile, funding schemes focused more on increasing the supply of care rather than on raising its quality.

Efforts were made to develop coordinated care partnerships across the value chain and a value-based patient journey that focuses on improving maternal and neonatal health outcomes, creating a sustainable business model for providers and creates transparency of outcomes and costs through the care journey.

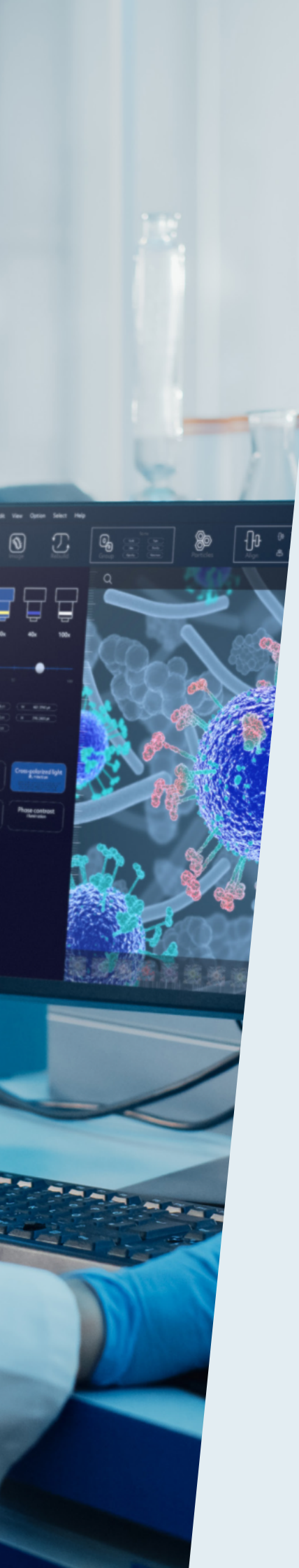
The new model was implemented starting with 3 clinics in 2017 and expanded to 18 clinics in 2019 – Participating clinics varied based on the service mix and complexity of care offered, and the network included care providers from level 1 community service centers to level 6 large private teaching hospitals.

Community clinics were connected to a digital platform (called M-TIBA) that facilitates patient journey tracking via claims data, SMS and phone calls.

The new model redefined care pathways covering the entire pregnancy journey from antenatal care (ANC) visits, delivery, postnatal care (PNC) visits and child immunizations. Pregnant women and their newborns in Nairobi and Western Kenya enrolled in a subsidized health insurance scheme offering “health wallet” to pay for care within the participating clinics. The total cost of care per mother for the entire pregnancy journey was stratified by risk and age.

Improved patient outcomes were delivered with reduced maternal mortality, improved ante- and postnatal care and neonatal care, and significantly better patient experience with community support, patient education, awareness, and advocacy.





Since embracing a value-based care model, there has been^{14,15}:

16% increase in adherence to antenatal care visits for all mothers

15% % rise in antenatal care visits featuring a full set of hemoglobin, syphilis, HIV, blood glucose, urine, and tuberculosis tests

Early risk stratification and increased awareness about delivery signs, benefits and guidance for breastfeeding, and regular appointment reminders for mothers.

Lessons learned/ key takeaways:

The value of adapting a phase-based approach and conducting a pilot on a limited number of participants, making it possible to summarize learnings/key takeaways and adapt these for future implementation

The need to leverage technology and data platforms to standardize data capture and reporting.

Patients with low health literacy, from rural areas with potential language barriers, limited access to care were included in the bundle, with adequate patient education and awareness, support and access to care services

Section 10

Emerging GCC Initiatives

In the GCC region, interest in value-based care is rising and beginning to take tangible form, led by Saudi Arabia and the UAE.





Kingdom of Saudi Arabia

The Council for Health has created a national framework for measuring patient-reported outcomes and experiences (the implementation of PROMs and PREMs). It has also designed a series of VBC bundle payments for seven health procedures and conditions for implementation. Further measures include the adoption of ARDRG¹⁶ pricing – a clinically meaningful way to relate/group the number and type of patients treated in admitted acute episodes of care to the resources required in treatment. This is now the basis for improved ICD 10 coding (standardized diagnoses documentation) and paves the way for shadow billing, where services are not billed for in the traditional way. The Council has also designed a population health management model for five designated conditions.

KSA's Center for National Health Insurance (CNHI), meanwhile, has introduced payment bundles for knee replacement for members covered by CNHI using private-sector hospitals. It has also developed risk-adjusted capitation models for reimbursement of care in the KSA clusters and introduced a series of population health-management initiatives.

United Arab Emirates

Dubai Health Authority (DHA) has further advanced Diagnosis Related Groups (DRG) implementation and introduced these for day-care and ambulatory care services. DHA has also implemented a VBH model (Ejadah), which should span 30 disease areas by the end of 2025. In addition, DHA has now implemented pay-for-performance reimbursement models linked to Ejadah outcomes and pathways.

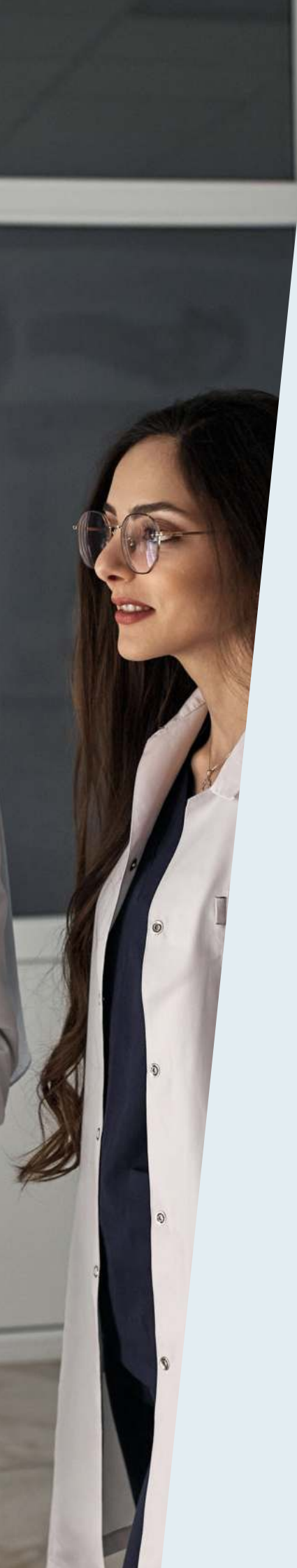
Abu Dhabi's Department of Health (DoH), meanwhile, has planned the rollout of primary care 'stay healthy' initiatives for certain specialisms and services. It has also implemented ambulatory care VBC-based reimbursement reform, and embedded and enabled the use of AI 'virtual triaging' to support services across the care continuum.



Section 11

Considerations As GCC's Interest In Value-Based Care Intensifies





As GCC governments and regulators continue to assess opportunities to implement value-based care and associated reimbursement models locally, and as they start to plan their roadmaps, there are several priorities and challenges to consider. Understanding and preparing for these from the outset will help overcome some of the main logistical challenges associated with implementing and delivering a value-based care model.

Data access and availability

The ability to track, measure, and reward value relies entirely on the ability to capture, process, exchange, view, and report on high-quality data. It must be consistent, complete, standardized, accurate, trustworthy, and timely.

Currently, approaches to data collection are fragmented and inconsistent, limiting the scope for meaningful, actionable insights and making performance comparisons difficult. Related to this, the frequency of data sharing is currently inadequate and data exchange methods are insufficient and lack maturity – for instance, capabilities do not support timely (on-demand/ near-real-time) data transfer.

Patient experience and patient-reported outcomes

Currently, the measures for patient-reported outcomes and experience are limited and not culturally adapted for the evolving needs of the patient population in GCC.

Patient centricity is fundamental to the design and implementation of VBC bundles, yet collecting PROMs data presents notable challenges. This process demands real-time dashboards customized with varying layouts and details to address the unique needs of both clinicians and patients. Furthermore, creative strategies are crucial to support patients in independently completing questionnaires, ensuring accurate and valuable data without causing undue burden. Measuring PROMs and CROMs adds another layer of complexity, as it requires adjusting health outcomes for case-mix variables to effectively analyze differences across diverse patient populations.⁴⁷

Mechanisms for performance measurement

The ability to track and report on performance measures in an agreed, consistent, and reliable way is fundamental to a workable value-based care model. Currently, there is a lack of transparency, definition, and standardization around the various methodologies currently in use (attribution, benchmarking, KPIs), which will need to be addressed.

Transformation of care

In the short term, delivery of coordinated, standardized patient-centric care will inevitably mean disruption of normal provider workflows. This is likely to trigger resistance as private-sector providers are asked to change the way they approach care, so there will need to be proactive change-management and engagement strategies to overcome hesitancy and address any barriers, as well as consider opportunities to integrate the KSA Model of Care initiatives which include care guidelines and pathways for several health services across the value chain.

New administrative undertakings

Initially, all parties will be burdened with administrative responsibility in setting up a value-based care environment, and different reporting requirements across health plans and contracts will need to be overcome. To streamline this work, the current lack of harmonization of rules and regulations across models will also need to be addressed.

Additional investment

Upfront investments will be needed in technology and additional staffing resources and competencies to establish new value-based care capabilities. Additional or new IT infrastructure requirements must encompass the appropriate tools, reporting systems, and analytic capabilities to support VBC measurement and reporting (see also 'AI-Enabled Opportunities for Honing VBC' above).

Stakeholder collaboration

For VBC rollouts to be efficient and effective, alignment and proactive cooperation must exist between all stakeholders in the care ecosystem, particularly between payers and providers. Clearly defined objectives and expectations will be essential but may be challenging to achieve: the division of responsibility for administrative and clinical services could prove ambiguous or be the subject of conflict/non-adherence. Close collaboration with clinicians and nurses in the design of clinical pathways, rollout of pathways with provider education on pathways, patient engagement, reimbursement, adequate and appropriate patient education, and other change management approaches would determine the success of bundle implementation. Data sharing expectations and service terms (SLAs) are among the elements that must be clearly defined and agreed upon.

Incentive alignment

Linked to the point above, all parties must be motivated to cooperate to achieve the same goals. Misalignment of incentives, particularly between payers and providers, could occur if these are not overtly linked to the patient experience, are insufficient, or are not equitably distributed to all providers.

Risk management

With so many moving parts and such a fundamental shift in care provision in focus, the scope for risk in VBC adoption needs to be considered both holistically (across the entire care journey) and discretely (within specific care settings or scenarios). There also needs to be consideration of strategic risk factors, such as the implications of late adoption and conflict with existing or emerging regulations relevant to the particular GCC market.

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Section 12

Recommended Actions For Healthcare Regulators, Payers, And Providers





Achieving success with value-based care models requires sustained investment guided by strategic alignment, thorough planning, and diligent execution. As interested parties across the GCC and beyond look to explore and implement VBC more purposefully, we recommend the following actions to maximize the success of their programs:

Strategic planning and alignment

Development of a coherent and actionable plan for value-based care implementation and rollout, aligned with patients, payers and providers

Extending the scope of value-based care across the care continuum to drive care integration

Tailoring reimbursement arrangements to share savings and promote the financial sustainability of providers and health plans

Stakeholder engagement and collaboration

Working together to implement value-based care initiatives requires stakeholders to form a collaborative partnership with articulated objectives and expectations

Training and education for providers (frontline operations staff, clinicians, revenue-cycle management) to enhance their understanding of pay-for-quality concepts and methodologies

Data integration, interoperability, and digital ecosystems

VBC requires a digital ecosystem that enables seamless integration of data from various sources, with investment to support data collection, monitoring, and advanced analytics

Scalable digital platforms are needed to facilitate the implementation of complex value-based payment models by accurately tracking and reporting relevant quality and outcome metrics, including using AI and machine learning models to support this





Risk management and outcome measurement

Introduce and improve measurement of outcomes, including CROMs, PROMs, and PREMs, using digital technology to measure, report, and compare outcomes and use the data to incentivize providers and drive patient care improvements

Adequate tracking and reporting of healthcare outcome metrics should be in place uniformly across providers

Models should adjust for risk in different population groups across care plans and understand the risk exposure and implications of several types of risk (including financial, operational, and strategic)

Culture of trust, transparency, and care integration

Develop and promote a culture of trust and transparency on data sharing, measurement of outcomes and patient experience

Build up a culture of continuous monitoring, review, and improvement

Section 13

Benefits Of Getting Value-Based Care Right





Once implemented within GCC health systems, value-based care models should have a positive and tangible impact on standardized care delivery, patient outcomes, and sustainable health spending. For each stakeholder group respectively, the benefits will come from:

Patients

- Shared decision-making between patients and providers
- Improved impact of and emphasis on factors that matter to them (via the emphasis on patient outcomes and experiences as the main measure of care value)
- Reduction of health disparities and provision of more tailored care

Payers

- Improved Management of rising healthcare costs and wastage reduction
- The ability to 'buy' healthcare based on quality outcomes
- Improved medical claims efficiency and health premiums sustainability

Care providers

- Long-term financial sustainability
- Better resource allocation and fewer repeat interventions
- Increased staff motivation toward delivering quality care
- Greater care coordination across clinicians and specialties

Pharma/Medtech suppliers:

- Demand for innovation to help improve the patient experience
- Greater accountability and recognition for patient outcomes
- A basis for productive new collaboration across and between the private and public sectors



Conclusion: A Reality Check

Value-based care models and their delivery will take time to design, implement, and realize, but the urgency of this transition is no longer in doubt. Across the world, and within the GCC, VBC offers national governments and healthcare ecosystems the best chance to provide sustainable, affordable care to everyone who needs it as demands on services continue to rise and change.

Existing deployments of value-based care models worldwide demonstrate VBC's potential as an effective, sustainable solution that will be instrumental in addressing complex and intensifying health system challenges. These include rising care costs, as well as the inefficiencies and risk to patients associated with a lack of standardized care and fragmented delivery.

Challenges need to be better understood by regulators and other health ecosystem players, supporting systems and data platforms need to be developed, and stakeholders need to be aligned, particularly clinical teams, to translate this into tailored and workable models.

A period of testing, shadow billing and risk sharing mechanisms needs to be thought through, considering the level of risks providers are willing to accept.

Value-based care models place patients firmly at the center. They also emphasize excellent practice and superior results while offering transparency on quality, outcomes, processes, and resource management.

Programs need to be championed at a national level, considered and planned holistically, and delivered through the right balance of standardization, optimized technology and data investment, skills development, and change management – including the early engagement of all stakeholders. With these elements in place, the scope for fundamental and enduring healthcare transformation is tremendous for GCC health systems.



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