VBHC
Italian Center

WHITE PAPER

VALUE BASED HEALTHCARE

CHALLENGES AND OPPORTUNITIES FOR THE ITALIAN HEALTHCARE SYSTEM

Edited by:
Telos Management Consulting
FIASO

VBHC
Italian Center

www.vbhcitalia.it

Follow us on

Value Based Healthcare Italian Center

Table of Contents

Giovanni Migliore

PRESIDENT OF FIASO

"The present and, most importantly, the future of our healthcare system and the health of citizens depend on how capable we are of moving away from the current logic of chasing performance to focus instead on the real production of value.

For many years, FIASO has been at the forefront of promoting a truly 'value-based' approach in all healthcare and hospital organizations, aimed at maximizing the value of services provided to patients.

This is why we are particularly pleased with the launch of the VBHC Italian Center, the first network within our healthcare system designed to identify and share high-value and quality choices to be disseminated throughout the national territory.

It is a great challenge for healthcare managers. A challenge that has always inspired us and that we want to share with all those who, like us, strongly support and advocate for the public National Health Service and the protection of health."

Alessandro Bacci

CEO OF TELOS MANAGEMENT CONSULTING

"The transition to VBHC as a new way of thinking, managing, and envisioning healthcare is not only an opportunity but also an urgent necessity.

The VBHC Italian Center represents a highly powerful tool for the implementation of new value-oriented health strategies.

In order to achieve this, the first step is to 'build a system', which is why the main players in the health ecosystem come together in an integrated way, each bringing their own vision and expertise, to collectively define the boundaries and content of a new approach to conceiving and organizing healthcare.

Revising organizational structures, ensuring real integration, breaking down silos, enhancing cross-functional actions, empowering patients to become active and informed participants, collecting data, and, most importantly, measuring—these are just some of the key elements in the transition to a new understanding of Value, Health, and Healthcare."

VALUE-BASED HEALTHCARE: *Urgency Beyond Opportunity*

In a global context where all healthcare systems are facing unprecedented pressures, there is an increasing urgency to reconsider the paradigms that govern healthcare management. This is especially true in the Italian context, where the universal healthcare system is considered a fundamental pillar for collective well-being.

Although with due differences, all the various healthcare systems in developed countries are facing similar challenges today, largely driven by demographic changes and their related socioeconomic implications.

One of the most relevant phenomena is the progressive aging of the population, which leads to an inevitable increase in the incidence of chronic diseases. These represent one of the main causes of disability and loss of self-sufficiency, significantly affecting the long-term sustainability of the system.

Demographic projections indicate that the number of citizens with at least one chronic disease will reach 25 million by 2028, whereas those affected by multi-morbidity will rise to 14 million[1].

This demographic trend places significant long-term pressure on the economic sustainability of healthcare systems.

At the same time, technological innovation has undoubtedly contributed to substantially improve well-being and quality of life, bringing forward significant progress in the diagnosis, treatment and management of diseases.

However, this technological expansion has not always been integrated into existing processes and procedures following adaptation and optimization logic, thus frequently increasing complexity and management costs. Increased access to information and data for citizens has also raised expectations regarding their quality of life, in a context where, for years, attention has been focused on the volume of services provided, often neglecting what was actually generated for the patient in terms of "value" and "health".

Although improving health outcomes for patients while optimizing the use of resources is the goal of any healthcare system and organization, it is estimated that in Italy, 19% of public spending, at least 40% of family spending, and 50% of intermediation spending do not improve the health and quality of life of individuals[2].

Today more than ever, the sustainability of healthcare systems depends on defining organizational and managerial choices that can guarantee higher levels of health and financial sustainability related to the rational use of limited resources available.

Creating a value-based healthcare system is the real challenge today, and the strategy to address it can only go through Value-Based Healthcare (VBHC): a strategic and methodological framework capable of guiding healthcare towards maximizing the value delivered to the patient. A differentiating approach that aims at truly putting the "patient at the centre" from both an organizational and a clinical perspective.

[1] Università Cattolica del Sacro Cuore, 2019. *La cronicità in Italia: Focus.*

[2] Fondazione Gimbe, 2019. *4th Report on the Sustainability of the National Health Service.*

A strategy that focuses on measuring results in terms of the overall value generated for patients, also measured according to their "perceived" value, and on the relationship between these results and the costs incurred to achieve them.

Value-Based Healthcare was first introduced in 2006 by Michael Porter and Elisabeth Teisberg as a tool aimed at revitalizing healthcare systems, and highlighting how healthcare policies were at odds with economic reality and were seriously jeopardizing the sustainability of the system[3].

The concept of "Value" is defined by Porter as "the health outcome achieved per dollar spent", i.e., the ratio between the health outcomes achieved (numerator) and the resources used to achieve these outcomes (denominator). Within the model, the patient is the primary focus to create value through their active involvement in the processes.

In 2013, Michael E. Porter and Thomas H. Lee presented the "Value Agenda", a strategic framework consisting of six key points, based on the fundamental need to shift from a volume-based approach to a result-oriented approach focusing on health returns for patients[4].

This consequently requires a shift from a supply-oriented system to a demand-oriented system, that is focused on the needs of patients. The system must evolve from an organization focused on the activities of doctors and healthcare professionals to one that places primary attention on patients and the principle of their centrality.

In 2007, Sir Muir Gray, one of the leading proponents of Evidence-Based Medicine, developed a Value-Based Healthcare model strongly influenced by Porter's theories but adapted to the reality of universal healthcare systems. Sir Muir Gray proposed an integration between VBHC and Population Healthcare, adding to Porter's model an evaluation of healthcare based on broader population health measures, where patients are grouped according to the similarity of their needs. In this context, the concept of value is defined in three dimensions[5]: Allocative Value, determined by how well resources are distributed across different population groups; Technical Value, determined by how appropriately these resources are used to achieve health outcomes for population groups with specific needs and Personal Value, determined by how these health outcomes align with each individual's value system and preferences. Recently, the European Commission, through the "Report of the Expert Panel on effective ways of investing in Health (EXPH)", has revisited this model, integrating it with the addition of a social dimension[6].

---

[3] Porter M. E., Teisberg E., 2006. Redefining Health Care: Creating Value-Based Competition on Results.

[4] Porter M. E., Lee T. H., 2013. The Strategy that will Fix Health Care.

[5] Gray M., & Jani A., 2016. Promoting Triple Value Healthcare in Countries with Universal Healthcare.

[6] Expert Panel on Effective Ways of Investing in Health (EXPH), 2019. Defining value in "value-based healthcare".

A significant example of the implementation of Value-Based Healthcare (VBHC) within a national healthcare system is that of Wales. The process began in 2014 with the launch of the "Prudent Health Care"[7] policy, which is based on three fundamental principles: co-creation with patients, equity in access to care, and reduction of excessive reliance on medical treatments. After conducting several local-scale experiments within individual healthcare settings to define standardized indicators aimed at measuring value from the patients' perspective, the Welsh public healthcare system, NHS Wales, developed a national portal for collecting Patient Reported Outcome Measures (PROMs) for 31 care pathways starting in 2017. Simultaneously, the National Data Resource was created, a platform offering reporting, research, and clinical-operational support, accessible even to citizens. To facilitate the adoption of VBHC, NHS Wales established "Learning Communities" to promote awareness and communication on the topic.

Another notable example of VBHC implementation in a public system is represented by AQUAS, the Health Quality and Assessment Agency of Catalonia. AQUAS began its journey with a significant effort in data centralization, for which it is responsible throughout Catalonia. To address citizens' needs and hinder the continuous rise in healthcare spending due to demographic growth and increased care demands, in 2011, it created the "Innovation and Perspectives" area with the specific goal of investigating needs and opportunities for innovation in the region, to be implemented within a VBHC cultural and operational framework.

The necessity of tackling emerging healthcare system challenges and the need for innovation both led to the evaluation of VBHC as a methodology for the improvement of health outcomes.

This is how they initiated value-based purchasing of "innovations", leveraging collaboration with external stakeholders and risk-sharing—i.e., purchasing models based on result-linked payment schemes through risk-sharing agreements.

[7] Aylward M., Phillips C., Howson H., 2013. Simply Prudent Healthcare – achieving better care and value for money in Wales – discussion paper.

VALUE-BASED HEALTHCARE: *Italian Center*

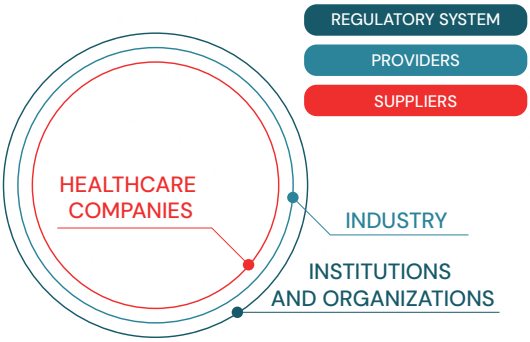
Within their activities, Telos Management Consulting and FIASO (Italian Federation of Healthcare and Hospital Companies) stand out as promoters of a path of innovation and transformation of organizational and healthcare management models, oriented towards the principles of Value-Based Healthcare.

This multi-year collaboration has led to the creation of the Value-Based Healthcare Italian Center, an initiative that represents a decisive step towards the transformation of the Italian healthcare system.

The mission of the VBHC Italian Center is to promote the development of healthcare organizational models focused on value generation, capable of addressing contemporary challenges by placing the patient at the centre in both organizational and clinical terms, with particular attention to the resources employed in the care process, in order to ensure sustainability.

The imperative principle guiding the conception and realization of the VBHC Italian Center was: "building a system", literally meaning "connecting elements into a cohesive whole that is both consistent and functionally unified". In this context, the centre is positioned as the first Italian network that brings together the key players in the healthcare chain, including Institutions, Organizations, Trade Associations, Research and Innovation Centres, Industry and Healthcare Companies, creating the conditions for sharing, generating influences and for the development of integrated actions.

A CENTER ENGAGING ALL HEALTH ECOSYSTEM PLAYERS AND CREATING STRONG PARTNERSHIPS



With a view to internationalization, the VBHC Italian Center also integrates international collaborations established with:

- Hospital da Luz – Lisbon. A hospital fully oriented towards value with high patient-oriented performance, demonstrating the feasibility of organizational transformation based on value.
- AQUAS – Catalunya. The Agency for Health Quality and Assessment of Catalonia (already introduced in the previous pages).
- Hospital Clinic and Vall d'Hebron University Hospital – Barcelona. Two exemplary cases of applying the Value-Based Healthcare model to targeted clinical pathways in collaboration with AQUAS.

The Value-Based Healthcare Italian Center aims at creating the necessary cultural and systemic conditions for the implementation of a value-based healthcare model, as well as to systematise expertise and tools for the development of a uniquely Italian model of Value-Based Healthcare.

The activities of the Value-Based Healthcare Italian Center are primarily structured around two main areas.

Development of a Value-Oriented Culture

Through initiatives on awareness, training, and sharing of best practices, the centre seeks to promote a healthcare culture that places value at the heart of clinical and organisational decisions. To this end, it organises dedicated events, think tanks, webinars, summits, hackathons, and offers managerial training with the goal of fostering a cultural shift within the healthcare system fully embracing the principles of Value-Based Healthcare.

Practical Application of the Value-Based Healthcare Model

The center is dedicated to translating theoretical principles into concrete practices through experimentation, outcome measurement (Value KPIs), benchmarking, and international collaborations. These efforts aim to demonstrate the effectiveness of the VBHC model and promote its widespread adoption.

DEVELOPMENT PATH OF THE *VBHC Italian Model*

International experiences in the field of VBHC demonstrate that, despite the challenges, the opportunities for innovation and improvement are vast and can lead to a revolution in the way healthcare is delivered. However, VBHC, with its new set of practices aimed at improving health outcomes and efficiency, is a typical example of managerial innovation and, as such, far more complex to implement than technical or medical innovations, due to conceptual ambiguity and context dependency. In this regard, as suggested by international experience, adaptability and the dynamic process of implementation are more important than adherence to the original concept[8], and it is crucial starting from the specificities of each healthcare system to introduce patient centrality, reorganisation of models, and data integration in a targeted manner.

It is precisely the need for adaptability and contextualisation that drives the spirit of this work, which has seen the individual stakeholders of the VBHC Italian Center come together to think, envision, and design a new model for delivering Service and Health. This contribution by systematising works, evidences, experiences, visions and positions collected in the early months of the VBHC Italian Center's existence, aims at defining in an organised manner the main directions and key milestones for the development of a systemic, sustainable VBHC model, strongly aligned with the starting context of Italy.

The Value Vision Workshop

The work of the Center began with the "Value Vision" Workshop, aimed at sharing with the Center's professional community (experts and stakeholders of the Health Italian ecosystem) their individual visions on the development of a Value-Based Italy model. This was done in terms of main directions, opportunities to exploit and obstacles to overcome, in order to ensure the creation of a healthcare model oriented towards value generation.

The workshop proceedings, the evaluation of "thematic insistence" coefficients, as well as the collection of key terms expressed by the Center's Community, allowed for the crystallisation of three main directions that must be addressed in the development of an Italy-specific VBHC model:

- ORGANISATIONAL MODELS, PATHWAY AND DATA INTEGRATION
- THE ROLE OF THE PATIENT
- VALUE PROCUREMENT AND HEALTH TECHNOLOGY ASSESSMENT

[8] Colldén C., & Hellström A., 2018. *Value-based healthcare translated: a complementary view of implementation.*

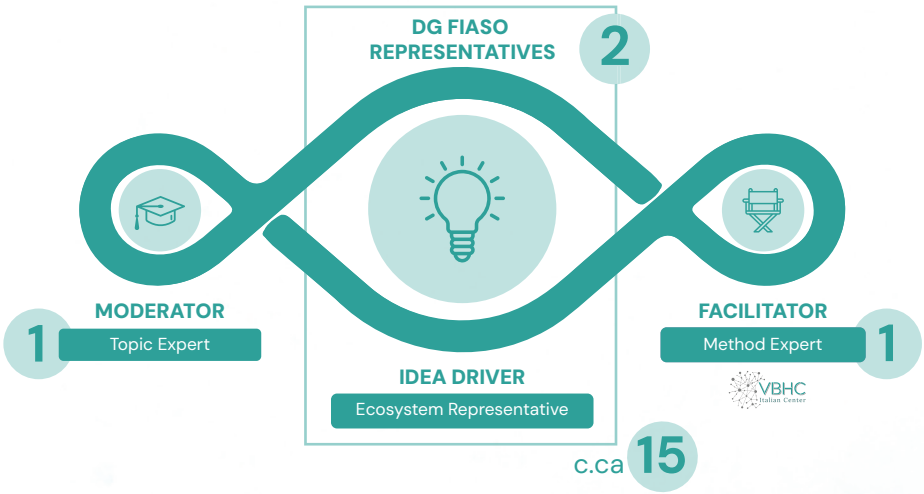
The First VBHC Italian Center Summit

The First VBHC Italian Center Summit, held in Rome on 26th September, not only represented a unique and extremely valuable moment for in-depth exploration of the topic on two levels—institutional (thanks to the roundtable discussion with the main stakeholders of the healthcare ecosystem) and operational (thanks to the presentation of a collection of field experiences)—but also provided the opportunity to develop technical working groups focused on each specific thematic area.

National and international sector experts, institutions, associations, general directors, clinicians, academics, and representatives from the industry, procurement, and patient associations gathered in thematic roundtables. They were guided through a deeper exploration of each thematic area and its impact in relation to the reference context, identifying gaps and highlighting the benefits it offers. The context presented as occasionally ready in terms of opportunities, yet immature in terms of limitations and vulnerabilities. The work facilitated a guided exchange, encouraged cross influences and lateral thinking, and supported the generation of inputs for cultural change.

The Protagonists of Roundtables

Each roundtable is made up of various stakeholders, each with a specific role to play in guiding the discussions.



The Working Method

For the management and development of roundtable discussions, a specific method based on ATP thinking was defined within the Center.

The ATP acronym:

- Refers to the three distinct phases of development of the Roundtable:

- Refers to ATP (adenosine triphosphate): the most important energy carrier in our body and ideally in our Health System.

Each phase of the work has specific objectives and tools.

Analysis and Development of the Thematic Guidelines for the VBHC Italian Model

The discussions and reflections arising from the various technical working groups have provided the foundation for the drafting of this document. This document aims at taking an initial step in the development of the VBHC Italian model by systematising a series of insights and considerations. It aspires to serve as a preliminary yet tangible guide—an initial action plan to be implemented in order to facilitate a comprehensive and systemic transition towards a value-based healthcare model.

The paper examines the framework of each thematic direction as a key pillar for the development of the VBHC model, with the aim of ensuring optimal alignment between its progression and the relevant context or scenario.

Organisational Models, Pathway and Data Integration

Maximising value for the patient by achieving the best possible balance between optimal clinical outcomes and the costs incurred necessarily requires innovative and disruptive organisational choices.

This involves organisations that, among other strategies, focus on process redesign with a view to agility and value maximisation, fully leveraging the potential offered by the integration of Lean Healthcare Management and the VBHC approach in terms of generated value.

Cross-cutting, Integrated and Multidisciplinary Dimension

Discussing VBHC organisational models entails reconsidering and restructuring healthcare organisations to better coordinate services and optimise patient management. This approach promotes integration to ensure patient-centred care, active patient participation and the effective delivery of health outcomes. Integration and coordination are two overarching themes that encompass the entire organisational structure, spanning various care settings, people and professionals, data and tools. This requires the development of models that support value creation throughout the care delivery process, addressing specific health needs while shifting the focus from service volume to meaningful health outcomes for patients.

Indeed, the first of the six points in Porter's Agenda emphasises the importance of "organising healthcare delivery around specific medical conditions"[9], through the implementation of Integrated Practice Units (IPUs).

[9] Porter M. E., & Lee T. H., 2013. The strategy that will fix health care.

This approach entails structuring healthcare services around specific medical conditions rather than around traditional specialities or departments. Integrated Practice Units (IPUs) are multidisciplinary teams managing all stages of treatment for a given condition, from initial contact to long-term care, ensuring continuous and integrated assistance.

Particularly in the context of chronic disease management, the complexity of the various stakeholders involved necessitates looking beyond the boundaries of a single healthcare provider. It requires fostering collaboration and integration across care pathways, settings and system stakeholders—including hospitals, community healthcare facilities, home care, general practitioners, insurers and patients—to ensure that decisions are made with a focus on improving patient outcomes while reducing costs that do not generate the expected value.

A notable example of bold organisational transformation in line with the VBHC approach is the Karolinska University Hospital in Stockholm. This hospital was designed from the ground up with an innovative structure that prioritises patient-centred care, moving away from traditional speciality-based models towards a new thematic organisation. The core unit of this model is the flow, defined by the specific condition being treated, with a corresponding managerial role: a Patient Flow Captain (PFC) assigned to each flow. This "horizontal" organisation based on themes and flows intersects within a matrix system with five "vertical" functions guiding the patient's journey, shifting the focus from specialities to conditions. The thematic organisation allows greater emphasis on the general clinical needs of patients.

To ensure dedicated multidisciplinary assessment and intervention, each flow is assigned a specialised team—the Patient Flow Management Team—which oversees not only the clinical process but also financial responsibility[10].

Expanded Alliance

Organisational models prioritising patient-centred care focus on redefining the patient's role, moving beyond a "passive" position towards an active and engaged one. These models are based on a renewed approach to relationships, characterised by partnerships and "expanded" alliances within a multi-stakeholder framework, involving doctors, healthcare professionals, patients and their families.

Ensuring patient-centred care and delivering a coordinated and integrated response to their needs requires organisational models able to establish multidisciplinary teams. These teams collaborate to manage the entire care pathway for a given condition, optimising processes and enhancing the quality of care.

Further alliances and partnerships can also be fostered at an ecosystem level. Healthcare providers alone often lack the necessary expertise and resources to drive effective innovation.

[10] Lega F., Cavazzana L., Magnoni P., 2020. Il modello di value-based healthcare del Nya Karolinska Solna (The Value-Based Healthcare Model of Nya Karolinska Solna).

For this reason, it is essential to establish collaboration with the industry, conceiving it not as an outsourcing of innovation, but as a strategic partnership. Industries can provide support and guidance, helping healthcare organisations identify the priorities that truly generate value.

Measurement: Data Usability and Integration

Measurement is another key aspect. It is essential that outcomes, or the value perceived by the patient, are measured effectively, efficiently and clearly, avoiding unnecessarily complex approaches and immediately clarifying the measurement goals.

To create a mechanism promoting the value generated through effective measurement, another form of integration becomes equally important: data integration. This involves the flow of clinical and administrative data across the entire care pathway and all the settings in which the patient is involved. Clearly, the usability and integration of data related to the individual patient are critical success factors for monitoring and evaluating outcomes throughout the entire care cycle, in terms of health and well-being, as well as the costs incurred to achieve them. These costs should be calculated by associating the time and resources, both direct and indirect, dedicated to each stage of the care process.

The digitisation of health data, the use of solid and advanced analytical platforms, as well as digital innovation to ensure the sharing of information provide a holistic view of the care pathway, facilitating clinical decisions based on concrete, timely and easily accessible data.

Although artificial intelligence is widely discussed today, the reality is that reliable and robust databases are still lacking to fully realise the potential of this innovative tool. The choice of projects should be guided by existing information assets. In the absence of such assets, it is necessary to develop Value-Based Information Systems able to support the decision-making process.

Data analysis not only forms the foundation for measurement but can also rationally guide the design of care pathways and promote comparison and benchmarking on value-based performance achieved across similar care pathways.

Although data and technologies are available, they are often underutilised. It is imperative to create teams capable of collecting data and, subsequently, providing the necessary support for its interpretation. Without this, it becomes difficult to conceptualise improvement models for the healthcare system.

At an international level, several institutions have adopted innovative methods to integrate organisational models and data within VBHC. In countries like Sweden, data integration has enabled the creation of national health registries that track patient outcomes on a large scale, providing valuable insights for the continuous improvement of clinical practices. For example, the NHS in the United Kingdom has implemented

the 'My Care Record' programme, which allows the integration of health data across different services, improving the continuity of care and the personalisation of treatments. These methods require a cultural and organisational shift, but they offer the opportunity to radically transform healthcare.

People-Driven Change

Beyond the strategic dimension, the execution phase is evidently guided and, if we may say, even influenced by the people who are actively part of the change and organisational transformation process.

In terms of the intangible dimension, we refer to people as the driving force and lifeblood of every change process. The human aspect in the development of VBHC models refers to all individuals who, in various capacities, take an active role in it. This includes leaders—those who drive the change, from strategic management to other organisational levels—key individuals who, through true leadership, ensure that the seeds of VBHC models sprout and flourish across the organisation, becoming self-sustaining over time. Among the leaders driving the change process, the role of General Directors is central. This is due to their ability to have a global view of the organisation, albeit at a high level, but also, and above all, due to the opportunity to engage with external realities and translate benchmarking into the adoption of new organisational models and/or best practices from similar contexts. Their role is to conduct a comprehensive analysis of the organisation, not only in terms of economic sustainability, but also regarding the efficient use of available resources.

Alongside the leaders, we find professionals—both clinical and administrative—who play a central role in the development process and transfer VBHC principles and tools into their daily operations. Of course, patients also play a crucial role, expanding the traditional concept of "patient" to include the "citizen" or "person", potential users of value-driven initiatives. The active participation of patients, expressing their expectations and satisfaction in terms of health and the value they anticipate, becomes a key tool in aligning actual needs with the key actions that should guide change.

In a nutshell, an organisational model oriented to VBHC:

- Is featured by an organisational and managerial approach based on transversal integration and multidisciplinary care pathways, creating strong alliances between professionals and patients, as well as between healthcare organisations and the key players in the health ecosystem.
- Is capable of measuring results in terms of produced value and costs incurred throughout the patient's care journey, with accessible and integrated data, thanks to advanced information systems tracking clinical and administrative data across all settings, promoting benchmarking on performance achieved with equal needs and pathways.

- Fuels change processes by placing people, including patients / citizens, at the heart of the journey.

With the contribution of:

Marsilio Marta, Full Professor, University of Milan and President of IRCCS Carlo Besta Neurological Institute

Colombo Eva, General Director, ASL Vercelli

The Role of the Patient

In the context of Value-Based Healthcare, patient involvement emerges as a fundamental element in creating a healthcare system aimed at maximizing the value of care. This approach focuses not only on clinical effectiveness but also on the personalization of the care pathway, listening to and integrating the experiences and perspectives of the patients themselves.

Patient Engagement

Active patient participation translates into a series of tangible benefits: from increased satisfaction and adherence to therapies to improved clinical outcomes and reduced overall costs. Methods such as "Patient Empowerment"[11] and the creation of personalized care pathways are tangible examples of how engagement can be implemented, allowing patients to take a more active and informed role in decisions regarding their health. This leads to more effective care.

In support of this, existing literature highlights how greater patient involvement can lead to more effective management of chronic diseases and a reduction in unnecessary hospital visits, emphasizing the importance of well-structured engagement strategies.

[11] Wallerstein N., 2006. What is the evidence on effectiveness of empowerment to improve health?

Moreover, a study published in the "Journal of the American Medical Association" (JAMA) highlighted that patient engagement programs can improve clinical outcomes and reduce healthcare costs[12]. These studies provide actual evidence that involving patients not only enhances the quality of care but can also contribute to a more efficient and sustainable healthcare system.

Moreover, at an international level, there are many VBHC initiatives where patient engagement plays a key role. For example, the United Kingdom's NHS has adopted the VBHC framework to improve the quality of care provided to patients, introducing the "Patient Reported Outcome Measures" (PROMs) program, which collects patient feedback on their health conditions before and after elective surgeries[13]. This allows for evaluating the impact of healthcare interventions from the patient's perspective, thus guiding clinical decisions and health policies toward outcomes that truly matter to patients.

Another example that demonstrates the importance and validity of the patient's role, beyond the characteristics of the National Health Service (NHS) in which it is implemented, comes from the United States. The Centers for Medicare & Medicaid Services (CMS) has promoted the VBHC model through its "Value-Based Purchasing" program, which incentivizes hospitals to improve the quality of care by offering financial incentives based on performance[14]. This program focuses on quality measures such as patient safety, clinical effectiveness, and patient satisfaction, encouraging hospitals to actively involve patients in the care process.

Initiatives like these highlight the importance of a healthcare approach that values patient involvement, recognizing that their experience and feedback are essential to building a healthcare system that delivers high-value care.

In Italy, even at local, regional and interregional levels, initiatives are emerging that integrate the principles of VBHC with strong patient involvement. A relevant example is the "Osservatorio PROMs e PREMs", coordinated scientifically by the Scuola Superiore Sant'Anna di Pisa, which involves various regional healthcare systems and healthcare organizations. This monitoring authority collects patient-reported outcomes (PROMs) and patient-reported experience measures (PREMs) to evaluate and improve the impact of care with a solidaristic, population-based approach, providing valuable insights to guide clinical decisions and health policies toward aspects that matter most to patients.

However, this process is not without challenges. First, there is a cultural challenge—changing the traditional perception of the patient as a mere recipient of care to embrace a more active and participatory role. This shift in mindset requires time and commitment from both healthcare professionals and patients, and it necessitates adequately informing patients[15] about their conditions and available treatment options.

---

[12] Michalowsky B., Blotenberg I., Platen M., et al., 2024. Clinical Outcomes and Cost-Effectiveness of Collaborative Dementia Care: A Secondary Analysis of a Cluster Randomized Clinical Trial.

[13] NHS England, 2018. The national Patient Reported Outcome Measures (PROMS) programme.

[14] Burwell S. M., 2015. Setting value-based payment goals—HHS efforts to improve US health care.

[15] Coulter A., Entwistle V., & Gilbert D., 1999. Sharing decisions with patients: is the information good enough?

This requires the creation of accessible educational materials and the implementation of training programs that can increase health literacy and help overcome language barriers. Indeed, the complexity of medical language and the differences in levels of understanding can make it difficult for patients to actively participate in decisions regarding their health.

On a practical level, patient engagement also involves evaluating the accessibility and usability of existing technologies, which are supportive but, in some cases, a challenge in themselves. It is important to consider:

- The necessary trade-off associated with the increase in the average age of the population.
- The consequent need for simple, integrated and user-friendly tools.
- The complexity of measuring outcomes from the patients' perspective (in terms of defining and quantifying what is important to them, which is closely tied to their experiences and expectations).
- The guarantee of data protection and respect for privacy.
- The impartiality and sustainability of such engagement.

For all this to work, it becomes essential that all patients have the opportunity to be engaged in their care journey, regardless of their socio-economic background. At the same time, engagement models must be sustainable and easily integrated into the daily routines of healthcare facilities.

Overcoming these challenges requires collective effort and continuous evaluation of patient engagement strategies to ensure that VBHC can truly centre the healthcare system around the patient, improving the quality of care and the overall efficiency of the healthcare system.

To bring out what truly matters to patients in a VBHC context, a cultural change is essential, enabling different stakeholders to engage in dialogue around the concept of value at the levels of the organization, region and national healthcare system in Italy.

Value Co-Production

The patient plays a key role in identifying, measuring and creating value, by pinpointing elements to act upon to modify processes, outcomes and experiences. This results from collaboration with individuals and users, allowing for innovation generation. The very notion of value requires examination from multiple perspectives: in its personal sense, taking into account the needs, preferences and values of patients; as Societal Value, which refers to the value created with a positive external impact; as Social Value[16] in connection with Population Medicine, highlighting the value generated when communities are activated. This recent field of research studies the co-production that arises when individuals are activated to act "in place of" others, with the transfer of power and role that follows, significantly impacting the redesign of care pathways.

[16] Pennucci F., De Rosis S., Murante A.M., Nuti S., 2022. Behavioural and social sciences to enhance the efficacy of health promotion interventions: redesigning the role of professionals and people. Behavioural Public Policy.

This highlights the importance of expanding the pool of potential contributors to the definition of value: the patient, the individual, the user, the caregiver, but also and especially the community they belong to. It is likewise essential to review the effectiveness and impact of patient associations within healthcare organizations. While collaboration with patient associations is foreseen at systemic level through Participation Committees, we must take a step further and actively involve them in the decision-making process, enabling them to have a meaningful impact at both the organizational and regional levels.

There are experiences of Community Building on processes mapped in a multidisciplinary way, which can lead to the construction of Diagnostic and Therapeutic Care Pathways (DTCPs) shared by all stakeholders, including General Practice and the active participation of patient networks.

Micro-Meso-Macro Value Co-Production

These levels of activity, focusing on the importance of active patient engagement in their care journey, have the power to influence organizational culture and to facilitate the shift from one-off initiatives to systemic actions.

At Micro level, the focus is on the relationship between healthcare professionals and patients, which requires a combination of communication skills, active bidirectional listening, health literacy levels and a patient-centred approach to the care pathway offered to the individual.

At Meso level, the importance of organizational models, particularly their flexibility or rigidity from a VBHC perspective, is emphasized. The cross-cutting importance of care coordination and integration activities is crucial for the achievement of a comprehensive vision of patient care. Furthermore, the interoperability of digital platforms for data integration plays a significant role, as does the training and education of healthcare professionals. In particular, the latter asset is strategic in exposing professionals to these issues from the start, promoting a mindset fostering the concept of integrated value, with the active role of the patient in defining it. This is complemented by the use of longitudinal quantitative tools, such as PREMs and PROMs. A positive and constructive example in this regard is the nursing science course at the University of Pisa – Scuola Superiore Sant'Anna. This course includes a managerial training program with a focus on value production in healthcare from a patient-centred perspective, fostering a comprehensive approach to VBHC principles.

At Macro level, decision-making responsibility in resource utilization and the impact that this responsibility generates in creating value and experiences for the population emerge as central. This raises the need to consider how to use PROMs and PREMs in the context of constructive benchmarking at systemic level, with an initial focus on developing awareness of the positive outcomes that can arise from comparing healthcare outcomes. This is undoubtedly a significant challenge because it requires

strong motivation and willingness to engage in dialogue on these issues. It also involves evaluating the role that part of the community can play in terms of co-producing process innovation in care.

Health Literacy

"Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health." (Health Promotion Glossary© World Health Organization 1998). For patients, individuals, caregivers, and communities to truly contribute to the improvement of healthcare pathways in a VBHC context, it is crucial to develop comprehension and expression skills enabling them to take actions to improve their health, change personal behaviours, and influence their communities through social actions that actively promote the achievement of health, rather than simply the absence of disease. This highlights the importance of implementing actions that measure and improve health literacy across all population strata, with a particular focus on patients, so that active and informed participation can be fostered. Consequently, it is vital to give significant attention to institutional communication, which, beyond being informative and positive, must also be bidirectional: a healthcare organization should communicate both to and with citizens, listening to understand where improvements can be made in the services provided.

VBHC and Patient-Centred Care

The challenge of improving and standardizing processes through patient involvement (by making visible the outcomes and experiences that truly make a difference) also involves defining how to balance this ambition with the necessary personalization of care. In fact, within the VBHC (Value-Based Health Care) paradigm, patient-centred care is one of the pillars of high-quality care but it is complex to apply in a standardized way. Speaking of the centrality of the person would also expand the scope of intervention and better define the patient's role in creating value. This requires implementing a powerful and radical shift from taking unilateral actions to improve healthcare pathways and promote health for people, to working with them in identifying how value is created within the activity flows of the patient journey, taking into account the multiple variables at clinical, functional, experiential, cultural and value-based levels.

With the contribution of:

De Rosis Sabina, Assistant Professor of Management, Scuola Superiore Sant'Anna

Natalini Nicoletta, General Director of AST Ascoli Piceno

In the world of procurement, value procurement emerges as a philosophy transcending the simple search for the lowest cost. It is a holistic approach that evaluates every aspect of a product or service, from its creation to its end-of-life use.

This concept was first introduced by Michael Porter in 2010, who identified its foundational principle in the procurement of healthcare services and technologies capable of generating the best clinical outcomes relative to the money spent[17]. Value-Based Procurement (VBP) is often practically associated with Health Technology Assessment (HTA), a multidisciplinary process that synthesizes information regarding the medical, social, economic and ethical implications of using a healthcare technology in a systematic, transparent, impartial and robust manner. This process includes the analysis of clinical evidence, costs and the organizational and social impacts of healthcare technologies. HTA is therefore closely related to Value Procurement in the healthcare sector, as it plays a fundamental role in providing a solid information base for purchasing decisions. Through HTA, healthcare organizations can identify medical devices and technologies that offer the best value for money, considering not only initial costs but also long-term benefits for patients and the healthcare system as a whole.

Since Porter's conceptualization of value, there have been numerous European and Italian experiences applying VBP methodology. The transition from theory to practice began in 2020[18] in the field of pharmaceutical innovation procurement, with Canada[19] as one of the first countries to implement it, followed by the Netherlands, and subsequently expanding its application to a variety of areas (such as cataract surgery, breast cancer surgery, maternal and neonatal care, depression and anxiety, substance abuse[20]). The projects have since expanded from pharmaceuticals to diagnostics, in vitro tests, as well as to Medical Devices (MD) and surgical equipment[21,22].

[17] Porter M. E., 2010. What is value in health care?

[18] Pennestrì F., Lippi G., & Banfi G., 2019. Pay less and spend more—the real value in healthcare procurement

[19] Prada G., 2016. Value-based procurement: Canada's healthcare imperative.

[20] Dohmen P. J., & van Raaij E. M., 2019. A new approach to preferred provider selection in health care.

[21] National Institute for Health and Care Excellence, 2016. Controlled drugs: safe use and management.

[22] Sampietro Colom L., & Restovic G., 2018. MEAT pilot test at Hospital Clínic Barcelona: Final revision.

In Italy, the concept of value, understood as the goal of maximising benefits for patients and the healthcare system as a whole and capable of providing a significant contribution of every euro spent towards improving citizens' health, was introduced with the so-called Patto della Salute 2014-2016 agreement[23]. From this, the definition and subsequent implementation of the National HTA Programme for Medical Devices[24] emerged. A thorough experience of Value-Based Procurement (VBP) in the Italian landscape was developed by the ESTAR Purchasing Centre of the Tuscany Region, which, in relation to certain medical devices primarily in the field of arrhythmology, applied the VBP methodology. Following some trials conducted by ESTAR, it was demonstrated that the effort to verify what actually happens to the patient using a specific device—that is, the real-time monitoring of clinical outcomes—reduces the discretion of the technicians in favour of objective parameters[25]. The Tuscany Region was the first in Italy to adopt two resolutions[26,27], establishing Value-Based Procurement as a consolidated approach for the procurement of medical devices. This was aimed at combining strategic procurement and value for patient health.

What are the concepts and issues underlying the Value-Based Procurement model?

Cultural Transition

To shift from a purchasing logic based solely on costs to one based on evaluating the health outcomes that a product or service can deliver, a significant cultural shift is required, involving all stakeholders in the procurement chain. Current structures are still constrained by bureaucratic procedures that create congestion in the management of access to tenders and their structuring. Even scientific societies have not yet defined guidelines aligned with value-based principles, understood not only as a synonym for cost reduction but considering all the variables that contribute to improved outcome quality. Therefore, it is essential to develop an innovative vision that goes beyond the centrality of the tendering process. This vision should be based on fundamental characteristics such as collaboration among stakeholders in the process (e.g., procurement centres, suppliers and regions) for the sharing of information, patient involvement and training operational teams to support them in value analyses.

[23] State-Regions Conference, 2014. Health Pact for the years 2014-2016: Article 9, paragraph 2 of Agreement No. 82/CSR of 10 July 2014.

[24] Ministry of Health, 2023. Decree of 9 June 2023: Adoption of the National HTA Programme.

[25] Monica P., 2023. Value-Based Procurement Programme for high-frequency neurostimulators in diabetic neuropathy – Tuscany Region.

[26] Tuscany Region. Resolution No. 1093/2019 – Recommendations for drafting tender specifications for the procurement of medical devices.

[27] Tuscany Region. Resolution No. 1038/2021 – Regional guidelines on Value-Based Procurement of established-use medical devices.

Starting from a literature review and the definition of value procurement, it is essential to focus on the tools and different purchasing methods that enable the selection of products and services capable of delivering the best care at an accessible cost, based on outcome evaluation. In addition to the previously mentioned Health Technology Assessment (HTA), which, through a systematic process, assists decision-makers in determining which technologies should be adopted and integrated into healthcare systems, another key tool is Bundle Payment. Michael E. Porter, in developing his agenda for Value-Based Healthcare, included the concept of Bundled Payment (BP) as one of its key components, defining it as the best financing method for value-based care. Unlike traditional financing models, BPs are structured around patients' specific needs, covering an entire care cycle for acute conditions or comprehensive treatment over a defined period for chronic diseases. They also include incentives aimed at achieving health outcomes beyond predefined expectations[28]. This highlights the importance of defining specific Key Performance Indicators (KPIs) at a contractual level, structured into fixed and variable components based on the achievement of specific goals. These may relate, for instance, to HTA themes, alongside the implementation of a monitoring system throughout the contractual lifecycle. This system should justify additional rewards or penalties depending on whether objectives are met. For this reason, bundled payment models are considered superior to capitation models by Porter, as they encourage competition among service providers to create value for patients, thereby improving care quality and reducing costs[29].

A key consideration for the entire procurement supply chain is the potential combination of these two tools to support more informed, evidence-based decisions regarding the adoption of new technologies and their management in care delivery. To create value-based tenders, a new approach is required, based on the following conditions:

- ***Public-Private Collaborations.*** Healthcare institutions must engage with private companies to develop service packages based on HTA and financed through bundled payments.
- ***Feedback Systems.*** The implementation of continuous feedback mechanisms, integrating patient experience data with HTA evaluations.
- ***Patient Involvement.*** Ensuring that patients participate in the decision-making process.
- ***Training of Healthcare Professionals.*** The need for specialised expertise to manage clinical processes, appropriateness of care, and economic sustainability.
- ***Policies and Regulations.*** Collaboration with institutions to develop guidelines and regulations that support the integration of value procurement (scientific societies have yet to establish guidelines aligned with value-based principles).

[28] VIHTALI Università Cattolica del Sacro Cuore, 2018. The Value Agenda for Italy.

[29] Kaplan R. S., 2016. The case for bundled payments in health care.

Ultimately, full transparency among stakeholders must be ensured regarding expectations and potential benefits for all individuals affected by a condition. This includes selecting appropriate measures and metrics to guide procurement decisions and assess the achievement of each programme's overarching objectives. Suppliers should be chosen based on objective and measurable performance evidence rather than solely on price or lower costs, with greater accountability for the final outcome of the contract. As a result of this new approach, decisions made during the product evaluation phase are based on the principle that, although a product may have a higher initial cost, a longer lifecycle with lower overall expenses generally justifies a greater upfront investment[30,31].

Patients as Active Partners

It is now widely recognised that pursuing objectives derived from the patient's perspective is fundamental. Direct feedback on adopted technologies and treatments helps to inform purchasing decisions, while patient involvement ensures that the implemented solutions effectively address their real needs and enhance their overall experience. However, what level should patients be involved, and how can their support within value-based procurement be maximised? This question highlights the significance of the patient's perspective and their active role in the procurement process to achieve a sustainable healthcare system. It requires the establishment of an engagement framework that begins with identifying the "typical" patient—someone who accurately represents their category through direct experience. Selected patients should then undergo dedicated training and education programmes to understand the purpose of their involvement and the role they will play throughout the entire process.

Nevertheless, it is important to acknowledge that all Value-Based Healthcare (VBHC) procurement initiatives come with challenges and difficulties. In particular, resistance is often encountered, especially in the initial stages, from both the business sector and technical committees. These stakeholders are required to engage in public-private partnerships for the co-design and co-management of evidence-based procurement mechanisms, which involve defining measurable clinical outcomes. This, in turn, necessitates not only deep technical expertise but also long-term commitment to collaboration, with a different perspective on shared risks and responsibilities. Furthermore, such procedures are highly complex and cannot be applied to all types of procurement transactions. They are, therefore, suitable only for specific products or services where their implementation can generate tangible value.

[30] Mvere D., & Bond K. (Eds.), 2002. The blood cold chain: guide to the selection and procurement of equipment and accessories.

[31] Pennestrì F., Lippi G., & Banfi G., 2019. Pay less and spend more—the real value in healthcare procurement.

However, an outcome-based procurement process presents a significant opportunity for the National Health Service (NHS), as it both generates health benefits and enhances sustainability. Moreover, it fosters a trust-based dialogue and the alignment of shared objectives with suppliers. This approach not only improves the quality of products and services but also encourages innovation, leading to solutions that have the potential to transform the entire sector.

With the contribution of:

Caltagirone Alessandro Maria, General Director, ASP Siracusa

Marchesi Cristina, General Director, AUSL Reggio Emilia

Snapshot of the Maturity Level of the Context: Limits, Weaknesses and Opportunities

In an effort to chart the most effective path for developing VBHC organisational models, the characteristics of which have been outlined earlier, it becomes crucial to ask ourselves how and to what extent the current context is ready to face this challenge.

This section, which revisits the work carried out during the Summit through thematic roundtables using the ATP method, is dedicated to capturing the state of maturity and receptivity of the Italian context. The aim is to provide an analysis that, on one hand, highlights the limitations and weaknesses of the current framework, while on the other, underscores the opportunities it offers at this particular historical moment. The analysis will be structured around three main areas: Culture and Skills, Models and Tools, and Rules.

Culture and Skills

The introduction of innovative models in healthcare, as in any other context, is not an easy process; the support and drive necessary to face such a change cannot solely rely on the introduction of new rules or tools, but must be grounded in an essential cultural shift. Cultural change, in turn, cannot be reduced to a mere recipe of notions and techniques, but involves the deep internalisation of new values and principles, which are reflected in the way strategies and changes are interpreted and implemented, and in how these values permeate everyday practices. This represents a renewed effort to break down the typical barriers of resistance to change, which are a significant obstacle to an urgently required transformation.

The introduction of new VBHC organisational models also suffers from the classic resistance to change, both generational and cultural, alongside the difficulty of

"disconnecting" from the daily routine to take a step towards innovation and moving away from the entrenched mentality of "we've always done this way". This inability to move beyond the boundaries of one's daily comfort zone is often due to a general mistrust in the system, which further complicates overcoming the current state of affairs and adopting new approaches.

The real breakthrough, essential for overcoming these barriers, lies in the profound shift in mindset and organisational culture, which translates into thinking and creating an organisational model focused on delivering value perceived by the patient, led by data-driven decisions and based on care pathways characterised by efficiency and effectiveness.

The current fragility of the VBHC culture is the result of:

- A regulatory system traditionally oriented towards parameters other than patient value.
- Models traditionally organised in specialist "silos".
- An educational offering that has not yet been updated to new value-based healthcare models.
- A lack of training in leadership and soft skills.

The cultural gap is evident not only among professionals and operators but also among patients and their caregivers, and more broadly, among service users, citizens and communities.

There is a lack of a shared cultural foundation and a common language capable of bridging disparities in power and communicative skill among various stakeholders. This foundation should empower the patient not only to produce data and experiences but also value by actively participating in the measurement of outcomes and experiences for process innovation. The real challenge, therefore, is to foster a holistic cultural change that fully involves all stakeholders, not just healthcare professionals, but also patients, who, through healthcare empowerment, can make a difference in decision-making moments, actually contributing to the shift from a "performance-based" approach to a "health-based" approach.

Alongside culture, there is the entire set of **competencies** possessed by the staff, which are essential for embedding the cultural shift and making it operational. Both hard and soft skills must necessarily be present and introduced at various levels of the organisational structure. A competency-related issue concerns the collaborative gap between clinical and administrative staff, which arises from differing visions and objectives. This becomes a critical issue, particularly in procurement, where the lack of integration between these two perspectives—especially due to the absence of clinician involvement in shaping competitive dynamics—hampers effective purchasing planning. This prevents purchases from aligning with specific clinical needs and, on the administrative side, it fails to ensure compliance with regulatory and economic constraints. The **integration of skills**, fostered by greater collaboration between clinicians and administrative staff, is crucial for structuring more informed tenders, where quality is not viewed as an additional cost but as a key element capable of

generating economic value. The added value, therefore, lies in communication and the ability to translate clinical needs into concrete parameters for tenders. Even multidisciplinary and multiprofessional teams, which have been widely developed in recent years and are key elements of VBHC models, also present an opportunity for cultural permeability and inclusion of expertise. The influence of diverse competencies and methodologies acquired represents, in this context, a critical opportunity to transmit the culture of value and to drive continuous improvement in the healthcare system. The lack of competencies is an issue rooted in education, which is not yet equipped to meet the demands of the current healthcare system. University training itself often proves inadequate, failing to equip future professionals with the skills needed to navigate the sector's complexity and tackle emerging challenges.

In terms of competencies, the current context presents a significant opportunity: leveraging the generational shift associated with the retirement curve. This transition serves as a catalyst for breaking established patterns and preconceived notions, fostering greater openness to innovative approaches. This is a pivotal moment—an opportunity to enhance competencies and reinforce a *data-driven* corporate culture centred on patient value, ensuring a shared and coherent **language** for effective communication. Often, the difficulty in communication among different stakeholders, and even within the same group, arises from the absence of a shared language and a common framework. This lack hinders effective collaboration and coordination, thus compromising the success of decision-making processes and shared initiatives.

Training is an issue that cannot be confined to the "professional" dimension, which involves those working to provide a service to meet the needs of a patient and who interface with them, but must necessarily involve and incorporate the patient as well.

The powerful role of the patient encounters a disempowering factor—the weakness of their own voice, which is constrained by low **Health Literacy**, a poor understanding of the healthcare system's functioning, and a lack of awareness of actionable steps and expected outcomes. These factors make it critical for citizens to participate in defining the health offer or in the creation of value-based tenders. On the other hand, we have all the tools provided by the ongoing digital revolution that enable the establishment of structured listening channels, social listening, feedback provision and the creation of person-centred initiatives, fostering a dialogue between citizens and clinicians.

Another point of weakness concerns the **recruitment system**. The current model is not always able to respond to the real needs of healthcare organisations, often leading to the hiring of staff whose competencies and culture do not align with the requirements needed to support the transition to value-oriented organisational models.

Skills such as data management, data analysis, project management, leadership and value procurement, although crucial in this transitional phase, must contend with a context characterised by extreme rigidity in task shifting. When discussing **leadership**, a key element in the development of large-scale change projects, it is necessary to broaden the scope to include the concept of "ownership" of processes and to ensure a clear definition of responsibilities at each stage.

To date, few organisations focus on the **introduction of new key roles** that, with appropriate competencies, can embody the role of "orchestra conductor" for the entire process, ensuring the introduction and management of new technologies and methodologies in a way that is consistent and aligned with the system's value objectives. These roles must facilitate cross-disciplinary collaboration, support project management and ensure that the healthcare system evolves in accordance with its strategic goals.

Models and Tools

The crisis of the NHS is a crucial opportunity to rethink established, volume-driven practices and advocate for **models** that drive organisational transformation towards approaches that emphasise the **value** of the services provided. The acute shortage of human resources necessitates an urgent reassessment of pathways and utilisation strategies for the limited available resources, highlighting the critical need for the consistent application of reference models across the entire national territory. If models capable of producing value need to be defined, it is important to address a point related to the lack of general agreement on the type of value that should be delivered within the healthcare system, a topic affected by the unclear and inconsistent **definition of value** across the various stakeholders involved. While, over time, the value in its clinical dimension, as well as the quality of the patient journey and experience, has become more clearly defined in the context of healthcare procurement, the short-term horizon in which its costs and benefits are analysed presents a critical issue that must be considered. Current **operating modes** are unable to support value-driven strategies. Therefore, this is a productive moment to begin defining the scope of pilot initiatives based on target pathologies, particularly focusing on those prevalent in terms of healthcare expenditure, such as chronic conditions. We are facing a context where, from North to South of the country, there are isolated experiences of VBHC projects, realised following a bottom-up approach and driven by the visionary leadership of a few. Although this represents an opportunity, the downside is represented by institutional stagnation, with regional systems that do not always internalise pilot experiences, which inevitably "die" with their promoters, generating widespread distrust in system change. Thus, while the bottom-up approach may appear "successful" on paper, it becomes a boomerang if pilot initiatives launched by enthusiastic professionals, equipped with skills and leadership, fail to secure the necessary support for their natural evolution. Many of these innovative efforts tend to dissipate along with the individuals who proposed them, lacking the appropriate scalability. The absence of a clear strategy to integrate and foster these initiatives prevents them from transforming into sustainable and replicable models, thereby limiting the potential for change that they could bring to the healthcare system.

Bureaucracy, along with fragmented and overly complex procedures ill-suited to multi-stakeholder processes, makes systemic change exceedingly difficult—pushing feasibility to its limits. This, in turn, fosters a fragmented, non-systemic approach that obstructs the development of agile, value-driven models.

The current context exhibits clear signs of an ongoing cultural shift that must be supported and reinforced at all levels—transitioning from a disease-centred approach to holistic care. At the heart of this paradigm is what patients truly value throughout their healthcare journey, shaping both their quality of life and overall health. These elements are increasingly central to the redefinition of the patient journey.

Patient involvement is, therefore, central. From this perspective, clinicians cannot overlook the importance of listening to patients and their caregivers as individuals living within their specific communities, as these aspects significantly impact possible health outcomes. New operational models must consider the patient as a member of the care team. A valuable opportunity lies in the application of "integrated medicine" in clinical practice and in identifying what makes a difference for patients in the patient journey. Two factors in particular seem to favour this paradigm shift: on one hand, the presence of Patient Associations and the Third Sector, where highly motivated volunteers work to understand what it means to produce health and not merely provide services, could act as a catalyst for change within the communities they serve, enhancing awareness and direct involvement in the change processes. On the other hand, the presence of healthcare professionals who are better trained and able to perform cross-functional roles in coordination, information, and communication enables the consideration of an integrated vision of care pathways and their impact on outcomes and patient experiences. The immense value of patient involvement extends far beyond the patient journey, influencing procurement decision-making processes. It is clear that while the patient is the ultimate beneficiary of healthcare services and bears the associated costs, their perspective and evaluative input remain undervalued in the decision-making process. Even when patients are involved, which is a rare occurrence, they are often not fully and effectively engaged, leading to confusion and informational distortions. The implementation of a recruitment and selection process for the "ideal" patient is becoming increasingly urgent and central; this refers to the individual who, through their direct experience, can truly represent the voice of their category. The collection of the patient's voice remains weak, whether through direct interactions with individual patients or through large-scale surveys involving a broad number of patients, which can yield generalisable data to guide clinical and organisational decisions. A key focus in the development of VBHC models should be on the more technical and instrumental aspects, as well as the broader concept of **digitalisation**. We are currently experiencing a historical moment marked by rapid technological development, particularly in the field of artificial intelligence, creating a favourable context for the development of integrated **data** management models. Recent digitalisation initiatives, together with resources from the National Recovery and Resilience Plan (NRRP), present unique opportunities to promote a conscious approach. On one hand, it can be stated that post-COVID digitalisation has raised awareness of data, and large amounts of data are now available. On the other hand, there is a need for "conscientious" integration aimed at adding value. Although data are existing—consider, for example, the vast quantity required to meet various information obligations—they are often not fully accessible, highlighting how a precious information resource remains underutilised. Each healthcare facility manages

its own database independently, leading to a situation where the data remain isolated, unintegrated, and therefore inaccessible and unusable within a "patient pathway" logic. Additionally, privacy regulations and GDPR impose further restrictions on data use, complicating access and utilisation of information. It is important to recognise that while access to data is taken for granted in the context of VBHC, the reality is that without adequate integration and accessibility, the potential of data remains untapped and cannot effectively contribute. There is also a communicative deficit related to IT, interoperability, system integration and data accessibility within a "patient pathway" framework. These are critical factors impacting multidisciplinary collaboration, the timeliness and appropriateness of clinical decisions, as well as the measurement of the actual value produced and the associated costs.

A critical aspect concerns the **collection of outcome data**. Currently, healthcare organisations face a significant lack of outcome data that can adequately certify the results of care. Once clinical objectives are defined and the hospital phase is completed, patient information is often lost, limiting the evaluation to a superficial view that considers the patient as "cured" without exploring other relevant factors, such as quality of life or long-term health conditions. The absence of comprehensive information on long-term clinical outcomes represents one of the largest gaps in the current system, limiting the ability to certify results and to monitor the effectiveness of technologies or treatments over time. A telling example is shown by gene therapies, recognised as interventions with high potential value, but for which there is still a lack of robust data to certify their long-term impact. In defining a structured data management system, the starting point is the establishment, by the participants in procurement tenders, of the clinical objectives to be achieved, the data required to measure them, and the methods for monitoring and reviewing progress. A supportive tool for information gathering in tenders is the **HTA** (Health Technology Assessment), which can enhance the collection and usability of outcome data, providing a solid foundation to properly define and structure tenders. The HTA can be a crucial tool for assessing the effectiveness of new technologies and treatments over a longer timeframe, which is often difficult to track due to patient mobility across different regions. Only through accurate data collection and subsequent in-depth analysis will it be possible to ensure the sustainability and effectiveness of the healthcare system, preventing patient information from being lost once hospital treatment has been concluded. The same methodologies used in the definition of a healthcare product can also be applied in the design of a procurement tender, ensuring consistency, transparency, and a focus on outcomes that can deliver tangible value to the healthcare system. Methodologically, it is useful to apply the same criteria used in HTA to the design of procurement tenders, ensuring that every aspect of value is considered in a systematic manner.

Rules

The adoption of VBHC (Value-Based Health Care) logic requires a revision of systemic rules. Therefore, the reflection must involve all healthcare system stakeholders, starting with policymakers, including the Regions, which could play a central role as promoters of this change.

Our regulatory context is notoriously characterised by a limited willingness to embrace change, and regional systems are still far from adopting such a shift, although there are faint signs of progress in this regard. Regarding the system of rules, a central issue that emerges as a limitation and obstacle to the creation of value is the current **reimbursement models**, which are inadequate for the required change and fail to fully optimise the use of the limited resources available.

The current "siloed" funding system and outdated reimbursement mechanisms hinder change and prevent the adoption of innovative models. The existing reimbursement model tends to penalise less remunerative activities, with a predominance of economic drivers rather than health pathways, focusing on volumes rather than distributed value. This generates a mismatch between what the model requires and what is actually rewarded and valued by the system.

One of the limitations of the current model is the lack of recognition of innovations. Despite the opportunities offered by the NRRP (National Recovery and Resilience Plan), which encourage investments in digital innovation, provide resources, and call for change, investment and innovation (both digitally and in process organisation), the current system is unable to acknowledge these efforts and results. The existing constraints prevent the purchase of higher-cost goods that could generate future savings, failing to consider such purchases as true strategic investments. In this context, the NRRP represents an opportunity for the reorganisation of healthcare services according to a new model that can bring value and innovation to the system. This reorganisation should be driven by an approach that rewards long-term efficiency, encouraging investments that can ensure future benefits both in economic terms and in the quality of care.

It is imperative to change the funding model, shifting the focus from payment for disease treatment to a system that incentivises health promotion. A crucial step in this direction is the recognition of common value measures as well as the inclusion of an innovation coefficient in technical and economic evaluations, which provides a new perspective for resource allocation. This shift should also involve updating the public procurement code, with the goal of promoting value-based procurement.

Many interventions and technologies may present a high initial cost but generate significant savings in the long term, both in economic terms and in terms of patient quality of life. Many of these approaches are complex to implement, but neglecting their potential long-term benefits means losing opportunities for innovation and improvement. Once the value is defined, it must be translated into both qualitative

and quantitative objectives, with the establishment of appropriate measurement tools, such as Key Performance Indicators (KPIs), to enable an objective evaluation of outcomes. In this regard, the Italian National HTA Programme for Medical Devices 2023-2025 (PNHTA) plays a fundamental role. The regulatory approach outlined by the PNHTA provides coherence across the entire healthcare system, reducing the duplication of interventions and promoting efficiency. The application of best practices at a national level is crucial to achieving tangible results in reimbursement mechanisms, which currently remain rigid and inflexible. Continuing to work on the pathways already initiated and improving the design of tenders using these methodological principles will align the tenders with the value and quality objectives of the healthcare system.

Another key aspect is the differing funding methods of hospitals and Local Health Authorities (ASL). Currently, ASLs are funded on a capitation basis, while hospitals are reimbursed according to the Diagnosis-Related Group (DRG) system. This duality highlights the need for a unified reimbursement system that reflects real costs and accommodates new technologies.

Moreover, the current SDO coding system leads to the generation of DRGs that do not always ensure more accurate and transparent reimbursement methods.

An additional limitation of the current model is the **budgeting system**, which is not yet oriented towards care pathways and processes. It is characterised by a consolidated "silo" approach, where there is, furthermore, no legal or administrative definition of a responsible party for a particular process or pathway.

The budgeting system is based on separate dimensions of revenue, costs and investments, and is still far from, and evidently contrary to, the vision of pathway-based budgeting, which presupposes shared responsibility among the various professionals involved. Again, despite the NRRP offering rarely seen opportunities and providing the tools for change, it is necessary to adapt the budget regulation to make it effective and productive. The management and use of data, as well as patient involvement, are central aspects of VBHC models whose implementation must contend with obstacles arising from regulations regarding privacy and **data protection**, especially concerning the collection of both quantitative and qualitative data on patient functional and experiential outcomes. Current practices risk diluting the transformative potential of the reform process by hindering the participation of Patient Associations in healthcare organisations. While personal data protection is crucial, it often incumbers the collection of useful information to assess the effectiveness of a pathway, the value perceived by the patient, and the value of healthcare technologies and treatments. General evaluations, based on broader contexts, may not be applicable or relevant to local realities. For this reason, it is essential that the evaluation process takes local specificities into account, ensuring that the healthcare system's value is fully recognised in all its components.

WHAT TO WORK ON: *the Checklist of Change*

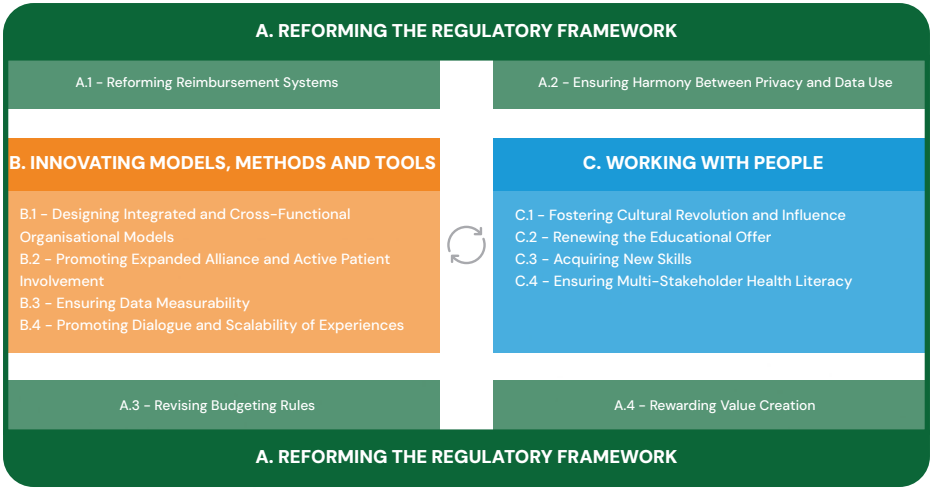
Given the complexity and multidimensional nature of the topic extensively described in the previous chapters, the transition to a VBHC model cannot be limited to the mere translation of international best practices. It must necessarily combine strategic and operational aspects within a coherent framework that integrates the various dimensions of change: institutional, technical and human.

The contribution of the various working groups aims to represent an initial, albeit ambitious, attempt to design a change pathway that, while safeguarding the foundational pillars of the model, can truly align with the reference context and avoid the fractures and natural "rejections" typical of the application of solutions that work elsewhere but do not fully address the needs of the local scenario.

This scenario has been outlined with the aim of highlighting in detail the limitations, vulnerabilities and opportunities offered in this particular historical moment. This section therefore intends to describe in a precise manner a series of actions that could allow for "overcoming limitations and vulnerabilities" and "seizing opportunities" in our Italian context during this epochal transition to a healthcare system based on "value".

In a nutshell, the change checklist is presented as a framework supported by a transversal axis, that is, the regulatory framework, within which two vertical axes operate: the technical dimension and the human dimension. This process is shaped by continuous influences, where the cultural shift and the internalisation of a new concept of health and healthcare serve as essential enablers for the implementation of innovative models.

The change process could be envisioned as a dynamic mechanism through the alternation of top-down (national and regional bodies) forces that define regulatory limits, strategies, and directions, and bottom-up (healthcare organisations, sector operators, associations, patients themselves) forces that work on the operational implementation of the same. In this way, the complex transformation process would benefit from the harmonious contribution and vision of the entire health ecosystem.



A. Reforming the Regulatory Framework

A.1 - Reforming Reimbursement Systems

This entails transitioning from a volume-based reimbursement model, centred on individual products or services, to a value-based approach that considers the entire care pathway and the distributed value across the treatment plan. The objective is to establish a model that enhances innovation—both at organisational and technical levels—to maximise the generation of value, outcomes and quality across the end-to-end patient journey.

In this regard, the institutionalisation of Patient-Reported Outcome Measures (PROMs) is crucial to validating resource allocation and expenditure management, while also redefining the concept of value.

Key Elements: Bundle Payment Model, Regional Experimentation: Health Budget, Standard Cost and Standard Tariff Model, Definition of Standard Value Drivers and PROMs.

A.2 - Ensuring Harmony Between Privacy and Data Use

For the Value-Based Healthcare (VBHC) model to function effectively, access to data is essential.

Consequently, it is necessary to work within the regulatory framework to remove existing barriers to data utilisation as a central driver in measuring value, whether clinical or personal—an invaluable aspect that can be captured through the "patient's

own voice". This requires establishing shared regulations that balance the need for data accessibility with privacy protection, ensuring that data usage adheres to stringent privacy standards while supporting value-based assessments.

Key Elements: Data Assessment, Identification of Gaps and Barriers to Utilisation, Technical Working Group with the Privacy Authority, Intervention Proposals.

A.3 – Revising Budgeting Rules

Revising budgeting mechanisms and models involves two key aspects: the temporal dimension of objectives and the logic of resource allocation.

The achievement of health outcomes necessitates an extended timeframe for setting objectives, aligning them with the broader scope of the care pathway.

Reforming resource allocation and distribution rules requires moving away from traditional expenditure silos and adopting a horizontal, cross-sectoral approach to care pathways. This approach should align with organisational models (see B.1) and support a sense of "ownership" over the care pathway.

Key Elements: Organisational Model for Care Pathways, Budget Objectives, Pathway Budget, Allocation Drivers, Pathway Ownership.

A.4 – Rewarding Value Creation

This involves introducing mechanisms able to reward value creation in healthcare by implementing standard KPIs that encompass the multidimensional nature of value for each pathology, along with benchmarking models that enable an objective evaluation of outcomes.

The incentivisation of value could therefore entail a revision of organisational performance evaluation models as well as individual performance assessments (including incentive systems, objectives for general directors and executives, etc.).

Value-based incentives also play a crucial role in procurement. To effectively measure the value of goods and services procurement, it is essential to adopt appropriate methodologies extending beyond mere economic evaluation and incorporating clinical, social and organisational parameters. Stakeholders must recognise that investing in quality and innovation can translate into a long-term value strategy, generating positive impacts on both clinical outcomes and economic efficiency.

Key Elements: Value Dimensions, Pathway Value KPI, Incentive System, Value Procurement.

B.1 – Designing Integrated and Cross-Functional Organisational Models

This entails a revision of traditional organisational models, which are typically structured in a "vertical" manner based on specialisations, departments and operational units, in favour of models designed around pathology pathways, adopting a horizontal dimension. These models should be based on: integrated units for care delivery and response to health needs; structured multidisciplinary and multi-professional collaboration; clinical and nursing ownership of the care pathway; pathway-based budgeting; integrated communication and co-working systems to foster skills integration and cross-disciplinary knowledge exchange. The methodological approach must evolve towards a greater awareness of the importance of integration by involving multidisciplinary working groups with both specialised and cross-disciplinary competencies. This ensures that clinicians and frontline staff are actively engaged in the design of processes, with the aim of making more effective decisions and optimising resource utilisation.

Key Elements: Process-based Approach, Model for Disease Pathways: Integrated Units, Multidisciplinary and Multi-professional Teams, Pathway Ownership, Objectives and Pathway Budget.

B.2 – Promoting Expanded Alliance and Active Patient Involvement

In the design, implementation, and performance measurement of new models, it is essential to adopt a holistic approach fostering structured and stable engagement of all stakeholders, following a logic of "alliance" aimed at generating health and well-being for the Italian system. This requires redefining network-based relationships by promoting "broad" and "multi-actor" partnerships that involve not only physicians but also healthcare professionals, patients and their families, as well as industry representatives and associations.

These relationships should be based on knowledge sharing, the recognition and valorisation of competencies, and the development of concrete actions through co-design and co-planning processes.

Key Elements: Multi-Stakeholder Partnerships, Patient Engagement, Competency Sharing, Permanent Multi-Actor Working Groups, Public-Private Partnerships, Co-Design, Structured Patient Involvement in Evaluation (PREMs, PROMs).

B.3 – Ensuring Data Measurability

The accessibility of data is fundamental for the development of VBHC models across the entire process, from pathway design (through epidemiological analyses and

assessments of population needs) to their multidisciplinary management and the measurement of value generated during and at the end of the care pathway.

The potential and utility of big data are directly proportional to the ability to process and effectively utilise them. Therefore, when data are available, it becomes urgent to address two key aspects: the integration of management systems and the ability to interpret and use data effectively.

Collaboration is once again crucial, making it essential to promote the establishment of working groups that also involve those who generate and use data, namely healthcare professionals.

Simultaneously, it is necessary to foster a renewed data culture and enhance competencies to ensure that once data are accessible, they can be utilised and interpreted in the most effective way. In this regard, leveraging the opportunities provided by the National Recovery and Resilience Plan (NRRP) for healthcare digitalisation is of central importance.

The integration and interoperability of systems—and consequently of data—are merely enabling conditions. Their full potential can only be realised when framed within a data-driven model capable of guiding strategies and operational actions based on objective information.

Key Elements: Regional Integration of Systems, Multidisciplinary Working Groups, Big Data, Data Analysis Competencies, National Recovery and Resilience Plan (NRRP).

B.4 – Promoting Dialogue and Scalability of Experiences

At a national level, there are numerous best practices and isolated experiences that constitute a valuable asset to be systematised. If collected and disseminated, these experiences could become part of a shared innovative framework. Some of these initiatives have already reached a mature stage of implementation and include comprehensive information on organisational models, direct cost analyses, and methodologies for allocating indirect costs. This wealth of knowledge represents a crucial resource for the development and dissemination of a new model, as well as a solid foundation for regional and national benchmarking activities to assess the value generated and the corresponding reward mechanisms.

In parallel, it would be beneficial to establish a benchmarking system based on the definition of standardised KPIs and common measures, both in terms of outcomes and pathway quality, as well as in terms of the costs incurred to achieve these outcomes.

A targeted selection of the most effective variables, techniques, tools and metrics for each pathology-specific pathway should be developed to capture the value generated both from a clinical perspective (CROMs) and a patient perspective (PREMs and PROMs), alongside cost evaluations according to standardised methodologies.

This approach would support the creation of a shared system for both the dissemination of results and the organisational models underpinning them. This could take the form of a structured "library" tailored to each care pathway, compiling organisational elements, key performance indicators, and the most suitable measurement tools for evaluating specific pathways and their respective outcomes.

Key Elements: Value Benchmarking for Pathways, Best Practice Repository, KPI Library: CROMs, PREMs, PROMs and Measurement Methods.

C. Working with People

C.1 – Fostering Cultural Revolution and Influence

In order to create a shared cultural system, ensuring the scalability and widespread applicability of the model, it is essential that the culture of value becomes deep-rooted within the system. This must extend beyond the vision of individual decision-makers or enlightened managers, so that turnover in political roles and executive leadership does not disrupt the continuity of culture and objectives.

This is a process that requires a system-wide change, not just a local one. Local experiences can provide stimuli and support the development of a regional model, as the region can offer input without restricting, but rather guiding, local adaptation.

To achieve this, it is first necessary to establish a unified definition of "value" that brings together the perspectives of the system, organisations, industry, citizens and, of course, patients.

Once the scope and content of "value" are defined, it may be beneficial to proceed with public awareness and institutional communication campaigns aimed at raising citizens' awareness of their role in the ongoing transformation. For the first time, patients / citizens, industry, healthcare providers and institutions would collaborate in partnership to implement a new concept of health creation. Therefore, it is crucial that everyone understands their role and contribution within this process.

The shift in perception of the patient's role—from a mere recipient of care to an active, competent, and participatory subject—also requires the dissemination of proper information and the empowerment of the patient.

Cultural change, at an organisational level, can also be supported by the application of new models. Thinking in terms of care pathway budgets and reimbursement models for patient management are examples of elements that indirectly promote cultural change in healthcare service management.

Key Elements: Value Dimension, Information, Communication Campaigns, Stakeholder Participation, Transition from Patient to Citizen / Person.

C.2 – Renewing the Educational Offer

Coping with new objectives, the use of new tools becomes central, and the current educational offer is no longer aligned with the skills and "visions" required. The issue of education obviously involves various levels: decision-makers, managers, clinicians and also patients, for whom separate considerations are clearly necessary. It is therefore essential to rethink educational programmes, however complex, to ensure that professionals are equipped with the technical and leadership skills necessary to tackle the future of the healthcare system.

With regard to university and professional education, it is appropriate to proceed with a revision of university and specialised training plans, introducing concepts, models, managerial techniques, and tools that steer thinking towards a patient-centred approach, leadership, multidisciplinary / multiprofessional collaboration, and value-based orientation. This involves moving away from the concept of treating disease towards that of treating the person. In doing so, professionals from their university education onwards will be able to integrate the concepts of value, the active role of the patient, and the use of evaluation tools (such as PREMs and PROMs), with other more specific specialisation areas.

Training is also necessary at an institutional level for decision-makers, who must renew strategic visions for health production and translate them into operational programmes.

Key Elements: Educational Needs, Revision of University and Specialist Training Programmes, Professional and Institutional Training.

C.3 – Acquiring New Skills

The implementation of new models evidently requires new, specific and transversal competencies, both for their design and for their operationalisation: from patient engagement to data analysis, from project management to activity-based costing, to value procurement.

These competencies are available in the market and can also be acquired by revising current recruitment models, taking advantage of the opportunities presented by the current retirement curve.

It is necessary to identify new professional roles, equipped with the appropriate skills, who can foster the creation of a multidisciplinary environment, guide "teaming" and interaction among professionals from different areas, support project management and ensure that the healthcare system evolves in line with the established strategic objectives. The presence of figures capable of ensuring the introduction and management of new technologies and methodologies in a consistent and aligned manner with the system's value objectives becomes central.

Furthermore, competencies in development and innovation (such as Lean management, Agile techniques, etc.), as well as in organisational and process innovation, are essential.

Key Elements: Competency Gaps and Needs, Recruitment Models, Introduction of "Change Makers" and Key Technical Roles (Digital, Managerial, Procurement, etc.).

C.4 – Ensuring Multi-Stakeholder Health Literacy

The level of health literacy possessed by individuals influences the efficiency of the healthcare system and also impacts health outcomes, negatively affecting them, as health literacy is a critical social determinant of health. Therefore, it is essential to assist individuals in accessing, understanding, evaluating and applying information to navigate complex healthcare systems.

It is necessary for decision-makers, healthcare professionals and service providers to prioritise measuring citizens' health literacy needs, so that the application of good health literacy development practices can be guided by gathered evidence.

This process forms the foundation for the genuine participation of the individual / citizen / patient / community in co-designing the patient journey from a VBHC perspective (see B.2), through transformative actions that impact citizens, healthcare professionals, associations and companies, and share existing best practices at a European level.

Key Elements: Assessment of Literacy Needs, Health Literacy, Institutional Campaigns.

The Checklist of Change

		ACTIONS	KEY ELEMENTS	DIMENSION	INTEGRATED RELATIONS											
					A.1	A.2	A.3	A.4	B.1	B.2	B.3	B.4	C.1	C.2	C.3	C.4
A. REFORMING THE REGULATORY FRAMEWORK	A.1	Reforming Reimbursement Systems	Bundle Payment Model, Regional Experimentation: Health Budget, Standard Cost and Standard Tariff Model, Definition of Standard Value Drivers and PROMs	REGIONAL		☑	☐	☑	☑	☐	☑	☐	☐	☐	☐	☐
	A.2	Ensuring Harmony Between Privacy and Data Use	Data Assessment, Identification of Gaps and Barriers to Utilisation, Technical Working Group with the Privacy Authority, Intervention Proposals	CENTRAL	☑		☐	☑	☑	☑	☑	☐	☐	☐	☐	☐
	A.3	Revising Budgeting Rules	Organisational Model for Care Pathways, Budget Objectives, Pathway Budget, Allocation Drivers, Pathway Ownership	REGIONAL	☐	☐		☑	☑	☐	☑	☐	☐	☐	☑	☐
	A.4	Rewarding Value Creation	Value Dimensions, Pathway Value KPI, Incentive System, Value Procurement	CENTRAL REGIONAL	☑	☑	☐		☑	☑	☑	☐	☐	☐	☑	☐
B. INNOVATING MODELS, METHODS AND TOOLS	B.1	Designing Integrated and Cross-Functional Organisational Models	Process-based Approach, Model for Disease Pathways: Integrated Units, Multidisciplinary and Multi-professional Teams, Pathway Ownership, Objectives and Pathway Budget	LOCAL	☐	☑	☑	☑		☑	☐	☑	☐	☐	☑	☑
	B.2	Promoting Expanded Alliance and Active Patient Involvement	Multi-Stakeholder Partnerships, Patient Engagement, Competency Sharing, Permanent Multi-Actor Working Groups, Public-Private Partnerships, Co-Design, Structured Patient Involvement in Evaluation (PREMs, PROMs)	LOCAL	☐	☑	☐	☐	☑		☑	☑	☑	☑	☑	☑
	B.3	Ensuring Data Measurability	Regional Integration of Systems, Multidisciplinary Working Groups, Big Data, Data Analysis Competencies, National Recovery and Resilience Plan (NRRP)	REGIONAL	☐	☑	☐	☐	☑	☐		☐	☑	☑	☑	☐
	B.4	Promoting Dialogue and Scalability of Experiences	Value Benchmarking for Pathways, Best Practice Repository, KPI Library: CROMs, PREMs, PROMs, and Measurement Methods	REGIONAL	☐	☑	☐	☑	☑	☑	☑		☐	☐	☑	☑
C. WORKING WITH PEOPLE	C.1	Fostering Cultural Revolution and Influence	Value Dimension, Information, Communication Campaigns, Stakeholder Participation, Transition from Patient to Citizen / Person	CENTRAL LOCAL	☐	☐	☐	☐	☑	☑	☐	☑		☑	☑	☑
	C.2	Renewing the Educational Offer	Educational Needs, Revision of University and Specialist Training Programmes, Professional and Institutional Training	CENTRAL LOCAL	☐	☐	☐	☐	☑	☑	☐	☐	☑		☑	☑
	C.3	Acquiring New Skills	Competency Gaps and Needs, Recruitment Models, Introduction of "Change Makers" and Key Technical Roles (Digital, Managerial, Procurement, etc.)	REGIONAL	☐	☐	☐	☑	☑	☑	☐	☐	☑	☑		☑
	C.4	Ensuring Multi-Stakeholder Health Literacy	Assessment of Literacy Needs, Health Literacy, Institutional Campaigns	CENTRAL LOCAL	☐	☐	☐	☑	☐	☑	☐	☑	☑	☐	☐	

BIBLIOGRAPHY AND WEB REFERENCES

AYLWARD M., PHILLIPS C., HOWSON H., *Simply Prudent Healthcare – achieving better care and value for money in Wales* – discussion paper. Bevan Commission, 2013.

BACCI A., NARDIELLO A. (a cura di), Strategia Lean. *Casi ed esperienze nei settori Healthcare e Lifescience*. Knowita, 2019.

BURWELL S. M., *Setting value-based payment goals—HHS efforts to improve US health care*. N Engl J Med, 2015.

COLLDÉN C. & HELLSTRÖM A., *Value-based healthcare translated: a complementary view of implementation*. BMC health services research, 2018.

CONFERENZA STATO-REGIONI, *Patto per la salute per gli anni 2014-2016: Articolo 9, comma 2 dell'Intesa n. 82/CSR del 10 luglio 2014*.

COULTER A., ENTWISTLE V. & GILBERT D., *Sharing decisions with patients: is the information good enough?*. Bmj, 1999.

DOHMEN P. J. & VAN RAAIJ E. M., *A new approach to preferred provider selection in health care, 2019*.

EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH (EXPH), *Defining value in "value-based healthcare", 2019*.

FONDAZIONE GIMBE, 4° *Rapporto sulla sostenibilità del Servizio Sanitario Nazionale, 2019*.

GRAY M., JANI A., *Promoting Triple Value Healthcare in Countries with Universal Healthcare*. Healthcare Papers, 2016.

KAPLAN R. S., *The case for bundled payments in health care. Harvard Business Review, 2016*.

LEGA F., CAVAZZANA L., MAGNONI P., *Il modello di value-based healthcare del Nya Karolinska Solna in L'organizzazione per temi dell'ospedale, 2020*.

MICHALOWSKY B., BLOTENBERG I., PLATEN M. ET AL., *Clinical Outcomes and Cost-Effectiveness of Collaborative Dementia Care: A Secondary Analysis of a Cluster Randomized Clinical Trial*. JAMA Netw Open, 2024.

MINISTERO DELLA SALUTE. *Decreto 9 giugno 2023: Adozione del programma nazionale di HTA*. (GU Serie Generale n.207 del 05-09-2023).

MONICA P., *Programma di Value-Based Procurement per i neurostimolatori ad alta frequenza nella neuropatia diabetica* - Regione Toscana, 2023.

MVERE D. & BOND K. (EDS.), *The blood cold chain: guide to the selection and procurement of equipment and accessories*. World Health Organization, 2002.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, *Controlled drugs: safe use and management, 2016*.

NHS ENGLAND, *The national Patient Reported Outcome Measures (PROMS) programme, 2018*.

PENNESTRÌ F., LIPPI G., & BANFI G., *Pay less and spend more—the real value in healthcare procurement*. Annals of Translational Medicine, 2019.

PENNUCCI F., DE ROSIS S., MURANTE A.M., NUTI S., *Behavioural and social sciences to enhance the efficacy of health promotion interventions: redesigning the role of professionals and people. Behavioural Public Policy, 2022*

PORTER M. E., TEISBERG E. O., *Redefining Health Care: Creating Value-Based Competition on Results*. Harvard Business Review Press, 2006.

PORTER M. E., & LEE T. H., *The strategy that will fix health care*. Harvard Business Review, 2013.

PRADA G., *Value-based procurement: Canada's healthcare imperative in Healthcare management forum*. Sage CA: Los Angeles, CA: SAGE Publications, 2016.

REGIONE TOSCANA, Delibera n.1038/2021- *Linee di indirizzo regionali su Procurement Value-Based di dispositivi medici di uso consolidato*.

REGIONE TOSCANA, Delibera n.1093/2019 - *Raccomandazioni per la stesura dei capitolati di gara per l'acquisizione di dispositivi medici*.

SAMPIETRO COLOM L. & RESTOVIC G., *MEAT pilot test at Hospital Clínic Barcelona: Final revision*. MedTech Europe, 2018.

UNIVERSITÀ CATTOLICA DEL SACRO CUORE, *La cronicità in Italia:* Focus, Osservatorio Nazionale sulla Salute nelle Regioni Italiane, 2019.

VIHTALI UNIVERSITÀ CATTOLICA DEL SACRO CUORE, *The Value Agenda for Italy*, 2018.

WALLERSTEIN N., *What is the evidence on effectiveness of empowerment to improve health?*, World Health Organization. Regional Office for Europe, 2006.

ACKNOWLEDGEMENTS

The accomplishment of this work has been made possible thanks to the contributions of the participants in the First VBHC Italian Center Summit:

Alessandrello Rossana - Value Based Procurement Director, AQuAS
Alessandri Massimo - Director of the Department of Internal Medicine and Medical Specialities, Azienda Usl Toscana Sud-Est
Alparone Mario - General Director, Finpiemonte S.p.A.
Andreone Vincenzo - Director of UOC Neurology & Stroke Unit, AORN Cardarelli, Naples
Annovi Silvia - Junior Consultant, Telos Management Consulting
Basile Michele - Co-Founder & Partner, ALTEMS Advisory
Bellucci Silvia - Director of UOP Innovation, Azienda Usl Toscana Sud-Est
Bertuzzi Emma - Senior Consultant, Telos Management Consulting
Bissacco Valentina - Junior Consultant, Telos Management Consulting
Bonelli Gianni - General Director, Fondazione Mondino
Brett Eamon - Partner & Access Strategy Lead, Takeda
Caltagirone Alessandro Maria - General Director, ASP of Siracusa
Cappannelli Simone - Nursing Coordinator, PO Gubbio-Gualdo Tadino
Castaldini Federica - Senior Consultant, Telos Management Consulting
Causio Francesco Andrea - Vice President, SIIAM
Caviglia Valentina - Public Policy & Advocacy and Market Access Manager, BD
Cimaglia Antonella - Senior Consultant, Telos Management Consulting
Colombo Eva - General Director, ASL Vercelli
Corinti Simone - Market Access Manager, Takeda
Cozza Valentina - Director of UOC Management Control, ASL Napoli 1 Centro
D'Urso Antonio - General Director, Azienda USL Toscana Sud-Est
Dall'Acqua Alberto - HEMA Manager RM Italy & Spain; HEMA Country Head Italy, Boston Scientific
De Filippis Giuseppe - General Director, AOU Perugia
De Rosis Sabina - Assistant Professor of Management, Scuola Superiore Sant'Anna
De Santis Maria Carmen - Radiation Oncologist, National Cancer Institute
De Simone Lucia - Anaesthetist, ASL Napoli 1 Centro
Ferron Chiara - Health Economics & Market Access Graduate - Uro, Boston Scientific
Forni Silvia Laura Maria - Representative, Associazione Conto alla Rovescia
Gelera Alessandra - Head of Public Affairs, Health Economics & Market Access Country Lead, Boston Scientific
Gellona Fernanda - General Director, Confindustria Dispositivi Medici
Giordani Emma - VBHC Project Delegate, SIFO
Goretti Giulia - Healthcare Process Improvement and Lean Manager, Istituto Clinico Humanitas

Guidoni Federico - Vice President, AIOP

Inglese Stefano - Representative, Cittadinanzattiva

La Torre Edoardo - Junior Consultant, Telos Management Consulting

Leonardi Francesca - HSP Lazio, Roche

Locati Francesco - General Director, ASST Papa Giovanni XXIII – Bergamo

Maccari Andrea - Senior Consultant, Telos Management Consulting

Mancini Federico - Senior Consultant, Telos Management Consulting

Marchesi Cristina - General Director, AUSL of Reggio Emilia

Marsilio Marta - Full Professor, University of Milan and President, IRCCS Istituto Neurologico Carlo Besta

Massaro Rossella - Country Business Leader, BD

Menicocci Elio - Medical Director of Primary Care and Prison Medicine, ASL 4 Liguria

Mensorio Mario Massimo - Medical Director, AORN Cardarelli

Modanesi Augusto - Regional Access Head, Takeda

Musella Walter - HSP Campania, Roche

Nardiello Alida - Partner, Telos Management Consulting

Nasoni Duccio - Junior Consultant, Telos Management Consulting

Natalini Nicoletta - General Director, AST Ascoli Piceno

Nicora Carlo - General Director, National Cancer Institute, Milan

Palazzi Silvia - Senior Consultant, Telos Management Consulting

Paone Simona - UOC HTA, Agenas

Pestelli Nicolò - Head of Supply Chain and Logistics, Telos Management Consulting

Petralia Paolo - National Deputy Vice President, FIASO and General Director, ASL 4 Liguria

Pocaforza Maurizio - Executive, Directorate-General for Person Care, Health and Welfare, Emilia-Romagna Region

Poletti Roberta - Medical Director, Cardiologist, and Head of Daytime Outpatient Activities, San Cataldo Hospital, Fondazione Monasterio

Ponzani Paola - Head of SSD Diabetology and Metabolic Diseases, ASL 4 Liguria

Silenzi Andrea - Executive, Ministry of Health

Torre Marco - General Director, Fondazione Monasterio

Torrico Paolo - Director of the Department of Procurement of Goods and Services, ESTAR

Triarico Antonio - Medical Director, National Cancer Institute

Tucci Vincenzo - Head of Sales and Marketing Peripheral Intervention Italy, BD

Tuccillo Bernardino - Director of UOC Cardiology and UTIC, Ospedale del Mare, ASL Napoli 1 Centro

Vannucci Andrea - Member of the Steering Committee, Accademia Nazionale di Medicina

VBHC
Italian Center

www.vbhcitalia.it

Follow us on

Value Based Healthcare Italian Center

Telos Management Consulting

FIASO

Founding sponsors

Takeda

Johnson&Johnson

Roche

Boston Scientific

BD

VBHC Italian Center