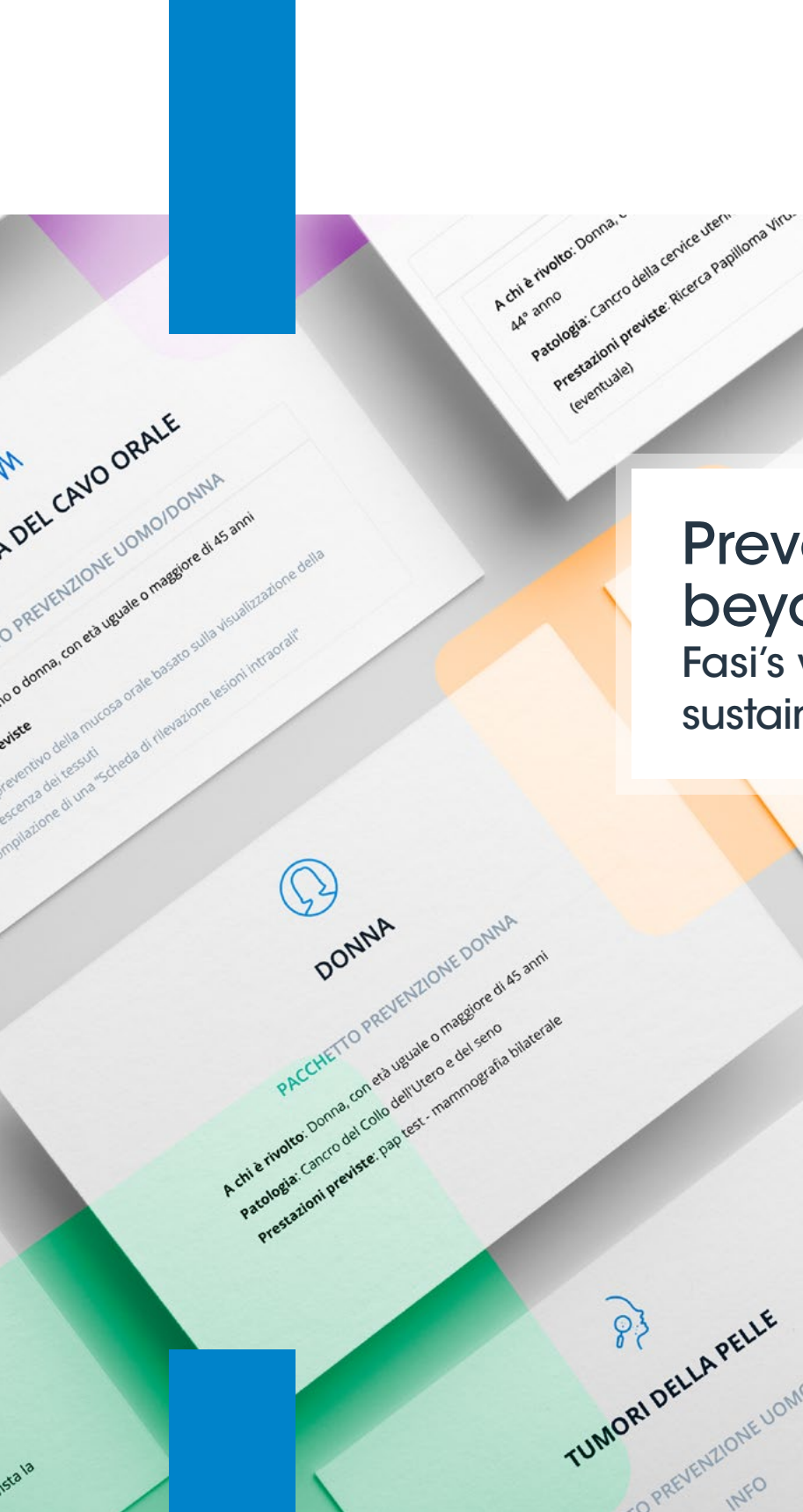




Prevention beyond health

Fasi's value and
sustainability-oriented model

White paper
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EXECUTIVE SUMMARY

The progressive ageing of the population, together with the rising prevalence of non-communicable chronic diseases and of multi-morbidity across the entire life course, is driving a structural escalation in the demand for healthcare, thereby exerting mounting pressure on the welfare systems' economic sustainability. Against this backdrop, prevention assumes strategic significance, operating as a high-yield investment apt to enhance individual and collective health outcomes and to fortify the healthcare welfare system as a whole.

*Consistent with the Italian Ministry of Health guidelines, the World Health Organisation recommendations and the Value Based Healthcare principles, Fasi reads prevention as a **structural instrument for the healthcare expenditure governance**, in alignment with the Fund's own evolution, moving from a model centred upon the acute episode towards a holistic approach to healthcare.*

The purpose of this white paper is to elucidate the foundational components of the prevention model that Fasi has developed and progressively refined since 2011. The model is grounded on three pillars: reliance on clinical and scientific evidence, operational standardisation achieved through the integration of "prevention packages" in the Fund's Nomenclature, and a structured monitoring system designed to underpin traceability and impact measurement.

The prevention model adopted by Fasi is characterised by an approach spanning the entire continuum of care, encompassing not only the delivery of the so-called "prevention packages" but also the education and engagement of the "healthy patient", by means of education and the safeguarding of effective service accessibility. Informed participation reinforces adherence to prevention initiatives, which, articulated into primary and secondary prevention, enable intervention before the onset or consolidation of complex clinical conditions.

Taken as a whole, the model herein outlined constitutes a building block in support of the Italian National Health Service, one able to underpin the long-term sustainability of the healthcare system, to reinforce the appropriateness of care, and to foster the generation of shared value for all actors within the healthcare ecosystem.

1. FASI'S VISION

For supplementary health funds, the Italian National Health Service (NHS), and the country system as a whole, prevention constitutes a strategic investment, as far as it can influence individual and collective health, social cohesion and economic sustainability.

The convergence of demographic, epidemiological and economic factors is, indeed, placing mounting pressure upon traditional models of healthcare delivery¹. The ageing of the population², the rising prevalence of non-communicable chronic diseases (NCDs)³ and of multi-morbidity across all age cohorts⁴ are driving a structural expansion in the demand for healthcare and social-care services, along with the attendant costs. In the absence of a systematic and structured reinforcement of prevention policies, the escalating strain upon financing mechanisms, compounded with persistent decline in birth rates⁵, threatens to compromise the long-term sustainability of the entire architecture of the healthcare system.

Against this backdrop, Fasi is evolving from a model centred on the acute episodes coverage towards a health protection holistic approach, which recognises prevention as one of the foundational pillars of its mission, alongside the provisions for long-term care dependency and the stewardship in technological innovation. Such evolution is consistent with a conception of welfare as a pillar of civil society, one in which health plays a pivotal role in the country's social and economic stability.

Prevention enables, indeed, structural action on the determinants of health, the reduction of the probability of onset and progression of pathologies, and the improvement of the quality of life of individuals, while at the same time contributing to a more efficient and effective management of resources. Viewed from this vantage, supplementary healthcare plays a genuinely ancillary role: it does not overlap with the public healthcare system, but rather operates alongside it, enabling modalities of health protection that privilege the anticipation of risk over late-stage treatment, the appropriateness of interventions and the generation of value along the entire care pathway.

1. Source: The European House – Ambrosetti, September 2024, "The Value of Prevention for Economic Growth and the Sustainability of Healthcare, Social Care and Welfare Systems".

2. Source: ISTAT, Population Census and Dynamics – Year 2024, published on 18 December 2025, available at: <https://www.istat.it/wp-content/uploads/2025/12/Censimento-e-dinamica-della-popolazione-Anno-2024.pdf>.

3. According to the definition provided by the Italian National Institute of Health (Istituto Superiore di Sanità), the principal groups of NCDs include cardiovascular diseases, respiratory diseases, cancer and diabetes, although the broader category of non-communicable conditions also encompasses the domain of mental health. Source: <https://www.epicentro.iss.it/croniche/oms-report-invisible-numbers-2022>. According to the WHO, NCDs constitute the leading cause of morbidity, disability and mortality worldwide (accounting for up to 86% of deaths in Europe). Source: <https://www.who.int/europe/health-topics/noncommunicable-diseases>.

4. Source: ISS, Passi d'Argento Surveillance System, available at: <https://www.epicentro.iss.it/passi-argento/info/archivio-2025>.

5. Source: ISTAT, Births and Fertility of the Resident Population – Year 2024, published on 21 October 2025, available at: https://www.istat.it/wp-content/uploads/2025/10/Natalita-e-fecondita-della-popolazione-residente_Anno-2024.pdf.

2. THE METHODOLOGICAL ARCHITECTURE

Since 2011, Fasi has progressively developed its prevention packages, beginning with specific clinical areas⁶, and has progressively expanded the range of packages over the years. Such selection reflects assessments conducted under medical supervision, oriented towards directing the Fund's resources to those areas that potentially generate the greatest impact on the quality of life of beneficiaries, and therefore towards areas characterised by the highest burden of disease⁷, prevalence and clinical and care impact. The pathologies identified present, in fact, a significant epidemiological relevance and, if not intercepted early, are associated with an increased risk of complications, disability, loss of autonomy and an increase in care needs.

The prevention model adopted by the Fund is grounded in three key structural elements: systematic reliance on scientific evidence, operational standardisation of interventions, and the measurability of results.

The reliance on scientific evidence constitutes the methodological prerequisite both for the epidemiological analysis of the assisted population⁸ and for the clinical validation of the 22 prevention packages currently offered⁹. Such packages are, in fact, designed to ensure clinical appropriateness, effectiveness of interventions and sustainability, reducing the risk of redundant or low added value services.

The overall framework is oriented towards a logic of integration and complementarity with the prevention strategies of the Italian NHS, fostering synergies between supplementary healthcare and public healthcare¹⁰.

Operational standardisation is the second qualifying element of the prevention model packages, formally defined within the Fasi Nomenclature. Such standardisation ensures uniformity in access and in delivery by the network of healthcare providers affiliated with IWS S.p.A. that adhere to the project, with full economic coverage borne by the Fund. Each package is structured with a specific set of diagnostic and instrumental procedures, selected on the basis of scientific evidence and reference clinical guidelines.

Lastly, the methodological architecture of the model includes a monitoring system, based on process and output indicators, such as the volumes of packages utilised and their distribution

6. The first prevention packages introduced in 2011 addressed the prevention of cervical and breast cancer, prostate cancer, ocular pathologies (macular degeneration and glaucoma), oral cavity cancer and edentulism.

7. The burden of disease denotes the overall impact of a pathology, or set of health conditions, on a population in terms of mortality, morbidity and disability, including the loss of years of life and of healthy life. It is commonly quantified through standardised composite indicators, such as Disability-Adjusted Life Years (DALYs), which integrate Years of Life Lost (YLL) and Years Lived with Disability (YLD).

8. With the support of medical advisory expertise, Fasi conducts an epidemiological analysis of the assisted population, aimed at identifying priority health needs through the integrated examination of epidemiological data and areas of unmet need. Such analysis constitutes the foundation for the design of prevention packages consistent with the health profile of beneficiaries and with the principal emerging epidemiological trajectories.

9. In 2026, Fasi offers its assisted population 22 prevention packages, fully covered by the Fund and designed on an epidemiological basis for specific target groups, with the support of medical advisory expertise.

10. The design of the prevention packages is conducted in alignment with the directives of the National Prevention Plan 2020-2025 issued by the Italian Ministry of Health, which promotes an approach grounded in the appropriateness of interventions, in the reduction of health inequalities and in the sustainability of the system.

by type, territory and age group. Such a system enables not only the prevention activities traceability, but also the assessment of their coherence with respect to objectives, and it supports continuous improvement processes of the model itself.

In this regard, the Fasi Centro Studi has conducted an empirical study¹¹ on beneficiaries and family members of the Fund over the age of 45 who utilised a subgroup of prevention packages at least three times over the 2019–2024 period. The brevity of the time horizon is justified by the limited number of users in the preceding years, in proximity to the introduction of the packages. The analysis is therefore limited to the short to medium term to compare two clusters of beneficiaries identified as the “treated group”, where they used the packages, and conversely, the “control group” (also referred to as “untreated”).

The objective of the comparison is twofold:

- to capture the “differential” effect in terms of mean expenditure;
- to compare the differing mix of demand for services at the end of the period.

The results of the study, still preliminary, are summarised in the infographic.

The empirical evidence presented in the charts confirms the theoretical hypothesis advanced in the relevant literature, namely that prevention, on the one hand, raises expenditure in the short term and, on the other, by reducing the probability of rare and costly events occurring in the medium term, compresses expected expenditure over the long term.

Specifically, the panel of treated subjects observed from 2019 onwards shows, in 2024, fewer hospital admissions (51% fewer than the untreated) and lower expenditure for surgical interventions (–22%). At the same time, the healthcare demand of the treated is strongly skewed towards diagnostic examinations and specialist visits, with a quantity of reimbursement requests for services nearly twice that of the untreated.

Also, owing to prevention, healthcare expenditure of the treated grows at a progressively slower pace, and it produces a reversal of trend at the end of the period, with the subsequent overtaking of the expenditure dynamics of the untreated relative to those of the treated.

Taken as a whole, such evidence confirms the twofold role of prevention: not only promoting health at the individual level, but also governing healthcare demand, guiding the allocation of resources towards anticipatory care models and underpinning the shift from hospital-centred pathways to continuous, integrated patient care management¹².

11. The Fasi Centro Studi conducted an observational analysis based on a quasi-experimental approach which, in addition to defining the use of prevention packages as a binary treatment variable (taking the value 1 if used, and 0 otherwise), applies a counterfactual method whereby, on the one hand, what actually occurred for treated subjects is observed (factual) and, on the other, what would have occurred for subjects with comparable characteristics (age, sex, place of residence) in the absence of treatment is simulated (counterfactual). The outcome variable is the average expenditure during the period under analysis. Preliminarily, the total population of reference (over 300,000 beneficiaries) was identified for the five-year period from the Data Warehouse; the treatment group (4,355) was then extracted from the subset of those who undertook prevention activities, and the control group (4,355) from those who did not. In addition, the Centro Studi complemented the results through a cluster analysis aimed at identifying expenditure behaviours (demand mix) on the basis of the composition of the macro-categories of services.

12. In line with the trajectory outlined by Ministerial Decree no. 77 of 23 May 2022 of the Italian Ministry of Health, which sets out the regulatory framework defining the models and standards for the development of community-based care within the Italian NHS.

3. IMPLEMENTATION PROCESS

The prevention model implemented by Fasi is configured as a structured and continuous process, not limited to the mere delivery of the “prevention packages”, but extending along the entire continuum of care and encompassing also the phases preceding and following their utilisation.

Within this framework, the inception of the care process oriented towards the early identification of risk factors and subclinical conditions is represented by the proactive management of the asymptomatic person or of the person in apparent good health. The so-called “management of the healthy patient” therefore constitutes the initial moment of a pathway that enables the anticipation of the emergence of healthcare needs, fostering a preventive approach grounded on the timely identification of vulnerabilities and their appropriate management¹³. Such an approach further enables demand governance oriented towards proactive anticipation rather than reactive response, contributing to a sustainable rebalancing between health promotion, prevention and treatment within person-centred care models.

The beneficiary engagement at a stage preceding the onset of clinically evident manifestations is made possible by the creation of conditions that enable informed and conscious participation. To this end, health education interventions, structured communication instruments, and accompaniment pathways are activated, able to strengthen adherence to prevention programmes and maximise clinical and organisational effectiveness. Within this context, investment in health literacy¹⁴ is configured as a fundamental driver for the empowerment of the person¹⁵ and consequently for the overall effectiveness of the prevention model. Education in the culture of health is a phase often underestimated, yet it plays a fundamental role: the critical element of prevention does not, in fact, reside in any shortfall of supply, but rather in adherence to good practices and screening programmes. By its very nature, healthcare prevention is principally directed towards subjects who perceive themselves to be in good health in the absence of symptoms; these individuals tend to postpone or regard as non-priority those interventions that aim to reduce risk. Through targeted initiatives¹⁶ and the deployment of multichannel communication instruments¹⁷, the Fund is in a position to go beyond mere information provision and to foster proactive behaviours aimed at reducing psychological, cognitive and organisational barriers, and at counteracting the mechanisms of decisional inertia that hinder adherence to prevention programmes, whether public or private.

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13. Prevention is articulated as an intervention along the life stages, oriented towards sustainability, effectiveness and equity (life-course approach; early diagnosis; identification of at-risk subjects), in line with the directives of the Ministry of Health, National Prevention Plan 2020–2025 (adopted 6 August 2020; updated as of 31 December 2024).
 14. Health literacy denotes the cognitive and functional competence of the beneficiary in retrieving, understanding, processing and applying clinical and preventive information, with a view to making proactive and informed decisions concerning his or her own health. Such capacity is decisive in safeguarding decision-making autonomy and in fostering evidence-based health behaviours.
 15. Patient empowerment denotes the process by which the individual is enabled to develop and consolidate decision-making competences, awareness and self-management capacity in relation to his or her own health, fostering active and continuous involvement in pathways of protection, prevention and care, as well as a stable and informed relationship with the healthcare system. This is consistent with the conceptual framework of patient empowerment and people-centred care set out by the World Health Organisation, and with the care-management and continuity-of-care models referenced in Ministerial Decree no. 77 of 23 May 2022.
 16. Fasi has designed and launched a series of health-promotion initiatives aimed at enhancing awareness, health literacy and adherence to prevention pathways, valorising occupational welfare as an instrument for supplementary healthcare. These include the “Fasi al tuo Fianco, prevenzione oltre la cura” (“Fasi at Your Side: Prevention Beyond Care”) event cycle, the participation in the Race for the Cure and the adoption of the cardiovascular risk screening programme (CV Risk).
 17. Through the development of a thematic podcast, Fasi has sought to overcome traditional informational barriers by conveying – in a digital, modern and accessible format – clinical content (including complex topics) related to proper nutrition, screening and access to services. The on-demand audio format ensures maximum flexibility of use, contributing to the democratisation of high-quality health information.

The second level of intervention pertains to the actual delivery of the prevention packages, articulated along the entire continuum of primary and secondary prevention and with no economic contribution required from the beneficiary. Such packages are designed to foster the early identification of pathologies with the greatest clinical, epidemiological and economic impact across the principal areas of healthcare need.

In the design of prevention programmes, the robustness of clinical and scientific evidence constitutes a necessary but not sufficient condition to guarantee a significant impact on the health outcomes of the assisted population. To produce the intended results, prevention must also be executable, that is, usable by the beneficiaries in relation to the temporal and territorial dimensions of the services.

From this perspective, the third level of intervention is aimed at ensuring the effective usability of the prevention packages: access times for health procedures are guaranteed in accordance with the timeframes set out in the clinical guidelines, so that the early detection is not compromised by the delays typically associated with waiting lists.

4. PROJECT OUTCOMES AND EXPECTED BENEFITS

The prevention model thus conceived, implemented and progressively refined by Fasi over the years, enables the generation of systemic effects articulated across multiple and interdependent levels, along the entire continuum of care.

At the clinical level, the primary outcome is the enhanced capacity for early detection of chronic conditions and of the principal modifiable risk factors. This favourably affects individual prognosis, reduces the incidence and severity of complications, and supports the maintenance of function and quality of life over the medium to long term.

For beneficiaries, this translates into equitable and structured access to prevention programmes; the model further strengthens individual empowerment and health literacy, sharpening awareness of one's risk profile and encouraging the adoption of healthy behaviours. From this perspective, prevention is not confined to the delivery of services, but takes on an educational function, directed towards the active and responsible safeguarding of health.

For the Fund, the early identification of emerging healthcare needs and the governance of expenditure dynamics are decisive for its long-term sustainability. The empirical analysis confirms that, in the medium term, such capacity reduces acute events, rebalances demand towards outpatient and diagnostic services and improves the predictability of needs, thereby strengthening the Fund's planning. At the same time, it helps to defer the loss of functional autonomy and the onset of disability and long-term care dependency among beneficiaries.

On the systemic level, prevention delivered within the supplementary healthcare sector operates alongside that of the Italian NHS in a logic of full complementarity. The synergy between the two components reduces the burden on the healthcare system and consolidates a genuinely value-oriented welfare system. Prevention thus stands confirmed as a structural factor in the resilience and endurance of healthcare systems, capable of generating measurable benefits at both the social and the economic level, as evidenced by the well-established findings of public health and immunisation programmes, which for decades have constituted the principal benchmark for assessing the return on investment in health¹⁸.

18. Source: The European House – Ambrosetti, September 2024, "The Value of Prevention for Economic Growth and the Sustainability of Healthcare, Social Care and Welfare Systems", and Masters, Rebecca et al., "Return on investment of public health interventions: a systematic review", *Journal of Epidemiology and Community Health* 71.8 (2017), 2024 data.



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