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Value-Based Healthcare from a Management Perspective: A Systematic Review and Proposal for an Integrative Framework

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1. Introduction

In recent decades, healthcare systems have faced mounting challenges stemming from increased demand, resource constraints, and the imperative to improve clinical outcomes in a sustainable manner (Gorman e Horn 2022; Hussain et al. 2024; Kruk et al. 2018; Zurynski et al. 2022). Within this context, the Value-Based Healthcare (VBHC) model has emerged as a promising framework to align the interests of patients, healthcare professionals, managers, and healthcare providers. Introduced by Porter e Teisberg (2006), the central premise of VBHC is to maximize the value delivered to patients, defined as the ratio between clinical outcomes achieved and the costs incurred to obtain them.

Since its inception, the concept has generated a substantial body of empirical literature, predominantly within the fields of medicine, public health, and health policy (eg. Etges et al., 2020; Francis-Auton et al., 2024; Gupta et al., 2019; Van Der Nat et al., 2020). However, when analyzed through a managerial lens focusing on organizational structure, governance, leadership, implementation dynamics, and administrative models, a significant decline in scholarly output becomes evident. From over 1,200 articles initially retrieved from the Scopus and Web of Science databases, only 132 met the criteria related to thematic focus and disciplinary alignment. When further narrowed to the fields of Business, Management and Accounting, and Economics and Finance, the number decreased dramatically, revealing that over 80% of VBHC research remains situated within clinical or biomedical domains. This imbalance underscores a critical research gap. Although VBHC entails profound organizational transformations, such as the establishment of Integrated Practice Units (IPUs), the adoption of value-oriented costing models, process redesign, and the development of distributed leadership and governance structures, these dimensions are seldom addressed outside clinical literature.
This article seeks to address this gap by conducting a systematic review of the international literature on VBHC through the lens of management studies. The analysis aims to demonstrate the conceptual underrepresentation of VBHC in the administrative sciences and to highlight the need for interdisciplinary integration between clinical and organizational fields. To support this investigation, we draw on General Systems Theory (Bertalanffy 2009), which conceptualizes organizations as open and interdependent systems, along with complementary frameworks such as Soft Systems Thinking (Checkland e Scholes 1999) and creative holism (Jackson 2003), which stress the necessity of integrating multiple perspectives in complex environments such as healthcare. This systemic perspective underscores that value creation in healthcare extends beyond clinical actions, encompassing sociotechnical, cultural, and institutional dynamics.

Accordingly, this review examines the literature focusing on the organizational, structural, and managerial dimensions of VBHC and seeks to address the following research questions: (*RQ1) How has the VBHC model been explored from a managerial perspective within the healthcare sector? (RQ2) What are the key limitations and gaps in the existing literature regarding the interface between VBHC and management? (RQ3) What are the future research avenues for integrating VBHC with the management sciences, particularly in relation to governance, culture, performance, and sustainability?* By performing a systematic literature review (n=68), we found that the implementation of Value-Based Healthcare (VBHC) is still fragmented, with limited integration between clinical initiatives and organizational strategies. The literature reveals critical gaps, particularly the lack of systemic approaches to implementation and an overemphasis on financial and clinical metrics to the detriment of cultural, governance, and technological dimensions. By applying General Systems Theory (GST), this study offers a

novel analytical lens to synthesize these dispersed insights and highlight the dynamic interdependencies among VBHC dimensions. The proposed framework identifies six interconnected thematic domains - patient focus, governance and leadership, digitalization and innovation, organizational implementation, economic sustainability, and institutional culture - forming a comprehensive map of transformation vectors in healthcare.

The contribution of this review is twofold. Firstly, we bring a managerial perspective to VBCH studies. While most of research is focused on medicine, public health, and health policy (e.g. Etges et al., 2020; Francis-Auton et al., 2024; Gupta et al., 2019; Van Der Nat et al., 2020) we argue that the adoption of VBHC is rooted in management studies, which calls more strategic-oriented perspective articles. We intend to discuss future studies avenues highlighting how management best-practices influences medical outcomes.
Secondly, by discussing VBHC through the lens of general systems theory (Bertalanffy 2009), as later adapted to organizational analysis (Checkland e Scholes 1999; Jackson 2003) we offer a theoretical foundation particularly well-suited for examining complex, interdependent, and adaptive systems. This systems-oriented perspective allows us to conceptualize healthcare not as a fragmented set of isolated functions, but as a dynamic ecosystem where clinical, economic, cultural, and technological dimensions are deeply interconnected. Leveraging this lens, we propose an analytical framework that captures the multidimensionality of VBHC implementation and its potential as a transformational process. This contribution encourages a more holistic and integrative understanding of organizational change in healthcare contexts.

2. Methodology

2.1 Systematic Review Strategy

This study follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (Page et al. 2021), in order to ensure transparency and reproducibility throughout the review process. The systematic review focused on the application of the VBHC model within healthcare organizations, through the lens of organizational and management sciences. The review strategy comprised three main stages: construction of the search string, definition of inclusion and exclusion criteria, and article screening.

2.2 Inclusion and Exclusion Criteria

Study selection followed predefined eligibility criteria designed to ensure both thematic and methodological relevance of the analyzed sample. The review included empirical research and case studies that directly addressed the adoption, implementation, or management of the VBHC model in healthcare organizations. The time frame covered publications from 2006 to 2025, thereby encompassing the original formulation of the concept by Porter and Teisberg, as well as more recent contributions to the field.

Thematically, selected studies were required to explicitly address organizational, structural, managerial, or strategic dimensions related to VBHC. This includes topics such as governance, leadership, institutional culture, innovation, performance, sustainability, or implementation processes. Articles with an exclusively clinical focus or addressing only patient outcomes without connecting to management aspects (Albsoul et al. 2025; Chapman et al. 2022; Conceição, Major, e Clegg 2023) were excluded, as were studies with a purely technological scope focused on the development or assessment of digital tools without organizational context (Basile et al. 2023; Esposito et al. 2024). These criteria enabled the construction of a sample

more aligned with the research objectives, prioritizing an interdisciplinary approach that integrates management, healthcare, and complex systems perspectives.

2.3. Study Selection Process

The databases used for the search were Scopus and Web of Science, applying the following string: ("value-based healthcare" OR "value based health care" OR VBHC) AND ("organizational characteristics" OR "organizational structure" OR governance OR leadership OR "healthcare management" OR "implementation factors" OR "organizational change") AND ("healthcare organizations" OR hospitals OR "health system"). In the WOS database, 73 records were initially identified using the predefined search string. After applying filters for publication year (2006 to 2025), document type (articles), and thematic categories such as health policy services, healthcare science services, business finance, management, sociology, and public administration, 36 articles remained. In the Scopus database, 1,173 records were retrieved. Applying filters for publication year (2006 to 2025), document type (articles), subject areas (Business, Management and Accounting; Economics, Econometrics and Finance), and source type (journals), reduced the sample to 101 articles. The combined results from both databases totaled 137 articles. After removing five duplicates, 132 unique documents were screened by title and abstract. In this stage, 64 articles were excluded for not meeting the inclusion criteria, such as lacking an organizational focus, being exclusively clinical in nature without managerial relevance, or not explicitly addressing the concept of Value-Based Healthcare (VBHC). Ultimately, 68 articles were selected for full-text reading and included in the final qualitative synthesis. These studies discussed VBHC within organizational contexts and provided theoretical or empirical evidence on its adoption, implementation, and management. The entire bibliographic review process followed PRIMA guidelines (Page et al. 2021) and it is illustrated in Table 1 .

Table 1. Methodological Table of the Screening Process

Stage	Description	Quantity
Identification	Records identified in Web of Science (WOS)	73
	Records after applying filters (year, document type, categories) – WOS	36
	Records identified in Scopus	1173
	Records after applying filters (year, document type, subject area, source type) – Scopus	101
Screening	Combined records (WOS + Scopus)	137
	Duplicates removed	5
	Unique records for screening	132
	Records excluded after title and abstract screening	64
Eligibility	Full-text articles assessed for eligibility	68
Inclusion	Articles included in the final qualitative synthesis	68

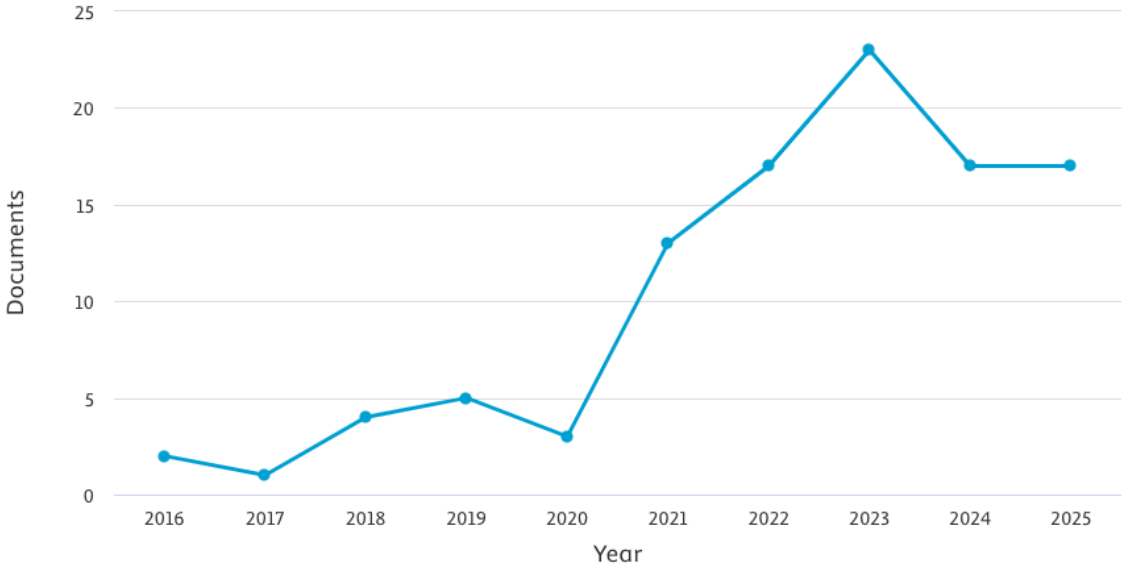
Source: Own elaboration.

3. Results

3.1. Characteristics of the Selected Studies

The descriptive analysis of the 68 selected studies reveals important trends regarding their temporal and geographical distribution. As illustrated in Figure 1, the number of publications increased significantly after 2020, peaking in 2023 with 22 publications. This recent rise suggests a growing interest in the topic of Value-Based Healthcare (VBHC), especially in the wake of health system restructuring driven by the COVID-19 pandemic.

Figure 1 – Documents per year



Source: Scopus

The articles are distributed across 63 different journals, highlighting the diversity and thematic dispersion of the literature on *Value-Based Healthcare* (VBHC). Only five journals published more than one article, indicating that the topic is addressed transversally across various fields, from healthcare and management to public policy, engineering, and organizational innovation. The journals with the highest number of publications are presented in table 2:

Table 2 - Journals with the highest number of publications

Journal	**No. of Articles**
BMC Health Services Research	4
Technological Forecasting and Social Change	4
Journal of Health Organization and Management	3
Health Care Management Review	3
Academic Medicine	2
Australian Health Review	2
Health Services Management Research	2
Information Systems Research	2
International Journal of Healthcare Management	2
Journal of Business Research	2
Manufacturing and Service Operations Management	2
TQM Journal	2

* The other journals had only 01 article published.
Source: Own elaboration

This distribution reinforces the interdisciplinary nature of the VBHC debate, with articles published in journals specializing in healthcare and hospital management, as well as in outlets focused on public administration, organizational studies, health economics, technology, and production engineering. The presence of journals such as *Technological Forecasting and Social Change* and *Information Systems Research* highlights the increasing relevance of technological innovation and digitalization in current discussions about value creation in healthcare.

Meanwhile, traditional healthcare and policy journals like *Health Affairs*, *BMJ Quality & Safety*, and *Milbank Quarterly* reflect the dialogue with public policy and clinical practice.
The low concentration of articles in a single journal can be interpreted as a sign of thematic fragmentation, which reinforces the importance of integrative approaches like the one proposed in this review. Additionally, this heterogeneity suggests that the field is still undergoing epistemological consolidation, with different scientific communities exploring the topic from diverse perspectives.

Also, the analysis of the selected studies indicates a predominance of qualitative designs (n = 38), underscoring the field's emphasis on understanding professional experiences, perceptions, and the contextual nuances of value-based healthcare (VBHC) implementation. Quantitative studies (n = 17) also hold significant weight, applying rigorous analytical techniques such as Data Envelopment Analysis (DEA), Time-Driven Activity-Based Costing (TDABC), Partial Least Squares (PLS), and other advanced statistical models to evaluate clinical efficiency, performance outcomes, and economic impacts. Theoretical and contextual contributions (n = 11) offer important conceptual frameworks and analytical lenses that support ongoing debate and model development. Additionally, two literature reviews consolidate empirical evidence and propose future research pathways. Collectively, these methodological trends reflect a diverse and evolving knowledge base, characterized by robust empirical inquiry, applied case study research, and increasing efforts to integrate theoretical and practical dimensions. As illustrated in table 3, this heterogeneity reinforces the understanding that the research field is maturing and increasingly addressing the complex challenges involved in measuring and delivering value in healthcare systems.

Table 3 –Selected studies by type

Type of Study	Quantity	Examples
Qualitative Study	38	(Chen, Cates, e Taylor 2023; Daniels et al. 2022; Festa et al. 2021; Leao, Pavlova, e Groot 2024; Matinheikki et al. 2024)
Quantitative Study	17	(Beaulieu, Belotti Pedroso, e Rebolledo 2025; Borzée et al. 2025; Duckham, Webster, e See 2024; Francis-Auton et al. 2024; Mauro et al. 2024)
Theoretical/Contextual Study	10	(Menear et al. 2019; Salvatore et al. 2021; Smalbroek et al. 2023; Triantafillou 2022; Veasey 2024)
Review	3	(Friedman et al. 2020; Kc, Scholtes, e Terwiesch 2020; Leite e Quadros 2025)

Source: Own elaboration

In this context, it is also worth noting the geographic diversity of the research. Although the United States and Western Europe dominate the production of studies, a growing number of articles from other regions (e.g., Brazil, Canada, India, Uganda, Qatar, and Australia) reveal the internationalization of the debate on value-based healthcare. This trend points to the global relevance of the subject, even if shaped by distinct institutional and healthcare system realities, as shown in table 4.

Table 4 – Studies by Country

Country	N° of Publications	Country	N° of Publications
USA	16	India	2
Netherlands	8	Brazil	1

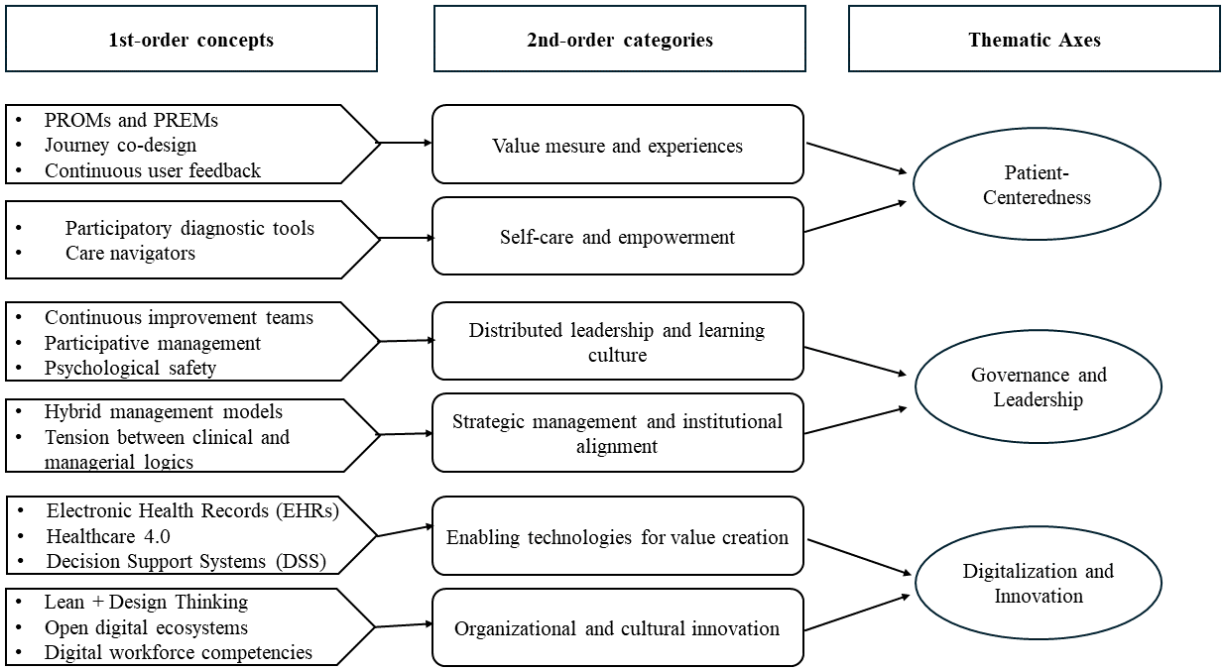
UK	7	Finland	1
Denmark	5	Hungary	1
Multiple Countries	5	Indonesia	1
Australia	4	Nordic Countries	1
Italy	4	Portugal	1
Canada	3	Qatar	1
Sweden	3	Spain	1
Europe	2	Uganda	1

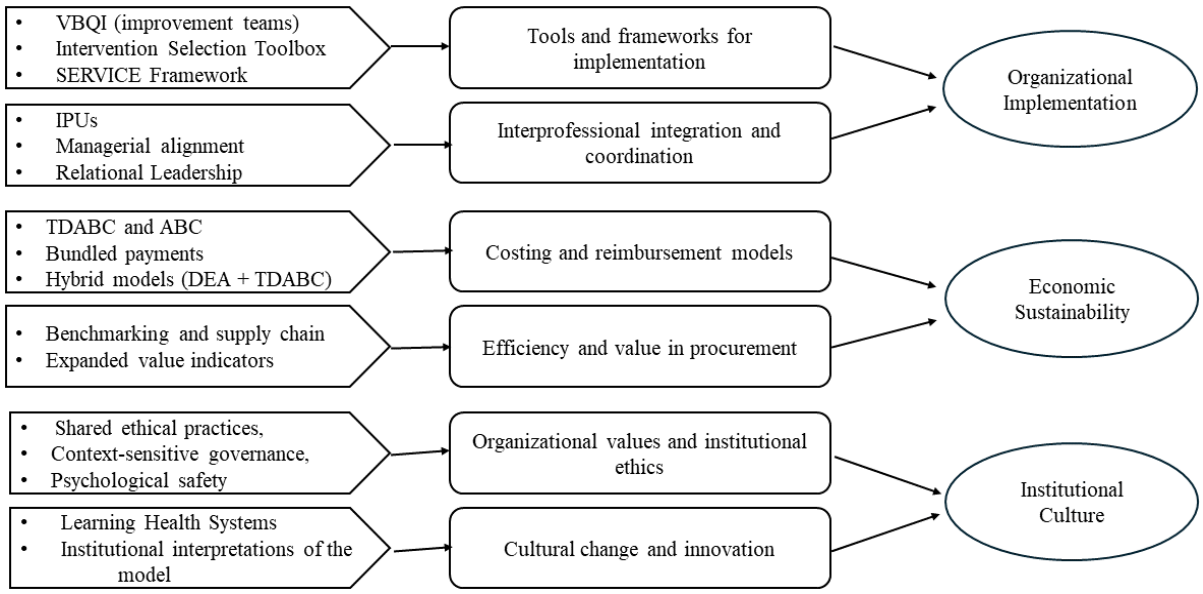
Source: Own elaboration

3.2. Emerging Thematic Axes in the Literature

Based on the qualitative and interpretative analysis of the 68 selected articles, a thematic categorization process was conducted through analytical reading, open coding, and conceptual clustering of the findings. This procedure followed an inductive and iterative logic, inspired by the coding approach proposed by Gioia et al. (2013), which recommends the construction of first order (descriptive) categories, second-order (conceptual) groupings, and aggregate dimensions (theoretical themes). As a result, six thematic axes emerged: patient focus, governance and leadership, digitalization and innovation, organizational implementation, economic sustainability, and institutional culture. These axes represent a synthesis of the main drivers of transformation discussed in the literature on the VBHC model from an organizational and systemic perspective as illustrated in Figure 2.

Figure 2 - Thematic Framework Based on Gioia Method Applied to VBHC Literature"





Source: Own elaboration

3.2.1. Patient-Centeredness

Patient-centeredness emerges as a fundamental pillar in the Value-Based Healthcare (VBHC) model. It is reflected in practices that actively involve patients in managing their own health and in designing care strategies. In this context, initiatives such as the co-creation of digital care journeys and programs that enhance active listening have proven effective in improving the patient experience(Duckham, Webster, e See 2024; Eamranond et al. 2022).

Another critical element is the use of Patient-Reported Outcome Measures (PROMs), which help improve decision-making processes and strengthen multistakeholder governance by integrating diverse perspectives into clinical management (Ferrè 2024; Møberg e Malmmose 2025). Despite recent advancements, significant challenges remain, particularly regarding the alignment of value perceptions between patients and healthcare professionals. This highlights the need for continuous, structured feedback mechanisms to enhance value delivery in healthcare services (Ali e Dzandu 2023; Wolf et al. 2024).

Through in-depth interviews with healthcare professionals and experts, diagnostic tools have been developed to support this alignment, encompassing essential dimensions such as quality and safety, positive experience, and cost-effectiveness (Souza, Lopes, e Lima 2025).

3.2.2 Governance and Leadership

The literature highlights that effective governance and committed leadership are key elements for the sustainable implementation of Value-Based Healthcare (VBHC). Distributed leadership models and organizational cultures oriented toward continuous learning are considered fundamental for internalizing VBHC principles within institutions (Bonde, Bossen, e Danholt 2018; Francis-Auton et al. 2024; Friedman et al. 2020). However, tensions between administrative and clinical logics are frequently observed, making hybrid management models particularly challenging, especially in complex systems such as the British NHS, which adds layers of difficulty to implementing value-based strategies (Kokko e Laihonen 2022; Ng 2022)

In this context, tools such as the High-Value Care Culture Survey have been developed to assess and promote institutional alignment, emphasizing the importance of local indicators and active

change management (Bonde, Bossen, e Danholt 2018; Gupta et al. 2017, 2019; Gupta e Moriates 2017; Le-Dao et al. 2020). Despite these conceptual advancements, research indicates that strategic decisions remain largely anchored in traditional clinical and financial outcomes. Some studies even explore how neoliberal ideologies affect the performance of VBHC initiatives (Triantafillou 2022). The literature underscores a significant gap between rhetoric and practice within healthcare organizations (Daniels et al. 2022; Schario e Pronovost 2024; Slingerland et al. 2024).

3.2.3. Digitalization and Innovation

Technological and digital innovation plays a catalytic role in the implementation of Value-Based Healthcare (VBHC), enabling the development of integrated digital ecosystems that directly benefit both patients and healthcare professionals (Kokshagina 2021). Studies on open innovation (Pundziene et al. 2023a) emphasize the importance of orchestrating these ecosystems through specialized organizations, as well as adopting multi-level innovation approaches that highlight organizational and national culture as critical determinants of digital success (Kokshagina 2021; Paiola et al. 2023; Sermontyte-Baniule et al. 2022).

Strategic use of Electronic Health Records (EHRs) and the implementation of the Healthcare 4.0 concept, which encompasses emerging Technologies, have proven fundamental in generating significant public value, improving operational efficiency, and enhancing clinical outcomes (Aranyossy e Halmosi 2024; Bardhan, Bao, e Ayabakan 2023). Additionally, combining Lean methodology with Design Thinking has emerged as a promising approach for the integrated optimization of clinical and administrative processes, showing how digital innovations can enhance outcomes without requiring significant additional investment (Bao e Bardhan 2022; Sales et al. 2023). Nevertheless, it is essential to note that workforce competency development remains a foundational pillar to ensure that such technological innovations achieve their intended impact (Mauro et al. 2024).

3.2.4. Organizational Implementation

The organizational implementation of VBHC requires clearly defined and structured strategies, including sequential models for implementation in academic and military contexts (Heijsters et al. 2022; Hernandez et al. 2019), as well as tools that support value-based decision-making, such as the Intervention Selection Toolbox (Smalbroek et al. 2023).

Elements such as interprofessional cohesion and coordination are crucial for effectiveness in primary care and Integrated Practice Units (IPUs), underscoring the importance of managerial alignment and relational leadership for long-term success (Abdelfadil et al. 2023; Shea et al. 2018; Van Der Nat et al. 2020; Van Staalduinen et al. 2023, 2025).

VBHC implementation can be supported by multiple approaches, including continuous improvement teams, specific frameworks, conceptual taxonomies, and Lean Management-based methods. Continuous improvement teams (VBQI) have been analyzed as effective strategies for driving organizational change (Daniels et al. 2022). Simultaneously, specialized taxonomies, such as the value taxonomy developed specifically for hospital management, help in clearly classifying value-oriented objectives and indicators adopted by institutions (Colldén et al. 2017).

Moreover, structured frameworks like the SERVICE model have proven effective in sustainably redesigning care pathways, emphasizing key elements for continuous innovation

and long-term improvement (Williams e Radnor 2022). Recent systematic reviews also reinforce that Lean methodology can be widely applied in hospital management, enabling integrated and efficient implementation of value-based practices (Leite e Quadros 2025) .

3.2.5. Economic Sustainability

Economic sustainability remains one of the primary challenges in the effective implementation of Value-Based Healthcare (VBHC), involving the adoption of innovative costing methods, performance-based payment strategies, and well-structured quality assessment metrics. In this regard, critiques of traditional departmental costing models have emerged, with recommendations favoring more accurate approaches such as Time-Driven Activity-Based Costing (TDABC), which promotes better alignment between costs and clinical outcomes (Malmmose & Lydersen, 2021; Da Silva Etges et al., 2022).

Simultaneously, Pay-for-Performance (P4P) initiatives and value-based procurement are gaining traction as essential tools to drive operational efficiency and hospital productivity. However, caution is needed regarding potential distortions in specific program indicators, such as those related to home care (Bao e Bardhan 2022, 2025; Bardhan, Bao, e Ayabakan 2023; Leao, Pavlova, e Groot 2024; Li 2022; Matinheikki et al. 2024). Moreover, value-based reimbursement models require the development of qualitative metrics aligned with the Sustainable Development Goals (SDGs), highlighting the need for clear measurement of the quality of services delivered (Chen, Cates, e Taylor 2023; Rattan et al. 2022).

Another relevant dimension involves the use of strategic concepts from supply chain management and benchmarking to enhance efficiency, as well as the deployment of contextualized performance indicators that consider elements such as social performance and internal entrepreneurship (Alam 2023; Beaulieu, Belotti Pedroso, e Rebolledo 2025; Betcheva, Erhun, e Jiang 2021; Ding 2024; Layman et al. 2023).

Finally, hybrid approaches combining quantitative methods such as Data Envelopment Analysis (DEA) and TDABC have gained prominence for personalized value measurement (Borzée et al. 2025), along with the strategic complementarity of bundled payments and target costing (Sedevich-Fons 2023). These approaches underscore the need for expanded metrics that capture non-monetary benefits beyond traditional financial returns (Jia, Hilafu, e Bichescu 2024; Thusini, Soukup, e Henderson 2024).

3.2.6. Institutional Culture

Institutional culture is fundamental to the consolidation of the VBHC model. Concepts such as Learning Health Systems, which aim to embed continuous organizational learning practices to improve both clinical and administrative outcomes, have emerged as critical to this discussion (Menear et al. 2019). Within this context, strategic models grounded in value-based competition are highlighted as mechanisms for guiding organizational behavior and fostering innovation (Salvatore et al. 2021).

An organizational culture that supports psychological safety and continuous experimentation facilitates the internalization of VBHC principles, reinforcing the commitment of both clinical and administrative teams to sustainable value creation (Francis-Auton et al. 2024; Gupta et al. 2017, 2019; Ng 2022). Additionally, the integration of service innovation with internal cultural

values is emphasized as a key determinant in transforming and consolidating a patient-centered organizational model (Berry 2019).

Effective implementation of VBHC also requires approaches that account for the complexity of organizational translation and micro-level tactics, enabling the adaptation of general guidelines to specific local realities (Colldén et al. 2017; Waldorff e Madsen 2023). In this regard, the incorporation of critical perspectives, such as Indigenous epistemologies and decolonial approaches, offers a more inclusive and context-sensitive understanding of value in healthcare (Veasey 2024).

Further discussions around institutional logics in value-based reimbursement models (Erikson et al. 2017; Eriksson, Levin, e Nedlund 2021), the integration of risk management into organizational cultural practices (Festa et al. 2021), and the intersection of environmental sustainability, governance, and institutional culture (Barber, Sinclair, e Cassidy 2025) reinforce the need for a holistic and integrated approach. Moreover, national policy analyses aligned with broader strategic goals, such as the Triple Aim, highlight the interdependence between institutional culture, sustainability, and value creation (Kokko e Kork 2021). Moreover, empirical evidence shows that ethical behavior and values-based practices significantly enhance organizational performance. This underscores the role of institutional ethics as a foundational element in the perception and delivery of value in healthcare systems, particularly in resource-constrained settings (Mutumba, Webb, e Kyambade 2025). Table 5 presents a summary of the discussions by thematic axis.

Table 5. Summary of Thematic Axes

Thematic Axis	Main Topics	Tools/Concepts	Authors
Patient-Centeredness	Patient centrality, PROMs, continuous feedback, care experience	PROMs, qualitative diagnostic tools	(Ali e Dzandu 2023; Duckham, Webster, e See 2024; Eamranond et al. 2022; Ferrè 2024; Møberg e Malmmose 2025; Souza, Lopes, e Lima 2025; Wolf et al. 2024)
Governance and Leadership	Distributed leadership, learning cultures, clinical-managerial tensions	High-Value Care Culture Survey, change management	(Bonde, Bossen, e Danholt 2018; Francis-Auton et al. 2024; Friedman et al. 2020; Gupta et al. 2017, 2019; Gupta e Moriates 2017; Le-Dao et al. 2020; Ng 2022; Schario e Pronovost 2024; Slingerland et al. 2024; Triantafillou 2022)
Digitization and Innovation	Digital ecosystems, digital culture, Healthcare 4.0, Lean, Design Thinking	Open innovation, EHRs, Lean, Design Thinking, digital skills	(Aranyossy e Halmosi 2024; Bardhan, Bao, e Ayabakan 2023; Kokshagina 2021; Mauro et al. 2024; Paiola et al. 2023; Pundziene et al. 2023b; Sales et al. 2023; Sermontyte-Baniule et al. 2022; Zhang e Shugarman 2024)
Organizational Implementation	Structured strategies, IPUs, relational leadership, continuous improvement	VBQI, SERVICE, Lean Management, IPUs	(Colldén et al. 2017; Daniels et al. 2022; Heijsters et al. 2022; Hernandez et al. 2019; Leite e Quadros 2025; Shea et al. 2018; Smalbroek et al. 2023; Van Der Nat et al. 2020; Van Staalduinen et al. 2023; Williams e Radnor 2022)
Economic Sustainability	Advanced costing, P4P, value-based reimbursement,	TDABC, DEA, bundled payments,	(Alam 2023; Bao e Bardhan 2022, 2025; Beaulieu, Belotti Pedroso, e Rebolledo 2025; Betcheva, Erhun, e

Thematic Axis	Main Topics	Tools/Concepts	Authors
	benchmarking, social indicators	target costing, extended ROI	Jiang 2021; Borzée et al. 2025; Chen, Cates, e Taylor 2023; Ding 2024; Jia, Hilafu, e Bichescu 2024; Layman et al. 2023; Leao, Pavlova, e Groot 2024; Li 2022; Malmmose e Lydersen 2021; Matinheikki et al. 2024; Rattan et al. 2022; Sedevich-Fons 2023; da Silva Etges et al. 2022; Thusini, Soukup, e Henderson 2024)
Institutional Culture	Organizational learning, cultural innovation, ethics, critical epistemologies	Learning Health Systems, micro-tactics, Triple Aim	(Barber, Sinclair, e Cassidy 2025; Berry 2019; Colldén et al. 2017; Eriksson, Levin, e Nedlund 2021; Festa et al. 2021; Francis-Auton et al. 2024; Gupta et al. 2017, 2019; Gupta e Moriates 2017; Kokko e Kork 2021; Menear et al. 2019; Mutumba, Webb, e Kyambade 2025; Ng 2022; Salvatore et al. 2021; Veasey 2024; Waldorff e Madsen 2023)

Source: Own elaboration

4. Research Avenues

The reviewed literature on Value-Based Healthcare (VBHC) indicates a field undergoing maturation, characterized by a growing diversity of approaches and increasing complexity in implementation strategies. The 68 analyzed studies converge on the understanding that "value in healthcare" is not a singular construct but rather a multifaceted concept shaped by the perspectives of different stakeholders: patients, managers, healthcare professionals, and policymakers. Accordingly, patient-centeredness emerges as a foundational principle, yet it remains insufficiently operationalized.

Although significant advances have been documented, such as the use of patient-reported outcome measures (PROMs), patient experience–focused digital pathways, and active listening initiatives, still, gaps persist between data collection and its translation into clinical and managerial decisions (Duckham, Webster, e See 2024; Ferrè 2024; Souza, Lopes, e Lima 2025). Aligning perceptions of value between patients and professionals continues to pose a barrier to model advancement (Wolf et al. 2024).

Within governance and leadership, studies highlight a shift in traditional power structures within healthcare organizations. Distributed leadership, clinical engagement, and organizational learning environments are more conducive to embedding VBHC principles (Francis-Auton et al. 2024; Gupta et al. 2017). Nevertheless, this transformation is not frictionless: tensions persist among managerial, financial, and clinical logics, underscoring the difficulty of implementing profound change in entrenched institutional cultures (Eriksson, Levin, e Nedlund 2021; Ng 2022). Analyses of VBHC's neoliberal paradoxes (Triantafillou 2022) and hospital executives' strategic decision criteria (Slingerland et al. 2024) further emphasize that value in healthcare is as much political as it is technical.

Digitalization and technological innovation play catalytic roles in healthcare transformation yet also widen disparities among institutions with varying digital maturity. Contributions of electronic health records (EHRs), artificial intelligence, and decision support tools to value

creation are well-documented (Bardhan, Bao, e Ayabakan 2023; Kokshagina 2021; Mauro et al. 2024). However, the success of these initiatives hinges on critical contextual factors such as organizational culture, workforce training, and technological infrastructure (Aranyossy e Halmosi 2024; Sermontyte-Baniule et al. 2022). A study by Williams and Radnor (2022) reinforces this by demonstrating how the SERVICE framework guided sustainable innovation in a chronic care community service, emphasizing user experience–centered process design.

At the organizational implementation level, VBHC reveals a fertile ground for innovative management strategies. The reviewed studies describe structured implementation models in academic hospitals (Heijsters et al. 2022), Lean Management and Design Thinking applications (Sales et al. 2023), and decision-support tools like the Intervention Selection Toolbox (Smalbroek et al. 2023). Successful implementation initiatives involve not only structural reorganization but also role redefinition, workforce development, and user engagement. However, replicating these best practices still confronts obstacles such as institutional resistance, system fragmentation, and resource limitations.

The debate on economic sustainability remains among the most complex and controversial areas of VBHC. Models such as time-driven activity-based costing (TDABC) combined with Data Envelopment Analysis (DEA) have demonstrated effectiveness in context-adjusted value measurement (Borzée et al. 2025; da Silva Etges et al. 2022), though their adoption remains limited. Thusini et al. (2024) challenge the sole reliance on ROI for quality governance, advocating for hybrid approaches that accommodate both monetary and non-monetary values. Sedevich-Fons (2023) supports this view by highlighting the complementarity between bundled payments and target costing. Critiques of pay-for-performance (P4P) also persist (Bao e Bardhan 2025; Li 2022), yet the model's potential to enhance efficiency remains, provided calibration mechanisms mitigate distortions and inequities.

Finally, institutional culture emerges as the essential foundation for any value-driven transformation. Rather than being imposed, a high-value care culture must be cultivated collectively, grounded in psychological safety, continuous learning, and clinical agency (Berry 2019; Gupta et al. 2019; Gupta e Moriates 2017; Menear et al. 2019). Research shows that ethics, sustainability, and governance are inextricably linked within healthcare systems (Barber, Sinclair, e Cassidy 2025; Festa et al. 2021). Evidence from Uganda indicates that ethical conduct and shared values directly contribute to improvements in organizational performance (Mutumba, Webb, e Kyambade 2025).

Taken together, these findings suggest that VBHC is not a fixed, universal model but rather a dynamic framework that requires adaptation to local realities, institutional capabilities, and social priorities. Its promises can only be fulfilled through supportive cultural, political, and technological transformations. More than an end goal, "value in healthcare" should be perceived as a continuous negotiation process among diverse actors, interests, and contexts.

Moreover, analyzing the literature review in a critical manner reveals significant gaps: first, there is a pronounced disconnect between rhetoric and practice: patient-centeredness is widely espoused, but not consistently reflected in managerial decisions and operational structures. Governance remains caught between clinical and administrative logics, hindering the adoption of distributed, collaborative leadership. Additionally, thematic fragmentation persists: literature often treats technological innovation, financial management, organizational culture, and clinical engagement in isolation, without proposing integrated approaches. Lastly, an overemphasis on ROI-based metrics narrows governance down to an economic perspective, neglecting the social, ethical, and cultural externalities integral to a broader concept of value.

Table 6 presents a synthesis of the main research gaps and corresponding suggestions for future investigation, as identified through the literature review. These are organized according to the six thematic axes developed in this study.

Table 6. Research Gaps and Future Research Directions by Thematic Axis

Thematic Axis	Research Gaps Identified	Possible Research Questions
Patient-Centeredness	Disconnect between rhetoric and practice in implementing patient-centered care.	How can PROMs and patient engagement be effectively translated into managerial practices and care delivery processes?
Governance and Leadership	Tension between clinical and administrative logics; difficulty implementing distributed leadership.	What leadership models best facilitate collaborative VBHC implementation in hierarchical health systems?
Digitalization and Tech	Fragmented integration of digital tools; disparities in institutional digital maturity.	How can EHRs, AI, and decision-support tools be integrated with governance and clinical workflows in a value-oriented way?
Organizational Implementation	Best practices exist, but are rarely replicated; contextual and cultural resistance is common.	What conditions support the transferability of successful VBHC implementation models across healthcare institutions?
Economic Sustainability	ROI is overemphasized; little attention to hybrid and non-monetary value frameworks.	What alternative models can balance financial performance with ethical and social dimensions in VBHC governance?
Institutional Culture	Culture change is essential but underexplored; lack of integrated analysis of ethics, learning, and governance.	How can institutional culture be shaped to foster sustainable, high-value healthcare delivery across organizational levels?

Source: Own elaboration

5. Makins Sense of the Literature: A Systemic Integrative Framework for VBHC

5.1. Foundations and Rationale

Based on the preceding analysis, the development of an integrative framework stems from the recognition that, although extensively discussed in medicine and public health, the Value-Based Healthcare (VBHC) model still lacks a robust operational architecture grounded in the fundamentals of organizational sciences and systems theory. To address this gap, we triangulated three fundamental dimensions: (i) Porter & Lee's Value Agenda (2013), composed of six transformational elements; (ii) the six thematic axes identified in our systematic literature review (n = 68); (iii) the principles of General Systems Theory (Bertalanffy 2009; Checkland e Scholes 1999; Jackson 2003), which frame healthcare systems as adaptive, interdependent, and non-linear networks. Systems theory offers a robust conceptual foundation to understand organizations as open, interdependent, and adaptive systems. Bertalanffy's original formulation in 1968, advocated for studying systems as integrated wholes interacting with their environments, moving beyond reductionist models. Checkland (1999) introduced Soft Systems Thinking, particularly suitable for complex organizational environments with divergent

stakeholder perspectives, such as healthcare. Jackson (2003) contributed the idea of creative holism, urging managers to combine multiple approaches depending on the complexity at hand.

This triangulation enabled the construction of an analytical-conceptual model capable of mapping the interactions among clinical practices, managerial decisions, and institutional structures through a systemic and integrative lens, as presented in Table 7.

Table 7. Conceptual Cross-Mapping

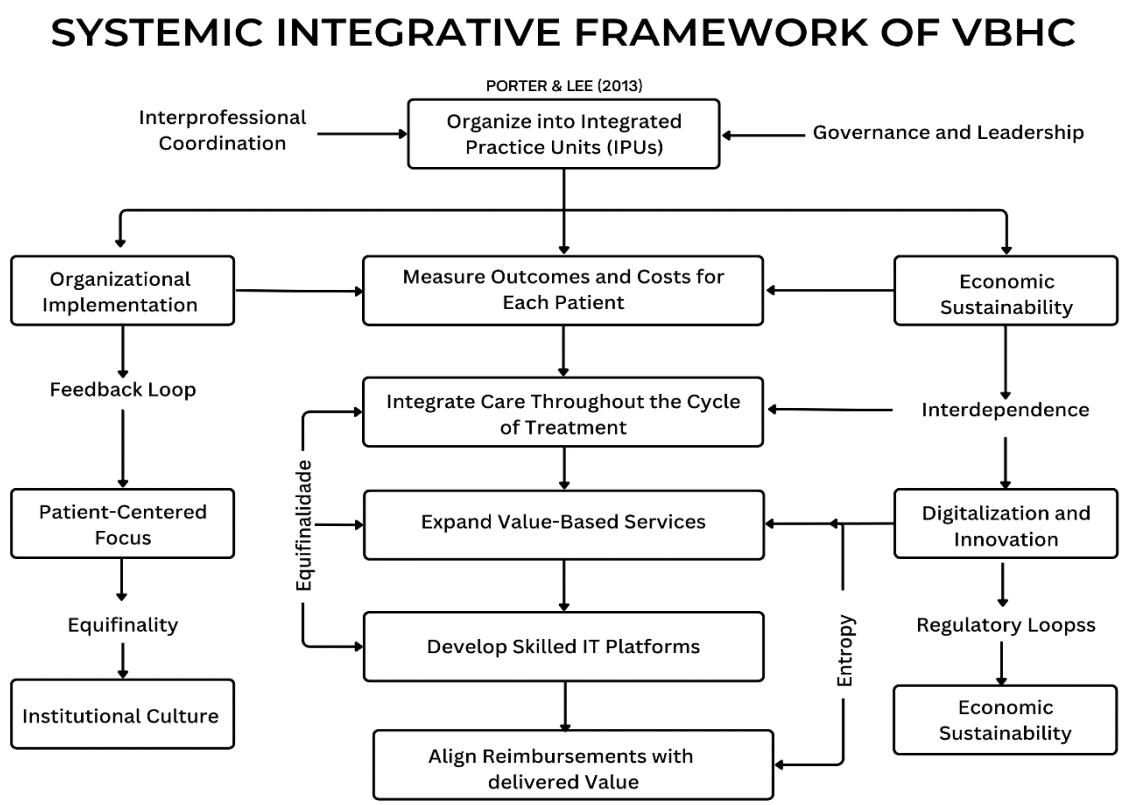
Value Agenda Stage (Porter & Lee, 2013)	Related Thematic Axes	Systemic Interpretation
Organize into Integrated Practice Units (IPUs)	Organizational Implementation Governance and Leadership	Structural reconfiguration requiring interprofessional coordination, flow integration, and role redefinition.
Measure outcomes and costs for every patient	Patient-Centered Care Economic Sustainability	Feedback loop mechanism that informs decisions and enables continuous adaptive learning.
Integrate care across the full cycle	Governance and Leadership Digitalization	Requires interdependent systems and interoperability to ensure continuity of care in complex networks.
Expand services across value-based networks	Institutional Culture Organizational Implementation	Requires equifinality: different configurations may achieve similar outcomes if core principles are maintained.
Build enabling IT platforms	Digitalization and Innovation Patient-Centered Care	Information systems as technical and symbolic infrastructures connecting subsystems and reducing entropy.
Align reimbursement with value delivered	Economic Sustainability Institutional Culture	Alters incentives and regulatory feedback loops, promoting behaviors aligned with systemic goals.

Source: Own elaboration

5.2. Description and Applicability of the Framework

The Systemic Integrative Framework for Value-Based Healthcare (VBHC) (Figure 3) is built upon a three-dimensional structure that interrelates strategic, analytical, and systemic foundations. Its first dimension, referred to as the Structuring Layer, is grounded in the Value Agenda proposed by Porter and Lee (2013). This agenda consists of six functional pillars that guide the structural transformation of the healthcare sector: (1) organizing care around clinical conditions and complete care cycles; (2) systematically measuring outcomes and costs for each patient; (3) implementing bundled payments for entire care cycles; (4) integrating care delivery across distinct units and geographic locations; (5) expanding access to high-quality services across regions; and (6) developing information technology platforms that support the complete cycle of care.

Figure 3: Systemic Integrative Framework for VBHC



Source: Own elaboration

The second layer, the Analytical Layer, links each of these structural elements to the thematic axes identified through the systematic literature review. For instance, patient-centeredness is directly connected to care organization and outcome measurement; governance and leadership are tied to service integration and the expansion of best practices; digitalization and innovation are central to performance monitoring and the development of IT platforms; organizational implementation depends on coordinated arrangements and technological support; and economic sustainability is closely related to value measurement and reimbursement models. Due to its transversal nature, institutional culture permeates all of these components and is considered a critical enabler for transformation.

The third layer, the Systemic Layer, incorporates foundational principles from General Systems Theory (Bertalanffy 2009; Checkland e Scholes 1999; Jackson 2003) to guide a dynamic reading of the framework.

Three core principles emerge from these theories: (i) Holism, which suggests that the pillars of the Value Agenda must be implemented in an integrated and coordinated manner; (ii) Interdependence, which highlights the feedback loops between strategic elements and analytical dimensions, illustrating, for example, how changes in governance can affect institutional culture and cost models; (ii) Adaptation, which underscores the system's need to continuously adjust to contextual variation through organizational learning, active listening, and incremental innovation.

The Systemic Integrative Framework for VBHC developed in this study provides a comprehensive and interdisciplinary lens to understand and operationalize the concept of

Value-Based Healthcare from an organizational, systemic, and strategic perspective. By triangulating the transformational agenda proposed by Porter and Lee (2013), the thematic axes identified in the literature, and systems theory principles, the model offers a robust conceptual tool to analyze the healthcare sector as a dynamic, complex, and adaptive ecosystem.

The framework's primary contribution lies in overcoming the fragmentation observed in the literature. Studies on VBHC often focus separately on clinical practices, costing models, or IT systems, without integrating these dimensions. This model demonstrates that the transformations proposed by Porter and Lee only lead to sustainable value when aligned with effective governance structures (Francis-Auton et al., 2024), learning-oriented institutional cultures (Menear et al. 2019), and integrated digital practices (Bardhan, Bao, e Ayabakan 2023).

The framework reaffirms that VBHC is not a technical toolkit or a checklist of best practices, but a systemic process of organizational transformation. It requires acknowledgment of the interdependence among actors, processes, technologies, and values (Checkland e Scholes 1999; Jackson 2003). The application of systems theory reveals that value creation depends on continuous feedback loops between clinical and administrative decisions (Bertalanffy 2009), and that isolated implementation attempts are likely to fail (Read "Crossing the Global Quality Chasm [s.d.]).

By articulating dimensions such as patient-centeredness, economic sustainability, and institutional culture, the model illustrates that VBHC effectiveness relies on a cross-cutting approach that integrates clinical logic with organizational rationality (Colldén et al. 2017). This implies incorporating feedback from patients and professionals not only into performance metrics but into decision-making processes, continuously and collaboratively (Ali e Dzandu 2023; Souza, Lopes, e Lima 2025).

6. Conclusion

The systematic review conducted in this study demonstrates that Value-Based Healthcare (VBHC) is one of the leading contemporary strategies for reorganizing health systems around the creation of real value for patients. The study sought to understand how Value-Based Healthcare (VBHC) has been interpreted, operationalized, and implemented from an organizational and systemic perspective. Grounded in General Systems Theory (Bertalanffy 2009) and following the coding procedures proposed by Gioia et al. (2013), we analyzed 68 academic articles selected from Scopus and Web of Science, resulting in the identification of six thematic axes that reflect the multifaceted nature of VBHC: patient-centeredness, governance and leadership, digitalization and innovation, organizational implementation, economic sustainability, and institutional culture. These axes formed the foundation for the Systemic Integrative Framework for VBHC, a conceptual model that triangulates Porter and Lee's (2013) value agenda, thematic findings from the literature, and the systems thinking approach. The results reveal that VBHC is not a fixed set of practices or a universal formula but an adaptive and context-sensitive model shaped by the continuous interaction of clinical, technological, economic, and cultural dimensions. The review shows a strong consensus on patient-centeredness as the normative cornerstone of VBHC; however, it also demonstrates that its practical implementation remains partial and fragmented. Challenges such as misalignment of value perceptions among stakeholders, institutional resistance, and overreliance on financial indicators hinder the model's potential. While several studies show advancements in digital infrastructure, PROMs, and innovative costing models like TDABC and bundled payments, the lack of integration between these initiatives limits their systemic impact.

6.1 Theoretical Implications

This study contributes to repositioning VBHC within the field of management and organization studies, emphasizing that its implementation requires more than clinical or policy adjustments. Through the systems theory lens, we highlight the importance of recognizing healthcare as a dynamic ecosystem, where interdependencies between leadership, different stakeholderts, culture, information flows, and technology shape the outcomes of transformation efforts. This approach challenges linear or reductionist interpretations of VBHC and invites scholars to explore its complexity through relational and emergent properties, rather than isolated tools or outcomes. It also provides a robust framework for examining how institutional configurations enable or constrain value generation in healthcare.

6.2 Implications for Decision-Makers

For practitioners, the Systemic Integrative Framework offers a strategic tool to assess readiness, structure implementation strategies, and foster organizational cultures that support collaborative governance and innovation. By aligning leadership, training, digital infrastructure, and user engagement around shared value principles, healthcare managers can move from fragmented initiatives to integrated transformation efforts.
For policymakers, the findings emphasize the need to design enabling institutional environments that go beyond economic incentives. Effective VBHC policies must promote regulatory stability, support interorganizational collaboration, and reinforce ethical, cultural, and participatory structures. Policies should guide systems toward sustainable value creation, balancing clinical outcomes with societal and organizational impacts.

6.3 Limitations and Future Research

This review is not without limitations. The literature search was restricted to two academic databases and limited to three languages, which may have excluded relevant contributions, especially from non-Western or practice-based contexts. Additionally, our analytical approach prioritized qualitative synthesis over quantitative meta-analysis, which may limit generalizability but allowed for depth and theoretical articulation. These limitations suggest caution in extrapolating the findings but also open avenues for complementary studies using diverse methods and sources.

Future research should investigate how hybrid costing models, such as TDABC combined with non-monetary measures, can be operationalized in different institutional contexts, especially in low- and middle-income countries. It is also essential to deepen empirical studies on patient and community co-production mechanisms, examining how participatory governance can influence both care quality and institutional learning. Another promising direction involves analyzing the role of interorganizational networks and knowledge ecosystems in scaling VBHC adoption across health systems. Lastly, scholars should investigate how regulatory environments and public policy instruments can shape institutional incentives aligned with a multidimensional view of value, incorporating ethical, clinical, economic, and cultural dimensions.

In conclusion, this study demonstrates that VBHC should be understood not as a prescriptive toolkit but as a strategic field of organizational innovation and cultural transformation. It requires integrative, adaptive, and systemic responses, anchored in local realities, institutional capabilities, and the evolving needs of diverse populations. Its successful dissemination will

depend on the ability of health systems to engage complexity, foster ethical commitments, and co-create sustainable pathways to deliver real value in healthcare.

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