The "Snail Model": Mapping the patient journey through an experiential standpoint

Agnese Palvarini*

Background
Patient journey mapping is widely considered a helpful tool to enhance the patient experience by supporting practitioners in the provision of patient-centered care.

Purpose
The ultimate goal of this paper is to introduce an all-encompassing framework that integrates the experiential dimension of care into the major phases of the patient journey, as well as identify how different patterns of behavior may influence the therapeutic path.

Methodology
The analysis is divided into two parts. The first involves the theory adaptation of a marketing framework to healthcare in the context of the Experience Economy. The second consists of the theoretical conceptualization of a patient journey map called the "Snail Model".

Findings
The results show how the interaction between health literacy and involvement may unearth four typologies of patients: resigned, informed, expert, and responsible. Furthermore, the following stages of the patient journey are identified: i) health communication policies and prevention programs; ii) health service access and diagnostic process; iii) patient involvement and therapeutic adherence; iv) doctor-patient communication failure and therapeutic non-adherence.

Practice implications
It is crucial for practitioners to adopt an experiential standpoint when providing care. The theories presented in this study should assist them in clustering patients according to their behaviors, as well as monitoring the effectiveness of the patient journey.

Conclusion
The NHS should ensure effective prevention programs, equal access to healthcare, and adherence to treatments. Overall, patient involvement is essential to improving the quality of care and the whole patient experience.

Keywords: patient experience, patient journey mapping, prevention and control, early diagnosis, patient participation, treatment adherence and compliance.

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SOMMARIO

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* *Agnese Palvarini*, Università Bocconi.

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1. Introduction

Thus far, patient experience has not been seen as a means to enhance service performance or manage regulatory constraints, and neither has been a core component of significant healthcare reforms worldwide (McCarthy *et al.*, 2016; Oben, 2020). Nevertheless, the last decade has been marked by a growing portion of academic research in the field of patient journey mapping (Davies *et al.*, 2023). Overall, these studies aim to improve the quality of care by investigating patient experience, which is the dynamic range of interactions between patients and health providers throughout the treatment process (ibidem, p. 84). There is broad agreement to consider patient journey mapping as a helpful tool for reconfiguring the therapeutic path from the patient's perspective to improve the care experience's effectiveness (Trebble *et al.*, 2010). As the identification of the main enablers, barriers, and gaps in the healthcare service delivery through this approach is relatively recent, general reporting guidelines have, however, yet to be developed (Davies *et al.*, 2023).

In an attempt to address the above-mentioned fragmentation, this study introduces an all-encompassing model to depict the main phases of the patient journey in their logical order. By adapting an existing framework developed in the context of the Experience Economy, four patient typologies are identified, and their peculiar behaviors are then integrated into a newly created patient journey map.

The paper is composed of five main sections. First, the current state of the art of patient experience and patient journey mapping is briefly described. The methodology adopted for conceptualizing the two frameworks is then presented. Subsequently, the results of the analysis are extensively explored and discussed. Finally, the practice implications and the conclusion point out the actual scope of the study, its theoretical limitations, and future research developments.

2. Theory

The Experience Economy represents a paradigm of the 21st century introduced by the American economists Pine and Gilmore to explain how companies create a new type of economic value for consumers distinct from commodities, goods, and services. According to this theory, the full benefit of staging experience is not limited to entertainment industries (Pine and Gilmore, 1998). As a result, even the health sector can be affected by this paradigm shift. Dealing with patients in a more caring and empathic manner is crucial to enhance both patient satisfaction and empowerment and improve clinical outcomes (Pine and Gilmore, 2001). Despite the increasing relevance of experience in healthcare, a shared and standardized definition is still lacking (Oben, 2020). This is primarily because patient experience is a complex and multidimensional concept that entails the number of interactions that affect patient perceptions during the continuum of care (The Beryl Institute, 2024). A clearer understanding of this topic will thus assist health providers in adopting patient-centered approaches and drive decision-makers to integrate patient experience into healthcare policies (Oben, 2020).

Patient journey mapping may help make progress in this field. Overall, the patient journey is indented as the mapping of patient experiences, relations, emotions, physical conditions, and interactions between the individual and multiple touch points during the continuum of care (ibidem, p. 356). From a more practical perspective, the optimization of the patient journey through an experiential standpoint is reported to produce positive results in terms of improved well-being perceived by all the parties involved (e.g., patient, family members, and medical staff, etc.) and costs reduction for the healthcare system (Rawson, Duncan, and Jones, 2013). Many studies have described this topic using different methodologies and for various purposes (McCarthy *et al.*, 2016). For instance, a patient journey map can result from a field analysis carried out on a disease-specific sample of patients (Schouten *et al.*, 2022) or a group of patients with different diseases (Philipot *et al.*, 2019). At the same time, the focus may be on planning healthcare logistics from admission to discharge (Simonse, Albayrak, and Starre, 2019) or solely on a particular stage of the patient journey (Pera *et al.*, 2020). The continuity of care emerges consistently as a critical element of patient safety (Beleffi, Mosconi, and Sheridan, 2020), which starts before the onset of illness and lasts throughout the whole experience of interaction between the individual and the healthcare system (Oben, 2020).

In such a context, this paper addresses the need to conceptualize a theoretical framework that holds together the therapeutic path's experiential dimension and the patient journey's main stages. The design of such a patient journey map will, therefore, give an incremental contribution to the existing knowledge by identifying the general features of the patient journey and their effect on the whole care experience.

3. Methodology

The methodology adopted in this paper follows two research approaches: theory adaptation and model conceptualization.

The first consists of adapting the "Four Realms of Experience" framework developed by Pine and Gilmore. From the interaction between the two dimensions of customer participation (passive vs. active) and connection (absorption vs. immersion), the authors identified four customer experiences: entertainment, educational, escapist, and esthetics (Pine and Gilmore, 1998). The main goal of the original framework was to help companies design and deliver memorable experiences for their clients based on their specific needs. With the purpose of applying this marketing theory to healthcare, the four realms of experience have been replaced by the main typologies of behaviors that patients can assume throughout the care experience.

The second consists of conceptualizing a theoretical framework called "Snail Model", a patient journey map aimed at holistically depicting the whole therapeutic path from an experiential standpoint. The "Snail Model" is composed of different colors, the meaning of which will be outlined in the following sections of the paper. The four parts of the animal's body are also associated with the specific steps of the therapeutic path. Each step has

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several sub-dimensions, classified as explanatory variables of the framework and associated with the corresponding outcomes of the patient experience.

4. Results and discussion

4.1. Patient experience: the "Four Typologies of Patients"

According to the original structure of the previously mentioned framework, the intersection between two fundamental dimensions of patient experience allows the detection of four typologies of patients. The first explanatory dimension is patient participation, which can be passive or active based on the amount of information that the patient has about the pathology. The second is patient involvement in the care path, which can be seen as the self-awareness of the disease, and it is considered a continuum from low empowerment to high empowerment. Consequently, four types of patients can be identified: resigned, informed, expert, and responsible. The resigned patient lives the care experience passively due to a low level of health literacy and poor self-care skills, that is, a low level of involvement. The informed patient has an active attitude that derives from a high level of health literacy while maintaining low involvement and little self-management skills. The expert patient is familiar with the pathology, behaves autonomously and adequately, and collaborates with the medical staff. The responsible patient potentially has the required involvement and self-care skills to deal with the disease. Still, the limited knowledge of the illness leads to a passive reliance on medical prescriptions.

It must be noted that this classification should also be seen from a dynamic point of view. Indeed, even the same patient can "move" from one typology to another. This movement's direction depends on several relational, disease-specific, and/or individual factors. A resigned patient may develop a proactive attitude and become an expert thanks to a collaborative doctor-patient relationship. This could happen directly or indirectly. In the latter case, the resigned patient becomes primarily informed or responsible and only then expert. On the other side, an expert patient may become resigned, informed, or responsible due to a number of reasons (e.g., sudden progression of the disease, a change in the treatment plan, a worsening of home life conditions, etc.).

Fig. 1 shows the framework explained above, with health literacy and patient involvement as the horizontal and vertical axes of the Cartesian graph, respectively.

4.2. Patient journey: the "Snail Model"

The "Snail Model", as shown in Fig. 2, depicts the stages of the care experience in their logical order. According to the structure of the framework, the patient journey map is represented by the following stages:

- the yellow antennas (i.e., health communication policies and prevention programs);
- the blue neck (i.e., health service access and diagnostic process);
- the green shell (i.e., patient participation and therapeutic adherence);
- the red tail (i.e., doctor-patient communication failure and therapeutic non-adherence).

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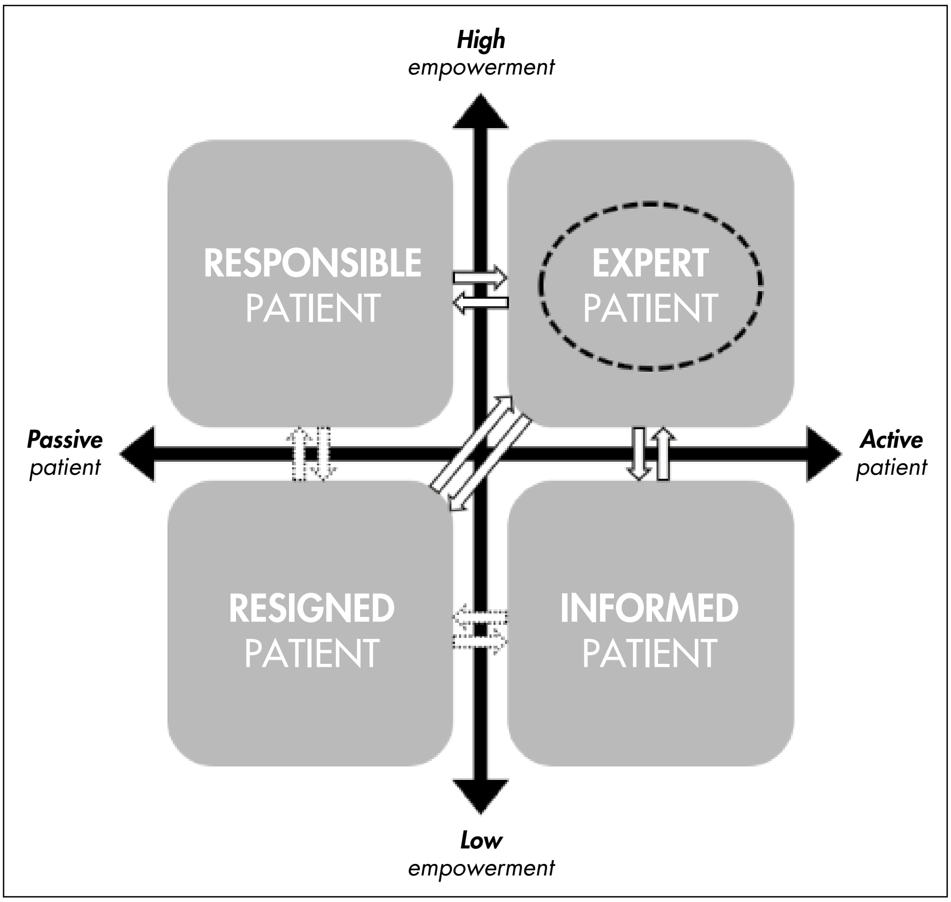

Fig. 1
The dashed black circle represents the ideal scenario (expert patient). Dashed arrows stand for indirect transitions from one patient type to another or vice versa, while continuous arrows stand for direct transitions from one patient type to another or vice versa.

4.3. The yellow antennas: health communication policies and prevention programs

The antennas and the eyes are the parts of the snail facing the outside world. For this reason, they represent the health communication policies (i.e., information and awareness policies) and the prevention programs implemented by health organizations toward the population. In this stage, the focus is thus on the "citizen" role of the individual. Yellow has been chosen as it is often used to attract the public's attention. Furthermore, the meanings of openness to the outside and looking to the future are commonly attributed to it. The first definition is well suited to the interventions mentioned above, through which the healthcare system proactively meets the citizens and their health needs. The second definition aligns with the meaning of these policies, thus avoiding the treatment of pathologies in advanced stages, which would increase mortality and entail higher costs for the health sector.

The antennas are composed of three explanatory variables: information policies, awareness policies, and prevention programs. Information policies concern the cognitive sphere of the individuals to whom they are addressed, namely the importance of leading a healthy lifestyle, doing periodic check-

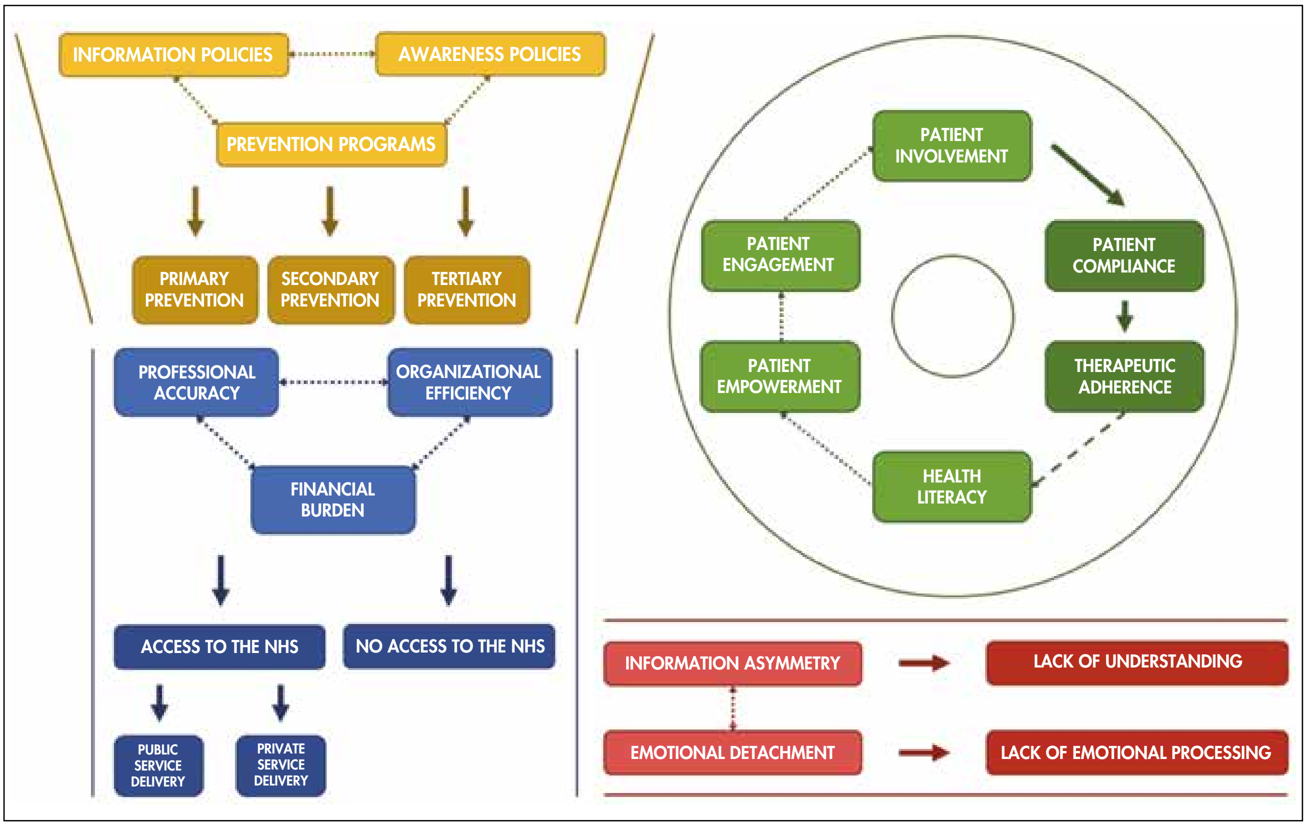

Fig. 2
Light-colored boxes represent the explanatory variables. Dark-colored boxes represent the outcomes. One-way dashed arrows stand for unidirectional influence between the explanatory variables. Two-way dashed arrows stand for mutual influence between the explanatory variables. Continuous thick arrows stand for causal relationships. The one-way dashed thick arrow of the shell stands for the virtuous cycle (re)activation of the process.

ups, and understanding the consequent benefits. Awareness policies relate to the emotional sphere as they aim to involve the population in protecting their own health and that of the entire community. Prevention programs refer to the conative sphere since they serve to encourage citizens to behave in a correct, prudent, and far-sighted manner. In particular, there are three types of prevention: primary, secondary, and tertiary. Primary prevention concerns the measures aimed at improving the population's lifestyle and vaccination coverage (Leavell and Clark, 1965). Secondary prevention is based on the implementation of screening programs to facilitate the early identification of warning symptoms, thus ensuring more effective diagnosis and treatments (Baumann and Karel, 2013). Finally, tertiary prevention provides a set of activities to prevent the recurrence and/or aggravation of the pathology in acute patients and the taking care of the individual to avoid worsening and progression of the disease in chronic patients (ibidem, p. 1532).
The outcome of this framework's dimension is adhesion to prevention programs. Indeed, the effectiveness of information and awareness policies and the implementation of prevention programs determine the behavior of the individuals in three scenarios:

- when they are healthy (i.e., adoption of a proper lifestyle and adhesion to both mandatory and recommended vaccination);

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- when they are at risk of disease (i.e., adhesion to cancer screening programs);
- when they are ill (i.e., adhesion to periodic check-up programs).

The health system should not only reach a broad audience of individuals through the messages it addresses to them but also encourage citizens to take care of their health proactively. In other words, in an ideal situation, the top and bottom of the funnel-shaped antennas would have the same width since almost all the target citizens adopt a healthy lifestyle, adhere to vaccination and screening programs, and do periodic check-ups.

4.4. The blue neck: health service access and diagnostic process

The neck is the part of the snail that connects the head of the animal both to the shell and the tail. Placing itself in such an intermediate position, it has a critical role in determining the patient experience. Indeed, it can significantly influence the perceptions and behaviors of the individual in the subsequent moments (Lee *et al.*, 2020). In this stage, the focus is thus on the "service user" role of the individual. Since the psychological meaning of blue lies in calm and quietness, this color is used to represent access to the health service and the diagnostic process, which will establish the clinical condition of the person. The health system should be able to gain the trust of the individual by meeting the subject's expectations and care needs, as well as actually providing the service (Levesque, Harris, and Russell, 2013). The NHS may assist those who have a physician's prescription to schedule a diagnostic test, a visit, and/or a hospital stay and ensure short waiting time for the health service delivery. A rapid diagnosis can, in fact, be critical for the treatment of the disease in non-advanced stages and a positive health outcome (Hanna *et al.*, 2020). From a more holistic view, healthcare access has, however, a broader scope than service availability as it includes supply-side, demand-side, and procedural features (Levesque, Harris, and Russell, 2013). This paper tries to merge those different perspectives by analyzing how NHS accessibility influences the choices and behaviors of service users.

The neck is composed of three explanatory variables: professional accuracy, organizational efficiency, and financial burden. Professional accuracy refers to the appropriateness of both the medical prescription and the diagnostic results. Several NHSs worldwide suffer from the overuse of diagnostic testing, mainly due to the mismatch between the medical prescription and the actual health needs of the individual (Müskens *et al.*, 2022). The adoption of ex-ante criteria to both prevent healthcare from inappropriate costs and patients from unnecessary worries is thus a significant issue. The Italian NHS, for instance, obliges physicians to specify the diagnostic question in any prescription and, in the case of first access, its priority class. The accuracy of the diagnostic results is also a crucial issue. Indeed, they are essential to establish the presence (or absence) of a pathology, thus affecting the reliability of the diagnosis and the consequent choice of treatment. Organizational efficiency concerns the feasibility of the scheduling process, the

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required waiting time for the health service delivery, and the availability of health structures. Literature has shown that the effectiveness of the scheduling procedure can ease access to medical services and enhance their use (Gupta and Denton, 2008). Moreover, it is proved that the expected time an individual has to wait before the health service provision can adversely impact health access, the continuum of care, and patient satisfaction (Anderson, Camacho, and Balkrishnan, 2007). Waiting time is indeed a significant danger for any public health system aimed at achieving universal health coverage. For instance, the Italian NHS has introduced a set of priority classes for both ambulatory care and hospitalizations based on the clinical urgency of the requested health service. The aim is to force local healthcare authorities to stay within the time deadlines established on a centralized basis. Finally, the availability of health structures may affect both the actual and perceived service accessibility. This depends not only on the geographical location (i.e., inside vs. outside the hometown) and distribution (i.e., urban vs. rural areas) of those facilities but also on the personal mobility (i.e., private vs. public means of transport), working hours (i.e., flexible vs. fixed schedule) and the knowledge about existing health services (Levesque, Harris, and Russell, 2013). Financial burden relates to the costs (direct and indirect) involved in accessing healthcare (ibidem, p. 22). Even if public health systems aim to provide universal healthcare access and coverage for the entire population – by removing direct costs – poverty, social isolation, and illiteracy may restrict the capacity to afford indirect and/or hidden costs (e.g., transport, food, loss of income, etc.) for the needed care without reimbursement (Mahajan, Tirakotai, and Masayaanon, 2023). Furthermore, long NHS waiting lists could exacerbate these inequalities (Domenighetti *et al.*, 2010). In fact, people who are unable to pay out-of-pocket for private healthcare – which would ensure shorter waiting lists – might fail to access the same health service through the public health system within a reasonable time (ibidem, pp. 502-503).

The outcomes of this framework's dimension can be classified into two consequent decision-making moments. The first concerns the possibility of accessing or not accessing the NHS. The second – in the case of healthcare access – consists of public or private service delivery. Based on the potential service user's behaviors, three scenarios are thus identified:

- access to the NHS through public service delivery (i.e., access to free health services or payment of prescription charges for public healthcare);
- access to the NHS through private service delivery (i.e., out-of-pocket expenses for private healthcare);
- lack of access to the NHS (i.e., physical, emotional, cultural, and/or financial inability to access the needed care).

In an ideal situation, the snail's neck should be as short as possible. The main goal is, indeed, to remove any barriers that prevent equal access to healthcare and/or cause excessive delays in health service provision.

4.5. The green shell: patient participation and therapeutic adherence

The shell is the part of the snail that protects against the dangers coming from the surrounding environment. It is, indeed, in moments of danger that the animal retreats inside it and remains there until it feels safe. The green color is usually associated with health and nature. This color, therefore, reinforces the meaning that the shell covers in the model: allowing patients to protect themselves from the disease through a participative attitude. In this stage, the focus is thus on the "patient" role of the individual. A rich literature focuses on the positive impact of patient involvement in health, economic, and social fields. Indeed, patient empowerment and patient engagement are reported as significant drivers of the perceived value of care, patient satisfaction, and better clinical conditions (Small *et al.*, 2013). Several studies also show that proactive patients are correlated with more appropriate and efficient use of resources (e.g., drugs, hospital beds, diagnostic technologies, etc.) and an overall cost reduction for the healthcare system (Lian *et al.*, 2019). Furthermore, patient empowerment has a social impact on the entire community since it helps reduce unequal access to treatments between individuals and/or populations (WHO, 2013).

Based on the systematic literature review made by Hickmann, Richter, and Schlieter (2022), the shell is composed of four explanatory variables: health literacy, patient empowerment, patient engagement, and patient involvement. Health literacy refers to acquiring knowledge and skills that enable the patient to gain independence in the health decision-making process (Liu *et al.*, 2020). A greater mastery of the causes, symptoms, and consequences of the illness may indeed help the individual manage the pathology (ibidem, p. 5). At this point, the informed patient plays a crucial role in determining the care experience. Patient empowerment can be seen as both a process and a patient's state (Hickmann, Richter, and Schlieter, 2022). In the first case, the emphasis lies on activities that increase personal motivation, while the second focuses on individual confidence and attitude. Generally speaking, patient empowerment is the proactive role of the patient during the therapeutic care path and the consequent adoption of an engaged attitude (Bravo *et al.*, 2015). Patient engagement can be seen as both a process and a behavior that takes place when the empowered patient has the required skills and motivation to establish a therapeutic partnership with the health provider (Hickmann, Richter, and Schlieter, 2022). Generally speaking, patient engagement occurs when the patient goes from being a seeking help person who passively follows medical prescriptions to an active part of the therapeutic alliance (Coulter, 2011). Furthermore – when engagement occurs on both the patient's and health provider's sides – the increasing flow of information and common values may lead to shared decision-making (Hickmann, Richter, and Schlieter, 2022). Patient involvement occurs when the patient achieves the autonomy to self-manage the disease, its symptoms, and the required lifestyle changes (Barlow *et al.*, 2002). An example of patient involvement is self-care, which is the ability of individuals to prevent and maintain health autonomously

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throughout life (Hickmann, Richter, and Schlieter, 2022).

The outcomes of this framework's dimension can be classified into two different behavioral patterns based on the way patients' behaviors correspond to health providers' recommendations. The first is patient compliance, namely the unconditional consent to the doctor's decisions according to a paternalistic conceptualization of medical treatments (Chakrabarti, 2014). The higher hierarchical status of the health provider, in fact, leads the patient to adopt a passive attitude (Hickmann, Richter, and Schlieter, 2022). As such, the responsible patient plays a crucial role in determining the care experience. The second behavioral pattern is therapeutic adherence, which is the process where therapeutic prescriptions are determined only after an adequate discussion with the patient (Chakrabarti, 2014). Given the active attitude of the individual, the goal of all the actors involved is to achieve a consensual agreement on the care plan (Hickmann, Richter, and Schlieter, 2022). Therefore, the expert patient plays a crucial role in determining the care experience. In this context, the nature of doctor-patient interactions defines two scenarios:

- the patient passively follows and relies on the health provider's decisions (i.e., hierarchical doctor-patient relationship);
- the patient actively follows and shares the decisions with the health provider (i.e., therapeutic doctor-patient partnership).

This process is circular because its four explanatory variables occur consequently and cumulatively. Patient participation should be seen as a virtuous cycle, the strength of which depends on how long the involvement lasts over time and increases its intensity.

4.6. The red tail: doctor-patient communication failure and therapeutic non-adherence

The tail is the final part of the snail's body and represents the second viable way after the crossroads at the end of the neck. If the first way leads to the shell (i.e., patient participation and therapeutic adherence), the second leads to the snail's exit, namely therapeutic non-adherence. To make an analogy, walking through the shell is like facing a storm – the disease – using a safe boat with expert people helping each other at the helm. On the other hand, walking through the tail is like facing the same storm alone, using a raft and no oars. Since red is often used to communicate a sense of danger and urgency, this color is applied to the model's tail to highlight the pitfalls deriving from the doctor-patient communication failure. The withdrawal of treatment represents a significant risk for patients' health (e.g., worsening of the disease, slower and/or worse healing, increased mortality, etc.) and the economic sustainability of the whole healthcare system (Hovstadius and Petersson, 2011). In this stage, the focus is thus on the "patient" role of the individual. In academic literature, the determinant factors of therapeutic non-adherence are analyzed from at least three standpoints: clinical, relational, and individual (Naghavi *et al.*, 2019). Clinical variables concern disease-specific (or clinical) characteristics, such as the type of disease, the severity of health conditions, the typology and frequency of treatments, the time of diagnosis, and the available healthcare services (ibidem, p. 417). Relational variables concern the doctor-patient relationship and refer to the quality of the communication between the involved parties (Julius, Novitsky, and Dubin, 2009; Kardas, Lewek, and Matyjaszczyk, 2013). Individual variables concern person-specific characteristics such as age, gender, income, education level, past experiences, propensity for risk, and family support (Naghavi *et al.*, 2019). Since both clinical and individual factors may vary from disease to disease and subject to subject, this model analyses exclusively what should be done to improve the doctor-patient relationship. Indeed, acting on clinical drivers (e.g., number of daily pills, therapy duration, medication adverse effects, etc.) in the short term is rather challenging. Similarly, changing individual features (e.g., demographics, socio-economic conditions, cultural status, etc.) is sometimes impossible. Moreover, since the whole framework emphasizes the experiential component of the patient journey and patient experience is widely defined as the sum of doctor-patient interactions (The Beryl Institute, 2024), it stands to reason that only relational factors are covered in this paper.

The tail is composed of two explanatory variables: information asymmetry and emotional detachment. Information asymmetry is a content-related communication barrier. This is an intrinsic and long-standing phenomenon caused by the knowledge and skills imbalance between doctors and patients. Even if information asymmetry has significantly decreased in recent decades thanks to the broader access to health information on the Internet, there is still the matter of patients' insufficient medical competence (Major, 2019). To overcome this imbalance, health providers should be effective communicators and leverage their ability to make health issues within reach of those who have not received formal medical education. When this is not the case, information asymmetry may occur in the form of unintelligible verbal communication of the physician (e.g., failure to give comprehensible answers to the patient's questions, unclear disclosure of clinical information concerning the diagnosis, prognosis, available therapies, risks/benefits of treatment options, discharge planning, etc.) and/or incomplete information provision about the care path (Julius, Novitsky, and Dubin, 2009). Emotional detachment is merely a relational communication barrier. It is not enough for health providers to communicate clearly and in a comprehensible manner. They should also adopt an empathetic attitude and enhance the emotional dimension of the doctor-patient relationship. This approach would help build trust with patients and facilitate the acceptance of their own clinical condition (ibidem, p. 33). When this is not the case, emotional barriers may occur in the form of insensitive behavior of the physician (e.g., insufficient listening skills and empathy, lack of non-verbal and para-verbal communication, anxiety-inducing attitude, etc.) and/or physician sense of self-superiority (Keshavarzi *et al.*, 2022).

The outcomes of this framework's dimension can be classified into two different behavioral patterns of therapeutic non-adherence. In both cases, therapeutic non-adherence occurs as the mismatch between the patient's behaviors and prescribed treatments (WHO, 2003). The core difference stands in the reason why this takes place: it could be due to the lack of the patient's understanding of medical recommendations or to the inadequate emotional processing of the disease. As such, the resigned patient plays a crucial role in determining the care experience. Based on the relational drivers of therapeutic non-adherence, two scenarios are thus identified:

- the patient does not behave adequately (e.g., incorrect drug intake, improper lifestyle, lack of autonomy and self-management skills, etc.) due to the unintelligible and/or incomplete medical information communicated by the health provider;
- the patient does not behave adequately (e.g., drug and treatment refusal, incautious lifestyle, unawareness of the disease and its consequences, etc.) due to the insensitive and/or paternalistic communication style adopted by the health provider.

In an ideal situation, the "Snail Model" would be tailless. As a result, it should not include therapeutic non-adherence.

5. Practice implications

The theoretical frameworks presented in this paper have several managerial implications, as explained below.

The adaptation of the "Four Realms of Experience" framework can be adopted as a classification tool in clinical practice. Indeed, it may be helpful for practitioners to cluster patients according to how they behave throughout the care experience. In this way, health providers would have a deeper understanding of what their patients need most and adjust their communication style. The "Four Typologies of Patients" could be used across diseases to identify which behavioral patterns define each category and – other things being equal – whether some inter-group variation arises in the distribution of patients among them.

The "Snail Model" can be seen from a micro (i.e., individual), meso (i.e., hospitals and health structures), and macro (i.e., healthcare system, rules, and policy) perspective. The framework's ideal shape may be compared with the actual one in different scenarios, such as across health providers, hospital units, and NHSs. A similar comparison could also be made using clinical (e.g., type of disease, time of diagnosis, prescribed treatments, etc.) and structural (e.g., age, gender, income, education level, etc.) variables of a sample population. In both cases, the goal would be to monitor and assess the patient journey in each relevant stage.

6. Conclusion

The evidence arising from this paper is manifold. Firstly, implementing effective prevention programs is crucial to encourage citizens to be proactive, thus allowing for early diagnosis and better treatments. Equal access to the NHS should also be ensured within a reasonable time and consistently to the individual's clinical condition. Moreover, a patient-centered approach could enhance the doctor-patient relationship and increase treatment adherence. The involvement of the patient emerges, in fact, as an essential condition to improve the quality of care and the overall patient experience.

The limitations of this analysis stand in the nature of the research itself. This is a purely conceptual paper that needs to undergo further validation. For this purpose, a systematic literature review of the topic and data collection through desk and/or field analysis will be suitable. Quantitative (e.g., questionnaires, surveys, correlation studies, descriptive statistics, statistical regressions, etc.) and qualitative (e.g., interviews, focus groups, participant observation, etc.) studies may be conducted to track patients' perceptions and behaviors. At this point, it would be possible to have a more reliable understanding of the care experience and identify additional variables that compose and influence the patient journey. Proper indicators to measure the dimensions of the two frameworks should also be pointed out before their actual implementation. These metrics ought to be differentiated according to the level of analysis (i.e., micro, meso, or macro) and address all the relevant factors described in this paper.

Future research developments should thus focus on the experiential dimension of the therapeutic path by integrating the performance indicators conventionally used in healthcare (e.g., appropriateness, efficacy, equity, etc.) with patient-centered measures. As such, new and standardized guidelines must be identified. This is essential to sort out the current fragmentation in the field and assist health providers in adopting a single and formalized clinical approach aimed at improving the empowerment of patients throughout the whole therapeutic path.

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