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Review article

What do we mean when we talk about the Triple Aim? A systematic review of evolving definitions and adaptations of the framework at the health system level

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ABSTRACT

Notwithstanding important contributions of the Triple Aim, uncritical enthusiasm regarding the implications of the framework may be leading to inconsistent use, particularly when applied at the health system level, which goes beyond the original positioning of the framework as a strategic organizing principle to guide improvement initiatives at the organizational or local community level. We systematically identified uses of the Triple Aim that extended beyond its original intention to focus on uses at the whole health system level, to assess convergence and divergence with the original definition. We also attempted to identify consistencies in the way the Triple Aim was adapted for different contexts and settings. Data sources were indexed databases, web search engines, and international experts. Forty-seven articles were included in the analysis. We found that the definition of the Triple Aim has been subject to important modifications when the framework is used to define goals for whole health care systems or globally. Despite widespread recognition of the name, what constitutes the Triple Aim framework varies. We identified the need to consider the inclusion of at least two additional aims of health care systems – the provider experience of care, and the desire to achieve health equity for populations.

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1. Introduction

In 2008, Donald Berwick, Thomas Nolan, and John Whittington published the article "Triple Aim: Care, Health, And Cost" in *Health Affairs* [1], which reflected the ideas they were working on at the Institute for Healthcare Improvement (IHI) [Cambridge, Massachusetts. www.ihi.org]. As of today, IHI continues to promote the use of the Triple Aim as part of its influential quality improvement work. This framework intends to guide health care improvement initiatives to simultaneously pursue three goals: improving the individual experience of care (including quality and satisfaction), improving the health of populations, and reducing per capita cost of care for populations.

The idea of balancing the effects of each aim when conducting interventions to improve performance has been widely accepted by a number of diverse organizations, and has helped guide numerous improvement initiatives in several organizations in the U.S. and other jurisdictions. The simplicity and clarity of this concept has made it popular among healthcare practitioners, researchers and policy makers in North America, and has been progressively extending its influence worldwide [2,3]. Consequently,

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what this popular triad has accomplished is to influence health care organizations and providers to "think outside the box" and look at some of the consequences of their health care improvement initiatives, beyond the immediate outcomes of the intervention.

Providing better care to individuals and better health to populations at a lower per capita cost are certainly not new concepts, and neither is their simultaneous pursuit. While the IHI's Triple Aim emphasizes the simultaneous consideration of the three aims, of particular value is the framework's advocacy for the inclusion of the population perspective in every health care improvement initiative, even when involving a single organization and/or a small scale local development.

Notwithstanding its contribution, the apparent simplicity of the three dimensions of the Triple Aim may be generating uncritical enthusiasm, leading to inconsistent use of the framework in two aspects: first, in how the three aims are defined; and second, in its use at a different level of health care systems than was originally conceived, without revisiting the validity or comprehensiveness of the model for different levels and contexts.

Regarding the first point, IHI has maintained a consistent definition of the Triple Aim as first published by Berwick et al. [1]: "improving the patient experience of care", "improving the health of populations," and "reducing the per capita cost of health care" [retrieved 12-02-2015, from www.ihi.com]. However, there has been a variety of definitions of the Triple Aim as adopted by other authors and users over time, which has been acknowledge by IHI themselves [4]. The magnitude and implications of this variability have not yet been explored.

Regarding the second point, in the years since 2008, the health services and policy debate has seen a growing number of examples where the Triple Aim is recommended or adopted as the framework to represent the goals of an entire health care system, or even globally across all health care systems. Despite numerous references by Berwick et al. in their original work about the implications of pursuing the Triple Aim for the health care system, the framework was proposed as the strategic organizing principle to guide improvement initiatives at the organizational or local community level [1,2]. Targeting the Triple Aim at the system level is different than how the framework was originally positioned and, although its use at this level could be appropriate in many situations, changing the framework's scope of validity or relevance may require adaptations, and thus should be the subject of careful consideration.

For Berwick et al. [1], improving the U.S. health care system requires simultaneous pursuit of the Triple Aim, but this should not assume that these three aims comprehensively address all relevant goals of the U.S. health care system as a collective whole. Furthermore, they did not make the claim that every health care system in the world needs to pursue this same particular set of aims.

These two points of concern motivated the two objectives of this study. First, we systematically identified uses of the Triple Aim at the whole health system level to assess convergence and divergence with IHI's original definition. Second, we attempted to identify consistency in the way the Triple Aim was adapted for different contexts and settings. We used health care system as a whole to refer to national, state, or provincial level (depending on jurisdiction) health care systems, and also to autonomous closed health care systems serving specific populations, such as the military. We also included uses of the Triple Aim that go beyond specific jurisdictions and apply to health and health care globally, or to every health care system regardless of specific contexts. Given this focus, articles at the level of organizations, local communities, or non-autonomous regions were not considered for this analysis, because they were deemed to be within the original boundaries of the Triple Aim scope.

2. Methods

We conducted a systematic review to identify published uses of the Triple Aim since the 2008 publication by Berwick et al. Our approach emphasized the search for grey literature, given our anticipation of a high number of reports and other non-journal articles referring to the use of the Triple Aim. The three main data sources used were: indexed databases, web search engines, and international experts. The search covered the period from 2008 until August 2014.

We first searched Medline, with the search term 'triple aim'. Second, we searched Web of Science using a cited reference search for Berwick, Nolan and Whittington's [1] article. Then, we searched Google Scholar using search terms 'triple aim' paired with any of 'framework', 'intervention', 'evaluation', 'healthcare system' or 'health care system', anywhere in the article. Next, we searched Google Web Search (google.com), with search terms "triple aim" and "healthcare" or "health care", anywhere in the article. For the third component of our review, we sought expert advice regarding uses of the Triple Aim, using formal interviews and informal discussions with health care leaders, contact through emails, and postings to online groups of international health care experts.

The title and abstract of identified articles were screened by two research assistants (RAs), with articles excluded based on the following criteria: articles published in languages other than English, articles that neither mentioned the phrase 'triple aim' nor referenced the Berwick et al. [1] paper, articles that referred to a different 'triple aim' (e.g., non-health care related), and information from the IHI explaining or promoting the adoption of the Triple Aim. For the Google Web Search, references were screened page by page until no new relevant results were identified.

After the title/abstract screening, full-text articles were retrieved and classified into three major groups, depending on the level of analysis or scope of implications: a) global or with general implications, beyond specific organizations or jurisdictions; b) at the level of a whole health care system, as previously defined; and c) at the level of organizations (e.g., hospital, primary care centre, integrated delivery organizations), communities, or non-autonomous regions. Articles in the third group were excluded given our study objectives outlined above. Full-text articles were first screened by the RAs with a study investigator (GM) monitoring the consistency of the screening process. A subset

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