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Taking triple aim at the Triple Aim

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Abstract

Since its introduction to the US, the Triple Aim is now being adopted in the healthcare systems of other advanced economies. Verma & Bhatia (2015) (V&B) argue that provincial governments in Canada now need to step up to the plate and lead on implementation of a Triple Aim reform program here. Their proposals are wide ranging and ambitious, looking for governments to act as the 'integrators' within the healthcare system, and lead the reforms. Our view is that, as a vision and set of goals for the healthcare system then Triple Aim is all well and good but as a pathway for system reform, as articulated by V&B, it misses the mark in at least three important respects. First, the emphasis on improvement driven by performance measurement and pay-for-performance is troubling and flies in the face of emerging evidence. Second, we know that scarcity can be recognised and managed, even in politically complex systems and so we urge Triple Aim proponents to embrace more fully notions of resource stewardship. Third, if we want to take seriously 'population health' goals then we need to think very differently and consider broader health determinants; Triple Aim innovation targeted at healthcare systems will not deliver the goal.

Competing interests

We have no competing interests.

Introduction

Since its introduction to the US, largely as a driver of system and organizational improvement, the Triple Aim, as with many American health policy initiatives, is now being adopted wholesale in the healthcare systems of other advanced economies. Several Triple Aim sites have been established in each of Australia, Canada, New Zealand, Singapore, Sweden and the UK (McCarthy & Klein, 2010).

In their main paper, Verma & Bhatia (2015) (V&B) argue that provincial governments in Canada need to step up to the plate and lead on implementation of a Triple Aim reform program. Their proposals are wide ranging and ambitious, looking for governments to act as the ‘integrators’ within the healthcare system, and lead reforms in their various roles: as healthcare financers, as health system stewards and as resource generators. We endorse much of what is called for by V&B but take issue with some aspects of their arguments. The primary focus for our discussion here will initially be definitional (what is really meant by Triple Aim innovation?), and then move to consider the real challenges associated with health system and resource stewardship. Finally, we consider the true challenge implied by having population health improvement as one of the goals, and what this means for the scope of integration.

Let’s be clear... Triple Aim and Triple Aim Innovation

Of course, the Triple Aim framework, with its focus on population health, patient experience and cost, is very difficult to object to at the level of a vision or grand goal statement for the healthcare system – many have argued that these represent ‘laudable goals’ (Berwick et al, 2008). One would then assume that the practical initiatives engendered by such an admirable vision would be easy to support and endorse, including the collection of patient-reported outcome measures (PROMs) and

implementing processes based on 'lean thinking' (Berwick et al, 2008; McGrail et al, 2011; Westwood et al, 2006).

However, the originators of Triple Aim themselves discuss several foundational pieces in preparing a healthcare system for Triple Aim reform: (a) the ability to undertake rational collective action, which is, of course, engendered by (b) greater integration (Berwick et al, 2008). Hence the suggestion by V&B that Canada's provincial governments play an integrating role to support Triple Aim-focused policy development. At a gross level of comparison, one can see why the originators of Triple Aim, coming from the US, would spot integration as a critical success factors: many US healthcare sorely lack in integration and the ability for rational collective action. It is, then, easy to go on and think that systems like those in Canada and the UK are better suited to Triple Aim initiatives.

The term 'Triple Aim innovation' is used many times in V&B's paper and yet it remains unclear to us precisely what is being referred to (maybe as a result of it never being formally defined). Is it any policy change that seeks to achieve Triple Aim goals? Does it just have to deliver on one or must there be impact simultaneously on all three? A very wide scope for Triple Aim innovations is consistent with the tenor of the paper; a highly varied and eclectic mix of system-level initiatives is discussed, including changes to procurement, payment reform, performance metrics and reporting, inter-sectoral integration, IT investment, professional education, etc. The reader is then left wondering about priorities and starting points: if we can't do it all, which do we pick off first?

Health system stewardship, performance measurement and managing scarcity

As economists, we were naturally drawn to the stewardship challenge and V&B's proposals to enhance health system stewardship under a Triple Aim banner. We strongly endorse the emphasis on stewardship and see this as core to the argument on how effective innovation can happen to

support a Triple Aim vision. Some aspects of V&B's arguments we agree with entirely, namely the importance of government articulating a strong Triple Aim focused vision, and the routine measurement of patient-reported outcomes and experience to drive improvement within the system. These are necessary components to move towards achieving the grand goal.

Where we have some reservations concerns the 'P' word: 'performance'. There have now been many attempts in healthcare to measure the performance of actors in the system, and to link payment to such performance metrics, and yet we seem not to be taking an evidence-based approach to this policy. To us, it is not clear that such initiatives are helpful in achieving Triple Aim goals, and there is a growing body of evidence indicating that it is positively unhelpful (e.g., Jha et al, 2012). Maynard and Bloor (2010) show that the NHS quality and outcomes framework (a form of pay for performance in primary care) came at a cost of \$2bn with very little evidence that the health outcomes justified such an expense. There were no controlled studies and there is no evidence on opportunity costs in the sense of what is displaced due to paying attention to targets required by the focus on quality.

Of surprise to us, under the stewardship topic, was V&B's silence on resource stewardship and managing scarcity. From our economics perspective, what is required is a process that facilitates decision making to match needs to available resources, recognising that what is available will be outstripped by the claims made. If we recognise this, and accept that we need better to manage scarcity at any level of the system, five questions about resources apply:

- 1) What resources are available in total?
- 2) In what ways are these resources currently spent?
- 3) What are the main candidates for more resources and what would be their effectiveness and cost? This might be characterised as our 'wish list', often of service developments.

- 4) Are there any areas of care which could be provided to the same level of effectiveness but with fewer resources, so releasing those resources to fund candidates from (3)?
- 5) Are there areas of care which, despite being effective, should have fewer resources because a proposal (or set of proposals) from (3) is more effective (for the \$s spent)?

As implied, these questions can be applied at 'micro', or programmatic, levels or, in principle, across such programs. Project management schemes have been developed for implementing these questions in ways that take account of planning cycles in health regions, and there are now various examples of the successful development and sustained use of schemes based on answering such questions, especially in Western Canada and the Prairie Provinces (Mitton & Donaldson, 2004; Donaldson & Mooney, 1991; Mitton et al, 2003; Peacock et al, 2006). This framework incorporates lean (see question 4) and evidence on costs and outcomes. It goes further than Triple Aim by allowing for multi-criteria to be adopted in decision making (Peacock et al, 2007), which can, thus, include potentially important criteria omitted from Triple Aim such as equity (Mitton & Donaldson, 2004). Through question 5., it explicitly deals with the possibility of disinvestment. A further essential feature is that, through extensive qualitative research (Mitton et al, 2003), it has been formulated as a process that can be embedded into management systems. This all sounds well and good, but it is still a minority activity amongst our health economics colleagues who tend to focus more on producing evaluations for national-level decision-making about single interventions, rather than on the more-local level where resource allocation and reallocation is the day-to-day reality. In short, no-one is really managing scarcity in the way outlined above, and Triple Aim does not either.

Triple Aim requires both sectoral and inter-sectoral integration

We are in complete agreement with V&B that integration is critical to achieve Triple Aim goals but we think a broad scope for the integration is important with separate consideration of within healthcare system integration and inter-sectoral integration.

In a Canadian setting, much work is ahead of us if we want to bring integration to the healthcare sector and provincial governments will need to grasp some pretty thorny nettles if they are to move forward in this area. Some 20-25% of Canadian health expenditure comes from the private purse and part of the integration challenge is bridging the public-private divide. And then, even within the publicly-funded sector, including physician and hospital services, we see a 'fractured' system: physician remuneration relies on a predominant payment type (fee-for-service), the physician payment 'pot' is thus run as a separate system and, primary and secondary care are not integrated either. Now, of course and to an extent, reliance can be placed on professionalism, communication and good leadership. But, clearly, the system is not integrated structurally in a way that makes alignment with Triple Aim that obvious.

Further, if we want to take seriously the Triple Aim goal around population health then we have to start thinking much bigger picture and get into the business of inter-sectoral integration. The term 'population health' itself is interesting in that its use seems to take us away from public health initiatives based on notions of community. For example, the term has been hijacked by many health research funders, resulting in more and more epidemiological evidence continually refining the diagnosis for health inequalities in societies. This is great work, but, if it leads anywhere in terms of solutions, it is usually to a focus on those that can be characterised as 'products chasing diseases' (i.e. some sort of pharmaceutical or technology-based solution, often centred around personalised medicine) or solutions based on individual risk-factors (like smoking, alcohol consumption, diet and exercise). Whilst all this world-class population health research is going on, and various quality initiatives are (perhaps) improving our publicly-funded healthcare systems, health inequalities continue to grow. The work of Sir Michael Marmot shows that the difference in life expectancy

between best and worst off in the City of Glasgow, for example, is now as high as 28 years (Marmot, 2010). This is not a problem of poor health service delivery.

The point, though, is that the clues to potential solutions lie in our continued lack of ability to move 'upstream'. If it is hopelessness and exclusion that kill people, then we need to work on these, the causes of the causes, an 'upstream' agenda likely not best served by investing more in the healthcare system. Leading public health thinkers are questioning risk-factor-based solutions with respect to their future additional impact (Hanlon et al, 2011). US healthcare may be able to generate significantly improved population health via reform and adoption of schemes like Triple Aim because it is so inequitable in the first place, but it is somewhat of a stretch to say that this same logic would follow in countries such as Canada and the UK.

In conclusion: Triple Aim at Triple Aim

As a vision and set of goals for the healthcare system then Triple Aim is all well and good. As a pathway for system reform, as articulated by V&B, it misses the mark in at least three important respects. First, the emphasis on improvement driven by performance measurement and pay-for-performance is troubling and flies in the face of emerging evidence. We would point in the direction of work by Ovretveit (2011) who argues for system reform focused on better coordination of services and managing chronic disease where patients want to be (in communities). However, often unspoken in this regard are the radical implications this might have for redesigning physician payment systems (e.g. fee-for-service needs to go in terms of being the main remuneration form) and primary care and secondary care structures (with further integration and a reduced, or at least a differently configured, acute sector).

Second, we know that scarcity can be recognised and managed, even in politically complex systems and so we urge Triple Aim proponents to embrace this notion. Managers need permission to get on with this, working in conjunction with the health economics community. If we do not, then the risk is that the current tide of austerity and constraint will serve as a further threat to the very existence of our publicly-funded systems. We see some entertaining thoughts of tax incentives to encourage greater uptake of private healthcare in the naive view that this will somehow relieve the burden on the public system (Kite, 2013).

Third, if we want to improve so called 'population health', then we need to think differently about how to do this. Of course, new innovations and policies in this regard will require evaluation, as always. But, the innovations and policies themselves require new thinking about what would constitute this 'fifth wave' of public health (Hanlon et al, 2011), taking us beyond a focus on individual risk factors and treatment masquerading as prevention. If Triple Aim gets the job done in progressing these issues, then fine. The contention here, however, is that it is likely to focus us too much on healthcare rather than health and, even within healthcare, has the potential to divert us from recognising and managing scarcity and undertaking more fundamental and required reforms.

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