Pay-for-performance for hospitals

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Pay-for-performance initiatives - in which health care providers are rewarded with more funds for meeting clinical targets - have been adopted in the UK and Australia. The approach has been piloted in the US by the Centers for Medicare and Medicaid Services (CMS), which is responsible for government-sponsored health insurance.

The first wave of implementation across the US is slated for 2013, when hospitals will have some revenues withheld and then returned if they meet clinical targets. However, pay-for-performance assumes that hospitals have the economic and human resources they need to meet the targets despite the current inequalities in resources in the health care system. Jan Blustein, of New York University, and colleagues tested this assumption in a new study published this week in *PLoS Medicine* by examining the association between local economic and human resources and hospital performance for two common heart conditions.

Identifying hospitals that had reported performance for treating heart failure and heart attack between 2004 and 2007, the researchers used the pay-for-performance model to calculate scores for these hospitals. They looked for associations between the hospitals' performance scores and measures of local human and economic conditions. Hospitals in counties with longstanding population poverty had lower average performance scores for treating heart failure and heart attack than those in affluent counties. Hospitals in areas with a lower percentage of college graduates in the workforce also had lower average performance scores.

Despite improvement over the study period, hospitals in disadvantaged

areas lagged behind with lower performance scores, even after four years. This suggests that pay-for-performance may transfer resources from hospitals in disadvantaged areas to those with better local resources, exacerbating inequalities in the health care system. They researchers suggest that the "reverse Robin Hood" consequences of the program could be avoided if a previously-proposed model for scoring were modified. "Holding providers accountable is not an unreasonable approach to quality improvement" the study concludes, but "it must be done in a way that attends to the profound inequalities in local circumstances that shape life in the twenty-first century."

More information: Blustein J, Borden WB, Valentine M (2010) Hospital Performance, the Local Economy, and the Local Workforce: Findings from a US National Longitudinal Study. PLoS Med 7(6): e1000297. doi:10.1371/journal.pmed.1000297