HEALTH CARE EXECUTIVE COMPENSATION

Principles and Strategies

Jerad D. Browdy

AN ASPEN PUBLICATION

HEALTH CARE EXECUTIVE COMPENSATION

Principles and Strategies

Jerad D. Browdy

Vice President
Witt & Dolan Associates, Inc.

AN ASPEN PUBLICATION®
Aspen Systems Corporation
Rockville, Maryland
London
1983

Library of Congress Cataloging in Publication Data

Browdy, Jerad D.
Health care executive compensation.

Includes index.
1. Health services administrators—Salaries, pensions, etc.—United States. 2. Health services administrators—Salaries, pensions, etc. I. Title.
RA971.B837 1982 362.1'1'0683 82-11384
ISBN: 0-89443-827-1

Publisher: John Marozsan
Editorial Director: Michael Brown
Managing Editor: Margot Raphael
Editorial Services: Dorothy Okoroji
Printing and Manufacturing: Debbie Collins

Library of Congress Catalog Card Number: 82-11384
ISBN: 0-89443-827-1

Printed in the United States of America

1 2 3 4 5

Preface

When asked by Aspen Systems Corporation to prepare a book on health care executive compensation, I gave considerable thought as to what would be the best format and offer the most meaningful information to the readers.

There are textbooks available that detail the specific mechanics and techniques of compensation administration, and most standard texts on personnel administration include the "how-to" information. Most hospitals already have some type of standard wage and salary administration program in effect for their general employee group. Therefore, I felt the "how-to" approach would not be particularly meaningful or beneficial to those interested in health care executive compensation.

I thought then, that because of the changes that are occurring so rapidly in health care, the best approach to this subject would be to address the issues that are and will be affecting the compensation of every executive and key manager in the nonprofit hospital and health care sector.

Having been professionally involved in compensation in industry, academia (as an instructor), and health care for 25 years, I would like to state unequivocally and contrary to the statements of many practitioners in the field that wage and salary administration and particularly executive compensation *is not* an exact science by any means. While there are myriads of quantitative and statistical applications involved in the development of compensation programs, there is no magic formula or mathematical calculation that will indicate exactly how much an executive or manager should be paid. Anyone who claims this can be done is living in a dream world. The best that any "expert" can offer an institution, whether that individual be an outside consultant or an internal compensation, human resources professional are guidelines, good judgment, and common sense. The ultimate test of an executive compensation program, regardless of complexity, rests squarely on the answer to the following question: Does the program enable the institution to attract, retain, and motivate the best qualified and most competent talent?

Compensation programs, whether designed for executives or the general employee groups, are predicated upon any number of influences, most of which are viewed as external. General market trends, inflation and the cost of living, union pressures, affirmative action practices, availability of qualified people, and the laws of supply and demand are considered to have the greatest impact on compensation.

The issue of comparable worth will certainly influence compensation design. In the executive and high salaried employee area, Internal Revenue Service (IRS) rules and regulations certainly govern to a great extent the design of compensation programs.

As important as all of these are, the factors having the most impact and influence on health care executive compensation are the attitudes of the trustees, the changing role of the health care executive, and the attitudes of the executives themselves.

The health care delivery system in the United States is rapidly changing. The institution, whether it be a 25-bed, rural hospital or a 2,500-bed, highly complex multihospital system, is a dynamic corporate organism struggling for survival in a volatile and increasingly competitive environment. The acute care hospital is being challenged by alternate health care systems such as Health Maintenance Organizations (HMOs) and independent ambulatory care centers. Mergers, acquisitions, and the development of the multifaceted health care corporation are common trends in all parts of the country. Of course there is no easing of regulation, and there will be severe reductions in capital financing and funding from public and private sources. The organizations that will survive and prosper are those that achieve efficiencies, productivity, and profitability without sacrificing the highest standards of patient care.

As dedicated as boards may be and as competent as the medical and patient care professionals may be, the institution must depend on its executives and professional managers to carry out those programs necessary to ensure the institution maintains its rightful place in the health care community. In other words, the institution will only be as good as its managers. Unfortunately, this is not always recognized in the nonprofit health care sector. This directly reflects the attitudes of the trustees.

All too often hospital trustees do not fully understand or appreciate that their most valuable commodity and asset for the continued successful viability of their institution is competent executive talent. Too frequently trustees are willing to accept and tolerate mediocre executives because such persons may come "cheap" and stay with the hospital (until eventually discharged). This, incidentally, is not only true of trustees; it is also true of some chief executive officers (CEOs) with respect to their subordinate executives and managers.

These attitudes, which affect health care executive compensation levels, are understandable. There is a difference between the composition of an industrial

board and a hospital board, although the same individuals often serve on both. Generally speaking, the board members of industrial corporations are business executives themselves. They are usually organizationally astute and understand what is necessary to attract and motivate competent executive talent.

This, unfortunately, is not always true of hospital boards. Hospital trustees serve in a difficult role that taxes their energy and can be exceedingly time consuming. They truly are dedicated to the success of their hospital. However, many of these same board members are not organizationally sophisticated. They may not be businessmen or businesswomen, and their corporate experiences may be limited or minimal at best. Even more important, their income levels may be relatively low when compared with the salaries of the hospital executive group. It can be extremely difficult for some of these trustees to comprehend the changes that are occurring in health care executive compensation. As a result, what may be absolutely defensible in terms of marketplace realities and accepted executive compensation practice may not be practical or politically feasible because of such attitudes and local community standards.

This attitude, however, is not necessarily restricted to the lower income or organizationally unsophisticated trustee. It also applies to the trustee at the other end of the economic scale who does not appreciate the complexity of the hospital chief executive officer's job and cannot relate upper income salary levels to executives in the nonprofit sector. Furthermore, the negative impact of this attitude on the key management group may be compounded by chief executive officers who do not want to call attention to their own compensation level, thereby compressing the compensation of their immediate subordinates.

Another attitude affecting compensation is the trustee's perception of what motivates the health care executive. There has always been considerable discussion and debate among psychologists, behavioral scientists, and human-resource professionals about the importance of money as a motivator. These discussions have centered primarily on attitudes in the industrial and business sector. Assumptions have been made that those entering the nonprofit sector did so knowing that their incomes would not be comparable to salaries in the private proprietary sector. In other words, they were not motivated by the same factors as those entering business careers.

Without question, those entering the nonprofit arena are not primarily motivated by money, but it is an increasingly important consideration, inflation and the cost of living notwithstanding. Even the most altruistic and humanistic health care administrator feels that there has to be considerably greater financial reward and financial protection than has been traditionally the case because of the elements of risk, stress, and competition now inherent in the nonprofit health care sector.

Another attitude or idea expressed by both boards and health care executives is the concept that everyone deserves an annual increase, regardless of performance. As a result, it is not at all unusual for there to be absolutely no correlation between

the rate of salary increase and the financial growth of the institution. In other words, salaries may increase at the same rate as the consumer price index, while hospital revenues decline. There may be no motivation to improve performance if it is anticipated that one's salary will automatically continue to increase annually.

Fortunately, these attitudes, while not disappearing, are changing. More and more hospital trustees recognize that their institutions must be managed in the same professional manner as any successful multimillion dollar, multifaceted business corporation. The successful nonprofit hospital executive today is the individual most able to combine the decisiveness and risk-taking ability of the successful business manager with the altruistic and humanistic motives of the health service professional.

What many of these executives are saying is that if the trustees expect their institutions to be managed on the same basis as the successful business corporation, they must be compensated accordingly. Having worked in private industry for 15 years, I can certainly attest to the fact that the responsibilities of nonprofit health care executives are just as taxing and demanding as those of their counterparts in business and industry. In fact, health care executives must deal with a much broader constituency and a more rigid regulatory burden than do their industrial counterparts.

The individuals required to manage the changing health care delivery system must be fiscally and politically astute; competitive and unafraid of risk, viewing risk not as a threat, but an opportunity; decisive; and, probably most important, exceedingly adept at managing stress and conflict. They must be superb negotiators and mediators, and they must be able to win the trust and respect of the medical and nursing professionals who are concerned that practical business considerations will outweigh patient care decisions.

Do these individuals exist? Certainly. There are any number of individuals who personify this "new breed" of health care executive. But they do not come "cheap." Compensation programs must be designed to attract and retain such individuals. This includes not only improvement and greater sophistication in traditional compensation methods, but additional fiscal incentives and equity types of arrangements, which in effect will give the executive a "piece of the action." Contrary to popular belief, this can be done in the nonprofit hospital.

This will require more involvement and time of the trustees. It will mean that compensation planning will have to be an essential element of the institution's strategic and long-range planning process. It will mean that the ability of the institution to carry out its mission and meet its responsibilities to the community will depend on the quality of its executives. This in turn may depend on the trustee's philosophy of and attitude toward key management compensation.

Jerad D. Browdy
November 1982

Table of Contents

Chapter 1

Historical Perspectives and Attitudes Affecting Health Care Executive Compensation

1

One of the most perplexing questions facing trustees of nonprofit health care institutions is how to determine objectively the appropriate compensation level for their chief executive officer. Indeed, chief executive officers are faced with the same question with respect to their subordinates. There are no simple answers or solutions, but the wrong approach can directly affect the future of an institution in today's volatile and increasingly complex and competitive health care environment.

DIFFERENCES IN ATTITUDES

In order to appreciate fully the impact of an executive compensation program on the organization, it is necessary to explore the difference in both approaches and attitudes in the business and industrial sector, and the nonprofit health care sector. The differences are significant. Every major American business and industrial organization understands that a sound compensation program is absolutely essential to attract, retain, and motivate competent executive talent. These programs, regardless of how complex or simple, are based on the premise that effort and achievement will be rewarded both financially and professionally. These systems are generally not only designed to ensure financial reward based on achievement, but also to provide upward mobility and growth opportunity for those identified as successful, talented, and having potential for greater responsibility within the organization. In the same respect, professional business managers understand early in their careers that if their efforts contribute to the profitability of the organization, they will be rewarded accordingly, in both financial and professional growth. Obviously, this does not always occur, for any number of reasons, and obviously, a well-designed executive compensation system will not protect an organization from failing if it is not well managed or if it is affected by adverse economic conditions or external forces over which it has no control. The point to

be considered is that there is a major difference between the profit and nonprofit sectors. In the main, compensation in the nonprofit sector, including health care, is not geared to individual achievement. It is egalitarian in nature with little distinction made between the performers and the nonperformers.

Does this mean that the business executive is motivated solely by money? Obviously this varies with the individual, but the professional business executive is usually motivated by the same factors that motivate other professionals, that is, job satisfaction, prestige and status, and tangible accomplishments. However, unlike the executive in the nonprofit sector, the business executive expects a tangible and substantial monetary award for achieving specific results. Executives and managers in the private sector, especially at the higher level of an organization, thoroughly understand the risks involved in their work and know that if their company does not perform well, their income level could be affected, and indeed their jobs could be in jeopardy. In other words, business executives think in terms of specific results and expect their compensation to be commensurate with those results. This is an attitude or philosophy that is completely foreign to many executives in the nonprofit arena, whether it be health care, government, education, social service, or similar areas of endeavor. This is not intended to be a criticism of the nonprofit sector. It merely indicates a fundamental difference in the approach to work.

This difference in attitude has had a profound impact on compensation practices in the nonprofit health care sector. Current nonprofit health care executive compensation philosophy is largely attributable to three important factors:

1. service versus profit motive
2. trustee attitudes
3. managerial style and attitude

Service Versus Profit Motive

Business executives fully recognize that their efforts will affect the profitability of the organization and that their compensation will be established accordingly. Their every effort and decision is to ensure that their organization maximizes its capital and investment and produces a product profitability in the most efficient, economic manner possible.

Until recently, few nonprofit health care executives were encouraged to think in terms of profitability and productivity. In fact, these concepts were contrary to the essence of successful health care delivery. Attempts to establish sound business practices were often met with resistance (especially from those involved in direct patient care) based on the premise that any attempt to industrialize the hospital would have an adverse effect on patient care. This notwithstanding, health care

executives entered the profession because of altruistic and humanistic motives. This is particularly true of many who entered the field in the early 1950s when it was emerging as a recognized profession. While they expected to be compensated fairly, they were motivated more by a personal philosophy of service. In fact, until recently health care was viewed by many on the outside as a secure, risk-free, noncompetitive environment, attracting the same type of individuals who entered professions such as teaching, social work, the ministry, and career civil service. Health care was also viewed as a career choice by some who philosophically were opposed to the profit motive in any area. Today many in health care understand that the concepts of productivity and profitability no longer have negative connotations, but there is no question that the attitudes just discussed have affected the compensation of health care executives.

Trustee Attitudes

A significant factor contributing to current health care executive compensation approaches is the attitude of hospital trustees. Their motives, for the most part, like those of their institutional executives, have been service-oriented. It was and is not uncommon for trustees to feel that health care administrators, because of their service orientation, should not be overly concerned about compensation. The same attitude has been demonstrated by school boards regarding their teachers and by church boards with respect to their pastors.

Even more important, however, many hospital trustees do not fully appreciate or understand the job of the health care executive. This has resulted in many trustees feeling that all hospital employees should be treated alike, with little distinction in benefits or compensation practices. This is true even among hospital and health care boards composed of organizationally astute industrial executives whose own firms have developed elaborate and sophisticated approaches to managerial compensation.

While the attitude of health care executives toward their own compensation affects boards, an even more important attitude affecting compensation levels is that many trustees, including those who are sophisticated business executives, believe that the health care administrator functions differently from the business executive. This certainly was true at one time. Trustees correctly viewed their executives as little more than caretakers responsible for day-to-day housekeeping activities. The successful health care executive was the one who satisfied the needs of the physician. It was inconceivable that a hospital would close or not survive. It was not perceived that the efforts of the institution's chief executive and his or her subordinate executives were directly related to the continued viability of the institution. In simple terms, health care administration was not viewed by many as being particularly stressful or arduous.

Compensation practices for health care executives also reflected the basis on which the institution was governed. Church-related and church-governed hospital boards often felt strongly that individuals entering health care administration should not be motivated or concerned with money. Indeed, in some institutions the chief executive's salary was given to the church. The governance of municipal hospitals was and is often political in nature, and this, of course, affects the pay levels of executives in those institutions. It was not (and is not) unusual to equate the pay level of the municipal hospital with that of other municipal executives whose responsibilities are in no way comparable to the hospital executive.

All of this obviously affects the executive compensation process, but the most important factors are the experience levels, degrees of sophistication, and perceptions of the trustees. A complaint commonly expressed by hospital executives is that their salary levels and increases are restricted by trustees who are not well paid themselves.

Trustees who are small businesspersons, academics, blue collar workers, and retirees can and do have a great deal of difficulty relating to the changing salary administration climate in nonprofit health care. It may be almost impossible for the individual who has never earned more than $15,000 to $20,000 per year to accept the fact that they may have to pay their hospital's chief executive officer $100,000 (or more) per year. It may be even more difficult for them to accept the fringes, perquisites and other noncash and tax exempt forms of compensation necessary to attract an executive to their hospital.

This attitude, though, is not peculiar to the low income or "unsophisticated" trustee. It is also quite common among well-paid corporate executives and/or independently wealthy individuals who cannot relate high salaries to the nonprofit sector. This is a direct reflection of the feeling that individuals entering the nonprofit sector are not motivated by fiscal reward, but even more important, do not work as hard as their counterparts in business.

Regardless of socioeconomic status, the degree of provincialism of the board has a significant impact on the compensation of their hospital's executives. There is no question that in smaller or rural communities it is difficult for some trustees to relate to a "national" rather than a local market comparison concept. It is also quite common in these particular situations for compensation comparisons to be made between the executives in the hospital and those in the local bank or small manufacturing company. As a result, the trustees may find themselves unable to attract a first-class executive or manager to their hospital. This usually becomes painfully apparent when they must replace a long-service chief executive officer.

Managerial Style and Attitude

Occasionally an executive or technical specialist enters the nonprofit hospital from private industry. As hospitals become more complex and adapt business

practices, an increasing number of technical and professional specialists are being actively recruited into the nonprofit health care sector from industry, especially in the areas of human resources, management information systems, finance, and materiel management. Often the entry of these technical specialists into health care is marked by trauma as they find themselves in a strange new world. One of the most obvious differences and probably the one that affects compensation most heavily is a different view of the manager's responsibilities.

In the business sector there are functional and professional specialists in executive and management positions. However, while concentrating in a particular functional area, these specialists understand first and foremost that their role is managerial in nature. They also aspire to more responsible positions and hope to be promoted out of their functional specialties into broader, more general executive roles. In health care, however, technical specialists or professionals in an executive capacity may have little understanding of their managerial role. They view themselves as professionals in a particular discipline, and they view their output as such. Concepts such as efficiency, cost reduction, and effective utilization of human and fiscal resources may be the bane of their existence.

Business executives may also find themselves in a highly participatory managerial environment with heavy emphasis on committee work and committee decisions. Decisions may often be delayed, or when made, may be done on the basis of group concensus. They may find themselves in an environment in which the chief executive officer may be hesitant to make an independent decision for fear of offending a key member of the executive staff, a physician, or the board. However, most important, they may find themselves in an environment in which executives and managers are more concerned about systems and processes than results and objectives. Business executives who have been trained to meet specific performance goals and objectives suddenly find themselves in the midst of managers who do not view their performance in such terms. They may find themselves in a situation in which it is virtually impossible to equate compensation with performance and one in which there is little or no rationale for the way in which managers are paid or the manner in which managerial performance is judged. The transition period for the executive entering nonprofit health care from the business sector may be traumatic and frustrating.

A marked difference in managerial attitudes is the perception of the health care executive that the annual salary increase is a matter of right. While certainly managers in the business sector have the same attitude, there is a greater recognition by higher level industrial executives that their salary increases are directly related to their firm's "bottom line."

Obviously, there are any number of well-publicized situations in industry in which compensation levels are excessive and may be a contributing factor to a company's poor economic condition. On the other hand, there are many well-