

COMPENSATION IN CATHOLIC HEALTHCARE

A Roundtable Discussion

Do people involved in Catholic health ministry have different motives than other healthcare workers? *Should* they have different motives? Should the market determine the salaries of executives in Catholic healthcare? How much disparity should Catholic healthcare organizations allow between their highest- and lowest-paid employees? Is incentive pay worthwhile? Should nurse aides and janitors get it, too?

These were some of the questions taken up last September in a Catholic Health Association (CHA)-sponsored teleconference on employee compensation. Participating in the discussion were executives from seven CHA-member healthcare organizations (two of the executives were interviewed after the teleconference) and several CHA staff members. **Ann Neale**, a CHA senior associate for mission and ethics,

moderated the conference.

In their remarks, participants responded to a recent magazine article about compensation: Jeffrey Pfeffer's "Six Dangerous Myths about Pay" (*Harvard Business Review*, May-June 1998, pp. 109-119). Pfeffer argued that certain widely accepted management "truths"—including the idea that people work primarily for money—are in fact myths; and that, because they are myths, they cause a good deal of unnecessary confusion (see **Box**).

MYTHS FOUND IN CATHOLIC HEALTHCARE?

"Is this article pertinent to healthcare?" Neale asked participants. "Do leaders in Catholic healthcare fall prey to these myths? Can you buy performance?"

Linda Drey, postcritical care supervisor, Marian Health Center, Sioux City, IA, agreed that the myths were common in the Catholic

PFEFFER'S "SIX DANGEROUS MYTHS"

1. *Labor rates and labor costs are the same thing.** Not true. Labor rates are wages divided by time (e.g., employee X earns \$10 an hour). Labor costs are the rate an employer must pay to attain a certain level of productivity. Employee X who produces 50 widgets an hour is a better bargain than employee Y, who, for \$5 an hour, produces only 20.

2. *You can lower your labor costs by cutting labor rates.* No. If it were true, an employer would automatically

replace highly paid employee X with lower-paid employee Y—which would obviously be a mistake.

3. *Labor costs constitute a significant proportion of total costs.* This is sometimes true. But the proportion of labor costs to total costs varies widely among industries and companies. An employer seeking to retrench should examine all costs, rather than immediately laying off workers.

4. *Low labor costs are a potent and sustainable competitive weapon.* The

employer who acts on this belief may cut into productivity. Encouraging innovation, improving quality, and focusing on service are often safer ways to compete.

5. *Individual incentive pay improves performance.* On the contrary, incentive pay can, by seeming to pit workers against each other, wreck teamwork and reduce performance.

6. *People work for money.* True, but they prefer jobs that are fun and meaningful as well.

*The "myths" (in italics) are from Jeffrey Pfeffer, "Six Dangerous Myths about Pay," *Harvard Business Review*, May-June 1998, p. 112.

health ministry, especially Pfeffer's Myth No. 1, the belief that labor rates and labor costs were essentially the same thing. Because they confuse the two, Drey said, managers often try to solve financial problems by downsizing staff or freezing wages. "And then later, after their facilities have had big increases in employee dissatisfaction and turnover, they see that they've actually compounded their problem."

According to **Regina Clifton**, a CHA senior associate for mission integration, most people in Catholic healthcare know that the myths are not true, yet somehow still feel bound by them. Speaking of Myth No. 1, she said, "We behave as if, by reducing labor budgets, we are really reducing overall expenses and increasing productivity. We recognize the myths as myths, but we still operate out of them."

Tony Filer, vice president, finance, Daughters of Charity National Health System, St. Louis, agreed that Myths No. 5 ("Individual incentive pay improves performance") and No. 6 ("People work for money") are indeed myths. But he argued that the market is an unavoidable force in determining salary levels, even in Catholic healthcare. "To build organizations that have competent, effective leadership, we need to be able to attract folks who are, not necessarily at the top of market value, but at least somewhere in the comfort zone of market value."

Drey and **Michael Fordyce** agreed that market values must be taken into account. "We need the best and the brightest people in Catholic healthcare leadership," said Fordyce, senior vice president, human resources, Catholic Health Initiatives, Denver. "We can't attract them if we offer them less than they're making somewhere else."

Drey mentioned the union-organizing campaigns that registered nurses have waged at healthcare facilities in various parts of the country. "At the beginning of those campaigns, the nurses often say they want a union because it will give them more autonomy, more say in decision making. In the end, though, they come to realize that a union can't do much about Medicare,

"The [group incentive] plan has had a team-building effect."

Medicaid, or managed care. So they often decide that asking for more money is their only choice."

Even so, for many in Catholic healthcare a job's meaning is more important than its salary, said **Barbara Prosser**, executive director, Nazareth Living Center, St. Louis. Nursing home salaries have historically tended to be lower than they are in systems and hospitals, she noted, which may

be one reason why less emphasis is put on salary ranges in long-term care. "Still, I've found that the people who come to us, managers as well as front-line employees, are usually making a lateral move—they're not getting paid more," Prosser said. "They want to be part of a team, to be in on the decision making. Salary takes up a relatively small part of the discussion."

"I also don't believe that people work primarily for money," said **Maureen Finn**, corporate director, mission effectiveness, Catholic Health Partners, Cincinnati. "I think extramonetary factors—having interesting colleagues, up-to-date equipment, and family-friendly scheduling, for example—are much more important to most people than salary."

DO INCENTIVE PLANS WORK?

Stephanie McCutcheon, president and chief executive officer, SSM Health Care, St. Louis

ROUNDTABLE PARTICIPANTS

- Regina Clifton, Catholic Health Association, St. Louis
- Linda Drey, Marian Health Center, Sioux City, IA
- Maureen Finn, Catholic Health Partners, Cincinnati
- Tony Filer, Daughters of Charity National Health System, St. Louis
- Mike Fordyce, Catholic Health Initiatives, Denver
- Jack Glaser, St. Joseph Health System, Orange, CA
- Stephanie McCutcheon, SSM Health Care, St. Louis
- Ann Neale, Catholic Health Association, St. Louis
- Barbara Prosser, Nazareth Living Center, St. Louis

Region, described her system's experience with incentives. "In the early 1990s we had a plan that provided for bonus goals for 16 of our hospital presidents, but we dropped it in 1993 because most of the presidents didn't like it. Then, last year, we decided to try it again, as a way to encourage our senior executives to keep spending within budgetary limits. It's only a one-year program, and

we don't know whether we will continue it. I really can't say whether it's been a dramatic motivator for our executives."

Neale asked McCutcheon whether SSM was considering extending its incentive plan to employees below the executive level. "We're currently reevaluating the whole thing," McCutcheon replied. "The best incentive plan I've ever seen was in an organization that had only about 90 employees. Every single employee, from the company president down to a part-time switchboard operator, had an incentive bonus component of his or her pay."

Finn said that, in 1997, Catholic Healthcare Partners inaugurated a group incentive plan for those who work in its corporate office. "According to the plan, if we as a group achieve certain objectives, then we as members of the group will all be rewarded. The incentive is a percentage added to our retirement fund, not to our salaries. The plan works very well and has had a team-building effect on our office. I think it's preferable to an individual incentive plan, which can lead people to compete against each other, eroding team spirit."

CAN COMPENSATION BE MADE MORE FAIR?

"I think we're all realistic enough to realize that the top people in Catholic healthcare are going to get very good salaries," Neale said. "But some people have expressed concern about the great discrepancies between salaries at the high end of the pay scale and those at the low end. They fear that these discrepancies run counter to our idea of ourselves as a *ministry*, not just an industry."

Jack Glaser, vice president, theology and ethics, St. Joseph Health System, Orange, CA,

"If pay practices are not equitable, other things will be suspect."

said it was important that workers in Catholic healthcare at least *feel* they are compensated fairly. "If pay practices are not equitable, then the other things we do will be suspect as well. Compensation issues are like traffic laws: We don't begrudge the guy driving a Mercedes his fancy car, but he's got to stop at red lights just like the rest of us. Healthcare workers don't mind executives'

big salaries, but they do like to think everyone is getting essentially what he or she deserves."

Fordyce agreed. "A compensation system that is not being run fairly can be a tremendous demotivator," he said. "If we're freezing salaries, on one hand, and giving incentive pay to executives, on the other, we're sending the wrong message."

"At SSM Health Care, when we find ourselves in an economic bind, we sometimes freeze or even cut *only* executives' pay," McCutcheon said. "And we're at a much higher percentage of market for entry-level employees' pay than for higher executives' pay. Those things help send the right message."

"I don't know how these issues are going to be resolved," Finn said. "If we in Catholic healthcare pride ourselves on being 'mission oriented' and thus different from other organizations, I think we need to demonstrate that in our pay practices. We can't allow the market to shape us. Our employees have to be able to feel that Catholic organizations *are* different and that maintaining the difference is worth the effort."

Glaser urged CHA to draft a "Catholic philosophy of the workplace" and create a process whereby executives in Catholic healthcare around the country could provide feedback on the draft and further develop the philosophy. "I believe we could build a consensus about the Catholic workplace the way we have built one around care for the poor. If we had such a philosophy, we could develop goals, audit our organizations, and develop plans for improvement. We've talked about this long enough. Let's get on with doing it."

—Gordon Burnside

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, January-February 1999
Copyright © 1999 by The Catholic Health Association of the United States
