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Negative Secular Trends in Medicine: High CEO Salaries

In 2011 or 2012, 30 executives at nonprofit health care organizations in the US made more than $4,000,000 in a year, with a mean total compensation of $6,500,000.[1] Two executives made more than $10,000,000, and one more than $20,000,000. For perspective, the average executive on the list made more in 2 days than a housekeeper makes in a year, more in 3 days than a registered nurse (RN) makes in a year, and more in 2 weeks than the average physician makes in a year. One can assume they were not mopping floors, emptying bedpans, or seeing a patient in the Emergency Department on nights, weekends, or holidays to pull down their super-sized salary.

Is one health care executive making $6,500,000 in a year more valuable to society than 100 RNs? My initial impulse was to say "I don't think so" but the answer is simply: "No!" To provide another perspective: a 200-bed hospital with 1000 full-time-equivalent employees working 365 1/4 days a year will do well to generate a profit of $5,000,000, still not enough to fund the mean salary of one high-level executive.

I believe the rock star salaries of the top executives at ostensibly nonprofit health care organizations has many negative effects on the practice of medicine and the cost and delivery of health care in the US.

In the past, administrators at nonprofit hospitals had 3 constituencies of relatively equal importance. First was the owner, almost always a religious organization, government entity, or academic institution. Turning a profit is always important, as no institution will long exist as a money loser, but this was in the context of demonstrable community benefit and providing the best possible care and facilities, not to maximize profits or executive's salaries.

Patients were the second constituency. They are still important, but in a more indirect, obtuse way. Patient satisfaction is an important determinant of chief executive officer (CEO) compensation, although patient outcomes, such as mortality and readmission rates, are not.[2] Keeping the patients happy can land the CEO a bigger raise than producing superior clinical results.

Physicians are now the weakest constituency, with increasingly less influence on hospital operations. They often have little input into issues with a direct impact on their practice and patient care, such as treatment protocols or the construction of operating rooms or endoscopy suites. While staff engagement and satisfaction are important CEO incentives, physician engagement is near the bottom of the list.[3] In truth, hospital administrators view physicians as merely a cost center to be controlled to maximize profits, no different than a custodian, piece of capital machinery, or how much it costs to repave the parking lot.

There are many reasons for these changes, but I believe 3 predominate. First: in years past, physicians controlled patient flow, giving them considerable leverage. Now patient flow, and revenue, is usually determined by the patient's insurance coverage. Physicians give up further control by allowing a hospitalist to admit their patient rather than admitting and caring for them themselves. The harder a person works, the more they control their own destiny.

Second, many physicians are now hospital employees. They prefer not to deal with business issues such as billing or meeting overhead, and the certainty of receiving a fixed paycheck every month, without realizing they have foregone one of the greatest traditional allures of being a physician, namely, being your own boss. They might only appreciate who really is the boss when it's too late, when they have not pleased the CEO and their contract is not renewed.

Third, I believe the high compensation packages of CEOs have a negative effect on health care in the US. For-profit hospitals are in business to generate a return for their shareholders. They pay income taxes to all levels of government, and property taxes to local governments. One can argue that the CEOs at tax-exempt health care organizations have seized this tax advantage to fund their salaries, rather than improve clinical services, raise employee salaries, or lower the cost of patient care. Measures of community benefit show no association with the CEO's pay.[2] The issue of excessive CEO inurement prompted the Internal Revenue Service to conduct the Tax-Exempt Organizations Hospital Study.[4]

It is my opinion that a conflict of interest arises by tying administrator's compensation to hospital profits. Several

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scenarios: say the traditional patient-to-nurse ratio on the night shift was 5 to 1. At a ratio of 6 to 1, the nurses are frazzled and harried, but being dedicated health care professionals, they get the job done, and performance criteria are maintained within acceptable limits. Leaving 6 RN positions unfilled saves the hospital $400,000 per year, a fraction of which the administrators receive as a bonus and a potential salary increase the next year. Or changing the pension benefits to the detriment of higher-salaried nurses, resulting in the loss of 15% of the nurses with 10 or more years' experience, to be replaced with less expensive recent nursing school grads. After all, an RN is an RN, right?

One can argue that the current system of CEO compensation is an important driver of increasing health care costs. First are the high salaries themselves. The 30 CEOs described in the first paragraph made a total of almost $200,000,000 in 1 year, equivalent to the salaries of 3000 RNs. Second, CEO compensation is skyrocketing, up a whopping 24.2% from 2011 to 2012.[5] Third, because the CEOs of hospitals with more advanced technologies receive higher compensation, they may feel pressured to add gadgets such as extracorporeal membrane oxygenation, robot-assisted surgical devices, or helicopters, that make no economic sense but are highly marketable and allow them to say they are the first in the area.[6]

The increase in nonprofit CEO compensation is part of a larger corporate trend in the US. In the last 40 years, CEO salaries at S&P 500 companies have increased more than an order of magnitude faster than the average worker, yet have not correlated with increased corporate performance.[7] The astronomical salaries are rationalized by noting the complexity and expertise required to run a large, modern business, and as a means to recruit and keep superior talent. To this, Charles De Gaulle might respond "The graveyards are full of indispensable men."[8] To me it appears the CEO's best justification for their high salaries is that they have them.

I believe it is no coincidence that all of the references for this article with negative comments on the salaries of nonprofit CEOs, except the study from the Harvard School of Public Health,[2] are from the nonacademic, lay press. To criticize the man that signs your paycheck in public and in print can have a direct effect on one's career.

In 2014, the average physician's salary in the US was about $250,000. Five years earlier, in 2009, the average compensation for a nonprofit CEO was almost 2 1/2 times greater at $595,781.[2] The authors note that even this may be an underestimate. In general, the average health care administrator requires 1-2 years less of postcollege schooling than a physician. Furthermore, when an administrator graduates, they immediately step up to a higher level of compensation, whereas physicians are doomed to another 3-7 years of the financial purgatory of Residency and Fellowship. Taken together, health care administrators, as compared with physicians, have the advantages of 1) fewer years in school and thus less tuition and student debt, 2) 4-8 fewer years of minimal salary post training, and 3) significantly higher salary, 4) with the potential to earn 10 or even 20 times more than the average physician. The best and brightest, who can do what they wish, will increasingly choose health care administration over the stethoscope.

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