Gainsharing experiment in health care

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Gainsharing has been lauded as a major technique for improving organizational productivity—especially in manufacturing circles. Such programs can be viewed as compensation programs designed to provide variable incentives tied to aggregate performance measure(s) and/or as organizational development techniques designed to generate a major cultural change. While the potential of gainsharing has attracted the attention of a number of theoreticians and practitioners, a national survey by three of the authors, Steven E. Markham, Beverly L. Little, and K. Dow Scott, found that its actual use might be overestimated. In fact, their data revealed a perplexing pattern in the degree to which such programs actually are used in various sectors of the U.S. economy. With the exception of the government sector, all of the sectors had active plans that, on average, appeared successful. Despite this evidence of successful gainsharing programs, however, the service sector used gainsharing at a much lower rate than did the traditional manufacturing sector. (See “National Gainsharing Study: The Importance of Industry Differences” in the January-February 1992 Compensation and Benefits Review.) Quite simply, the evidence shows that the promise of gainsharing has not been realized in service industries.

Among the various groups composing the service sector, the medical/hospital industry is of paramount importance. Often considered the third largest component of our overall economy, there is little doubt that the medical industry is currently facing a financial crisis attributable, at least in part, to cost overruns of past years. On one hand, a number of hospital chains and pharmaceutical companies are extremely profitable, with average net profit ratios of 15%, far above the 4.6% recorded last year by the Fortune 500. On the other hand, a number of hospitals, especially those in urban areas, are in dire financial straits. More important from an outside perspec-
tive, businesses and their employees are paying a significantly greater proportion of their payroll for health care than they did five or ten years ago. At the national level, even Congress is preparing to intervene in the medical industry because of the escalation of costs that has far exceeded annual increases in the gross domestic product.

As a partial response to this deepening fiscal quagmire, the growing need for continuous improvement in the quality of patient care, and the initiation of Total Quality Management programs within the health-care industry, gainsharing may represent a way to address not only cost-related problems in the industry, but also some of the notorious organizational culture problems found in hospitals and medical bureaucracies. All too often, rigid walls between professional specialties and functional areas create bureaucratic barriers to improvement. Because patients' problems often require integrated treatment, patient care suffers from such departmentalization.

In this study, the authors address the feasibility of adopting gainsharing programs in hospitals by examining specific cases of hospitals with such plans and the industry characteristics that might hinder the use of gainsharing.

GAINSHARING

A brief review of gainsharing plans reveals that they really are far from new techniques, even in hospital settings. The gainsharing plan at St. Lukes Hospital of Kansas City, for instance, was initiated in 1979. In the manufacturing sector, Donnelly Mirrors and Herman Miller, Inc. have had Scanlon Plans since the 1950s. Not all gainsharing plans, however, are Scanlon Plans, which are usually viewed as high-end, full-featured techniques for employee involvement. (See "The Evolutionary Development of A Scanlon Plan" on page 50 in this issue.) While Scanlon Plans and some gainsharing plans are viewed as vehicles for structuring major organizational change, other plans have a smaller scope and focus primarily on more limited objectives. No two gainsharing plans are alike.

Typical gainsharing programs provide some method for employees to suggest ways to increase productivity and cut costs and some mechanism for sharing the increased earnings or cost savings with employees. Since 1984 a number of team suggestion systems have been very successful at places like Baylor Health, Hospital of University of Pennsylvania, Franciscan Health Systems, Henry Ford, Georgia Baptist, Ochsner, and at least 20 other medical facilities. Some gainsharing plans share any improvements in the bottom-line profit figures—whether they come from capital investment or improved labor performance—in an immediate cash payout, as opposed to the traditional deferred payment of profit-sharing plans.

While it is possible to design a gainsharing plan that is simply a group-based incentive formula, most plans also try to incorporate some degree of employee involvement. In fact, many programs will emphasize the importance of employee involvement above any financial bonus that might be paid. This feature distinguishes Scanlon Plans from gainsharing plans that are built solely around a financial bonus formula.

Employee involvement in a gainsharing plan can be solicited in these four ways:

1. Employees can serve on design committees during the planning stage.
2. After the design stage but before implementation, an employee vote on the plan can be scheduled. Scanlon Plans, for example, traditionally require an 80% to 90% positive vote before being installed for a trial period.
3. Employees can serve on governing committees to help administer the on-going program.
4. Employees can provide input into the change process through some type of suggestion system.

Because one of the purposes of a gainsharing program is to increase managerial and hourly employee competence, the successful implementation of a plan requires specific training. For example, employees usually want to know how the plan works and what it is supposed to do. To meet this need, a module on the technical aspects of the plan is called for. For either a formal or an informal suggestion system to work, employees need training in leadership and group process skills. Finally, to assess the results of the plan, employees need business literacy training to learn the basic financial and accounting information.
THE STUDY

In January 1991, three of the authors conducted the national study of gainsharing programs mentioned above by surveying a random sample of 10,000 human resources management (HRM) professionals drawn from the SHRM (Society for Human Resource Management) mailing lists. Industries were identified by their standard industrial code numbers, but because SIC 800 covers a variety of professional organizations, we included a separate box to identify medical and health organizations. To verify the information in the responses and to obtain more detailed information, we conducted follow-up telephone interviews with the HRM representatives of the gainsharing programs in the healthcare sector. These 20-minute interviews followed a semistructured format.

We identified nine plans in the health-care industry: (1) one Scanlon Plan, (2) one IMPROSHARE® Plan, (3) two profit-sharing plans, and (4) five custom-designed plans that did not fall in the above categories. The plans reported in the survey were all relatively new, with 1985 being the earliest date of implementation. Because of the relatively short life of these plans, other organizations in the industry have probably had limited opportunity to learn of any successes, and such successes haven’t been subjected to the strains of time. On the other hand, no one reported eliminating a plan.

Given the low number of actual plans (9) reported in this industry, it makes little sense to conduct any sort of statistical analysis of their characteristics. Rather, a discussion of the experiences of these hospitals and medical centers might prove more beneficial.

In the following paragraphs, we summarize the key elements of seven plans whose HRM professions were willing to share this information; we then present case studies of the seven for those who are interested in the plan details.

DISCUSSION

Exhibit 1 summarizes the wide diversity in key variables among the seven hospital gainsharing programs identified in this article. The following common themes, however, run through the variety of programs reported:

- The fact that these programs are all relatively new suggests that gainsharing is still very much an experimental rather than a proven technology in this industry. As financial pressures on hospitals increase, more experimentation of this type may well spread. In fact, in those cases where plans covered only a part of a facility, respondents reported that they had plans to extend the programs to the entire organization.
- These organizations place a strong emphasis on “customer orientation”—that is, patient care. While the connection between a renewed
customer-orientation and gainsharing might not be self-evident, a well-designed gainsharing program fosters a process of organizational self-examination and continual improvement that inevitably leads to the conclusion that quality pays off, both in terms of reduced patient days and a larger market share. Indeed, as one of our HR managers noted, “The true sign of a turnaround in a hospital’s culture is when the nurses send their families and relatives here.”

- A third theme, the strong emphasis on cost savings, parallels the experience of gainsharing organizations in the manufacturing sector. In contrast with gainsharing plans in other sectors, however, very few of the hospitals had formal suggestion systems.

- In most of these sites, the gainsharing program has been a catalyst to a serious reexamination of work methods. While the financial gains reported by these hospitals have been relatively small compared with other industries, the other benefits have been just as significant. Rather than large departments or wards that “mass produce” a service, most of these hospitals are experimenting with some version of self-managed work teams to provide higher quality, less costly, and more direct care. As a by-product of this effort, increased job flexibility and team-based organizational skills were emphasized in this nontraditional organizational design.

- Perhaps the most sensitive factor in the health-care setting is the financial bonus formula. Because many of these hospitals had traditionally been nonprofit, community-based organizations, they were just as reluctant to investigate alternative financial rewards as was the government sector. It is as if a part of the unwritten ethic for these sectors precludes them from the consideration of variable incentives. Indeed, many of the HR managers whom we interviewed emphasized the notion that the term “profits” was not to be used because (1) the program was not a traditional profit-sharing program and (2) the local community would neither accept nor understand an incentive program that they felt might cost them more money.

With more and more hospitals being purchased by larger corporations or merging with other local medical centers, we expect to see this psychological barrier fall. In fact, it requires only a moderate conceptual step to modify the traditional manufacturing bonus formula to one for a service industry. Key productivity indicators—such as length of patient stay, number of admissions, wastage of supplies, direct and indirect labor costs, and customer satisfaction—can all be built into a formula.

Given the successful cases we identified in this industry, coupled with the fact that we could find no plans that had been eliminated, we can only speculate about why there are so few gainsharing experiments in hospitals. In the national survey from which these cases were drawn, we received 150 responses from medical organizations, or about 9.2% of the total responses received. Only 6.0% of these 150 respondents reported any type of gainsharing. This overall rate of 6% is less than one-half to one-third of the rates reported for other industries.

Is this low utilization rate attributable to lack of knowledge about gainsharing? This doesn’t seem to be true: 78% of the respondents had heard of the term gainsharing before they received the survey questionnaire, a rate that is comparable with that of other industries. Yet this relative familiarity with gainsharing has not necessarily translated into either the consideration of or the installation of a plan. Only 42% of the HRM managers who were familiar with the term had even considered installing a plan. Clearly, there is still a major hurdle to get over before there is widespread, serious consideration of gainsharing in this industry.

Thus, gainsharing in the hospital industry is still in its infancy. There is little doubt, however, that as success stories, such as these cases, or previously reported programs, such as St. Luke’s Hospital of Kansas City or Boston’s Beth Israel Hospital, become more commonly known, there will be a surge in the number of gainsharing experiments in the hospital industry.

The Case Studies

Case 1: Cottonwood Hospital Medical Center, Utah

Cottonwood Hospital, located in Salt Lake City, had a gainsharing program that had been developed by the human resources (HR) department...
and general management, but it was not working. The hospital, therefore, called in consultants who initiated focus groups to break the log jams and get the client to involve the corporate finance group in a careful analysis of the financial bonus calculation. A Hay Healthcare Gainsharing Readiness Audit was conducted, and management and the consultants jointly concluded that quality of patient care needed to be addressed.

As a result, management and the consultants devised a custom-designed gainsharing plan that currently covers all 1,100 employees in the non-unionized, nonprofit facility. In effect for more than three years, this is one of the more senior plans in the hospital industry. All employees except for top management are eligible for the bonus, which has been paid every quarter since the plan's inception. Despite the fact that last year's bonus averaged only 1.6%, both managers and employees seem to be highly satisfied with the program.

Employees did not vote on the decision to implement the plan. Rather, the HR and accounting departments were most heavily involved in its design and implementation. The plan has no formal suggestion system. One key factor behind the program's success, however, has been employee training. Careful attention has been paid to training before, during, and after implementation. Lynne Cook, the gainsharing coordinator, considers the program a major success, especially in terms of increasing employee involvement, developing cost awareness, and improving quality. The plan has reaped the most benefits in improving responsiveness to patients, fostering innovation and improvements, and increasing labor productivity. While there have been a number of positive aspects to the gainsharing program, one problem that it has not been able to solve has been the perennial thorn of employee turnover. In spite of this drawback, management considers the program so successful that they plan to expand it to more hospitals in the group.

Case 2: Catherine McAuley Health Center, Ann Arbor, Michigan

This not-for-profit organization, sponsored by the Sisters of Mercy, operates (1) St. Joe's hospital, one of the oldest in Ann Arbor, (2) a chemical dependency unit, and (3) a center for mental health. Together they have more than 700 beds, with 546 of them in the hospital.

The organization's gainsharing program, a modified Scanlon Plan that was installed as a pilot in one laboratory department in 1989, covers 180 employees, 150 of whom are hourly. It was designed and implemented by the HR management and production departments, using outside consultants to a great extent. Top management and the accounting department were involved to lesser degrees. Contrary to traditional Scanlon Plan procedures, the employees did not vote on the decision to implement. However, employees were trained during the implementation phase. The bonus is calculated as a percent of the total, pooled savings from all suggestions. It is paid annually, with last year's bonus averaging $2,000 per employee, which represented savings from, among other things, reduced wastage and rework. Employees have provided an average of one suggestion for each two employees per year through the formal suggestion system. This average has remained constant during the last two years.

Management and employees are quite satisfied with the plan, which is seen as having increased innovation, quality, and profitability. The program is so successful that Paul Gladstone, director of human resources, reports that management plans to expand it to the rest of the hospitals.

Case 3: Sutter Ambulatory Care, An Affiliate of Sutter Health, Sacramento, California

Sutter Health Services, a not-for-profit corporation operating 12 hospitals throughout California, was a pioneer in gainsharing with its SutterShare program, which was first instituted in 1985. SutterShare was designed for all 2,200
employees of the hospital and health-care network (except administrators, directors, and vice presidents, who have their own plan linked to the same performance measures and reward pools). Measurement in SutterShare is based on productivity versus nationally published standards for income over budget and departmental quality. The plan measures performance on a bimonthly basis, providing timely and repeated feedback. Executives continue to report that the plan has resulted in significant gains in cost improvement and productivity. SutterShare is an integral part of Sutter's move into Total Quality Management and Continuous Quality Improvement efforts.

Looking back, several important steps took place before SutterShare was implemented. At that time, Sutter, with the help of consultants, worked on a range of projects, which included creating executive development and succession plans, redesigning the overall organization as well as the patient-care delivery system, adjusting staffing levels and costs, and creating a variety of new compensation programs for executives and key contributors.

SutterShare had an unusual evolution because the renewal effort began with focus group activity and included a Hay Healthcare Gainsharing Readiness Audit.

A gainsharing plan for Sutter's ambulatory-care division was set up after SutterShare had been in effect for several years. This division of Sutter Health operates five outpatient surgery and urgent care units, all of which are less than five years old. This custom-designed gainsharing plan, called Care and Share, was set up at the multiple nonunion sites less than two years ago. Most of the 80 covered employees are hourly; only five are salaried. No vote was held before the plan was adopted. Training was held before and during implementation. The plan was designed and set up by top management, the HR department, and the production department. Interestingly, not only does the plan incorporate a formal suggestion system, but special recognition is given to those employees who make four or more suggestions per quarter.

The Care and Share bonus formula is based on a combination of quality measures, performance measures, and net operating income. The bonus is paid quarterly to those who are eligible (office staff, production workers, and supervisors) as a percent of total earnings for the period. Only one period elapsed before the first bonus was paid, and a bonus has been paid 50% of the time. In 1990 bonuses averaged 5%. After three quarters, the 1991 bonus was 7%. The plan's effectiveness was judged as moderate in terms of overall success, employee satisfaction, and managerial satisfaction. The greatest improvements for the organization have come in the areas of customer responsiveness and profitability. As Diane LaHola, the program coordinator, noted, "While the Care and Share program has focused employees on productivity and quality targets, one of the real benefits is the process of employee involvement." As with many other plans, employee turnover problems have not been directly helped. Sutter Ambulatory's Care and Share plan is unique, and it is not tied to the level of success at the other units of Sutter Health System.

Case 4: South Central Mental Health, Bloomington, Indiana

This organization's profit-sharing plan has been in effect since July, 1987. The plan covers 180 employees (80 of whom are hourly) at one nonunion site. Everyone from top management through office staff and production workers is eligible for the bonus, which is paid quarterly on the basis of total earnings for the period. The actual distribution amounts are tied to employees' performance appraisal ratings for the quarter, in a guide-chart manner. The plan paid a bonus its first quarter and has paid 80% of the time since then. Last year's bonuses averaged 5%. With some use of outside consultants, top management, HR management, engineering, and accounting, were heavily involved in designing the plan. No employee vote was held before implementation, but training was held before the plan took effect. The plan does not include a formal suggestion system.

Managers are reported to be greatly satisfied with the plan, and employees moderately satisfied. The plan has contributed in areas that are often desirable but elusive for gainsharing programs — reduced employee turnover and the protection of jobs. Improved communication and increased profitability were also cited as favorable outcomes. Overall, the plan is per-
ceived as being a moderate success. Personnel Director Mark Uebel said he felt the overall reaction to the plan is not as positive as it could be because no quarter’s payout has been large enough to make a great impression.

Case 5: Anonymous Hospital, Alabama
The respondent from this hospital chose not to identify him- or herself or the organization. Thus, we can report only about the plan. This two-year-old, custom-designed plan covers 75 salaried managers in an Alabama health-care organization. Top management and the human resources department designed and implemented the plan, with assistance from the accounting department and outside consultants. There was no vote or training before implementation, but training was conducted during implementation.

Only top and middle management are eligible for the annual bonus, which is calculated as a percent of salary. The plan has paid a bonus both years it has been in operation. Despite last year’s bonus averaging only 1.56%, both administrators of the plan and those covered by it are reported to be very pleased with the plan. The success of the plan lies in its fostering of innovation and service improvements and, to a lesser degree, improvements in responsiveness to patients, communication, employee satisfaction and commitment, productivity, quality, and product differentiation.

Case 6: Anonymous Regional Medical Center, Pennsylvania
This gainsharing plan recently finished its first year of operation. It was custom-designed and covers 850 hourly and 150 salaried employees, all of whom are nonunion. Top management and the HR department designed and implemented the plan, with the assistance of outside consultants. Employees were trained before, during, and after implementation. The employees did not have input into the design of the plan before implementation, nor did they vote on it. They do, however, have an opportunity for ongoing input through a formal suggestion system.

Employees are eligible for monetary incentives through the suggestion system as well as through the gainsharing plan. Either as individuals or groups, employees are paid 10% of the projected savings from their suggestions. All employees, including salaried employees, are eligible for the gainsharing bonus, which is above and beyond the suggestion plan incentive. The most unusual aspect of the plan is that the gain-sharing bonus is paid only once a year. On the first anniversary of the plan, each employee received one week’s wages as a bonus.

As individuals or groups, employees are paid 10% of the projected savings from suggestions.

Case 7: Major Southwestern Health-Care System
In the summer of 1989, this medical center initiated a team suggestion system, which, in three months, identified more than $6.5 million in cost savings and new revenues sources. Upon the implementation of the suggestions, this goal was surpassed by 33%, so that by mid-1990, the total monetary gain realized was $8.6 million.

Employee participation was completely voluntary, but, to be successful, the plan needed widespread acceptance to obtain minimum levels of participation. To kick off the program, top management made its commitment visible by personally convening all 39 announcement meetings. As a result of these meetings, 4,000 of the nearly 5,500 eligible participants enrolled, and they were formed into 567 teams. Over the next three months, nearly 2,100 suggestions were submitted, reviewed, and approved or returned. Approximately 35% of the suggestions were ap-
proved, resulting in the $8.6 million savings cited above in the first year. Because studies had shown that savings from implemented suggestions impact the organization for about three years, the full impact of the cost savings during the second and third years accrued to the health system itself. The participants and consultants were paid from the first year's savings.

The health system experienced other benefits as well. Several months after the initial phase of the project ended, an employee survey indicated that the program had not only stimulated a greater understanding of operating costs, but it had also given employees a greater appreciation of the time and research involved in making changes. The health-care system's director of management development stated, "The program helped cut through corporate bureaucracy and forced people to make decisions they might have otherwise delayed."

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