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How to fix Maryland's ER wait times: Cut executive salaries. A lot.

By David Meyers and Dan Morhaim

Maryland leads the nation in Emergency Room extended wait times. As directors of E.R.s at Maryland hospitals, we faced this more than 30 years ago. Although steps have been taken to ease the problem, over the years it's gotten worse. Much worse.

Here's what's going on. For the typical community hospital, E.R.s are the source of 50% to 80% of hospital admissions. When admitted E.R. patients can't move to an in-patient bed, they stay in the E.R. It's not unusual to have half of E.R. beds taken by patients awaiting transfer, for hours or even days. Because these are the sickest patients, they require continuing attention, while new patients continue to arrive with no place to go. Thus, ever-increasing wait times.

These delays affect all patients — those with medical and surgical problems as well as those with behavioral disorders, especially children and adolescents who have been reported to spend as much as a week or more in E.R.s awaiting placement. The stress of these delays hits patients and their families, but also caregivers who face burnout from working harder with fewer colleagues and resources.

While inadequate bed space is a factor, the lack of staff at every level is even more significant: nurses, physicians, physician assistants, social workers, pharmacists, skilled technicians (lab, imaging, respiratory), housekeepers, transporters, security, unit clerks, dietary and many others. The new CEO of the Maryland Hospital Association, Melony Griffith, noted that roughly one in five nursing positions in the state is unfilled, and the shortage could get much worse without urgent, aggressive action.

Simply put, the key to fixing this requires better pay for more front-line staff. Where would this money come from?

Two prominent leaders recently addressed financial issues in business. Robert Reich, a U.C. Berkeley Professor and former Secretary of Labor under Bill Clinton cited dramatic increases in compensation of American corporate CEOs: "In 1965, CEOs earned roughly an average of 20 times the typical worker's pay. … As of 2021, the CEO-to-median-worker pay ratio had grown to 399 to 1." Since the 1970s, CEO pay has risen 1,200%, while the pay of the average American worker went up just 18%

Donald Berwick, a lecturer at Harvard Medical School and former administrator of the Centers for Medicare and Medicaid Services, wrote last year in an opinion piece in the Journal of the American Medical Association — entitled "Salve Lucrum: The Existential Threat of Greed in US Health Care" — that the "grip of financial self-interest in U.S. health care is becoming a stranglehold, with dangerous and pervasive consequences. No sector of US health care is immune from the immoderate pursuit of profit."

We looked at Maryland hospital executive compensation on a public website (HSCRC.maryland.gov/Pages/hospital-irs-990.aspx). There, one can see CEO and executive compensation for every Maryland hospital, all of which are nonprofit. Generous six- and seven-figure incomes are common, with one exec making over $15 million per year. These incomes then drive retirement and other benefits. Further, Maryland hospital executives make far more than their counterparts at non-health-care nonprofits.

In 2004, salaries for state workers were frozen due to financial shortfalls, and legislators voluntarily imposed the same freeze on themselves as was done to state employees. A similar approach should apply to hospital executives.

Here's a proposal for hospital governing boards: Cap hospital executives' compensation at $500,000 per year, a more-than-comfortable wage in Maryland. By our estimate, that would free up over $100 million annually to be used to recruit and retain thousands of much-needed frontline workers for our hospitals. That could help reduce E.R. wait times while improving other services.

The executives may object, arguing that their high salaries are needed to attract and retain the best and brightest for these challenging positions. But $500,000 per year is more than adequate for work in the nonprofit sector, which is heavily subsidized by citizens through taxes and charitable giving in exchange for the benefits these institutions are to provide to their communities.

Almost everyone else in health care makes less, far less, and they do so with dedication, professionalism and sacrifice. We should expect the same of those leading these organizations. Regardless, as administrators, theirs is the ultimate responsibility for E.R. wait times and other operational shortfalls, including those where quality and safety standards are not met.

Our proposal is a start, but it does not solve the myriad of problems affecting America's health and health care, including our poor ranking in health measures compared to other developed nations, falling life expectancy, rising infant and maternal mortality, profiteering pharmaceutical companies, medical debt now being the most frequent cause of personal bankruptcies our lack universal health coverage, in which we are alone among modern nations.

Don't let anyone tell you that we don't have the money to do better. We do. The money is there. It's just not going to where it's needed: to those who perform the front-line work of patient care and for preventive services and public health.

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