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Perceptions of Inequitable Compensation Reductions among Healthcare Workers During Covid-19

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Abstract

Healthcare systems across the United States implemented compensation reductions, layoffs, and furloughs during the early phases of the COVID-19 pandemic. However, there was a wide variety of approaches among health systems. This paper explores the perceived inequity of compensation reductions across the entire healthcare team through the lens of distributive justice. The study was conducted at a large academic hospital in the Southeastern United States. A survey was distributed regarding perceived fairness of compensation reductions, preferred compensation reduction arrangements, work environment, and stressors. Out of 715 respondents, the majority showed a preference for compensation reductions that were lowest for those physically treating patients, or physically treating COVID-19 patients. Ordinal logistic regression was conducted to determine predictors of increased odds of perceived inequity of the compensation reductions. Employees who had greater resiliency, greater exposure to the virus, treated COVID-19 patients and reported reduced income as a major stressor had higher odds of feeling the pay cut was inequitable. Those with a greater sense of perceived organizational support and females were less likely to perceive the pay cuts as inequitable when controlling for other factors. Healthcare organizations need to be mindful of perceptions of inequity on the well-being of their workforce and should engage in inclusive decision-making when allocating scarce resources within the organization.

Introduction

Throughout the height of the COVID-19 pandemic, many employees found themselves in vastly different roles due to the nature of the altered utilization of hospital resources. Some physicians and direct patient care staff worked extended hours with large patient caseloads and a high likelihood of viral exposure.[1] Conversely, because of mass outpatient and elective procedure cancellations, others had drastically decreased hours and minimal risk of exposure.[2] Throughout the U.S., hospitals accommodated the growing and expected demands of an influx of COVID-19 patients by drastically altering their equipment, personnel, and space utilization. Ventilators, beds, personal protective equipment (PPE), and other resources were set aside for critically ill patients in lieu of elective procedures, surgeries, and admissions.[3,4]

Beginning in March 2020, more drastic measures were taken and a significant percentage of elective procedures were canceled in an attempt to curb the spread of the virus.[5] In 2014, elective admissions accounted for greater than 30% of all inpatient hospital revenue.[4] Cancellations implemented in early 2020 were expected to result in $16.3 to $17.7 billion of lost revenue per month in hospitals in the U.S.[2] When elective cases were initially reduced or canceled, there was uncertainty about the magnitude and timing of federal funding to offset potential losses.

As a result, health systems took measures to adapt to sudden reductions in revenue. Health systems across the country implemented furloughs and layoffs, cancellation of fringe benefits, and compensation reductions.[6,7] For example, the Mayo Clinic furloughed or reduced the hours of 70,000 employees (42%) during the midst of the pandemic.[8] These measures ranged from being implemented to only a sub-segment of the health system employee population to affecting all personnel including frontline workers actively engaged in the pandemic response. Due to the timing of such measures, many healthcare workers found themselves working longer hours[9] with a high risk of exposure to a deadly disease,[10] while simultaneously experiencing a reduction in compensation and concerns about job stability.[11] In tandem, many non-healthcare related businesses struggled financially resulting in closures and layoffs within the broader community. This had the potential to create additional financial pressures to healthcare workers whose families may have also simultaneously experienced reductions in income or job loss.[12]

Each health system that decided to implement pay cuts, furloughs, or layoffs faced different trade-offs in relation to which employee groups would be affected, how, and to what degree. Furthermore, these decisions were often being made quickly in an environment of uncertainty regarding the longevity of the pandemic, and the timing and details of financial assistance from federal and state governments.[5]

One important consideration for these decisions is the perception of equity and fairness by employees. While pay cuts or furloughs may have been necessary, the way they were administered had the potential to either build or diminish an employee's sense of fairness within the healthcare organization. These perceptions of inequity have the potential to create a lasting impact within the organization, long after pay is restored. A study of distress among healthcare workers during COVID-19 found that perceptions of inequity of pay reductions were one of the top drivers of overall distress.[13]

Social psychologists have previously examined the idea of *distributive justice*, meaning the evaluation of fairness in the distribution of rewards (e.g., income, recognitions), to understand people's perception of unjust earnings and its effect on emotional and behavioral indicators.[14] The theoretical framework of this concept is based on the usage of three justice indicators: just reward, actual reward, and justice evaluation.[15] These elements influence one's perceived rights to the distribution of benefits and burdens to provide the foundation of fairness in the administration of rewards–especially monetary compensation.[16] People compare their perceptions of an ideal *just reward* with the *actual rewards* they receive to produce a *justice evaluation*. Consequently, this subjective assessment informs whether the actual reward is fair based on what the person thinks is just in exchange for the effort and sacrifice they invested in the work.

Prior scholarship has identified psychosocial pathways driving the relationship between unequal distributions of earnings and for-profit organizations' functional stability. For example, employees who perceive greater unfairness in earning distributions are more likely to feel less satisfied with their jobs,[17] are less productive,[18] and may quit their jobs.[19] Moreover, those who perceive an inequitable distribution of earnings are more likely to show worse physical and mental health profiles.[20,21] Workers who have higher perceptions of inequity in earning are more prone to experience stress.[22] Chronic stress is associated with the wear and tear of the body, resulting in deteriorated physical health,[23,24] which may increase workers' usage of sick leaves.[25]

Healthcare workers were already at higher risk for burnout prior to the COVID-19 pandemic.[26–30] The pandemic worsened the well-being of healthcare workers, with a reported 92% of clinical staff, 90% of nurses, 89% of APPs, 75% of administrative and non-clinical, and 71% of physicians reporting high distress.[13] Given the established relationship between perceived distributive justice and indicators of well-being and the high prevalence of distress among healthcare workers, financial decision-makers must have a clear understanding of how their choices can create perceptions of inequity. The purpose of this study is to evaluate healthcare workers' perceptions of inequity regarding COVID-19 related compensation reductions and to better understand what factors are associated with these perceptions. In the event that future pay cuts are warranted, having a better understanding of the drivers of perceived inequity can help inform decision-making for healthcare leaders.

Methods:

Study Design and Setting

This study examines the financial adjustments made by a large health system in the Southern United States during the early phases of the COVID-19 pandemic. The uncertainty of the financial impact prompted the health system to implement a pay reduction for nearly all health system employees in May 2020. The compensation reduction was graduated according to income, with administrative leadership taking the largest cut at 15%. Other employees had a percentage cut ranging from 0-7% based on income. Employees making less than $30,000 per year did not take a reduction in pay. The reductions were solely based on income and did not change based on work location, role, productivity, or job responsibilities. For example, a nurse on the COVID-19 ICU would have had the same percentage cut as a project manager working from home making the same salary.

An anonymous online survey was sent to clinical and non-clinical employees of a large health system in June 2020. This survey was approved by the institutional review board of the study organization. The survey measured distress, resilience, moral distress, perceptions of inequity of the pay cuts, and a number of measures of the quality of the work environment and specific work and non-work stressors.

Variables

Dependent Variable

The primary variable of interest was the perceived inequity of the reductions in pay that were implemented within the organization. Specifically, respondents were asked, "Given the financial challenges we had, I believe the COVID-19 compensation reductions were transparent, fair, and equitable." Responses were measured on a 5-point Likert scale ranging from strongly agree to strongly disagree. Additionally, respondents were asked to select which methods of pay reduction they believed were most fair and equitable. They were given a range of options in a multiple selection question, as well as the opportunity to input a free-text suggestion.

Independent Variables

Distress was measured using the validated Well-Being Index tool, which provides distress scores (-2 to 9, with 9 representing the highest distress level).[31–34] Respondents were also asked to select their most concerning general work stressors, clinical stressors, and non-work stressors from a list of over 50 options. Resilience was measured using the CD-RISC 2 scale[35] (0-8, with 8 representing the greatest resilience), and moral distress was measured using a single-item measure from the Veteran's Affairs Annual Employee Survey (0-5, with 5 indicating that moral distress is occurring almost every workday).[36] We used a 3-item measure of perceived organizational support asking specifically whether employees felt the organization cared about them and valued their extra contributions and efforts using a 5-item Likert scale (0-15, with 15 representing the greatest highest perceived organizational support).[37] Respondents were also asked to indicate whether they had direct contact with COVID-19 positive patients (excluding telemedicine or virtual interactions).

Results were stratified by role, which included administration and non-clinical employees, physicians, advanced practice providers (APPs), nurses, and clinical support staff. Clinical support staff included employees such as patient care technicians, respiratory therapists, pharmacy, and lab and radiology technicians.

Analytic Strategy

Using Stata16, we conducted ANOVA and Chi-Square tests to identify differences in perceptions of inequity and specific stressors among various employee sub-groups.[38] We utilized ordinal logistic regression to determine what factors were associated with an employee's perceptions of inequity regarding the compensation reductions.

Results

Table 1 includes the means and percentages of all variables included in the regression models. The analytic sample has a total of 751 healthcare workers, where 32% identified as Administrative or Other, 21% as APP, 15% as Clinical support staff, 14% as Nurse, and 18% as Physicians. Clinical support staff members had the greatest perceived inequity of the pay cut (38.4%), followed by Nurses (33.6%), and APPs (22.7%). Perceived inequity of the pay cut ($p<.001$), resiliency ($p<.01$), moral distress ($p<.01$), and perceived organizational support ($p<.001$) significantly varied by job role. APPs (M=6.87, SD=1.15) reported the highest mean resiliency score, followed by Physicians (M=6.66, SD=1.14), and Nurses (M=6.55, SD=1.21). In respect of moral distress, Nurses had a mean score of 1.91 which was the highest level of moral distress in our sample. Whereas Physicians had the highest perceived organizational support score (M=9.53, 3.27).

Table 1. **Characteristics of the Sample**.

	Administrative or Other (N=240)	**APP (N=154)**	**Clinical Support Staff (N=112)**	**Nurses (N=107)**	**Physician (N=138)**	***p*** [a]
Perceived Inequity in Pay Cut % [b]						***
Strongly Agree	14.6	7.1	5.4	0.0	13.0	
Agree	28.8	22.1	20.5	17.8	30.4	
Neutral	37.5	18.9	20.5	18.7	22.5	
Disagree	13.8	29.9	15.2	29.9	15.2	
Strongly Disagree	5.4	22.7	38.4	33.6	18.8	
Work Location % [b]						***
Administration or Other	89.9	7.8	44.6	20.6	17.4	
Ambulatory	5.4	28.6	8.0	13.1	20.3	
ICU	0.4	18.8	29.5	14.0	8.7	
Non-ICU	4.6	24.7	17.0	46.7	26.1	
Surgery/Procedure	0.0	20.1	0.9	5.6	27.5	
Resiliency Mean (SD) [c]	5.44 (1.36)	6.87 (1.15)	6.43 (1.33)	6.55 (1.21)	6.66 (1.14)	**
Moral distress Mean (SD) [c]	1.18 (1.50)	1.50 (1.55)	1.53 (1.69)	1.91 (1.72)	1.41 (1.51)	**
Heavy workload stress % [b]	26.3	38.3	55.4	50.5	25.4	***
Increased job demands stress % [b]	35.4	57.8	55.4	66.4	50.7	***
Rapid change stress % [b]	32.1	66.9	46.1	67.3	46.4	***
Working remotely stress % [b]	33.6	5.8	8.9	4.7	17.4	***
Scope of practice- unsure of adequate skills stress % [b]	0.0	15.6	5.4	26.2	11.6	***
High risk of exposure stress % [b]	0.0	52.6	31.3	46.7	36.2	***
COVID exposure % [b]	5.4	74.0	54.5	69.2	66.7	***

Treating COVID patients stress % [b]	0.0	20.1	21.4	19.6	5.8	***
Perceived organizational support Mean (SD) [c]	10.61 (2.86)	8.31 (3.08)	7.84 (3.85)	8.20 (3.14)	9.53 (3.27)	***
Fear of job loss stress % [b]	54.2	44.8	51.8	46.7	24.6	***
Reduce income stress % [b]	31.3	72.1	59.8	70.1	47.8	***
Fear of furlough stress % [b]	17.5	10.4	16.1	10.3	3.6	**
Female % [b]	71.7	73.4	75.9	79.4	43.5	***

Note: APP=Advanced Practice Provider, SD=standard deviation, ICU=Intensive Care Unit.
[a] Significance of ANOVA and x^2 test determining the association between listed predictors and job role.
[b] x^2 test
[c] ANOVA
*p <.05, **p<.01, ***p<.001

Stress due to heavy workload (p<.001), increased job demands (p<.001), rapid change (p<.001), working remotely (p<.001), unsureness of skills when being sent to an unfamiliar environment (p<.001), high risk of exposure (p<.001), and treating COVID-19 patients (p<.001) was associated with the job role. Nurses reported the highest percent of stress because of increased job demands (66.4), rapid changes (67.3), and being sent to a different unit where they are unsure of their skill proficiency (26.2). Clinical support staff members reported the highest percent of stress due to heavy workloads (55.4) and treating COVID-19 patients (21.4). Meanwhile, APPs show the highest percent of stress associated with a high risk of exposure to COVID-19 (52.6). Whereas Administrative and Other workers had the highest percentage of working remotely stress (33.6). COVID-19 exposure was associated with job role (p<.001). APPs reported the highest rate of exposure (74.0), followed by Nurses (69.2), Physicians (66.7), and Clinical support staff (54.5).

The stress caused by income reduction (p.<001), fear of job loss (p.<001), and furlough (p<001) was associated with the job role. Administrative and other staff showed the highest percent of major stress because of the fear of job loss (54.2%) and furlough (17.5%). APPs reported the highest rate of stress due to a reduction of their income (72.1%).

Table 2 includes the percentage of employees who supported pay cuts suggested in our survey by job role. Almost half of all healthcare employees supported lower compensation reductions for those working physically with patients infected with COVID-19 (49.3%) or any patients (45.8%). The majority of physicians (55.1%; 55.8%), nurses (52.3%; 51.4%), APPs (60.4%; 66.2%) preferred these arrangements, compared to roughly one-third of administrative and non-clinical employees. Administrative or other workers showed low support for any of the suggested compensation reduction options. 33.3% supported lower reductions for employees working physically with patients and 37.5% favored lower pay reductions for those working physically with patients infected with COVID-19. Support for lower pay cuts for workers who work physically with patients varied by job role (p<.001 Support for a lower pay cut for healthcare employees working specifically with COVID patients varied by job role (p<.001). Five percent of all participants supported equal compensation reduction regardless of the employee's productivity. This was the least supported option across all groups.

Table 2. Healthcare Workers' Compensation Reduction Preferences by Job Role

	Administrative or Other (N=240)	APP (N=154)	Clinical Support Staff (N=112)	Nurses (N=107)	Physician (N=138)	Total (N=751)	*p* [a]
Graduated percentage reduction regardless of productivity %	34.6	16.2	20.5	15.9	34.8	26.1	***
Lower pay cut for people working physically with patients %	33.3	60.4	64.8	52.3	55.1	45.8	***
People working the most should take the lowest cut %	31.7	46.1	37.5	40.2	42.8	38.8	*
Same percentage reduction in pay regardless of productivity %	7.9	5.2	2.7	3.7	2.9	5.1	
Lower pay reduction for those working physically with COVID patients %	37.5	66.2	41.1	51.4	55.8	49.3	***

[a] Significance and x^2 test determining the association between listed predictors and job role.
*p <.05, **p<.01, ***p<.001

Table 3 presents the odds ratios (OR) and standard errors (SE) of an ordinal logistic regression model predicting their perceived inequity of the salary cuts. Employees with higher resiliency (OR=1.607, p<.05) had higher odds of seeing the pay cut as an inequitable administrative measure. Employees who felt the stress of being at a high exposure to the virus (OR=1.607, p<.05) and treating COVID-19 patients (OR=1.906, p<.05) had higher odds of perceiving inequity in the implemented pay cut. However, higher perceived organizational support (OR=0.722, p.<.001) was associated with lower odds of perceiving inequality with the implemented pay cut. Indicating reduction in income as a major stressor (OR=2.13, p<.001) was associated with higher odds of seeing the pay cut as an inequitable administrative measure. Female healthcare workers were less likely to see the implemented pay cut as inequitable (0.670, p<.05).

Table 3. Ordinal Logistic Odds Ratio (OR) for Perceived Inequity in Pay Cut (N=751).

	OR (SE)
Job role (Ref = Administrative or Other)	
APP	0.731 (0.199)
Clinical support staff	1.313 (0.341)
Nurses	1.638 (0.421)
Physicians	0.628 (0.172)
Work Location (Ref = Administrative or Other)	
Ambulatory	0.752 (0.190)
ICU	1.214 (0.395)
Non-ICU	0.888 (0.230)
Surgery/Procedure	0.868 (0.278)
Resiliency	1.145 (0.067) *
Moral distress	1.087 (0.059)
Heavy workload stress	0.999 (0.169)
Increased job demands stress	1.011 (0.172)
Rapid change stress	0.996 (0.156)
Working remotely stress	0.996 (0.204)
Scope of practice- unsure of adequate skills stress	0.960 (0.218)
High risk of exposure stress	1.607 (0.344) *
Covid exposure	1.414 (0.318)
Treating COVID patients stress	1.906 (0.560) *
Perceived organizational support	0.722 (0.022) ***
Fear of job loss stress	1.015 (0.152)
Reduce income stress	2.137 (0.352) ***
Fear of furlough stress	0.657 (0.156)
Female	0.670 (0.110) *

Robust estimators used.
Note: OR = Odds Ratio, SE = Standard Error, Ref=reference, APP = Advanced Practice Provider, ICU = Intensive Care Unit
*p <.05, **p<.01, ***p<.001

Below is a series of quotes representing each employee group, which reflect the sentiments captured quantitatively.

"Anyone that works directly with patients affected by a pandemic shouldn't have to take a pay cut at all. They are putting their lives at risk." - Administrative/Non-Clinical Employee

"The lack of respect to those who worked the frontlines is astonishing... Happy to take my 7% cut and give it to my nurses and techs in the OR, I tried to absorb my CCNs cut because she worked the whole time right by my side and was told I couldn't do that."- Physician

"Giving us incentive pay for risking our health and lives every day instead of pay cuts… Many of my co-workers are looking for other jobs. The pay cut was a huge slap in the face for us. It was the "straw that broke the camel's back" for many." - Clinical Support Staff

"I do not believe those directly working with COVID patients should receive a pay reduction, as we were forced to change our lives both at work and at home with our families and not given much of a say in the matter." - Nurse

"It is unfair that people who have worked consistently have taken the same pay cut as employees with reduced work hours." -APP

Discussion

This survey study was conducted in a large academic healthcare system to evaluate factors associated with perceptions of injustice or inequity in how compensation reductions were implemented among healthcare workers during the financial uncertainty that occurred in the early phases of the COVID-19 pandemic. Overall, the majority of the participants in each job role either disagreed or were neutral in their belief that the compensation reductions were fair, transparent, and equitable. There was a greater perception of inequity of the salary reductions among clinical support staff, followed by nurses, APPs, and physicians, while fewer administrative and non-clinical employees disagreed with the salary cuts. This is expected, as the majority of clinicians believed that those working physically with patients or physically with COVID-19 patients should take the lowest pay cuts. On the contrary, less than 40% of administrative and non-clinical employees believed those were the best options. Therefore, the gap between what was perceived to be most fair and equitable—essentially sparing the frontline caregivers—and the method that was actually chosen was much wider for the clinical employees. Further analysis indicated that it is likely differences in the features of work, rather than job role or work location which explains differences in perceptions of inequity. The results of the multivariate regression models indicate that those reporting major stress related to high risk of exposure and treating COVID-19 patients had higher odds of believing that the pay reductions were inequitable, regardless of role. The employees directly involved in patient care were more likely to experience these stressors compared to administrative and non-clinical employees or clinicians that transitioned to delivering predominantly telehealth appointments. This is consistent with the tenants of distributive justice, that those with the heaviest burdens and highest risk believe they should get the greatest rewards.

Our results also indicated that greater perceived organizational support was associated with reduced perceptions of inequity. One possible explanation is that those that believed that the organization supported them were more likely to believe that the organization would act in their best interest by implementing a fair, transparent, and equitable pay reduction. In a sense, the organization may have built up a buffer of support and trust that may have protected against negative perceptions regarding the pay cut. An alternative explanation is that the perception the pay cut was unfair actually decreased the perceived support from the organization. While the

cross-sectional nature of this study does not allow the directionality of these relationships to be definitively determined, it suggests that leaders must be attentive to how these decisions may influence an employee's overall sense of being supported by the organization.

Greater resiliency was associated with an increased perception of unfairness. This seemingly paradoxical finding may be explained in a number of ways. Our clinical groups had higher resiliency scores compared to administrative and non-clinical employees. Simultaneously, these groups also demonstrated a greater number of stressors, including being more likely to feel stressed about being at high risk of exposure and treating COVID-19 patients, and tended to prefer pay cut models that did not affect frontline clinical workers. Therefore, it is likely that this relationship may be explained by greater resilience scores among the clinical population, but also greater stressors and a larger gap between which payment arrangements they perceived to be fair and what was chosen.

Respondents reporting that the reduction in income was a major stressor were also more likely to believe the pay cuts were unfair. Distress from reduced income was reported in over 70% of nurses and APPs, and nearly 60% of clinical support staff. These roles often make less than physicians and administrative leaders and thus may have been more impacted by the financial strain of the compensation reductions. Those who felt the negative impact of the financial reductions in their personal lives may have been more likely to perceive them as unfair. Even though the highest earners took the greatest cuts, they may have also had more of a financial cushion built up to absorb the income reduction while being able to maintain necessary expenses. A person's scarce financial resources prior to the cuts may have altered the response from being a frustrating pay reduction to a life-altering change that could impact their ability to meet daily needs.

Lastly, females were less likely to perceive the salary cuts as inequitable, irrespective of their category of work. There are several possible explanations for this relationship. For women in the workforce, there may be numbness to perceived injustices in pay. There is broad evidence of a gender gap in salaries between men and women working in healthcare and this has been attributed to continuity of historically low base pay, overt and implicit bias, and change in cultural perceptions regarding women's role and career aspirations after having children.[39] Because the gender pay gap is so widespread, females may have interpreted the pay cut as just one more in a long line of examples of unfairness in pay, relative to their male counterparts. The lower likelihood of perceptions of unfair pay in this context does not indicate a positive attitude towards salary cuts, but perhaps a reluctant acceptance of the status quo in disparity in pay differences between men and women in healthcare.

Implications for Practice

This study has several implications for practice. First, leaders need to understand what factors are associated with perceptions of inequity in their decision-making. Reducing perceived inequity is critical to maintaining the well-being and productivity of the workforce. In accordance with prior research on distributive justice, people who have the greatest risks and burdens expect the greatest rewards. In the context of compensation cuts, healthcare workers with higher risks of exposure and those treating covid patients likely expect to receive greater compensation/ lower

pay cuts. This must be balanced, however, with minimizing the impact on those that may endure financial hardship because of compensation reductions. This can potentially be extended to other resource allocation decisions within healthcare. For example, employees with the greatest job demands and risks will likely expect prioritized access to other scarce resources like personal protective equipment (PPE) and early access to vaccines. When perceptions of job demand and just rewards relative to actual rewards are unequal, perceptions of inequity are likely to persist.

Additionally, leaders must be inclusive in their decision-making, even when time pressures and constraints abound. In the healthcare organization featured in this study, leadership communicated frequently that they wanted the pay cuts to be fair, transparent, and equitable. Additionally, they attempted to engage physicians in discussions regarding physician compensation preferences. However, the results from Table 2 demonstrate that there is wide variation in what is perceived as equitable and that these perceptions vary among groups. While most clinicians favored an arrangement that accounted for their increased exposure to COVID-19 and contact with patients, the implemented solution only took current salary into account. By gathering diverse perspectives from all stakeholders, leaders can better identify what arrangements will meet their stated goals of equity. To do so, organizations must have routine listening mechanisms in place to gather rapid feedback from a broad range of stakeholders, such as internally developed and rapidly deployable pulse surveys. However, the complexity of organizational designs and constraints may be a barrier to implementing desired solutions in a rapid timeframe.

Conclusion

The financial uncertainty brought by the COVID-19 pandemic forced healthcare systems across the country to reduce pay, furlough staff, and implement other cost-saving measures. This study has highlighted the differences in pay reduction preferences and perceptions of inequity across various healthcare groups. Leaders must consider the tenets of distributive justice when making allocation decisions of scarce resources. Engaging with a broad array of stakeholders prior to implementation can help leaders avoid creating perceived injustice, while also potentially building trust and perceived organizational support. Overall, close attention must be paid to differences in job demands and risk when allocating scarce resources to avoid violating the tenants of distributive justice and increasing perceptions of inequity.

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