by Nancy Waters

Toward a Family-Friendly Workplace

The Radcliffe Public Policy Institute recently completed a year-long joint pilot project with the Fleet Financial Group, the country's eleventh-largest bank holding company, to determine if work reorganization designed to enhance employees' quality of life could also improve a company's bottom line. A team of researchers, led by institute director Paula Rayman BI '86 and former RPPI Matina S. Horner Distinguished Visiting Professor Lotte Bailyn AM '53, PhD '56, worked at two Fleet sites: a retail, small business banking unit in Framingham, Massachusetts, and a financial reporting and management information systems unit in Providence, Rhode Island.

In Framingham, surveyed employees expressed concerns about long commutes, difficulties in scheduling work loads, and burdensome administrative tasks that took underwriters away from their primary job duties and created overtime demands. To address these issues, certain administrative tasks were reassigned, freeing up more time for underwriting. A revised system for assigning and monitoring the status of loan underwriting, which facilitated workload management, and a small telecommuting experiment were also undertaken.

In Providence, employees were concerned about integrating the accounting and computer systems of recently acquired banks and the growing demands for faster, more sophisticated reporting. To address these issues, flex-time and telecommuting were introduced. Report request forms were also revised, giving employees more information about internal clients' reporting needs at the early stages of a project.

Results from both sites of the Radcliffe/Fleet project demonstrated that attention to quality-of-life issues can be beneficial to a company's bottom line. For example, work reorganization efforts were rated highly (eight on a scale of one to ten) by both supervisors and employees. At one site, there was a 35 percent reduction in the number of employees reporting incidents of insomnia and other sleep disturbances after the experiment was implemented. Employees also gained a heightened sense of control over their work, had more quality time to spend with their families, and felt better able to integrate their work and family lives. In addition, turnover rates for employees participating in the pilot projects were lower than those for other employees.

Nancy Waters is outreach and publication coordinator at the Radcliffe Public Policy Institute.

by Deborah Stone

A Sure Fix for Managed Care

Managed care had great promise. It was supposed to make medicine more efficient and to use the savings to buy insurance for some of the millions of people without it. Things haven't worked out that way. Managed care has its own inefficiencies, and the number of uninsured people has grown, not shrunk. But I've got a plan to recoup money from the very inefficiencies of managed care and put it to work insuring people.

First, let's understand the problem. Managed care has indeed reduced expenditures on health care, but how?

Some of the savings come from reducing unnecessary care. Other savings come from care denied. We'll never know how much, because no one keeps statistics on how many people should have had care but didn't, and then paid dearly in illness, pain, or death.

Still other savings come from delayed payments and bureaucratic runarounds. They're all tiny, but there are millions of them. Every extra day an insurer gets to keep somebody else's money in its bank account earning interest, that's a savings — if not a gain — for insurers, though not for the rest of us.

Last March, for example, I had surgery. I got all the appropriate referrals and made sure my HMO had "preauthorized" the surgery. Now I start receiving bills. The HMO, I learn, refuses to pay, claiming there was no referral. The surgeon's office has copies.

Three phone calls and one letter later, I sit back and take stock of all the costs of my HMO's bungle. One hour of my time. Five minutes apiece for the customer rep at the HMO, the billing clerk at the hospital, and my surgeon's assistant. Five minutes for my internist's assistant, and another five for her to read my letter and sign duplicate referrals.

I had to make these calls between nine and five, so my employer lost an hour of my time, for which it paid not just my salary but social security taxes and benefits. Although I have a professional job and won't get docked for my time on personal business, I will have to catch up on my work one evening this week. No one's going to pay me or my family for that time. And I'm sure today's calls and letter are not the end of it.

Then there are the costs to the surgeon and hospital of carrying these debts on my behalf.

These are all expenditures that aren't buying medical care. That's just how the industry wants it. Health insurers judge their fiscal health by a measure known as the "medical loss ratio." It's the portion of their revenues they "lose" by having to pay for our medical care.

So here's my plan: Every time an insurer causes a patient or doctor to spend time or money chasing down a bureaucratic delay, the insurer should have to pay a flat fine — let's say $100, which I figure is a conservative estimate of the social costs for a trivial runaround such as mine. These fines would go into a public fund to buy health insurance for people who don't have it.

A patient or doctor could send a copy of the correspondence for any hassle to a public ombudsman. The fact that somebody had taken the trouble to send a letter would be all the evidence the ombudsman needs to slap a fine.

With the money in the public kitty, the uninsured could buy into Medicare. Medicare certainly has its share of bureaucratic hassles, but at least it "loses" over 95 percent of its revenues to medical care, compared with only about 70 to 85 percent for most other insurers.

Before managed care, the story goes, nobody had the proper incentives to be efficient in health care. My plan should give insurers plenty of incentive to get their act together. And at least doctors, patients, employers, and hospitals would know that our forced contributions of time and money were being used to help people who needed medical care instead of insurance companies.

Deborah Stone is the 1997–99 Matina S. Horner Distinguished Visiting Professor at Radcliffe.