



Representing Wayne State Faculty and Academic Staff

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Critical Condition: The Detroit Medical Center and WSU

Charles Parrish, AAUP-AFT President

The Detroit Medical Center, in case anyone has not heard, is presently facing a financial crisis of considerable proportions. Dr. Albert Porter, its Director, has stated that by the end of the year both Hutzel Hospital and Detroit Receiving may have to be shut. In the meantime, DMC management has announced it will close about 300 beds in the two hospitals and lay off up to 1,000 employees.

Porter has publicly described these drastic measures as a "tourniquet" rather than a long-term fix for the DMC's growing budget deficits. There is considerable debate among WSU medical faculty about whether the closings might seriously damage the Center's national reputation and its access to present and future research grants, but there is little disagreement that the system is in a profound crisis. The DMC reported losses of \$80 million in 2002 and \$400 million over the last six years, much of it related to providing healthcare for about a quarter of Michigan's poorer citizens. Dr. Porter says that Medicaid, the state-federal program for the poor who qualify, reimburses the DMC for less than the cost of the care provided by its affiliated hospitals. Further, the DMC provides uncompensated care for the many uninsured poor patients who do not qualify for Medicaid. Together, these uncompensated costs and Medicaid shortfalls totaled \$130 million in 2002 according to published accounts.

In large part, the DMC's financial crisis reflects the severe problems in our nation's healthcare system. The number of uninsured people nationwide now totals more than 40 million, and the current policy agenda in Congress and the White House favors tax cuts for the wealthy over funding for healthcare and other social programs. The DMC, like other urban healthcare systems, is left reeling and threatened with bankruptcy.

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The DMC and WSU

Why is this important to members of the Wayne State community?

First, we should be concerned as citizens about the threat to the healthcare of the poor of our community. Healthcare for our impoverished citizens is already uneven in the best of circumstances. If the DMC hospitals begin to close their doors, it is difficult to see how or where they will get the care they need.

Second, the laid off employees will become a further burden on the economy of the city and the state.

Third, we need to be concerned because the fate of the Wayne State School of Medicine (SOM) is linked to that of the DMC, and the well being of the University as a whole is linked to that of the SOM. The DMC provides a major source of income to the SOM

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and the physician practice plans through which its faculty members provide patient care in the DMC's affiliated hospitals. The education of both graduates and residents associated with the SOM is primarily dependent on the DMC. If diminished income from the DMC leaves a huge hole in the SOM's budget, we can be sure that there will be demands placed on the budget of the University that will affect units on the main campus.

Fourth, we in the academic union must be concerned because there are a substantial number of our members whose salaries depend on the money that is generated by income from patient services. As revenues shrink, the stability of the system of employment in the SOM will be threatened. The SOM can appoint, under the collective bargaining agreement, clinical faculty members in clinical departments to positions of 25 percent tenure. This was agreed to a decade ago after the Administration argued that its faculty physicians needed to be integrated better into the academic life of the University, but that tenure for them was primarily symbolic as they could easily earn a living in private practice.

Unbeknownst to the union, the SOM administration also began appointing researchers to the faculty in clinical departments with as little as 25 percent tenure. The idea that these researchers can move easily into the private sector in a manner comparable to physicians is, of course, preposterous. The recent threat that the SOM administration would no longer appoint faculty members in the basic science departments to any but joint appointments with clinical departments, with only 25 percent tenure in the latter, focused the issue sharply. Such a practice could transform the SOM dramatically in the future and make tenure, with its attendant protections, irrelevant.

Tenure: Real or Virtual?

The issue of partial faculty tenure, or no tenure at all, in medical schools is one that has generated considerable controversy both nationally and in our own SOM. I served on the National AAUP Committee on Medical School Tenure and we struggled with the variety of tenure approaches across the 100-plus medical schools in the nation. We came up with a proposed policy, but we had the feeling that we were locking the barn door with respect to many of these institutions after the horses were long gone.

Dean Crissman has told the SOM Faculty Senate that a move to a system of 25 percent tenure across the SOM would be desirable. We do not agree. The purpose of tenure is to provide a guarantee of sufficient economic security to faculty members so that they can feel free to exercise their

rights academic freedom in the face of administrative or other coercion. It is difficult to see how 25 percent of one's salary provides any such a guarantee. At less than a 50 percent appointment, a faculty member does not qualify for fringe benefits, such as medical insurance.

Beyond this, one can imagine a nightmare scenario for a medical school administration in which faculty members are reduced in support to their 25 (or even 50) percent and they continue to do just enough to keep their tenure while devoting their principal efforts to making a living elsewhere. The advantages presently seen by the SOM administration in partial faculty tenure could well prove fleeting in such a situation.

Taking all of this into account, in the last round of collective bargaining the union negotiated a new provision in the contract stipulating that the Administration could appoint faculty members with at least 50 percent tenure in the non-clinical departments of SOM, with the safeguard that such an appointment would be permitted only after a majority of the departmental faculty agreed to it. The union has filed a grievance against the practice of appointing non-clinical faculty with 25 percent tenure in clinical departments and we will see the issue settled before a neutral arbitrator in the near future.

Equal Sacrifice

Regardless of whether faculty members are on partial tenure, or have contracts that have no tenure attached and are subject to subsidy condition, they must be treated fairly. This becomes all the more important in a period, such as now, when jobs and institutions are in jeopardy.

Recently we encountered cases in which research faculty members have had their appointments reduced. The impression has been that these decisions were made by administrative fiat and were not always consistent with past policies. It is well accepted that a bargaining unit member appointed with a subsidy-conditioned contract can be terminated when, and if, the grant or other source of income that supports the salary disappears. A problem arises when the source of the subsidy is not eliminated, but reduced. The sources of subsidy for most faculty researchers are grants and a number of such researchers derive parts of their salaries from different grants

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Healthcare Hassles

AAUP-AFT Files Grievance Over Benefit Snafus

Mary Cay Sengstock, Grievance Coordinator
Allen Goodman, Executive Board

In March and early April, the AAUP-AFT began to receive a number of complaints from bargaining unit members about healthcare benefits. Some members attempting to obtain treatment were told they had no healthcare coverage. Others who purchased prescription drugs were charged amounts that were higher than the approved co-payment negotiated by the union. Others attempting to access their flexible spending accounts for uncovered items (such as chiropractic care) were told they could not access the accounts because it was not clear whether or not the item was covered by their normal health insurance.

As these complaints mounted and as the union confirmed the many hassles that members were experiencing, we filed Grievance #231 on behalf of the entire bargaining unit. The grievance states that the Administration has not provided the contractually required health insurance and requests that the University immediately contact all medical insurance companies to insure that bargaining unit members have the coverage to which they are entitled. The grievance also asks that employees have access to their flexible spending accounts and that bargaining unit members be reimbursed for any losses they suffered as a result of these health insurance problems.

Collaboration or Conflict?

To the best of our knowledge, the Administration is as anxious to resolve these problems as we are. However, the union is concerned that the Administration's recent collaboration with the AAUP-AFT in efforts to protect benefits and control costs is flagging. The benefit hassles outlined above are only part of the problem.

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or from other funds. In other cases, researchers are well funded for a number of years, but then run into funding droughts due to various factors. Priorities at funding agencies may shift, for example, and leave a researcher scrambling for grants. The SOM has recognized this and, in the interest of maintaining continuity and loyalty among its faculty researchers, provided bridge funding for those in such a situation from funds generated by the practice plans or other sources.

We are well aware of the difficulties that are faced by the SOM and we would like to be able to contribute to the efforts to address them. But, where our members find their salaries reduced, or eliminated entirely, without following past policies for the allocation of bridge funding, the union has a deep concern. I have written a letter to SOM administrators in relation to this issue asking for information that is needed for us to proceed on this issue.

It behooves all of us who can play a role in assuring the stability of the employment system in the SOM to do everything we can to help the situation. The solution must be found in a fair and equitable system in which the sacrifices that must be made are shared fairly.

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Since 1999, the AAUP-AFT and the Administration have engaged in an ongoing procedure to discuss healthcare benefits. As part of this process, we established "2N" committees (made up of equal numbers of union representatives and administrators) to generate fact-finding reports and proposals for the contract negotiations of 1999 and 2002.

By 2002 it was clear that, with escalating health care costs, we could keep free office visits and extraordinarily low (\$1 and \$2) employee co-payments only if we were to take zero salary increases. In the negotiations, we therefore agreed to \$10 copays for office visits and a tiered drug co-payment system of \$5 for generic drugs and \$10 for brand-name drugs. In return, we expected reduced premiums, of which employees pay a portion (under the terms of the collective bargaining agreement, the university subsidy for health insurance ranges from —% of premium costs in the case of Omnicare to —% for HAP and —% for Blue Cross-Blue Shield). Moreover, the Administration agreed to begin taking the employee's share of healthcare benefits out of his/her "pre-tax" dollars, instead of deducting them from netpay. With income taxes withheld on a smaller base, the government in

effect would subsidize some of the health care benefits that were being paid out of pocket. The changes were to go into effect on March 1. In addition, another 2N committee was to be constituted to address additional ways to limit healthcare cost increases.

Implementing this agreement has been a problem. As noted above, there have been multiple errors in the charging of co-pays, and some members have even been told by their providers that their insurance has lapsed. Others have been charged fractional copayments for drugs that were not in a "formulary" (list of allowed drugs), even though no formulary arrangement had been negotiated. The pre-tax withholding of medical benefits has not yet been implemented, even though it was supposed to occur as of March 1. Moreover, the administration has asked that we cancel future 2N committee meetings "until further notice."

These are not welcome signs for continued partnership. For the time being, Grievance #231 is our response. Hopefully, we will soon be able to report a renewed effort at collaborative approaches to the ongoing crisis in healthcare costs.

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