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# Paving a Path to Privatization: The History of Health Care in Detroit

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## **Abstract**

The aim of this study is to provide insight into the privatization of the public Detroit General Hospital. The reasoning and objections behind giving the only public hospital at the time to a private company are examined. The benefits of privatization were more efficient care, less costs for the city government, more up-to-date equipment, and more competition between hospitals (which supposedly would lead to better health care). However, health care has become more expensive; there has been a loss of public jobs, disassembling of unions, and a larger health equity gap. In addition to this assessment, an evaluation of the Detroit safety net and the Urban Health Equity Response Tool with Community-Based Participatory Research are discussed. This is to better understand the health disparities among residents of Detroit. As a whole, Detroit is in one of the best situations to learn from its mistakes in order to better its future. The results of tools aimed at accessing the gap between the uninsured and access to quality care can contribute to conversations on how to improve resident well-being in the city of Detroit.

*Keywords:* Detroit, Michigan, Health Care, Health Equity, Community-Based Participatory Research, Detroit Safety Net, Detroit General Hospital

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## **Introduction**

In the early 1900s, due to the boom of the automotive industry, city-planners within Detroit were sensing a rapid growth in the city's population. With the influx of families moving next to the city factories, it was time for Detroit to acquire better health care measures to accommodate the new residents.

In 1909, the Detroit General Hospital Association was founded to build a public general hospital. At the time of this association's inception, Henry Ford was in the midst of developing what would be known as the Ford Highland Park Factory. While combating the "inefficiency" of the car-making process through his development of "Fordism," Henry Ford also believed that it was time he contributed to combating the inadequacies and resulting "inefficiencies" of health care in Detroit. However, due to the fact that the hospital's construction was a public enterprise, even a sizable contribution from Ford would prove inadequate. In 1914, the project stalled due to the lack of funding and the foundation of the building was left incomplete for eighteen months. As a result of this delay, the recommendation was made that the City of Detroit replace the Detroit General Hospital Association in completing the project. However, this resolution did not satisfy Henry Ford; he was an advocate for individualism and did not want a public entity to restrict the city's access to health care. It was due to this mindset that the idea for the Henry Ford Health System came to light.

In 1923, Henry Ford made the memorable statement, "Be ready to revise any system, scrap any method, abandon any theory, if the success of the job requires it" ("Henry Ford Quotes" sec. 25). While Henry Ford was more experienced in car-making than in health care, he believed in his vision for the city and was committed to making it a reality. In 1915, he took over the rest of the project for a general hospital in Detroit and by September 20 of that year, he elected his board of trustees, making himself the president and his son, Edsel Ford, the vice

president. In October of that year, on West Grand Boulevard at Hamilton Avenue, Henry Ford Hospital was completed, and its first patients admitted. To keep the hospital running in its early years, the Ford family would pay off any of its monetary deficits. While Henry Ford was one of the first to implement scientific management into the motor industry, he was also the first in the country to implement what was known as a “closed staff system” (“Encyclopedia of Detroit” par. 2). This meant that after Ford personally employed the physicians, the salaried employees could only work for Henry Ford Hospital. Ford’s philosophy for the hospital was to place “a strong emphasis on outpatient treatment” and stress “the importance of preventative care to help avoid chronic or life-threatening illnesses” (“Encyclopedia of Detroit” par. 2). Currently, the Henry Ford Health System has thirty medical centers, and is “the eighth largest employer in the state... responsible for over three million outpatient visits every year” (“Encyclopedia of Detroit” par. 6).

At a time when Ford was revolutionizing both automation and health care, the demographics of Detroit were quickly shifting. From 1910 to 1930 alone, it is estimated that over one million African Americans migrated from the rural south to the industrialized north. The reason for this migration has been attributed to several factors common to immigrants of the time, including increased employment opportunities and higher wages. Additionally, the African American migrants of the time “believed that the new labor markets in the North would provide the social, economic, and political freedom that did not exist in the South” (Bailey 721). However, when these immigrants arrived, they began to realize that their expectations might not become reality. For instance, Detroit accommodated the 120,000 African American residents of the time with only 1% of the city’s housing. In addition to the relatively small amount of neglected space allotted for the African American residents of Detroit, there was also a large

number of occupants per household and a poor sewage system. As Eric Bailey states in “Health Care Use Patterns Among Detroit African Americans: 1910-1939”:

The deplorable unsanitary conditions of the Lower East Side, sarcastically referred to as Paradise Valley, provided an excellent environment for a variety of diseases to propagate...The most prevalent causes of death among African Americans included pneumonia, tuberculosis of the lungs, heart disease and syphilis... In addition, African Americans had a relatively high infant mortality rate (54.7 deaths per 1000 births).  
(Bailey 722)

With the high prevalence of disease among the African American residents of Detroit came the lack of adequate health care facilities. In 1918, the Dunbar Memorial Hospital Association was formed to address issues of sanitation and maintain a hospital and school of nursing. The hospital was able to combat the fact that many hospitals refused to admit African American patients by hiring African American physicians and providing health care and jobs in medicine to this community minority. Other projects instituted to increase this population’s access to health care included a 23-bed facility known as Mercy hospital, that was founded in 1916, and a project conducted by the Board of Health to increase awareness of preventative measures to combat illness (Bailey 722). As a result of these initiatives, the increased number of African American physicians were able to provide direct relief to an otherwise underrepresented community at the time.

While the creation of the Henry Ford Health System as a non-profit and the initiatives geared toward minority communities were initially beneficial additions to the city, the privatization of Detroit General Hospital under the private Detroit Medical Center is a process remembered for its detrimental consequences to the residents of Detroit. The narrative begins in

1913, when there were not enough health care services for the sick poor residents. To resolve this, the Board of Poor Commissioners constructed the first unit of the Detroit Receiving Hospital, which in 1933 would be known as the Detroit General Hospital. However, after criticism from Detroit voters on the Welfare Department controlling the hospital, “the 538-bed Receiving Hospital, its branch, the Redford Receiving Hospital, ... and the City Physician’s Office were transferred to the Health Department” (Bukowski par. 5). This meant that from 1948, the Health Department had a monopoly over all hospitals in Detroit that were city owned. As a result of the hospitals being governed under the discretion of this department, the Detroit General Hospital was put on the path to privatization.

### **Background**

In 1976, a proposal was made to give control of the Detroit General Hospital over to the Detroit Medical Center (DMC). As this proposal was the first of its kinds in any major city, it was not taken over well by Local 457, an organization that represented workers at the Health Department and the Detroit General hospital with over 1200 members. From 1977-1980, in a coalition with the United Automobile Workers Local 3 which represented Dodge Main plant workers, Local 457 President Hazel Edwards launched a campaign known as “Save Detroit General Hospital.” In their fight against privatization, the organizers warned that if Detroit General was given to DMC and Dodge Main shut down, then the city would be in jeopardy. It was the jobs for the public employees that benefited Detroit’s economy. Workers were afraid that these private businesses would refuse to allow unions in their companies and not allow the employees to fight for their rights. As part of this campaign, a petition with tens of thousands of signatures from Detroit residents, to prevent privatization, was given to City Clerk James Bradley to put on the ballot. However, despite having enough signatures, the proposal to put the

question on the ballot was rejected, due to it containing “budgetary matters.” Ultimately, Detroit’s city council had the authority to make the final decision and voted “yes” to turn over the only public hospital in Detroit, the Detroit General Hospital, over to the Detroit Medical Center (DMC). It was after this take-over that the Local 457’s fears became a reality: DMC disassembled the union and got rid of its public jobs. More specifically, according to Diane Bukowski of the “Voice of Detroit: The city’s independent newspaper, unbossed and unbought,” “city jobs were contracted to private workers with no pensions attached, and the Department became a shell of its former self” (Bukowski par. 18). It was more recently, in late 2010, that the Detroit Medical Center officially became a for-profit hospital system as it was taken over by Vanguard Health Systems Inc. In this transaction, Vanguard claimed that it was committed to “continue providing charity care, to make substantial capital investments in projects at DMC’s main campus, and to assume responsibility for DMC’s heavy debt obligations” (“Detroit Medical Center” par. 1). The claims echoed those of other proponents of privatization, including the idea that it could lead to more efficient care, less pressure on the city government, and more up-to-date equipment. However, as Diane Bukowski of the Voice of Detroit highlighted, without this last public non-profit hospital, Detroit’s poor residents were left to battle more health disparities than ever before; further widening the gap between having access to and not being able to afford care.

## **Discussion**

One of the measures implemented to combat health disparities among racial and ethnic minorities involved evaluations of what is known as the Detroit safety net. According to a report given by the Detroit Health Care Stabilization Workgroup in 2003, “59% of Detroit’s population has an income below the 200% federal poverty level, as compared to 26% of Michigan’s

population” (“Strengthening the Safety Net in Detroit and Wayne County” 3). As a result, a majority of these individuals rely on “safety net” services that provide “high quality, cost-effective health services for people who are not eligible for insurance and people eligible for state or county insurance programs” (“Strengthening the Safety Net in Detroit and Wayne County” 5). In 2004, a research team made of members from The George Washington University Medical Center, School of Public Health and Health Services, and the university’s Department of Health Policy collaborated with Detroit hospital staff and Detroit community partners to examine key issues in the safety net that could be causing the wide gap between uninsured Detroit residents and quality health care. What they found was that the number of hospital health care services available had been on the decline. For instance, “more than 1,200 hospital beds have been closed in the city of Detroit since 1998” and “more than 4,400 hospital full-time positions have been lost” (Regenstein et al. 10). As hospital chains continue to follow insured patients into the wealthier suburbs, Detroit is left disproportionately uninsured, underserved, and with a safety net in a pressured and fragile state.

Deindustrialization had left a long-lasting mark on the city. Increased job unemployment, disinvestment, and racial tensions consequently caused upper class families to move away from Detroit and into the suburbs. It was the resulting downfall of Detroit from its symbol as a major city that contributed to the health inequities of “lack of access to employment and stable housing, healthy foods, health care, and clean environments; all determinants linked to negative health outcomes like asthma, cardiovascular disease, and psychological distress” (Mehdipanah et al. 662-663). As for primary care in the early 2000’s, health inequities continued to arise due to a lack of financing care for the uninsured. As working families were continuing to move out of the city, the economic and tax base continued to shrink. Hence, it had become difficult to maintain a



sustainable health sector that had the ability to support a strong safety net for the uninsured. As many business-oriented health care facilities chose to follow these privately insured families into the suburbs, they left behind patients that were relying on their primary and specialty care services. Some of the only remaining high quality primary care provided for the uninsured of Detroit come from Federally Qualified Health Centers: examples including the Community Health and Social Service Clinic (CHASS), the Detroit Community Health Connection (DCHC), and Detroit Health Care for the Homeless. However, with only “about 8 percent of the total uninsured population in the county” (Regenstein et al. 11) utilizing this resource, the capacity for care is still well below the needs of many.

Currently, as the need for addressing health equity gaps in Detroit is becoming increasingly pertinent, there has been an implementation in 2017 of a new tool to better understand and combat the health disparities of Detroit. Known as the Urban Health Equity Assessment Response Tool, or Urban HEART, it “combines statistical evidence and community knowledge to address urban health inequities” (Mehdipanah 663). As Detroit was the first city to implement this tool in the United States, its goal was to recognize some of the disparities that are most prevalent in the city using statistical evidence and community input. For the community aspect, a community-based participatory research (CBPR) partnership was used and “made up of community-based organizations, health service providers, and researchers based in academic institutions” (Mehdipanah et al. 662). The purpose of this partnership was to effectively promote health equity through a unique historical, economic, sociopolitical, and geographic context that only native Detroit residents would be able to have insight upon. Created by the World Health Organization (WHO), the Urban HEART focuses on five main areas: “physical environment and infrastructure, social and human development, economics, governance, and population health”

(Mehdipanah et al. 663). The community team chose indicators based on these five main areas to measure in the city, assembled data to access the indicators, generated evidence to present to facilitators of change in the city, prioritized certain equity gaps, and identified the best response to those gaps. Through this collaborative process, some of the indicators identified were the percent of children living in poverty, the percent of individuals without a high school education, and the percent of the population that was unemployed. However, due to the request of the community team, the names of these indicators were changed to promote a more asset-based portrayal of Detroit. This is because the members of the community team pointed out that Detroit is always portrayed in a negative light within the media. By altering the names but retaining some of their original forms, the indicators would be ones that “reflect strengths or assets within the community wherever applicable” (Mehdipanah et al. 665). The indicators previously mentioned were then changed to reflect positivity: “percent children not living in poverty,” “percent with a high school education,” and “percent in labor force” (Mehdipanah et al. 668). Some solutions to the inadequacies in these areas were then proposed and discussed among the team. Examples of solutions proposed include promoting “subsidized housing to assure parents with low income can use their money on other things to support their children,” “provide hands-on learning, vocational training, and job training while in school,” and “create policies that ensure that a proportion of all new jobs created in the city go to local residents” (Mehdipanah et al. 669). While these proposals have been created by the Urban HEART and CBRP initiative, it is now up to the policymakers and community organizations to make these solutions a reality.

Despite being effective in identifying major health inequities and applicable solutions to these problems, one of the major limitations of Urban HEART is that it can only be used to guide efforts, not create them. However, it is a good start in that it sparks a debate and puts health care

in the foreground of conversations between city residents. As residents spread awareness of their concerns for Detroit health care, more policy makers might be willing to promote the creation of local health clinics and community organizations might be willing to build them for the socioeconomically disadvantaged population.

One clinic in the 1960s, known as the Mom and Tots Center, took this idea of conversation and exemplified the ideals of integration in what was known as one of the first successful examples of community-based participatory *care*. The founder of this center, Nancy Milio, had a goal to keep the community as an integral element of the clinic. Due to the implementation of a plan to achieve this goal, the Mom and Tots Center was one of the only buildings to survive the Detroit riot of 1967, despite the surrounding buildings being burned down or destroyed as a result of retaliation from factors of housing, deindustrialization, and racial tensions. One reason for the success of Milio's plan for community integration stemmed from her novel approach to combating health disparities. As stated in the article "Addressing Disparities in Access to Care: Lessons From the Kercheval Street Clinic in the 1960s," "In an effort to incorporate the community, Milio staffed the center almost exclusively with people from local neighborhoods" (Deguzman and Keeling 204). In order to accomplish this, Milio was even willing to turn down outside volunteer nurses and students. While she admitted that this decision was difficult for her to justify to others, Milio wholeheartedly believed that:

...if they [the outside volunteers] and I were to put the project together, it would turn out to be *ours*. The project, if it was to be, was to belong to the people it was intended to serve, so *they* had to struggle to shape it and I with them for a while. *Then* it would be theirs. And when it was formed, I too would go. (Milio 31)

One of the members of the Center's staff, Johnnie West, was referred to by Milio as a "translator of culture." As a member of the African American community, she was able to relate to the culture of the patients in ways that the founder of the Moms and Tots Center, Nancy Milio (a white nurse), could not. In the end, it was the non-traditional community-based staff of the clinic that allowed the patients to perceive the clinic as a welcoming, rather than intimidating or imposing, environment. Therefore, in the midst of what would be known as "the largest disturbance of twentieth century America ...[with] forty-three deaths, almost seventeen hundred fires, and over seven thousand arrests" ("Uprising of 1967" par. 1), the Mom and Tots Center proved that neighborhood integration could be the key to solving the problem of ensuring equal access to health care for disadvantaged populations. Examples like this showcase that by having a sustainable and successful model of community inclusion in Detroit, health equity is possible.

### **Conclusion**

Currently, there is a great potential in Detroit for the promotion of health equity. However, the amount of financial resources allocated for this potential to become reality is still lacking. As deindustrialization continues to widen the gap between the uninsured and quality care, it becomes more difficult for Detroit hospitals and Federally Qualified Health Centers to sustain charitable health care services. Through increasing awareness using tools such as Safety Net Assessments and Urban HEART, conversations can continue to bring attention to the communities that have yet to be heard. Now is the time for Detroit's troubled past to lead to a brighter future. City legislators must learn from their mistakes, propose better solutions, and decide how to effectively implement those solutions for the betterment of Detroit as a whole. Through continuing these collaborative efforts, health care in Detroit can someday become accessible for all, especially for those that need it the most.

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