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Health-Care Policy as Urban Policy:

Hospitals and Community Development in the Postindustrial City

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Two Hospitals

On April 8, 2010, Massachusetts Governor Deval Patrick announced that his state would soon receive more than $3.2 million in federal stimulus funding for a program that would train state residents for jobs in health care. "The health care industry is a large part of the economic engine in Massachusetts, and my administration is working overtime to ensure that our workforce has every chance to become competitive in this field," Governor Patrick stated in a news release announcing the grant. Senator John Kerry added a statement to the release as well: "In this slumping economy when so many people are trying to find work, healthcare jobs are more desirable and marketable than ever. This substantial investment means thousands of workers can get the training and skills they need to find rewarding work."[1] Patrick's press release–and the training program that it trumpeted–highlighted the centrality of health care as an economic sector in Massachusetts and around the United States. Nowhere was this more evident than in Boston, the state's largest city, where hospitals constituted six of the ten largest private employers, and health care accounted for more than 17 percent of all jobs.[2] Hospitals, and the health-care sector more generally, had clearly emerged as a key anchor institution for the postindustrial city of the early twenty-first century.

Just three days before Governor Patrick's announcement, however, a different and far less optimistic dimension of the urban hospital's economic role had played out two hundred miles to the south in New York City. On the evening of April 5, the trustees of St. Vincent's Hospital had announced that the venerable but financially troubled hospital would close within weeks. St. Vincent's had been in operation since 1849, and had treated survivors of disasters ranging from the Triangle Shirtwaist Fire to the Titanic to 9/11.[3] More prosaically, it had provided regular free treatment for the poor and uninsured, had played a central role at the height of the AIDS crisis in the 1980s and 1990s, and had pioneered a "midwife-friendly," "minimally-invasive" approach to obstetrical services. St. Vincent also employed 3,500 people–all of whom would lose their jobs. The Village Voice penned an obituary for the hospital, quoting the head of the nurses union, who declared: "We are watching a murder here on Seventh Avenue."[4]

The discordant quality of these two events, occurring within days of each other in Boston and New York, is only heightened by the observation that they took place barely two weeks after President Obama signed the explosively controversial Patient Protection and Affordable Care Act of 2010. The health-care reform bill, however, points to a deep connection between Governor Patrick's health-care training initiative and the closing of St. Vincent's. That critical link lies in the relationship between hospital growth, including employment, and the excessive costs of the wider U.S. health-care system. Hospitals specifically and the health-care sector in general have been one of the few consistent economic growth engines in U.S. cities through the late twentieth and early twenty-first centuries. Typically, hospitals provide jobs at a wide range of skill and educational levels, often with better pay and more opportunities for advancement than other leading urban economic sectors.[5] The sector, quite simply, has been far more successful at promoting long-term urban economic development than most of the strategies put forth by either national-level policymakers or locally-based community development organizations. This is the dynamic, expansive quality that led the Patrick administration to focus stimulus funds on training for health-care jobs. Yet this very success is deeply rooted in the wider dysfunction of the U.S. health-care system, and, in particular, in its inability to control costs while providing universal access for lower-income Americans. Hospital costs are one of the most important contributors to the excessive cost structures that plague the U.S. health-care system. Yet it is these very costs that have facilitated the sector's expansive growth in U.S. cities. St. Vincent's, and its 3,500 mostly urban employees, found itself caught in the deep contradictions of this unstable and unsustainable system–trying to provide health

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1 "Patrick-Murray Administration Awards Over $3.2 Million in ARRA Funds for Training in Healthcare Industry Jobs," Press Release, Executive Office of Labor and Workforce Development, Commonwealth of Massachusetts, 8 April 2010, http://www.mass.gov/?pageID=elwdpressrelease&L=1&L0=Home&sid=Elwd&b=pressrelease&f=arra_healthcare_jobs_training&csid=Elwd.

2 Boston Redevelopment Authority (BRA), *The Boston Economy 2008: Holding Strong* (Boston: BRA, September 2008), 13; BRA, *The Largest Private Employers in Boston: 2001* (Boston: BRA, August 2001), 4.

3 Sharon Otterman, "St. Vincent's Votes to Shut Hospital in Manhattan," *New York Times*, 6 April 2010.

4 Susan Dominus, "With the Closing of a Hospital, Women's Childbirth Options Diminish," *New York Times*, 9 April 2010; Tom Robbins, "R.I.P. St. Vincent's Hospital," *The Village Voice*, 13 April 2010.

5 Marla Nelson and Laura Wolf-Powers, "Chains and Ladders: Exploring the Opportunities for Workforce Development and Poverty Reduction in the Hospital Sector," *Economic Development Quarterly* 24:1 (February 2010): 33–44.

care to people regardless of ability to pay while also depending on flows of revenue from third-party payers desperate to cut hospital costs.[6] As such, the connection between the Massachusetts training program, the closing of St. Vincent's, and cost-control imperatives of health-care reform highlights a central dilemma for the U.S. health-care system, for urban policymakers, and for community development activists.

This paper seeks to explore this dilemma, its history, and, in particular, the contradictions, challenges, and opportunities that it poses for community development in U.S. cities. Are urban hospitals, as Governor Patrick's training programs would suggest, a largely overlooked resource for urban economic development that can provide a ladder of long-term upward mobility for impoverished inner-city communities? Or, as St. Vincent's would indicate, are urban hospitals an anchor that has been dropped into sand, and that may be swept away by the winds of the health-care crisis that has begun to storm across the United States?

The Hospital as Urban Economic Anchor

A brief statistical review provides a measure of the importance of hospitals as urban economic institutions, and especially as employers. According to a study conducted in the late 1990s by Ira Harkavy and Harmon Zuckerman, hospitals were six of the top-ten private employers in Washington, D.C., three of the top ten in Baltimore, and five of the top ten in Philadelphia. Hospitals and universities together accounted for 34.7 percent of jobs in the twenty largest U.S. cities, each of which had at least one university or hospital among its top-ten employers. Five of the cities had four to six of these institutions among their top ten.[7]

More recent statistics derived from the 2002 and 2007 Economic Census demonstrate that the economic centrality of urban hospitals has continued into the new century. They also show that hospitals play a particularly critical role in high-poverty cities. Table 1 lists the ranking of the hospital sector as an employer in both 2002 and 2007 for the twenty-six cities with the highest individual poverty rates in 2007 (and population of at least 250,000).[8] In 2002, hospitals were the top employer in six of the ten highest poverty cities, and in eight or nine of the top twenty-six poverty cities. Hospitals ranked second or third in three additional cities in the top ten, and as many as six more in the top twenty-six. The sector ranked among the top five employers in all but one of the cities–hospitals in Atlanta ranked between fourth and seventh, as data limitations prevented a more precise ranking. The data showed a weak regional pattern as well. All of the cities in which hospitals ranked first or second in employment were located in the Northeast or Midwest, while five of the eight cities in which hospitals ranked fourth or lower were in the South or West (although hospitals also ranked fourth in Chicago, Columbus, and Toledo).

Similar patterns appeared in the 2007 data, with a slight decline in the relative importance of hospitals as urban employers. For 2007, hospitals were the top employer in five of the top ten highest poverty cities and eight of the top twenty-six. The sector ranked second or third for 2007 in three additional top ten cities and five in the top twenty-six. Once again, the sector ranked in the top five in twenty-five of the cities, with Atlanta again ranging between fourth and seventh. The limited regional differences also persisted, as all nine of the cities in which hospitals were the first or second largest employers were in the East or Midwest. Six of the eleven cities in which hospital employment ranked fourth or lower were located in the Sunbelt.

These rankings actually understate the centrality of hospital-related employment, as all of the cities also had substantial numbers of jobs in the category of ambulatory health-care services. Although this category includes employment in doctors' and dentists' offices, it also accounts for outpatient clinics and surgery centers, many of which have close connections to hospitals.[9] Overall, the health-care sector was the top employer in twenty-two of the twenty-six cities in 2002 and in twenty-one of the twenty six-cities in 2007.[10]

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6 Mark Levine, "St. Vincent's Is the Lehman Brothers of Hospitals," *New York Times*, 17 October 2010.

7 Ira Harkavy and Harmon Zuckerman, "Eds and Meds: Cities' Hidden Assets," The Brookings Institution (Center on Urban and Metropolitan Policy), Survey Series, August 1999. See also Timothy J. Bartik and George Erickcek, "The Local Economic Impact of 'Eds & Meds': How Policies to Expand Universities and Hospitals Affect Metropolitan Economies," The Brookings Institution (Metropolitan Policy Program), Metro Economy Series, December 2008; Marla Nelson, "Are Hospitals an Export Industry: Empirical Evidence from Five Lagging Regions," *Economic Development Quarterly* 23:3 (August 2009): 242–53; Nelson and Wolf-Powers, "Chains and Ladders."

8 Rankings are at the North American Industry Classification System (NAICS) 3-digit level; hospitals are NAICS code 621. Twenty-six cities were chosen in order to include New York City; although it ranked twenty-sixth in individual poverty, New York ranked twentieth in family poverty rates.

9 NAICS code 621.

10 This refers to the 2-digit NAICS level, code 62.

These data reflect a core reality of the U.S. economy as the second decade of the twenty-first century begins. Health care accounts for approximately 17 percent of U.S. GDP, and the nation's cities are the central locus of this industry. This reality must be taken into account in developing urban policy and community development strategies, particularly in relation to employment and workforce training. A key step toward doing so lies in understanding the history of the urban hospital sector and its relationship with the wider health-care system.

Urban Policy and the Health-Care Economy

Ultimately, the previous section illuminates a broader trend: as manufacturing has declined in the United States, hospitals have increasingly replaced factories at the core of the urban economy. Such numbers alone, though, tend to obscure another dimension of this change: public policies enabled the physical expansion of urban health-care institutions, and then played a crucial part in financing their health-care and research activities through both direct spending and tax expenditures. The remainder of this paper evaluates the history of these policy interactions and offers a preliminary assessment of their implications for community development strategies in inner-city communities. It starts from a simple premise: that in recent decades, health-care policy has also been urban policy.[11]

Four federal programs contributed to the expansion and modernization of urban hospitals during the post–World War II period, three of them directly and one indirectly. The direct policies included the Hill-Burton loan and grant program, the urban-renewal program, and the Federal Housing Administration's hospital mortgage insurance program. The indirect policy area consisted of the Medicare and Medicaid programs, which reshaped hospitals' financing and operational functions after 1965. Of these programs, only urban renewal was explicitly conceived of as an urban policy. Yet all four created intersections between urban hospitals' roles as providers of medical care–especially for the urban poor–and their increasing importance as anchor institutions in postindustrial cities. It is these intersections that blur distinctions between policy areas to the point where it can be concluded that in the United States, health-care policy has operated as a critical but largely unrecognized form of urban policy.

Hill-Burton is the most widely recognized but, for large cities at least, the least important of these federal programs. Passed in 1946 as the Hospital Survey and Construction Act, the Hill-Burton program was the only part of Harry Truman's 1945 national health-care proposal that actually became law.[12] The program primarily offered federal matching grants for the construction of new hospitals and nursing homes. From 1947 to 1971, it allocated $3.7 billion for hospital construction, which helped support approximately 30 percent of all such projects in the United States. As a result of the program's 2:1 state-local matching requirement, this covered about 10 percent of total hospital construction costs during the period. Initially, however, Hill-Burton focused resources on areas that lacked hospital facilities and did not make grants to regions with an average of more than 4.5 hospital beds for every one thousand residents. Many larger cities, which already had existing hospitals, exceeded this cap. This meant that the bulk of Hill-Burton money went to small communities and rural areas rather than cities. Cities with populations greater than 250,000 received only about 13.3 percent of Hill-Burton funds, despite having 22 percent of the total population in the 1960 census. This disparity declined slightly after a 1964 amendment permitted the program to make grants for the modernization of existing, outmoded hospitals regardless of the per capita bed ceiling. Although such facilities were common in central cities, the urban-rural gap remained. As late as 1968–70, larger cities still received only 18.1 percent of Hill-Burton funds.[13] Nonetheless, Hill-Burton was not unimportant for large cities: even with the funding disparity, 34.5 percent of the total inpatient beds the program eventually funded were located in central cities.[14]

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11 Although social scientists have identified the centrality of "eds and meds" in contemporary cities, the subject has received almost no research attention from historians. Existing scholarship on the history of hospitals approaches the subject from a history of medicine perspective. See, for example, Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 1999). For a limited exception, see Sandra Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City Since 1900* (New York: Oxford University Press, 1999).

12 Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 283, 347–51.

13 The program's matching requirement also meant that it disproportionately benefitted moderate-income communities, as poorer areas proved less able to provide the required local contribution. Judith R. Lave and Lester B. Lave, *The Hospital Construction Act: An Evaluation of the Hill-Burton Program, 1948–1973* (Washington, D.C.: The American Enterprise Institute for Public Policy Research, 1974), 8–9,16–21; U.S. Department of Health, Education, and Welfare, Public Health Service, *Hill-Burton Program: Progress Report July 1, 1947–June 30, 1961* (Washington, D.C.: Public Health Service, 1961), 32–33; U.S. Department of Health, Education, and Welfare, Public Health Service, *Hill-Burton Program: Progress Report July 1, 1947–June 30, 1961* (Washington, D.C.: GPO, 1968), 27–35; Stevens, *In Sickness and In Wealth*, 216–24, 294–96; Joseph Mantone, "The Big Bang," *Modern Health Care,* 15 August 2005, 6–16.

14 U.S. Congress, Senate, Subcommittee on Health of the Committee on Labor and Public Welfare, *Hill-Burton Hospital Survey and Construction Act: History of the Program and Current Problems and Issues*, 93rd Cong., 2nd sess., June 1973, Committee Print, 11, 13.

Although smaller than Hill-Burton in its overall contribution to hospital growth in the United States, urban renewal would prove more important for the urban hospital sector. Scholars have long recognized that urban renewal redefined American cities during the postwar period, usually for the worse. Most studies have focused on how urban renewal destroyed intact, often minority neighborhoods, displaced residents, exacerbated segregation, and facilitated the expansion of high-end service industries even as manufacturing declined in the cities' central cores. Urban institutions such as universities and hospitals have frequently been identified as among the leading contributors to such negative consequences.[15] The basic fact of such institutions' participation in urban renewal reflected tensions over core purposes that had been built into the program from its inception. The Housing Act of 1949, which provided the legislative basis for the program, explicitly stated that its purpose was to provide "a decent home and a suitable living environment for every American family." In order to gain the support, or at least the acquiescence, of the urban business and real estate interests who were well represented in Congress, advocates of low-income housing had to tie this goal to the related but not identical objective of clearing "blighted" areas from the urban core. As a result, urban renewal offered local governments a "write-down" subsidy that covered two-thirds of the costs of assembling and clearing blighted land that could then be made available for redevelopment. The legislation also required that projects merely be "predominantly residential." This language opened the possibility of including commercial and institutional developments along with housing as part of urban-renewal projects.[16]

Amendments to the legislation in 1954 further loosened the constraints on nonresidential components of urban renewal. By the late 1950s, universities and hospitals around the United States began to take advantage of the federal write-down to undertake expansions of urban campuses and medical facilities.[17] After 1959, however, linking institutional expansion to urban renewal became far simpler. Under Section 112 of the 1959 amendments to the housing act, Congress made universities eligible for urban-renewal funds with no requirement that such projects be linked to housing. Two years later, hospitals received the same privilege at the request of the American Hospital Association. As the University of Chicago's Julian Levi, an early leader in urban campus expansion, explained to the House Subcommittee on Housing, universities could not "live with the 51-percent residential requirement . . . because what we need are campus facilities . . . . You can't because the moment you try to use the urban renewal tool, you are confronted with the fact that your project isn't eligible and the only way you can make it eligible is to put housing back; and if you put housing back, you defeat the whole purpose of the operation."[18] Levi's comment about "the whole purpose of the operation" reflects the institutions' effort to shift the core purpose of urban renewal further away from its original, if nominal, housing purpose and toward an explicit emphasis on rebuilding cities through institutional expansion.

Section 112 had one other important feature. It allowed cities to claim any expenditures made by universities or hospitals for urban renewal as "grants-in-aid" that counted toward the required local contribution to the 2:1 federal-local matching grant ratio. If those grants-in-aid exceeded the necessary local expenditure, the federal government would provide credits of equal value towards ongoing or future urban-renewal projects in the city.[19] This did two things. First, it created an incentive for cities to expand their institutional urban-renewal programs in order to reduce immediate local costs (as the institutions would make the expenditures) while also generating subsidies for the city's overall urban-renewal program. By 1961, officials with the Urban Renewal Administration even became concerned that some local redevelopment authorities had come to view Section 112 as a way "to undertake these projects

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15 Arnold R. Hirsch, *Making the Second Ghetto: Race and Housing in Chicago, 1940–1960* (New York: Cambridge University Press, 1983); John F. Bauman, *Public Housing, Race, and Renewal: Urban Planning in Philadelphia, 1920–1974* (Philadelphia: Temple University Press, 1987); Jon C. Teaford, *The Rough Road to Renaissance: Urban Revitalization in America, 1940–1985* (Baltimore: Johns Hopkins University Press, 1990); Joel Schwartz, *The New York Approach: Robert Moses, Urban Liberals, and the Redevelopment of the Inner City* (Columbus: Ohio State University Press, 1993); June Manning Thomas, *Redevelopment and Race: Planning a Finer City in Postwar Detroit* (Baltimore: Johns Hopkins University Press, 1997).

16 The legislation defined "predominantly residential" to mean that 50 percent of the buildings either cleared or built in a project had to be residential. Roger Biles, "Public Housing and the Postwar Urban Renaissance, 1949–1973," in *From Tenements to the Taylor Homes: In Search of an Urban Housing Policy in Twentieth-Century America,* ed. John F. Bauman, Roger Biles, and Kristin M. Szylvian (University Park: Pennsylvania State University Press, 2000).

17 A survey completed during this period indicated that at least fifteen hospitals had participated in urban-renewal projects. Malcolm D. Rivkin to David Walker, 30 March 1960, and David M. Walker to Malcolm D. Rivkin, 12 April 1960, National Archives II, General Records of the Department of Housing and Urban Development (hereafter HUD General Records), Urban Renewal Administration (hereafter URA), General Subject Files, 1949–60, Box 340, Folder: "Reporting and Statistics 1960 (January–May).

18 Testimony of Julian Levi, Congress, House, Subcommittee of Housing of the Committee on Banking and Currency, *Housing Act of 1959*, 86th Cong., 1st sess., 29 January 1959, 241.

19 Lyman Brownfield to Teachers Insurance and Annuity Association of America, 23 January 1961, National Archives II, HUD General Records, URA, Subject Files 1961–65, Box 720, Folder: "College & University Projects 1961 (Section 112)"; Roger Montgomery to Dean Joseph R. Passonneau, 3 January 1963, National Archives II, HUD General Records, URA, Subject Files 1961–65, Box 755, Folder: "College & University Projects 1963 (Section 112)"; William L. Slayton to J. O. Lindstrom, 15 October 1963, ibid.; Testimony of Julian Levi, 242, 255.

without local contribution."[20] Second, it erased whatever weak distinction still remained between public and private in urban renewal and, more broadly, in the economics of urban land. Private institutional purposes, under this conception, were presumed to be inseparable from the public good. Despite their broad implications, these changes generated little controversy, and Congress passed the Section 112 amendment without debate.[21]

Congress may not have noticed what it was doing, but urban political and institutional leaders certainly did. By 1964, the Housing and Home Finance Agency reported that 154 urban-renewal projects around the United States, involving 120 colleges and universities and 75 hospitals, had already taken advantage of Section 112's institutional provisions.[22] This included both major urban medical centers such as the Detroit Medical Center and Johns Hopkins University Hospital in Baltimore as well as such smaller institutions as Druid City Hospital in Tuscaloosa and Mercy Hospital in Des Moines.[23] Neither HHFA nor later the Department of Housing and Urban Development compiled detailed information about such projects, but a 1964 study of Boston by Julian Levi demonstrated that the existing plans of colleges, universities, and hospitals in that city alone could generate almost $31.7 million in Section 112 credits.[24]

Both Hill-Burton and urban renewal involved various forms of direct federal expenditures to subsidize construction. By the late 1960s, however, hospitals began to finance a greater percentage of construction costs through debt rather than by raising capital.[25] This led to two significant shifts in federal policy, which in turn served to reinforce the trend. First, Congress added a Hill-Burton loan program in 1970–previously Hill-Burton had provided only grants–and then transitioned the entire Hill-Burton operation to loans four years later. Second, the federal government began to guarantee hospital mortgages. The post–World War II role of the Federal Housing Administration's (FHA) home mortgage insurance program in promoting suburbanization is well known.[26] Yet few scholars recognize that, beginning in 1969, the FHA also provided mortgage insurance for hospitals. Just as in housing, the availability of federal insurance reduces the risk to a lender in the event that a hospital defaults on its loan. This lower risk means that the lender can offer the loan at a lower interest rate, which significantly reduces the cost of credit to the borrower and, in turn, the overall costs of a project.

Authorized by Section 242 of the Housing and Urban Development Act of 1968, this program remains in operation today (in slightly modified form). As of January 2010, it had guaranteed $15.7 billion of hospital mortgages. In contrast to Hill-Burton, Section 242 has been a heavily urban program. Approximately $7.48 billion of the guarantees have gone to cities that ranked among the fifty largest in the United States in the previous decennial census. Many additional guarantees have gone to smaller but still distinctly urban places, as well as the suburbs of major cities. Until recently, it has also been heavily oriented toward the Northeast and Midwest. New York City alone has secured more than a third of the total guarantees, or $5.7 billion, far more than any other city. If a number of very large loan guarantees undertaken since 2005 are excluded, the remaining cities in the top-ten recipients include Buffalo, Boston, Jersey City, Philadelphia, Patterson, Detroit, Chicago, and Atlantic City, with only Miami, in sixth position, located in the Sunbelt.[27] Although the program has guaranteed only a relatively small portion of overall hospital construction during this period–about 4.5 percent of total private hospital construction–its role in these urban areas has been far more significant.[28]

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20 Frederick O'R. Hayes to William L. Slayton, 11 December 1961, National Archives II, HUD General Records, URA, Subject Files 1961–65, Box 720, Folder: "College & University Projects 1961 (Section 112)."

21 Testimony of Karl Klicka, Congress, Senate, Committee on Banking and Currency, *Housing Legislation of 1961*, 87th Cong., 1st sess., 11 April 1961, 724–29. Senator Prescott Bush of Connecticut did attempt to remove the amendment in 1959. Julian H. Levi, *Municipal and Institutional Relations Within Boston: The Benefits of Section 112 of the Federal Housing Act of 1961* (Chicago: University of Chicago Press, 1964), Appendix L, 131–36.

22 Housing and Home Finance Agency, *18th Annual Report 1964* (Washington, D.C.: GPO, 1965), 326.

23 Testimony of Julian Levi, Congress, House, Subcommittee of Housing of the Committee on Banking and Currency, *Housing Act of 1959*, 88th Cong., 1st sess., 19 November 1963, 258–59.

24 Levi, *Municipal and Institutional Relations Within Boston,* 3. For background on Levi's study, see Sylvan Kamm to Frederick O'R. Hayes, 7 September 1961, and Frederick O'R. Hayes to William L. Slayton, 23 October 1961, both in National Archives II, HUD General Records, URA, Subject Files 1961–65, Box 720, Folder: "College & University Projects 1961 (Section 112)."

25 Stevens, *In Sickness and In Wealth*, 294–95.

26 David M. Freund, *Colored Property: State Policy and White Racial Politics in Suburban America* (Chicago: University of Chicago Press, 2007), 118–39, 176–96.

27 Department of Housing and Urban Development, Federal Housing Administration, Office of Hospital Facilities, "Complete list of all FHA hospital deals," 1 January 2010, http://portal.hud.gov/portal/page/portal/HUD/federal_housing_administration/healthcare_facilities/section_242/our_clients.

28 Total private hospital spending for the period of 1969–2009 equals approximately $350 billion; the census bureau has provided three overlapping data series during the period, each of which calculates these statistics in a slightly different manner. U.S. Census Bureau, Current Construction Reports, Annual Value of Private Nonresidential Construction Put in Place by Region, http://www.census.gov/const/www/privpage.html & http://www.census.gov/const/C30/oldtc.html.

The Urban Hospital in the Community

These outlines of key federal hospital-aid programs simply sketch the bare bones of public policy in this area. They capture little of how these programs actually worked in cities, and of what the "on-the-ground" impact of hospital expansion has actually been in urban communities. The best means to assess such wider relationships is through a brief case study of the experience of a major urban medical center–the Tufts–New England Medical Center, located in Boston's South Cove neighborhood. Since the 1950s, Tufts–New England Medical Center has interacted with each of the major federal policies that have facilitated the expansion of urban hospitals. It has also frequently come into conflict with residents of the surrounding South Cove community of Chinatown. As such, it provides a potential archetype for how federal policies have facilitated urban hospital expansion and also suggests some of the possibilities–and the challenges–inherent in connecting urban hospital growth to community development.

By the mid-twentieth century, Tufts–New England Medical Center operated as a loose consortium of hospitals working in cooperation with Tufts University Medical and Dental Schools. The center occupied a group of aging and poorly coordinated facilities in the South Cove, surrounded by a neighborhood that included a commercial and theater district as well as the three- and four-story residential flats of an area that since the 1930s had become identified as the core of Boston's Chinatown. Many of the residential buildings had begun to experience significant deterioration, and in some parts of the neighborhood landlords had demolished significant numbers of older buildings to create income-generating parking lots. Highway construction along the South Cove's southern and eastern edge had already displaced thousands of residents and caused significant disruption to the Chinatown community. Determined to improve both its facilities and its surroundings, Medical Center leadership undertook a major internal planning initiative during the early 1960s.[29]

Like most urban hospitals, the Medical Center received only limited support from the Hill-Burton program, consisting solely of a 1953 grant of $81,816 for the remodeling of "adjunct service facilities."[30] The center's engagement with the urban-renewal program, however, provided the initial mechanism for expansion into a full-scale modern medical center. The availability of Section 112 credits allowed the Medical Center to link its own urban-planning process–conducted by an internal Medical Center planning office–to the citywide urban-renewal process pushed forward during the 1960s by Boston Mayor John Collins and urban-renewal director Edward Logue. Through Section 112, the growth of the Medical Center generated more than $5 million in credits that Logue and Collins could apply to their expensive downtown plans. [31] A nascent, citywide rebellion against urban renewal, however, left Boston's City Council hesitant to endorse the arrangement. To placate the council, the Medical Center agreed to set aside land for residential redevelopment by Chinese American community groups. Over the following decades, intermittent conflict with the community continued over the displacement of residents by the construction of parking garages and other hospital-related facilities. Under heavy pressure from the community, the Medical Center eventually cooperated in a series of projects that included the construction of affordable housing and the creation of a community health center.[32] Still, by 1975, urban renewal had allowed the Medical Center to complete the construction of its new Proger Hospital facility, which housed the center's main inpatient services, as well as a new building for the Tufts University Dental School. This construction followed the basic outlines of the urban-renewal plan that the Medical Center and the Boston Redevelopment Authority had finalized in 1965. Urban renewal, in short, had

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29 Kevin Lynch, *Medical Center in the South Cove: A Study for the Development of the New England Medical Center and Its Neighborhood; submitted to the Executive Board, New England Medical Center*, December 1955, Boston Public Library Government Documents, Internet Archive, http://www.archive.org/details/bostonpubliclibrary, 1–16, 20–24, 32–37, 80; Hermann H. Field, *Development of the Tufts–New England Medical Center: A Preliminary Study* (Boston: Tufts–New England Medical Center, October 1964), 1–2, 11–15; Hermann H. Field, "Application of Comprehensive Planning to the Urban Teaching Medical Center," *Hospitals* 39 (1 November 1965).

30 U.S. Department of Health, Education, and Welfare, Public Health Service, *Hill-Burton Project Register July 1, 1947–June 30, 1968* (Washington, D.C.: GPO, 1968), 101.

31 Levi, *Municipal and Institutional Relations Within Boston*, 7–14; Charles J. Horan to Edward J. Logue, n.d., and "Tufts–New England Medical Center Certificate of Resolution," 5 November 1962, both reprinted in ibid., 116–17; Field, *Development of the Tufts–New England Medical Center*, 2–9; John Morris Dixon, "New Dimension in Urban Renewal," *Architectural Forum* 129 (September 1968): 44.

32 Tufts–New England Medical Center, *The Economic Impact of the Tufts–New England Medical Center on the City of Boston and the Surrounding Metropolitan Area* (Boston: Tufts–New England Medical Center, [1974]), 95–100; Field, *Development of the Tufts–New England Medical Center*, 9–10; Dixon, "New Dimension in Urban Renewal," 44; BRA, *Chinatown–South Cove: District Profile and Proposed 1979–1981 Neighborhood Improvement Program* (Boston: BRA, 1979); Chinatown–South Cove Neighborhood Council, "Chinatown Community Plan: A Plan to Manage Growth," March 1990, Boston Public Library Government Documents, Internet Archive, http://www.archive.org/details/bostonpubliclibrary, 23, 26–27; Bill Kovach, "Growing Universities Fight Cities for Room," *New York Times*, 30 August 1970; Thomas H. O'Connor, *Building a New Boston: Politics and Urban Renewal, 1950–1970* (Boston: Northeastern University Press, 1993), 210–48.

solidified the position of the Tufts–New England Medical Center as a major part of Boston's emerging health-care economy.[33]

Expansion continued during the late 1970s and 1980s, as the Medical Center built a new facility for the Boston Floating Hospital, its primary provider of pediatric services. High debt levels from the Proger and Dental School projects, however, forced the Medical Center to turn to the FHA's Section 242 mortgage insurance program to help finance its continued growth during this period. In doing so, the Medical Center followed a pattern typical of hospitals in the urban Northeast during the period.[34] One estimate indicated that FHA insurance would lead savings of as much as $10 million in debt service because of reduced interest rates for the Floating Hospital project.[35] The new Floating Hospital building opened in 1982, followed soon thereafter by the renovation of the Medical Center's ambulatory-care facilities and the construction of a Magnetic Resonance Imaging Center. These projects completed the modernization process that hospital administrators and planners had envisioned more than a quarter of a century earlier.[36]

This growth had significant economic implications. As early as 1972–73, studies of the Medical Center's economic impact found that it had major effects in expenditures, employment, and construction.[37] By 1997, the center had 4,995 employees and had become the city's seventh largest private employer. Since the late 1970s, it has made an annual "payment in lieu of taxes" to the city, which is now more than $1 million; yet without the exemption, the center would pay $15.8 million in annual property taxes.[38] More broadly, health services accounted for 14.5 percent of all jobs in Boston by the late 1990s, and 17 percent by 2007.[39] The health-care anchor that Governor Patrick would highlight in 2010 had been established.

Some of the benefits of this growth have been captured for community development purposes. Beginning in 1983, the Medical Center reached an agreement with the Chinatown community under which it would provide "$100,000 to fund a contract allowing the CCBA [a Chinatown community organization] to conduct a job training program and educational program to train persons for hospital related jobs" in exchange for the community's support of previously controversial elements of the center's development program.[40] The agreement has continued to the present. More recently, a two-decade-long struggle against a Medical Center plan to build an 850-car parking garage concluded with the construction instead of the Metropolitan—a 23-story, mixed-income development that reserved 46 percent of its units for affordable housing and included space for four community agencies that offer child-care services, youth programs, job training, and ESL services.[41] Such examples suggest that under certain circumstances, inner-city communities can successfully exert the political pressure necessary to capture at least some of the economic benefits of urban health-care growth.

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33 BRA, *Urban Renewal Plan: South Cove Urban Renewal Area; Project No. Mass. R-92*, 8 June 1965; Coopers & Lybrand, "New England Medical Center Hospital: Report on Financial Feasibility Study of Proposed Construction Program," 16 January 1979, National Archives II, HRSA Records, Division of Facilities Financing, Loan Project Files for Hill-Burton Loan Program and Section 242 Mortgage Insurance Program, 1969–80, Box 11, Folder: "New England Medical Center Boston, Mass., 250024," 13; Tufts Medical Center, *Institutional Master Plan 2010–2020* Submitted to BRA, 7 April 2010, 2:3–9. For the original plan, see BRA, *Urba*n Renewal Plan: South Cove Urban Renewal Area; Project No. Mass. R-92, 8 June 1965, Boston Public Library Government Documents, Internet Archive, http://www.archive.org/details/bostonpubliclibrary.

34 Ellen Connolly to William R. Wilson, 24 August 1979, National Archives II, Records of the Health Resources and Services Administration, Bureau of Health Maintenance Organizations, Office of Health Facilities [hereafter, HRSA Records], Division of Facilities Financing, Loan Project Files for Hill-Burton Loan Program and Section 242 Mortgage Insurance Program, 1969–80, Box 11, Folder: "New England Medical Center Boston, Mass., 250024."

35 "Enclosure," undated, attached to Joanne Baxter Bluestone to Franklin Parker, 22 November 1978, National Archives II, HRSA Records, Division of Facilities Financing, Loan Project Files for Hill-Burton Loan Program and Section 242 Mortgage Insurance Program, 1969–80, Box 11, Folder: "New England Medical Center Boston, Mass., 250024," 4.

36 Tufts Medical Center, *Institutional Master Plan, 2010–2020*, 2:7.

37 Tufts–New England Medical Center, *The Economic Impact of the Tufts–New England Medical Center*, 1–10.

38 BRA, *History of Boston's Economy: Growth and Transition, 1970–1998* (Boston: BRA, November 1999), 22–23. Boston's PILOT (Payment In Lieu Of Taxes) program began during the administration of Mayor Kevin White in the 1970s, but the idea had been considered by Edward Logue as early as 1961. Eric A. Lustig, "The Boston City PILOT Task Force: An Emerging Best Practice," *New England Law Review* 44 (Spring 2010): 601–19; BRA, *Back Bay–Beacon Hill–Bay Village: District Profile and Proposed 1979–1981 Neighborhood Improvement Program* (Boston: BRA, 1979), 17; Hayes to Slayton, 23 October 1961.

39 BRA, *History of Boston's Economy*, 22–23; BRA, *The Boston Economy 2008*, 13.

40 New England Medical Center, "Master Plan, 1989–1999," July 1989, 12; New England Medical Center, "Master Plan, 1990–2000: Community Benefits; Final Version," March 1990, Boston Public Library Government Documents, Internet Archive, http://www.archive.org/details/bostonpubliclibrary, 2–6.

41 Tara Arden-Smith, "Fund to Aid in Chinatown Housing," *Boston Globe*, 4 December 2001; Thomas C. Palmer, "Barely Noted Project Has Chinatown Smiling," *Boston Globe*, 25 August 2002.

Conclusion: The Health-Care Crisis and Community Development

A final irony must be noted in evaluating the role of public policy in the development of the urban health-care anchor: at the time that the Tufts–New England Medical Center expansion projects were planned, none was explicitly thought of as economic development measures. Instead, all the projects were considered solely in the context of health care. The role of the hospital as an employer could even come into conflict with the growing imperative toward hospital-cost containment. At one point in the Section 242 process, a federal official directly questioned the Medical Center's high levels of employment relative to "the average for New England teaching hospitals" and wondered "why [full-time employees] would be projected to increase when a major objective of the building program is to increase efficiency." "An explanation," he concluded, "is necessary."[42] In a project concerned with economic development, no such explanation would have been required.

At times, the consequences of structural economic change intersected directly with the imperatives of health-care policy, reflecting the underlying pressures that would eventually pair Governor Patrick's health-care-training announcement with the closing of St. Vincent's Hospital in Manhattan. In the late 1970s, the Social Security Administration lowered the income classification of the Boston metropolitan area based on the region's declining per capita income. This action led to steep cuts in regional Medicare and Medicaid hospital reimbursement rates. Declining per capita income, of course, reflected the broader economic transformation under way in cities like Boston. One federal analyst even recognized this, assuring the director of the Medicare Bureau that "it can be reasonably assumed that the lower per capita income is an accurate reflection of the economic condition in that area. In Boston's case, it appears that the lower per capita income group is a realistic reflection of that city's relative standing in the country."[43] From the perspective of health-care cost control, this justified cutting rates, even if the policy hurt new urban anchors like hospitals–the very institutions that held the most direct promise for reversing the decline in per capita income. That, however, was not the SSA's concern.

Although the New England Medical Center had the resources to sustain itself through such uncertainty, a number of smaller institutions in Boston found their very existence threatened.[44] In such cases, just as at St. Vincent's thirty years later, the role of health-care policy as a form of implicit urban policy proved deeply problematic. Along with inadequate access to health care and insurance coverage, the chief underlying problem of the U.S. health-care system has been its inability to control costs. Yet it has been those excess expenditures that have funded the growth of the new urban health-care anchor, the economic sector that has provided the chief replacement for manufacturing at the core of urban economies.

The story of Tufts–New England Medical Center's growth embodies one promising aspect of the urban health-care sector that now stands at the core of the political economy of the postindustrial city. Although the modernization of the Medical Center caused significant residential displacement, it also made possible new community initiatives in affordable housing, health-care access, and especially job training. This outcome is the result of community development strategies as well as of explicit and implicit public policies. Yet the case of St. Vincent's Hospital, and the unsustainable cost pressures embedded in these same public policies, suggests a much more problematic relationship between long-term community development and the urban hospital anchor. Hospitals, it is clear, can generate very real benefits for community development. Their emergence as a major employer and service provider and their potential responsiveness to community pressure, as the Tufts case shows, have been largely overlooked by community development strategists. Meanwhile, however, their very success in the role of an urban economic anchor is based on, and even contributes to, the systemic cost problems of the U.S. health-care sector as a whole. While more attention must be given to the role of hospitals in inner cities and as potential partners in community development, their long-term stability in their present role must not be assumed.

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42 Paul C. O'Shea to Edward Reynolds Jr., 22 August 1979, National Archives II, HRSA Records, Division of Facilities Financing, Loan Project Files for Hill-Burton Loan Program and Section 242 Mortgage Insurance Program, 1969–80, Box 11, Folder: "New England Medical Center Boston, Mass., 250024."

43 Mike Maher to Thomas M. Tierney, 15 September 1977, National Archives II, HRSA Records, Division of Facilities Financing, Loan Project Files for Hill-Burton Loan Program and Section 242 Mortgage Insurance Program, 1969–80, Box 11, Folder: "Faulkner Hospital Boston, Mass., 250017, #2 of 2";

44 Coopers & Lybrand, "New England Medical Center Hospital: Report on Financial Feasibility Study," 21; Philip M. LeCompte, M.D., to Senator Edward M. Kennedy, 21 September 1977, National Archives II, HRSA Records, Division of Facilities Financing, Loan Project Files for Hill-Burton Loan Program and Section 242 Mortgage Insurance Program, 1969–80, Box 11, Folder: "Faulkner Hospital Boston, Mass., 250017, #2 of 2"; John A. Blanchard to Edward Montminy, 23 September 1977, in ibid.; John D. Kennedy to Senator Edward M. Kennedy, 10 November 1977, in ibid.; "Projected Effect of Group II Classification on Faulkner Hospital," 12 December 1977, in ibid.

Table 1: Rank of Hospital Employment (NAICS 622) in High-Poverty Cities, 2002 and 2007

	City	Population, 2007	Individual Poverty Rate, 2007	Hospital Employer Rank, 2002	Hospital Employer Rank, 2007
1	Detroit	808,327	33.8	1	1
2	Cleveland	395,310	29.5	1	1
3	Buffalo	264,292	28.7	1	1[b]
4	El Paso	605,410	27.4	4	4-7[c]
5	Memphis	637,425	26.2	3	3
6	Miami	348,827	25.5	2	3
7	Milwaukee	582,207	24.4	1[a]	4
8	Newark	270,007	23.9	2	3
9	Philadelphia	1,449,634	23.8	1	1
10	Cincinnati	297,304	23.5	1	1
11	Toledo	283,851	22.6	4	1
12	St. Louis	350,759	22.4	2-4	3
13	Fresno	476,460	21.9	4	5
14	Atlanta	432,511	21.1	4-7	4-6
15	Dallas	1,240,044	21.1	4	4
16	Pittsburgh	290,918	21.0	1	1
17	Columbus	732,974	21.0	4	4
18	Houston	2,046,792	20.7	4	4
19	Chicago	2,737,996	20.5	4	4
20	Minneapolis	351,184	20.4	2	4
21	Boston	613,117	20.4	1	1
22	Baltimore	637,455	20.0	1	2
23	Tulsa	389,536	19.1	2-5[d]	2-5[d]
24	St. Paul	266,258	18.9	1-3	1-4
25	Corpus Christi	290,010	18.8	2-5	4-5
26	New York City	8,274,527	18.5	3	5

Source: U.S. Bureau of the Census, 2002 and 2007 Economic Census, compiled from data reports generated using American FactFinder, http://factfinder.census.gov.

a Food services employment (NAICS 722) ranged from 27 more than hospitals to 1,421 less.

b Exact figure is not supplied; rank is based on minimum of range for the letter codes of NAICS 622 subcategories.

c Exact figure is not supplied; possible range of ranking calculated from minimum and maximum of letter-code ranges.

d 6-digit NAICS code provides range only.

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