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Urbanism and Gay Identity

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This paper proposes that the social, economic, and political drivers of urbanism constructed contemporary notions of gay identity. Starting around the mid-to-late twentieth century, lesbian, gay, bisexual, and transgendered (LGBT) individuals transformed urban spaces into centers of social, cultural, and political utility. As middle-class Americans suburbanized, socially stigmatized and emboldened gays settled into vacated urban spaces where deviant lifestyles were enshrined by the safety and anonymous milieu of the city (Bailey, 1998; Castells, 1983). Amid the physical construction of communities around residential and commercial gay concentrations, the social construction of a gay identity based on sexual personhood emerged contemporaneously (Lauria & Knopp, 1985). Although some scholars have commented on the topic of sexual identity and space (Castells, 1983; D'Emilio, 1981; Jackson, 1989; Knopp, 1990b), little research has been done to specifically connect identity to the drivers of urbanism. This paper provides a framework for further interdisciplinary research in sexual identity and community development.

The Social Construction of Identity: Urbanism and Sexual Identity Formation

Starting around the mid-to-late twentieth century, lesbian, gay, bisexual, and transgendered (LGBT) individuals transformed urban spaces into centers of social, cultural, and political utility (Bailey, 1998; Castells, 1983; D'Emilio, 1981; Lauria & Knopp, 1985). Sexually stigmatized pariahs were drawn into the city by a flourishing subculture where experimentation and romantic relationships could be pursued with same sex partners. The physical boundaries that would define "deviant" spaces, however, became more than just territories for sexually repressed outcasts: they became epicenters of an international countercultural identity movement that gave definition to the "gay self" and challenged broader heterosexual assumptions surrounding sex, gender, sexual orientation, and sexual identity (Castells, 1983; Epstein, 1987; Lauria & Knopp, 1985). This paper argues that the social, economic, and political drivers of urbanism socially constructed our contemporary notion of a "gay identity." Specifically, the analytical framework established here applies constructivist theories of human identity formation to urban space.

Before moving forward, it is important to define terms. "Gay" is an illusive word; although it is often used to describe male homosexuality exclusively, it is frequently used to describe all LGBT people. Some scholars have offered the term "queer" to more broadly recognize the community of non-heterosexuals, but "queer" is no less controversial (Khayatt, 2002). Berube and Escoffier (1991) for example, suggest that queer "[was] *meant* to be confrontational–opposed to gay assimilationists and gay oppressors while inclusive of people who have been marginalized by anyone in power" [emphasis added] (p. 168).

Scholars interested in LGBT identities have rejected "queer" precisely because it either speaks against the narrative of a single gay identity or because the suggestion of a queer identity dilutes subsidiary identities (lesbian, gay, bisexual, and transgender) (Berube & Escoffier, 1991; Harris, 1996; Khayatt, 2002). This paper employs the term "gay" precisely because homosexual males were primarily involved in the development of urban gay communities. Where appropriate, "lesbian" and "bisexual" will be distinguished to describe female-female sexual attraction and non-exclusive heterosexual attraction, respectively.

Research into the urban geography of sexuality creates some discomfort among scholars. Lauria & Knopp (1985) describe this feeling as "squeamishness." Christopherson (1989) adds, "This squeamishness regarding sexual issues is partly homophobic and partly a justifiable fear of never being cited except in a list of interesting, albeit peripheral work" (p. 88). Emergent research in the twenty-first century needs to move beyond the cultural discomfort (or "squeamishness") that limited work in previous decades. "It is time to bring gay and lesbian geographies out into the open, in order to fully understand the role of sexuality and sexual preference in shaping social space" (Bell, 1991, p. 328). Our collective cultural aversion to sexuality cannot restrict emergent scholarly research. The implications of this work describe LGBT geographies, the manifold issues involving marginalization, and the development of communities. Academic research should "produce meaningful discussions of the relationships between erotics, communities and identities" (Knopp, 2007, p. 30). This paper connects the social influences of urbanism to community development and identity formation. It will first describe how social influences shape our cultural perceptions of sexual identity, and then discuss how cities influenced the social, economic, and political development of gay communities between 1950 and 1980. At the conclusion, important implications for future research will be offered.

Identity as a Social Construction

The idea of an identity based on sexuality is peculiar in human history. French theorist Michel Foucault (1978) notes the "homosexual person" historically has not been conceived of as a "person" per se. Rather, conceptions of the "homosexual" were linked to human sexual behavior, specifically sodomy (Epstein, 1987). Foucault, arguing from a post-modern perspective, asserted that elements of Western civilization have created social constructions around identity. These specific drivers included the increasing importance attached to sexuality in general, the widespread proliferation of social control structures, the social control that operates through sanctions against specific acts, and the growing power of professionals (specifically doctors) to define social problems and reinforce social mores (Epstein, 1987; Foucault, 1978; Knopp, 1990a; Lauria & Knopp, 1985). Epstein (1987), for example, notes that the medical categorization of homosexuality starting in the early twentieth century was one reflection of Foucault's social control theory. As psychiatrists diagnosed homosexuals with mental disorders, a typology developed around sexual personhood that stigmatized people with same sex attractions, and made them feel separate and distinct from heteronormative society (Epstein, 1987; Foucault, 1978; Knopp, 1990a; Lauria & Knopp, 1985)

Many scholars have approached gay identity as a social construction (Epstein, 1987; Foucault, 1978; Lauria & Knopp, 1985). They posit that identity, in a broad sense, is the result of many social processes and developmental outcomes. Others, however, conceive of identity as predetermined, predisposed, and preordained. This view reflects a broader essentialist philosophy that Rahman (2000) describes as, "The common cultural understanding of sexuality as an innate and immutable identity, which is based on a model of biological sexual drives or instinct" (p. 5). Popular Western culture implicitly promotes a natural identity that suggests individuals express gay tendencies because "you're born this way" (Lady Gaga, 2011, track 2). This attitude is reverberant in some news magazines, such as this 2007 *New York* magazine cover story: "The Science of Gaydar; If sexual orientation is biological, are the traits that make people seem gay innate, too? The new research on everything from voice pitch to hair whorl" (France, 2007, p. 13). Constructivism and

essentialism question whether identity is the result of society or preordination: Is one's identity built through a lifetime of interactions, or is it predetermined from birth? Is it *nature* or *nurture*?

This piece assumes that identity is socially constructed. Essentialist philosophy suggests that people act certain ways *only* because of some immutable aspect of themselves. This view is dangerous because it conceives of a singular identity that may engender common stereotypes that are racial, chauvinistic, or homophobic in character. Alternatively, constructivism provides a platform for understanding the social control that drives urbanism, develops communities, and coalesces individuals around similar social, economic, and political goals. This view holds that urban gay communities formed as a response to shared meanings and stigmatization. Constructivism's subsidiary schools of thought—interactionism and labeling—are not at odds with one another, but complement each other in describing how sexual communities and their resultant identities are social constructions.

Symbolic Interactionism

Symbolic interactionists assert that sexual acts by themselves have no inherent meaning. The only meanings sexual acts do have are those ascribed to them by the larger society. Blumer (1969) established three premises to the symbolic interactionist perspective: (i.) humans act toward things on the basis of the meanings they ascribe to those things; (ii.) the meaning of such things is derived from, or arises out of, the social interaction that one has with others and the society; and (iii.) these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he/she encounters. The symbolic interactionist perspective has particular utility in theories that aim to describe why communities are created in the first place. Cohen (1982) notes that it is, "The sense of difference [that] lies at the heart of people's awareness of their culture, and […] makes it appropriate for ethnographers to designate as 'cultures' such arenas of difference" (p. 2). Symbolic interactionists argue that meaning is derived from a process of interacting with others. Under this framework, gay identity is formed out of shared community space where homosexual conduct and romantic relationships are regarded as the normal and accepted behavior (Cohen, 1982). Gagnon (1977) demonstrated how gay communities were created by sexual interactions, as well as other cultural factors. Where heteronormative culture viewed homosexual conduct as deviant, gays created their own identity by sharing experiences and bonds that modify and create a uniform system of conduct.

Labeling Theories

According to labeling theory, individuals in society are labeled "deviant" from the mainstream culture because their stigma deviates from the norm. In order to be stigmatized an individual must undergo a complex process of behavioral action and internalization (Goffman, 1963; McIntosh, 1968; Weeks, 1998). Noting the contribution of labeling theory to gay identity, Epstein (1987) describes behavioral action as "primary deviance" and the reactions and internalization of the labeling process as "secondary deviance." Primary deviance is represented by the action itself: in the homosexual example, it is the act of physical intimacy with members of the same sex. Jenkins (2008) notes that primary deviance, however, is not enough to stigmatize: people make excuses, they apply (ir)rationality or reason to the situation, and they try to justify their activity in some higher-order plane of social values. Secondary deviance is far more impactful simply because it internalizes the individual's feeling of difference from the group or society. One of the best-known examples in the sociological literature is the Rosenthal and Jacobsen (1968) experiment. In this study, Rosenthal and Jacobsen attributed intelligence to eye color and observed that schoolchildren possessing the stigmatized eye color consistently underperformed (Rosenthal & Jacobsen, 1968).

Goffman (1963) posits that the degree to which one is stigmatized relates to the disjunction between the "personal identity" and "social identity." Personal identity is autobiographical: it is the perceived set of facts that help an individual define their own personhood. Social identity refers to a larger construct. These are "[the] means of categorizing persons [to] complement [the] attributes felt to be ordinary and natural for members of each of these categories" (p. 2). Stigma is created by

the gap between the "actual" personal identity and the "virtual" social identity. When a person internalizes an act of primary deviance, the extent of internalized stigma is related to the gap between a person's self-concept and the social construct of deviance for that behavior. Autobiographically and internally, a person may believe "this is something I would never do," but cannot reconcile it with acts of primary deviant behavior. Stigma is the mark of disgrace one feels for personally possessing or manifesting a deviant social identity.

Stigmatization is not only a process of self-actualization, as illustrated above. Stigmatization is also a culturally produced phenomenon in which members of society actively participate in the application of labels to acts of deviance. As the Rosenthal and Jacobsen experiment demonstrated, schoolchildren actively applied labels to students with stigmatized eye colors. McIntosh (1968) notes that homosexuals occupy social roles in which sexual practices are stigmatized to keep the rest of society pure. Clearly, stigma is a bidirectional, participatory process where agreed upon moral values and social labels are imposed (i.) from the society on the individual, and (ii.) internalized from the perspective of the individual. Stigma, by its nature, is a mechanism that categorizes homosexuals to their social identity and subjugates them to the larger social control structure (Goffman, 1963; Jenkins, 2008).

Socially Constructed Communities

Closing this discussion on constructivism, it is important to note that mores, normative values, and imposed stigmas have historically varied across cultures. In some ancient civilizations, individuals were able to assuage the severity of labels when one partner in a same sex relationship would assume opposite sex characteristics (Knopp, 1990a). Same-sex unions have been documented in socially acceptable contexts throughout the world (Lauria & Knopp, 1985), including the Aborigines of Australia (Herdt, 1984), the Azande tribe of the South Sudan (Evans-Pritchard, 1970), and Native American Indian tribes in North America (Knopp, 1990a), among others. Several scholars have noted that it was not until recently in Western culture that many homosexuals began seeing themselves as culturally distinct (Foucault, 1978; Lauria & Knopp, 1985; McIntosh, 1968; Weeks, 1998). Lauria and Knopp (1985) identify the nineteenth century as this starting point and note:

> Prior to this period, homosexual behavior was conceived of as a personal transgression not unlike adultery. To be sure it was frowned upon, but there was no separate category of persons labeled "homosexuals" to which a host of characteristic personality traits was attributed. (p. 156)

Reevaluating McIntosh's work, Weeks (1998) describes two important implications for scholarship in identity and sexuality. First, the very classification of "gay" *is* cultural. In contemporary U.S. society, gay culture is precisely related to an identity built around behavioral activities and primary deviance. Borrowing from symbolic interactionism, primary deviance has absorbed a number of imposed meanings. Second, studies that seek to understand our conception of homosexuality could reveal more information about the evolution of the label, and thus the identity itself (Weeks, 1998). Evaluated over time and across cultures, variances in how societies label homosexuals could reveal similarities or dissimilarities in "gay" identities.

The transformation of sexual behavior to sexual personhood is a social constructivist critique reflective of post-modern philosophy (Foucault, 1978; Epstein, 1987). Identities are not innate, nor consistent, but constructed and dependent on culture and context. Constructivism holds that contemporary Western gay identity formed as a result of the meanings ascribed to sexual activity (symbolic interactionism) and the processes related to labeling deviant action. Instead of one's gay identity originating from a set of inborn, naturally occurring characteristics, constructivists assert that the meanings ascribed to gay individuals and subcultures are the result of many social and developmental outcomes. These outcomes are the result of socialization, labeling, and self-actualization (D'Emilio, 1992; Epstein, 1987; Maylon, 1982). In the next section, this paper will

explore how gay urbanism actually worked to construct this sense of community, and by extension, sense of identity.

Social, Economic, and Political Drivers of Gay Urbanism

The spatial movement of gays into urban spaces facilitated the social construction of communities within physically defined neighborhoods. As middle-income whites cleared the inner cities in the 1960s and 1970s, gays found residence in freshly vacated urban neighborhoods (Bailey, 1998; Castells, 1983; Knopp, 1990a, 1990b). Several important factors characterized the lesbian and gay migration into cities. Bailey (1998) notes that LGBT people were driven into the city by the desire for local political power, the need more resources, and a general sense of safety and anonymity. Sociologist Manuel Castells' (1983) prolific study of San Francisco documented many of these factors in rich ethnographic detail. He hypothesized that gays moved into urban spaces because cultural permissiveness allowed for sexual experimentation. Several scholars have since expanded upon Castells' (1983) analysis, describing the social, economic, and political dimensions behind the mass urban migration into cities (Armstrong, 2002; Jackson, 1989; Knopp, 1990b; Lauria & Knopp, 1985). Although some have commented on the topic of an emergent gay identity in specific neighborhoods (Jackson, 1989; Knopp, 1990b), the connection between urbanism and identity remains unclear.

Gay urbanism has been studied in a number of different social, economic, and political contexts. Some of these studies have included Los Angeles, New York, New Orleans and Minneapolis (Castells, 1983; Knopp, 1987, 1990b; Lauria & Knopp, 1985; Thomas, 1986). This piece uses San Francisco as a case study to base an argument for gay urbanism. Notes Jackson (1989): "[San Francisco] provides the most readily available evidence on which to base an understanding of the spatial expression of sexuality and for gauging the significance of territory in the development of gay politics" (p. 123). San Francisco's place in contemporary gay culture has made it a recognizable symbol of gay identity and community development. From a research perspective, it is a city with a rich scholarly and literary documentation of urban gay community development.

Lesbian and gay migration into cities complemented the mass exodus of white, middle-class Americans moving out of cities. In 1910, the five boroughs of New York accounted for 68% of the metropolitan area's total population; by 1970, it only accounted for 39%. Cleveland's metropolitan population fell at similarly dramatic levels, from 77% to 36% during the same period. Businesses and jobs also followed: in the 1960s, New York City lost 9.7% of jobs, while the suburbs gained an astonishing 24.9% (Thomas, 1977). Suburban migration was a general trend that defined post-World War II America.

Data relating to the extent of the lesbian and gay migration into cities is more difficult to ascertain. Evidence of the gay migration can be inferred by examining the proliferation of gay-friendly businesses and nonprofits. In San Francisco, Armstrong (2002) notes that in 1964, less than 25 gay-owned or gay-friendly nonprofits operated in the city, but by 1979 there were more than 100. Similarly, in 1964 there were 5 commercial businesses focused on sex, but by 1979 that number exceeded 230. Critics may suggest that San Francisco is a unique agglomeration of counter-cultural phenomena, but the general trend is consistent in major U.S. cities. Over the two-decade period spanning from 1960 to 1980, gays migrated into cities and came to occupy formerly abandoned urban spaces (Castells, 1983; Armstrong 2002). Although an approximation, Castells estimates that by 1980 there were 110,000–120,000 (two-thirds male, one-third female) lesbians and gays in San Francisco, among a total population of 678,000.

The pivotal moment for gay migration came after the Stonewall riots of June 28, 1969. By the late 1960s, homosexual intercourse was illegal in nearly every U.S. state. Police raids on underground gay bars were frequent. In New York City alone, police decoy practices entrapped hundreds of homosexuals each week for soliciting sexual intercourse in both public and private venues (Davis & Heilbroner, 2011). Stonewall was a catharsis for the underground and sexually repressed lesbian and gay community. After 1969, migration into San Francisco increased

exponentially (Castells, 1983). Armstrong's (2002) analysis of nonprofits and commercial sex establishments in San Francisco shows a three-fold increase in such establishments between 1964 and 1980.

Several interconnected social, economic, and political factors made cities attractive for urban migrants between 1950 and 1980. In order to demonstrate these factors, this paper will use Castells' (1983) foundational documentation of gay migration into San Francisco, and discuss other scholarly research where appropriate. First, a push/pull phenomenon fueled gay urbanism (social). Second, gentrification in the urban housing market and the emergence of an exclusive pink economy facilitated the distinctive look-and-feel of gay neighborhoods (economic). Last, the new emphasis on "coming out" identified the "gay person" as a distinct social and political entity. As gays concentrated in urban neighborhoods, political power became consolidated (political). Combined, these factors made gay spatial concentrations into real communities with identities.

Social Drivers of Urbanism

Permissive attitudes worked to attract gays into "deviant" spaces of cities (pull). However, heterosexual society often consigned gay subcultures to the fringes of the city (push). Starting around the 1950s, this push-pull mechanism opened fissures in the traditionally conservative American landscape (Castells, 1983). Peripheral urban spaces opened up as centers of condoned deviance, became more visibly sexualized spaces of gay cosmopolites, and finally were transformed into spaces of neighborhood and community organization. It was not until the 1970s that social and cultural upheaval finally erupted into the visible consolidation of urban gay sex life with broader social, economic, and political objectives. Cities were the perfect platform for emergent gay communities precisely because they were fortified from the forces of political and social opposition.

San Francisco condoned deviant subcultural spaces starting in the early 1950s (Castells, 1983; D'Emilio, 1981; Jackson, 1989). Gay bars sprung up around the North Beach area, and the Black Cat, in particular, became the center of early gay life in the city. Urban Beatnik culture was permissive of many activities U.S. society labeled "deviant" (Castells, 1983; D'Emilio, 1981). Accordingly, the City of San Francisco established informal physical boundaries for deviant activities to occur (including prostitution and drug use) (Castells, 1983). In 1951, a California Supreme Court decision barred police from raiding bars and revoking liquor licenses on the sole basis that the patrons were homosexual (Castells, 1983; Meeker, 1985). Compared to the rest of the country, gay social space was informally and formally sanctioned. The liberal culture that enshrined gay life ensured that the space was livable in the first place. More important, urban spaces were distinguished from nonurban spaces by the relative cultural acceptability of "deviant" behaviors and activities.

Throughout the 1960s, many gay men resided in less-visible, urban subcultural communes. In his ethnography of the early gay community in London, for example, Birch (1988) describes the day-to-day interactions of gay men residing in communes near Covent Garden. Like many of the early gay migrants, Birch himself was an expatriate of the English countryside who sensed the allure and freedom of the city. In Birch's analysis, the gay commune structure was very much tied to the Gay Liberation Movement in which the broader political objective of "challenging the role of the nuclear family and the ideal of monogamy […]" (p. 51) took precedence over more social objectives of local community transformation.

In San Francisco, gay social scenes and cruising locations facilitated real-estate speculation around previously underdeveloped areas (Castells, 1983). Bell (1991) calls these the "pleasure geographies of gay nightlife." From the beginning, the movement to construct an urban gay community was male dominated because "[…] male spaces [were] more numerous and frankly more sexually-oriented than female spaces" (Knopp, 1990a, p. 21). Knopp (1990b) concludes that the geography of sexuality, therefore, is primarily an urban geography. Bars, parks, bathhouses, and anonymous meeting locations—mostly located in cities—were gathering places for homosexual men.

As more men poured into cities the underground sexual geography transformed to a more social and cultural geography. Castells (1996) contextualizes the objectives of urban migratory movements as obtaining, "(i.) Urban demands on living conditions and collective consumption; (ii.) The affirmation of local cultural identity; and (iii.) The conquest of local political economy and citizen participation" (p. 60). Relating to Castells' first objective, the incoming wave of gay migrants demanded proximity to the city's many social and economic amenities for collective consumption (Lauria & Knopp, 1985). These included work, civic culture, and sex. In the early 1970s a movement was informally organized among San Francisco gays to take over an abandoned Irish Catholic working class neighborhood (Castells, 1983). "The Castro" district presented two distinct characteristics. First, the homes were traditionally Victorian and were in relatively decent condition. Second, the area was middle-income and relatively affordable for many gays. Since homosexuals were predominately young, single, and childless, many pooled their incomes to afford the cost of neighborhood rents. This purposeful effort to populate the Castro resulted in the cultivation of gay commercial and business enterprises. Income inequalities, however, forced poorer gays to populate the South of Market (SoMa) neighborhood (Castells, 1983).

Economic Drivers of Urbanism

Physical neighborhood transformation was mostly driven by changes in the urban housing market. Castells (1983) observes that a second wave of more affluent gay professionals soon replaced poorer gay migrants. These professionals moved into the community, formed collectives, and pooled their incomes to purchase and renovate inexpensive buildings. Castells (1983) notes that this movement both improved the overall aesthetic quality of neighborhoods and inflated home values. Many residences in the adjoining Western Addition, Haight Ashbury, Potrero Hill, and Bernal Heights neighborhoods were similarly in declining condition when gays arrived. Lauria and Knopp (1985) collapse this process of urban redevelopment and gentrification into the umbrella term "urban renaissance." The increasing valuation of homes in the Castro had the effect of pushing up neighborhood rents beyond the reach of many lower income minority groups (Castells, 1983; Jackson, 1989). Violent clashes with neighboring black and Latino communities became frequent as the demand for new housing expanded into working-class neighborhoods, such as San Francisco's Mission district and Haight Ashbury (Castells, 1983).

Knopp (1990b) reconsiders the specific drivers behind urban housing redevelopment in emergent gay neighborhoods. In his study of the gay community in New Orleans, Knopp found that gentrification is more related to changes on the supply-side than the demand-side. Gay communities did not necessarily gentrify because the demand for housing grew exponentially. Rather, Knopp found that wealthy (often gay) land developers bought many residential and commercial properties and sold (supplied) them to gay middle-class professionals. Knopp (1990b) states that even nongay land speculators often had to make a difficult choice "[between] allying themselves with an unpopular social movement, or sacrificing their economic self-interest in order to avoid such an alliance" (p. 338). Gay urban redevelopment, therefore, is more of an income driven-phenomenon than an identity-driven phenomenon. Although Knopp's perspective describes the availability of housing to a discriminated class at the time, it is more likely that a combination of identity and income-related variables influenced shifts along the supply and demand curves in urban housing markets.

The role of gays in these markets did not go unfettered by the larger social and economic structure of the city. Gay housing and community development was spatially bounded by several socioeconomic variables. Castells (1983) examined several factors including the spatial proliferation of gay commercial and business enterprises, votes for gay candidates, the locations of multiple-male occupied homes, and maps generated by key informants. He found that gay concentrations tended to evolve along similar neighborhood lines and concluded, "The old triumvirate of social conservatism," property, family, and high class, restricted gays from spreading across the city and into the suburbs (Castells, 1983, p. 199). According to Castells (1983), gays did not concentrate in or around areas with (i.) high proportion of property ownership, (ii.) high proportions of family

concentrations and/or (iii.) at or above an income threshold. High land value by itself did not restrict gays from moving into higher class residential neighborhoods, but they did exclude poorer gays. Although gays gentrified lower income neighborhoods, gay concentrations hit a spatial wall when they came up against any of these forces (Castells, 1983).

Curiously, lesbian women concentrate differently than gay men, and therefore do not gentrify. Castells (1983) argues that this difference is more natural than social. According to Castells, men are instinctually driven to conquer territory, whereas women are more familial and emphasize intimate social networks. Some urban geographers have concurred with Castells' assertion that the physical signs of lesbian concentrations are absent, but note that the absence of physical signs of subculturization does not imply the absence of lesbian concentrations altogether (Adler & Brenner, 1997; Bell, 1991; Jackson, 1989). Adler and Brenner (1997) applied Castells' methodology to lesbian concentrations in a major Southwestern city. Unlike gay men, Adler and Brenner conclude that lesbian women confront a number of issues that are salient to them *as women*. First, the authors argue that lesbians do not have the same access to capital that men have. Second, lesbians are more likely than gay men to be primary caretakers of children. Last, lesbians are particularly vulnerable to acts of male violence. These issues describe the unique concerns of women in U.S. and world society. With regard to spatial concentration, lesbians reside in "hidden neighborhoods" that blend into communities but lack the physically obvious signs of subculturization. Only gay men gentrify for these reasons.

Gay involvement in the urban housing market is a popularly cited, and often controversial, component of the urbanism discussion. Gay gentrification, particularly, is "continually us[ed] in such a way as to reflect gay cultural values and serve the special needs of individual gays vis-à-vis society at large" (Lauria & Knopp, 1985, p. 159). More than any other form of economic influence, gentrification changed the look and feel of urban neighborhoods. Elucidating a subcultural theory of urbanism, Fischer (1976) proposes that the distinctive traits of urban subcultures are intensified by the city's size, density and heterogeneity. As cities increase in density and size, individuals are more likely to feel different from one another and bind together around shared identities. Applying this framework, "gay space" is distinguished by the many racial, ethnic. and class-defined compositions of adjacent urban neighborhoods. Subcultural theory suggests that gentrification is one way space amplifies distinctions. It has been argued, however, that this amplification was not inclusive of the broader LGBT community. Hemmings (1997), for example, notes that bisexuals often feel like tourists in gay neighborhoods.

It may be true that gays increased the aesthetic quality of urban neighborhoods, but these physical transformations did not go unfettered by prevailing heterosexual society. In fact, housing structures may have even acted *against* the growth of an organic gay identity. Watson (1986) observes, "Housing exists not simply as a means to satisfy a need; it also embodies a set of social relations" (p. 8). Adds Bell (1991): "Housing is primarily designed, built, financed, and intended for nuclear families—reinforcing a cultural norm of 'family life' with heterosexuality and patriarchy high on the agenda" (p. 325). In this new urban territory, gays transformed homes insofar as the physical structure of urban housing market allowed. In a postmodern sense, gay urban redevelopment may have appeared to affirm the emergent local cultural identity, but inevitably, this identity was neither completely original nor unbounded by the current structure of social relations. The old Victorian homes of the Castro were originally built and intended for traditional families, but gays had to make do with the existing physical structures that occupy urban space. Therefore, the homes gays came to occupy and renovate were not organic cultural representations of gay identities, but constructions based on predetermined social realities.

The development of a parallel economy further marked urban spaces as distinctive neighborhoods. In San Francisco, the pink economy "took its name from the pink triangle […] Hitler forced homosexuals to wear in Nazi concentration camps" (Heger, 1994, p. 127). Jackson (1989) notes that gays employed one another, patronized gay-owned stores, sought gay professional advise (therapists, doctors, and lawyers), and took advantage of a variety of gay services—from plumbing to furniture removals. Both Jackson (1989) and Castells (1983) also describe the

prominence of the Golden Gate Business Association, which became an extensive network for gay business professionals. Gays not only used their cultural power to transform residential neighborhoods in the urban housing market, but they also used their economic prowess to build an alternative economic infrastructure. In essence, they constructed cities-within-cities where inhabitants never had to leave to satisfy their sexual, recreational, cultural, or commercial desires (Epstein, 1987).

Political Drivers of Urbanism

Throughout the 1950s, the stigmatization of lesbians and gays internalized feelings of difference with heterosexuals (Epstein, 1987). It was not until the 1960s that an urban-based LGBT movement was organized around the notion of radical liberation. "Liberation" was the countercultural reaction to the widespread oppression of lesbian, gay, bisexual, and transgender people. The purpose of liberation was to emancipate oneself from internalized stigmas, and to embrace sexuality as part of a natural order. Stated an organizer in the Gay Liberation Movement, "The reason so few of us are bisexual is because society made such a big stink about homosexuality that we got forced into seeing ourselves as straight or nonstraight" (Epstein, 1987, p. 18). Writing about the impact of radical liberation, D'Emilio (1983) notes:

> The gay liberation movement […] began the transformation of a sexual subculture into an urban community. The group life of gay men and women came to encompass not only erotic interactions but also political, religious and cultural activity. Homosexuality and lesbianism [became] less of a sexual category and more of a human identity. (p. 243)

During the 1970s, the movement shifted: "Gone were the dreams of liberating society by 'releasing the homosexual in everyone.' Instead, homosexuals concentrated their energies on social advancement *as homosexuals*" (Epstein, 1987, p. 21). This moment in the 1960s was important because, amid the tumult and disorganization of society, lesbians and gays started to organize around their common feelings of differences with the heterosexual majority. Thomas (1986) describes what it meant to become part of a gay community in the 1960s. Unlike other identity movements, the gay movement was unique because it required individuals to "come out" first. Coming out is a public proclamation of sexuality: it is both an affirmation of selfhood and a pronouncement of difference. By coming out, lesbians, gays, and bisexuals can enjoy the cultural institutions of urban gay spaces with some impunity from social reprisals (Jackson, 1989; Herdt, 1992; Bell, 1991). Following Stonewall, hundreds of thousands of men were attracted to the city because they too wanted to liberate themselves from stigma. In San Francisco, gay civic associations and communes were organized to unite lesbians and gays around common values and lifestyles. One of the earliest associations, the Society for Individual Rights, was established to protect the legal rights of gay men. Similarly, the Daughters of Bilitis was also founded in San Francisco to educate and support lesbian women who were afraid to come out. Cities provided lesbians and gays with a platform to organize, publicize, and consolidate. Coming out was as much of a self-affirming act as it was a political declaration.

Urbanism provided a platform for political power to consolidate around this newfound identity (Brown, Browne, & Lim, 2007). When confronted with a hostile popular culture, gay men turned to the political apparatuses of cities to defend their urban sexual, recreational, commercial, and residential spaces (Lauria & Knopp, 1985). This was primarily facilitated through concentrating in certain residential neighborhoods (Castells, 1983; Lauria & Knopp, 1985). The consolidation of political power at the neighborhood-level allowed gays to define the issues most salient to them and press for their attention locally (Thomas, 1986).

In San Francisco's Castro neighborhood, the movement toward a more diffuse power structure enabled gay concentrations to organize politically (Castells, 1983). The disintegration of pro-growth coalitions around 1974 opened up an opportunity for liberal Mayor George Moscone to win election. Former Mayor Joseph Alioto pacified many minorities and labor activists by working with

the business community in the city to create more service-sector jobs (Thomas, 1986). By 1974, however, President Richard Nixon defunded the federal Model Cities and urban renewal programs, effectively depriving the pro-growth coalition of the patronage that fueled it (Castells, 1983). Moscone's coalition included organized labor, black leaders, several middle-class neighborhood associations, and (for the first time ever) an organized gay community. In November 1976, San Francisco voters approved a referendum that would elect city supervisors at the district level. Previously, the city's board of supervisors comprised 11 citywide positions, which tended to disproportionately reflect the conservative orientation of suburban voters. Castells (1983) notes that the 1976 referendum changed the composition of the San Francisco Board of Supervisors. The referendum caused the election of "two pro-labor Black women, two progressive White women, a socialist gay leader, and a well-known civil rights lawyer" (Castells, 1983, p. 137).

Harvey Milk, who lost the race for city supervisor in 1973 and 1975, won in 1977 under the more diffuse, pluralistic, district-wide power structure. Although Milk attracted more support running under a refined "straight image" citywide in 1975, his 1977 district included the Castro, Haight-Ashbury, and Noe Valley. These neighborhoods were considered prime turf for the Milk campaign (Castells, 1983; Thomas, 1986). Writing about the ascendency of Harvey Milk, Thomas (1986) notes that he gave meaning to "gay politics." Before Milk, there was no formally organized gay political movement. "Gay politics," if it existed, exerted only limited influence from outside the political system. In the short 11-month period that Milk served as a city supervisor, he was instrumental in forming a gay voting bloc. As supervisor, Milk worked with groups such as the Chinese-American Democrats, the Teamsters, and the Fireman's Union, who were all improbable interests to coalesce around political and policy issues (Castells, 1983; Thomas, 1986).

A 1980 ballot measure reinstated citywide elections following a wave of conservative resurgence. Nevertheless, the San Francisco experience illustrates how gay spatial concentrations influenced local politics. San Francisco may seem unique for the simple reason that Harvey Milk was the first openly gay elected politician, however, gays influenced local politics in other U.S. cities, as well (Jackson, 1989; Lauria & Knopp, 1985). Bailey (1998) describes the gay influence in New York City's 1981 mayoral election. Lauria and Knopp (1985) indicate that, "openly gay candidates have been elected to mayoral positions, city councils, and state legislatures in San Francisco, West Hollywood, Minneapolis, Boston, Laguna Beach, and Key West. Straight mayors, councilors, and even statewide candidates have actively courted gay votes in virtually every major city in the country […]" (p. 159). The local impact of urban gay concentrations may have been a phenomenon unique to the United States (Knopp, 1990a). In comparison, organized gay concentrations could not exert similar local influence under a more centralized power structure, such as in London (Bell, 1991). Around the time of Lauria and Knopp's writings, LGBT political influence was in its infancy; it is now clear that gay political influence transcends national and even international boundaries (Contreras, 2007). It all started in neighborhoods.

Culturally distinct neighborhoods appeared in major U.S. cities in and around the early 1960s. Underground gay subcultures were not new, but the cultural self-identification with "being a gay person" was new. San Francisco is but one example of how the city could provide social, economic, and political utility to emergent local cultures. As Castells (1983) identified, urban migratory movements first make demands on the urban living conditions, then bond over shared cultural identities, and finally utilize these elements to broker for political power at the local level. In many major U.S. cities and across the Western world, social, economic and political drivers of urbanism transformed how the broader "gay community" identifies itself. Despite these changes several criticisms have been surfaced against the prevailing gay identity. In the following discussion, this paper will conclude with remarks on urban identity formation, and the emergent global competition for gay capital.

Discussion: On Identity and Urban Space

> *Places are more than locations on maps […] They are cultural creations with varying meanings to the different people that experience them. (Hodge, 1995, p. 43)*

As white, middle-class Americans depopulated cities after World War II, urban space became available for lesbian and gay migrants. Cities offered many amenities for lesbians and gays. For one, they liberated a stigmatized class of repressed people by allowing them to publically express their sexual preferences. Urban space also allowed lesbians and gays to concentrate in residential neighborhoods, create their own unique space, and organize politically. As gay communities were shaped in urban centers, so too was the cultural conception of a gay identity.

Social constructivists of either interactionist or labeling persuasions can agree that actions manifest meaning: gays created community space precisely out of the need to escape cultural stigmatization. In traditional suburban, middle-class American families, homosexual practices were reviled. "Coming out" was often met with family disownership at its worst or disapproval at best; acceptance was rare. Cities offered boundless opportunities. In Goffman's (1963) parlance, the internalized gap between "primary deviance" and "secondary deviance" could be reduced, if not fully eliminated, by moving to the city. Downtown districts offered early gay migrants the opportunity to lead free and expressive lifestyles. Many bound together in residential neighborhoods to protect themselves under the fortified fabric of the city. As gays migrated, concentrated, and even gentrified, the social construction of an identity followed the physical construction of a community. In the chaos and disorder of the city, it was almost necessary to distinguish oneself socially, economically, and politically in space. Urbanism allowed for individuals to represent their community in real, physically distinctive ways. Borrowing from symbolic interactionism, this construction of a shared identity was informed by the meanings collectives ascribe. In the gay community, these include shared values, norms, and mores. In creating a more concrete urban identity, gays inadvertently created a universally recognizable identity: "[A] shift from Gemeinschaft to Gesellschaft, from gay community, to gay culture nationally […]" (Herdt, 1992, p. 11).

This piece did not address whether the identity that resulted from urbanism was *representative* or even *authentic* of the entire gay population. Jackson (1989) advises readers to view what comes across as gay identity with extreme caution: "What usually passes for the 'gay community' is actually a minority of a minority—its most politicized and vocal fraction" (p. 128). Lauria and Knopp (1985) emphasize that urban gay identity is white, middle-class, and male. Knopp (1990b) later asserts, "[I]t is easier, economically and otherwise, for middle-class White males to identify and live as openly gay people than it is for women, non-Whites, and non-middle class people" (p. 339). Indeed, it has been argued that white, middle-income males generally have more discretionary income, and thus a greater allocation of resources that would enable them to move to a gay neighborhood in the first place. Therefore, we should view the shared norms, values, and mores that constructivists assert created an identity with extreme caution.

Several scholars contend that the gay identity is a cultural manifestation heavily driven by white, middle-income men (D'Emilio, 1983; Hodge, 1995; Jackson, 1989; Knopp 1990a, 1990b; Lauria & Knopp, 1985). In his study of suburban homosexuality outside of Sidney, Australia, Hodge (1995) finds that it is inappropriate to only look at sexuality and space through the lens of urban gay communities alone. If we exclusively scrutinize the most visible, we completely miss the invisible. What does *authentically* gay space look like? Of the estimated 25 million lesbian and gay Americans in 1989, Jackson (1989) notes, "[There were] 3.5 million [lesbian and gay] people below the federally-defined poverty line; 4 million malnourished people, many of them children; and 400,000 homeless people" (p. 128).[1] Straight space is easy to define because it is ubiquitous and so too are

[1] Jackson's (1989) figures are based on Kinsey, Pomeroy, and Martin's (1948) contention that 10% of the U.S. population is non-heterosexual.

its inhabitants. Gay space is limited to those *other* neighborhoods, where the majority of the people who identify as lesbian, gay or bisexual, or have same sex attractions, do not live.

Another invisible group, often overlooked in academic discussions of the LGBT community, are bisexuals. Hemmings (1997) notes that the prevailing "monosexual" cultural narrative does not acknowledge the existence of bisexuality (p. 152). Bisexuals lack physical spaces of their own, which prevents the shared bonds and experiences that create identities in the first place. A recent report out of the Williams Institute at the University of California at Los Angeles found that bisexuals are the "most closeted" group in contemporary U.S. society, even though they are the largest of the LGBT community (Gates, 2011).

Moving forward, urban gay communities confront a number of internal and external challenges. For one, lesbians and gays are increasingly leaving urban villages in favor of the suburbs and even rural areas. Kirkey and Forsyth's (2001) study on rural gay men revealed that many of the social amenities such as tolerance, free expression, and safety are now also available in rural areas. Doderer (2011) points out that many of the sexual amenities that once drew gays into the city have been phased out by new technologies, namely the Internet. Writing about gay suburbanization, Lynch (1992) notes that homeownership primarily drives lesbians and gays to relocate to the suburbs. However, Lynch also notes that lesbian and gay lifestyles are not always accepted in the suburbs. Looking at gay suburbanization internationally, Hodge (1995) calls for more research into this area. The process of deconcentration and attraction to the suburbs may be a subject for further research.

Another threat to gay culture and identity comes in the form of urban commodification and the "Disneyification" of gay space. Brown, Browne, and Lim (2007) note that several "wanna be world cities" are engaged in a global competition to attract capital (p. 126). One way to bring money into a city's coffers is to market a vibrant gay community. Examples of this include Manchester and Newcastle, United Kingdom, and Melbourne, Australia. Richard Florida's (2003) seminal piece describing the "creative class" of post-industrialized cities underscores the importance of the gay community to urban economic development strategies. Florida found that areas with high gay concentrations correlate strongly with areas of future economic growth. As cities work to attract high tech capital in the twenty-first century, marketing to potential gay constituencies attract creative professionals who seek a diverse and tolerant city culture. Several criticisms have been levied against these urban promotional strategies. First, these initiatives are unauthentic to the gay experience. A citywide strategy of nonorganic gay branding heightens the artificiality of gay neighborhoods. Second, cities that intentionally market a thriving gay culture may have more creative control over the forms of expression in these urban spaces. These controls conflict with the sexually expressive nature of many gay communities, as Castells identified. Finally, in de-sexualizing these communities, Brown, Browne, and Lim (2007) are concerned that gays have been inadvertently forced to display more heteronormative lifestyles to appease the often-straight tourists who visit.

Today, cities embrace and promote gay civic culture to attract creative capital. In contemporary U.S. society, it seems, having a vibrant and active gay community is associated with urban redevelopment and panache. This is a far cry from the relegation of gay sexual behavior to the periphery of the city. Between 1950 and the present, gay identity has undergone a significant transformation. Before 1950, there was no "gay person" so-to-speak, only deviant sexual behavior. After the Stonewall riots of 1969, however, thousands of migrants found social, economic and political empowerment in the city. Concentrating in residential neighborhoods not only bore local cultures, but local identities—and from those identities, a degree of freedom and self-affirmation.

The social construction of a gay identity draws many caveats. First, gay neighborhoods are arguably unrepresentative of a true identity (if there is one). One reason urban economic development offices regard gay civic culture so highly is because gays are thought to represent a monolithic demographic group that is characterized by medium-to-high wealth attainment and social status. This characterization is highly generalized. In 2010, an estimated 4% (8 million) of American adults identified as being lesbian, gay, bisexual, or transgendered, and a full 11% of

Americans (25.6 million) are estimated to acknowledge some same-sex attraction (Gates, 2011). If these proportions are correct, they seem to indicate that Kinsey, Pomeroy, and Martin's (1948) hypothesis (claiming that 10% of the population is non-heterosexual) is not that far off. Does the identity that emerges from gay neighborhoods represent all individuals with same sex attractions, or is it an urban-based identity? As Jackson (1989) describes, what would a poor gay identity look like? How about a black gay identity? Surely the identity of white, middle-income males cannot be the only version of what it means to be "gay." Second, the clustering of gay concentrations reinforces popular conceptions of gay identity, which are easily amplified by media portrayals of gay people in popular culture. These images support the notion that the people who reside gay neighborhoods represent all LGBT people. Last, and most abstractly, if we ignore the social processes that construct identity, we risk the blind assumption that "gay identity" is itself biologically innate.

Geographers, gender and queer theorists, and urbanist scholars need to more broadly recognize that identity, and gay identity in particular, is socially constructed. At a minimum, prevailing social science research in this area should examine the shared norms and cultural values that allowed for the creation of gay spaces and identities to flourish. In this new era of post-industrialized competition for global capital, it would be easy to forget about the link between gay identity and the social drivers of urbanism. Failure to do so could further engender stereotypes of LGBT transgender people.

References

Adler, S., & Brenner, J. (1997). Gender and space: Lesbians and gay men in the city. In J. Lin & C. Miele (Eds.), *Urban sociology reader* (pp. 200–207). New York: Routledge.

Armstrong, E. A. (2002). *Forging gay identities: Organizing sexuality in San Francisco, 1950-1994*. Chicago: University of Chicago.

Bailey, R. W. (1998). *Gay politics, urban politics: Identity and economics in the urban setting*. New York: Columbia University.

Bell, D. J. (1991). Insignificant others: Lesbian and gay geographies. *Royal Geographical Society, 23*(4), 323–329.

Berube, A., & Escoffier, J. (1991). Queer nation. *National Lesbian and Gay Quarterly, 11*, 12–19.

Birch, K. (1988). A community of interests: Structure and aims of the Gay Liberation Movement; commune life; relationships and concepts of liberation. In B. Cant & S. Hemmings (Eds.), *Radical records: Thirty years of lesbian and gay history, 1957–1987* (pp. 32–37). New York: Routledge.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

Brown, G., Browne, K., & Lim, L. (2007). Introduction, or why have a book on geographies of sexualities? In G. Brown, K. Browne, & L. Lim (Eds.), *Geographies of sexualities: Theory, practices and politics* (pp. 1–20). Burlington, VT: Ashgate.

Castells, M. (1983). City and culture: The San Francisco experience. In I. Susser (Ed.), *The Castells reader on cities and social theory* (pp. 130–231). Malden, MA: Blackwell.

Castells, M. (1996). *The information age, vol. 1: The rise of the network society*. Oxford, England: Blackwell.

Christopherson, S. (1989). On being outside the project. *Antipode, 21*(2), 83–89.

Cohen, A. P. (1982). *Belonging: Identity and social organisation in British rural cultures*. Manchester, England: Manchester University.

Contreras, J. (2007, September 17). Winning the war: Why the battle for gay rights is gaining ground across the globe. *Newsweek, 150*(12), 51.

D'Emilio, J. (1981). Gay politics and community in San Francisco since World War II. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (1st ed., pp. 59–79). New York: Columbia University.

D'Emilio, J. (1983). *Sexual politics, sexual communities: The making of a homosexual minority in the United States, 1940–1970*. Chicago: University of Chicago.

D'Emilio, J. (1992). Capitalism and gay identity. In *Making trouble: Essays on gay history, politics, and the university* (pp. 3–16). New York: Routledge.
Davis, K., & Heilbroner, D. (Producer), & Davis, K., & Heilbroner, D. (Director). (2011). *American experience: Stonewall uprising.* [DVD] WGBH Educational Foundation. Retrieved from http://www.pbs.org/wgbh/americanexperience/films/stonewall/
Doderer, Y. (2011). LGBTQs in the city: Queering urban space. *International Journal of Urban and Regional Research, 35*(2), 431–436.
Epstein, S. (1987). Gay politics, ethnic identity: The limits of social constructionism. *Socialist Review, 17*(3-4), 9–54.
Evans-Pritchard, E. E. (1970). Sexual inversion among the Azande. *American Anthropologist, 72*(6), 1428–1434.
Fischer, C. S. (1976). Theories of urbanism. In J. Lin & C. Miele (Eds.), *Urban sociology reader* (pp. 51–58). New York: Routledge.
Florida, R. (2003). Cities and the creative class. *City & Community, 2*(1), 3–19.
Foucault, M. (1978). *The history of sexuality* (1st ed.). New York: Pantheon Books.
France, D. (2007, June 25). The science of gaydar: If sexual orientation is biological, are the traits that make people seem gay innate, too? The new research on everything from voice pitch to hair whorl. *New York,* pp. 13.
Gagnon, J. (1977). *Human sexualities* (1st ed.). Glenview, IL: Scott, Foresman & Co.
Gates, G. J. (2011). *How many people are lesbian, gay, bisexual and transgender?* (Online). Los Angeles, CA: Williams Institute, University of California Los Angeles School of Law.
Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.
Harris, L. A. (1996). Queer black feminism: The pleasure principle. *Feminist Review, 54*, 3–30.
Heger, H. (1994). *The men with the pink triangle: The true life-and-death story of homosexuals in the Nazi death camps* (D. Fernbach, Trans.). New York: Alyson Books.
Hemmings, C. (1997). From landmarks to spaces: Mapping the territory of a bisexual genealogy. In G. B. Ingram, A. M. Bouthillette, & Y. Retter (Eds.), *Queers in space: Communities, public places, sites of resistance* (pp. 149–162). Seattle: Bay Press.
Herdt, G. (1984). Ritualized homosexuality in male cults of Melanesia, 1862–1983: An introduction. In *Ritualized homosexuality in Melanesia* (1st ed., pp. 1–82). Berkeley: University of California.
Herdt, G. (1992). Introduction: Culture, history and life course of gay men. In G. Herdt (Ed.), *Gay culture in America: Essays from the field* (pp. 1–28). Boston: Beacon Press.
Hodge, S. (1995). "No fags out there": Gay men, identity and suburbia. *Journal of Interdisciplinary Gender Studies, 1*(1), 41–48.
Jackson, P. (1989). Gender and sexuality. In *Maps of meaning: An introduction to cultural geography* (pp. 120-127). London: Unwin Hyman.
Jenkins, R. (2008). *Social identity* (3rd ed.). New York, Routledge.
Khayatt, D. (2002). Toward a queer identity. *Sexualities, 5*(4), 487–501.
Kinsey, A., Pomeroy, W., & Martin, C. (1948). *Sexual behavior in the human male*. Philadelphia: W.B. Saunders.
Kirkey, K., & Forsyth, A. (1992). Men in the valley: Gay male life on the suburban-rural fringe. *Journal of Rural Studies, 17*, 421–441.
Knopp, L. (1987). Social theory, social movements and public policy: Recent accomplishments of the gay and lesbian movements in Minneapolis, Minnesota. *International Journal of Urban and Regional Research, 11*, 243–261.
Knopp, L. (1990a). Social consequences of homosexuality. *Geographical Magazine, 62*(5), 20–25.
Knopp, L. (1990b). Some theoretical implications of gay involvement in an urban land market. *Political Geography Quarterly, 9*(4), 337-352.
Knopp, L. (2007). From lesbian and gay to queer geographies: Pasts, prospects and possibilities. In K. Browne, G. Brown, & L. Lim (Eds.), *Geographies of sexualities: Theory, practices and politics* (pp. 21–28). Burlington, VT: Ashgate Publishing Limited.

Lady Gaga. (2011). *Born this way*. Santa Monica, CA: Streamline Records.
Lauria, M., & Knopp, L. (1985). Towards an analysis of the role of gay communities in the urban renaissance. *Urban Geography, 6*(2), 152–164.
Lynch, F. R. (1992). Nonghetto gays: An ethnography of suburban homosexuals. In G. Herdt (Ed.), *Gay culture in America: Essays from the field* (pp. 165–201). Boston: Beacon.
Maylon, A. (1982). Biphasic aspects of homosexual identity formation. *Psychotherapy: Theory, Research and Practice, 19*(3), 335–340.
McIntosh, M. (1968). The homosexual role. *Social Problems, 16*(2), 182–92.
Meeker, J. W. (1985). State law and local ordinances in California barring discrimination on the basis of sexual orientation. *University of Dayton Law Review, 10*(3), 745–765.
Rahman, M. (2000). *Sexuality and democracy: Identities and strategies in lesbian and gay politics*. Edinburgh: Edinburgh University.
Rosenthal, R., & Jacobsen, L. (1968). *Pygmalion in the classroom: Teacher expectation and pupils' intellectual development*. New York: Holt, Rinehart and Winston.
Thomas, D. J. (1986). The gay quest for equality in San Francisco. In J. K. Boles (Ed.), *The egalitarian city: Issues of rights, distribution, access and power* (pp. 27). New York: Praeger.
Thomas, W. V. (1977). Saving America's cities. Editorial research reports 1977 (Vol. II). Washington, DC: CQ Press. Retrieved from http://library.cqpress.com/cqresearcher/cqresrre1977111800
Watson, S. (1986). Housing and the family: The marginalization of non-family households in Britain. *International Journal of Urban and Regional Research, 10*(1), 8–28.
Weeks, J. (1998). The 'Homosexual role' after 30 years: An appreciation of the work of Mary McIntosh. *Sexualities, 1*(2), 131–52.

Assessing Lending Institutions' Community Development Activities under the Community Reinvestment Act

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Most of the literature regarding banks' performance under the Community Reinvestment Act (CRA) has focused on mortgage lending, leaving other important effects of CRA on community development (CD) under-examined and overlooked. One of the reasons for this lack of research is that home lending data is more readily available. Another reason is that data on other CRA activities reported in CRA exams are vague and inconsistent. The lack of data makes it difficult to monitor and enforce CRA–regulated bank activity.

To understand this gap, this paper presents a brief literature review of the history and intent of CRA, and an analysis of CRA examinations of large banks operating in Delaware released between 2008 and 2010. What CD activities are lending institutions undertaking to comply with CRA? How are activities measured and reported? Is the level of detail provided sufficient to assess the extent to which these investments are contributing to CD efforts? The findings of this inquiry reveal inconsistencies in how regulatory agencies rate lending institutions. These insights provide the basis for recommending reporting changes that can make the CRA an even more effective policy tool for helping communities access credit, and for helping community organizations provide services in underserved areas.

Introduction

The Community Reinvestment Act (CRA) was passed to ensure that underserved communities have equal access to credit and opportunities for community development (CD). Consequently, banks that fall under its jurisdiction have become a valuable source of non-government funding for CD service organizations, as they have both the assets to provide grants and loans, and the motivation to do so due to CRA requirements. Most of the literature regarding banks' performance under CRA has focused on mortgage lending, partly because the lending score is weighted more heavily in the overall evaluation and partly because mortgage lending data through the Home Mortgage Disclosure Act (HMDA), which requires banks to collect basic demographic and financial data on all mortgage loans they originate, is easier for researchers to obtain. The lack of research on the impact of other CRA activities, such as CD lending and CD giving, "has resulted in overlooking some important impacts of CRA, including the building and strengthening of partnerships between banks and CD organizations and the development of a whole host of new institutions that, but for CRA, would not exist – at least not anywhere near the scale they exist today" (Immergluck, 2004, pp. 237).

The answers to the following research questions regarding banks' CRA CD activities in Delaware begin to make that assessment: What CD activities are lending institutions undertaking to comply with CRA? How are those activities measured and reported under CRA? Is the level of detail provided sufficient to assess how deeply these investments may or may not be contributing to CD efforts?

Methodology

For background on the history of CRA and its impact on banking and CD, a brief literature review was conducted. To answer the research questions above, the CRA examinations of large banks operating in Delaware released between 2008 and 2010 were assessed. The three-year time period was chosen because CRA examinations are required to take place every three to four years. Therefore, going back four years or more would have led to some banks being represented twice and some only once. The three-year span covers nearly every large bank with a presence in Delaware.

Large banks with assets over $1 billion are the focus of the study because different examination methods apply to small banks and wholesale banks, clouding an already difficult comparison. Large banks have more assets and are more likely to make sizeable investments and contributions to CD efforts. The 2008–10 time period yielded nine examinations of eight large banks. One bank was re-examined after one year because it received a score of "Needs to improve," which is the second lowest score a bank can receive. A score of "Needs to improve" could lead community groups or municipalities to challenge the banks' regulated activities such as acquisition of or merger with another institution, opening branches in new areas, or engaging in other regulated activities. Comparison of the nine evaluations resulted in data regarding total HMDA loan amounts, total CD amounts, summaries of community loan activities, total investments, summaries of investments and grants, and summaries of CD services.

Delaware's unique corporate environment has led to many of the nation's largest banks moving their headquarters there. Focusing on banks in Delaware provides an opportunity to study several large banks within the same service area. This allows an analysis of how CRA examinations report CD activities without having to account for regional differences in economy or socio-economic characteristics of the population. As noted below, the reviews in this study included assessments by each of the four regulatory agencies. Therefore, it can be assumed that the format of the exams reviewed here is followed in exams of banks nationwide.

History of CRA

In 1977, the CRA was enacted by Congress in response to evidence that banks were refusing loans to otherwise qualified individuals because they lived in certain areas of cities—a practice known as redlining. The act requires depository institutions above a minimum size to serve the credit needs of all the communities from which they draw deposits. The intent of the law is to ensure equal access to lending institution services and to encourage reinvestment in low- and moderate-income (LMI) communities as a way to reduce urban blight (Essene & Apgar, 2009). Reinvestment includes home mortgage loans, small business investment, investment in CD activities, and location of services. CRA does not require banks to make unsound and unprofitable loans. It does, however, require banks to implement processes for investing in poor communities, ensuring that qualified individuals and organizations within those communities can access credit and services (Essene & Apgar, 2009).

The law also requires the four federal bank regulators to evaluate an institution's lending, investment, and other services throughout the communities it serves, including LMI areas. The Office of the Comptroller of the Currency (OCC) is the primary regulator of commercial banks with national bank charters. The Federal Reserve Board (FRB) is the primary regulator of state-chartered commercial banks that are members of the Federal Reserve System. The Office of Thrift

Supervision (OTS) is the primary regulatory authority over most savings associations. The Federal Deposit Insurance Corporation (FDIC) has primary authority over state-charted, non-FRB member commercial banks and some federally chartered savings banks (Avery, Courchane & Zorn, 2009).

The four regulators periodically evaluate the CRA activities of banks and other lending institutions. After considering each institution's lending, investment, and services within their designated assessment areas, which are defined by the banks based on the communities in which their services are available, the regulators assign one of five possible ratings: Outstanding, High Satisfactory, Low Satisfactory, Needs to Improve, and Substantial Noncompliance (Schwartz, 2010).

In its first 10 years, CRA had little effect on banking activities as "regulators routinely gave lenders passing grades on their CRA assessments" (Immergluck, 2004, p. 163) and denied only eight of an estimated 40,000 applications for merger applications and branch openings (Immergluck, 2004). By the late 1980s and 1990s, enforcement of the CRA increased as bank mergers and acquisitions became more frequent and the federal government under the Clinton administration ramped up enforcement of the law. In 1995 new regulations made CRA examinations more objective and performance-oriented. Before 1995, CRA examinations focused mainly on banks' policies and procedures. Under the new regulations, the examination measures became more outcomes-based and highlighted four categories of CD: affordable housing, community services, economic development through either small business or farm lending, and the revitalization and stabilization of LMI communities (Essene & Apgar, 2009).

The revised regulations also tailored the examination process to account for the institution's size and business strategy. There are four examination modules. The first applies to small retail institutions and measures four lending ratios. The second type of examination is applied to large retail businesses and consists of rigorous tests to evaluate lending, investment, and service. The third module applies to wholesale or limited-purpose community institutions, which are permitted to select the criterion under which they are to be evaluated: CD lending, CD investments, and/or CD services. The fourth module is the "strategic plan" examination, which can be applied to any size institution where the institution determines its own lending, investment, or service performance standards (Ludwig, Kamihachi & Toh, 2009). Large banks—those with assets over $1 billion—are subject to the second module, the most rigorous CRA exams. Exams for small banks are more streamlined (Taylor & Silver, 2009).

The major enforcement provision of the CRA is that it gives standing to community groups and other organizations to challenge mergers, acquisitions, and other activities of banks that have failed to meet their CRA obligations. This is known as "regulation from below" because enforcement actions are initiated by groups representing areas the institution serves rather than by the agencies that oversee the institution's activities (Rust, 2009). To prevent challenges from community groups, many banks have negotiated CRA agreements with these organizations. Such agreements usually contain commitments to provide mortgages, sometimes at reduced interest rates, that target low-income and minority communities and households. Agreements also frequently involve commitments to provide small business loans and financing for construction of LMI housing developments (Immergluck, 2004; Schwartz, 2010; Squires, 2002). As of early 2009, several hundred agreements totaling more than $6 trillion had been signed since the CRA was passed. The majority of these originated from unilateral CRA pledges involving the nation's largest financial institutions (Taylor & Silver, 2009). Studies have shown that banks with CRA agreements tend to be more responsive than other institutions to the credit needs of low-income and minority households and neighborhoods (Bostic & Robinson, 2003; Schwartz, 1998 in Schwartz, 2010).

While community advocates, government officials, and most scholars agree that the CRA has made mortgages and other financial services more accessible to low-income and minority communities and families (Avery et al., 2009; Essene & Apgar, 2009; Squires, 2002; Taylor & Silver, 2009), changes in how the financial system operates have diluted the effectiveness of the CRA. With the consolidation of the banking industry in the mid-1990s, the lending activities in LMI areas of the top 25 large lending institutions has declined even as their total lending activities increased.

The law has no provisions to address the discriminatory tendencies in the pricing and marketing of mortgage loans, which are dominant concerns in fair lending policy (Avery et al., 2009).

In addition, the number of CRA–related loans has declined over the past three decades to the point that, in 2006 (the last full year before the recent recession), only 10% of all loans were CRA–related. Even among CRA–regulated institutions the fastest growth in lending occurred outside their assessment areas and was not subject to the most stringent CRA requirements. From 1994 through 2006, out-of-assessment lending among CRA–regulated institutions grew by 187%. (Essene & Apgar, 2009). The growth in loans outside their assessment areas gives CRA–regulated institutions an advantage in their CRA assessments because the lending portion of the test is worth 50% of the grade, while the investment and services portions are worth only 25% each. With fewer overall qualifying loans, it takes fewer loans to low-income individuals or businesses in low-income neighborhoods to achieve a high percentage and achieve a satisfactory score in the lending portion of the exam, ensuring at least a satisfactory score overall.

This highlights the need to be able to accurately assess the CD investments and services banks offer, and to determine whether they are indeed following the spirit of the CRA to ensure low-income communities have access to capital and good credit. As noted above, detailed data regarding an institution's mortgage lending activities are available in CRA exam reports and can be corroborated through HMDA data. However, "There has been essentially no systematic research on the impacts of CRA in the areas of CD investments and basic financial services. The anecdotal evidence suggests that CRA has been quite important for spurring bank investments, especially since CRA reform gave more explicit credit for such activity" (Immergluck, 2004, p. 246). Olson, Chakrabarti, and Essene (2009) concur, stating: "There is scant research on measuring outcomes from the CRA beyond the outputs of volume, cost access, and profitability of lending" (p. 6).

Community organizing facilitates CD and reinvestment (Squires, 2002). In order to advocate effectively for community reinvestment, community groups need to be able to monitor how banks are lending and investing in their communities. Many CD organizations require grants in addition to loan financing to carry out CD activities. But the evaluation of grants under CRA does not facilitate an assessment of their effectiveness, nor does the way they are scored encourage banks to increase their grant-making activities. Willis (2009) explained the following:

> Many grants for activities that are critical to the success of communities are given little weight or do not count at all. At best, they are included under the Investment Test, so their dollar volume pales in comparison to the dollar value of investments. Interestingly, although grants are more costly in that they do not offer the possibility of a direct monetary return, they earn less CRA credit than investments that can continue to qualify under the Investment Test in subsequent exams as long as they remain in the bank's portfolio. (p. 65)

It is clear that further study of banks' CRA–related CD activities and their effects on communities and institutions is needed.

CRA Community Development Activities in Delaware

As noted earlier, this study included nine CRA examinations of eight large banks in Delaware from 2008 to 2010, with assets ranging from $1.3 billion to $87 billion (Table 1). Each of the four regulating agencies is represented in this study. AIG Federal Savings Bank (AIG) is the smallest of the institutions with $1.3 billion in assets, while Chase Bank USA, N.A. (Chase) is the largest with assets of $87 billion. Only three of the eight banks carry out traditional banking services in Delaware in terms of maintaining full service branches with savings, checking, and lending activities (PNC Bank [PNC], Wilmington Trust Company, and Wilmington Fund Savings Society [WSFS]). The remaining five institutions (AIG, Chase, Citicorp Trust Bank, FSB [Citicorp], Discover Bank, and ING Bank, FSB [ING]) focus on consumer lending – mainly issuing credit cards – and

mortgage lending on a national level. ING does provide savings accounts and checking accounts, but all services are electronic with no branch services available (OTSb, 2008). Because of Delaware's favorable corporate environment, many large national banks are headquartered in Delaware. Each of the CRA examinations cited intense competition from other financial institutions because of the concentration of financial institutions in Wilmington.

Table 1 – CRA Exams Reviewed

Bank Name	Exam Agency	Date Exam Published	Asset Size (billions)
AIG Federal Savings Bank	OTS	2/25/2008	$1.3
AIG Federal Savings Bank	OTS	11/2/2009	$11.5
Chase Bank USA, N.A.	OCC	11/2/2008	$ 87
Citicorp Trust Bank, FSB	OTS	11/9/2009	$18.6
Discover Bank*	FDIC	11/26/2007	$31
ING Bank, FSB	OTS	8/6/2008	$79
PNC Bank, Delaware	FRB	2/4/2008	$3.2
Wilmington Trust Company	FRB	7/20/2009	$9.7
Wilmington Savings Fund Society, FSB	OTS	5/20/2008	$3.2

* Discover Bank exam completed in 2007 but released in 2010.
Data from: FDIC, 2007; FRB, 2008; FRB, 2009; OCC, 2009; OTSa, 2008; OTSb, 2008; OTSc, 2008; OTSa, 2009; OTSb, 2009.

The institution being examined is allowed to designate its assessment area, which is the area in which the bank conducts its lending and deposit activities. Though all but one of the banks in this study are headquartered in Wilmington, the specific assessment areas of each of the banks differed. Discover Bank's main location is Greenwood, Delaware, and so its assessment area comprised Kent and Sussex Counties, Delaware. The remaining banks tended to designate Wilmington-New Castle County, Delaware, and portions of some surrounding states such as Cecil County, Maryland; Chester and Delaware Counties, Pennsylvania; and the portions of New Jersey that fall within the Philadelphia-Camden-Wilmington Metropolitan Statistical Area. AIG changed its assessment area from the Wilmington-DE-NJ Metropolitan Division for its 2008 exam to New Castle County, Delaware, for its second exam.

Each examination includes a detailed description of the designated assessment area. The description includes data on the area's economy, such as the unemployment rate and the types of businesses and industries in the area, as well as demographic data including income, race, and household size. The data are taken from the U.S. Census and from HUD data defining median income in the designated area. The examiners use this data to rate the institution's lending practices, as they have to demonstrate that they are reaching a significant portion of the LMI population and that their activities affect LMI geographies. The varying assessment areas make geographic comparison of the banks' activities difficult. A more uniform method of applying an assessment area would allow for more accurate comparisons of different banks' activities. It would also allow for analysis of a bank's impact on a community over time.

Due to the changes in the banking industry discussed above and the loosening of CRA regulations during the Bush administration in the mid-2000s, the number of exams has fallen while the number of favorable ratings has risen (Quercia, Ratcliffe, & Stegman, 2009). The high number of favorable ratings is reflected in Delaware (Table 2).

Table 2 – CRA Exam Ratings

Bank Name	Overall Rating	Lending Rating	Investment Rating	Service Rating
AIG Federal Savings Bank	Needs to Improve	High Satisfactory	Outstanding	High Satisfactory
AIG Federal Savings Bank	Satisfactory	High Satisfactory	Outstanding	High Satisfactory
Chase Bank USA, N.A.	Outstanding	High Satisfactory	Outstanding	Outstanding
Citicorp Trust Bank, FSB	Outstanding	Outstanding	Outstanding	Outstanding
Discover Bank	Outstanding	Outstanding	Outstanding	Outstanding
ING Bank, FSB	Outstanding	High Satisfactory	Outstanding	Outstanding
PNC Bank, Delaware	Outstanding	Outstanding	Outstanding	Outstanding
Wilmington Trust Company	Outstanding	Outstanding	High Satisfactory	Outstanding
Wilmington Savings Fund Society, FSB	Outstanding	Outstanding	Outstanding	Outstanding

Data from: FDIC, 2007; FRB, 2008; FRB, 2009; OCC, 2009; OTSa, 2008; OTSb, 2008; OTSc, 2008; OTSa, 2009; OTSb, 2009.

AIG was the only bank with a less than Outstanding overall rating, receiving a Needs to Improve on its first test and a Satisfactory on its second test. These were in spite of receiving High Satisfactory and Outstanding ratings in its Lending, Investment, and Services ratings. AIG received its low overall score because it "failed to manage and control the mortgage lending activities outsourced to [an] affiliate" (OTSa, 2008, p. 18). Concern regarding oversight of the bank's fair lending practices was also expressed (OTSa, 2008). These concerns were reviewed in AIG's subsequent exam one year later, and its response was deemed sufficient enough to raise the overall score to Satisfactory (OTSa, 2009).

Scores in the specific tests were all high, with no bank receiving less than a High Satisfactory rating on any test. Wilmington Trust was the only bank with a rating of less than Outstanding on the Investment test and AIG was the only bank to receive less than Outstanding for the Service test.

Interestingly, there is slightly more disparity in the lending test scores. Five bank examinations reflected Outstanding scores in the lending test and four examinations showed High Satisfactory ratings for lending. Most of the banks made a majority of their HMDA loans, which are counted in the CRA exam, outside their assessment area. Some credit is given if loans outside the assessment area are made to LMI households, but regulators focus on loans within the assessment area. The percentage of loans in and outside the assessment area did not differ greatly among the banks, yet the scores varied, demonstrating that an element of subjectivity remains in the assessment process in spite of the efforts in 1995, noted above, to make it more objective. A detailed analysis of each section of the CRA exam follows.

Lending

The majority of the lending section of the exam reports is devoted to HMDA loan data. Regulators report on the number of HMDA loans, the geographic location in which they are made, and the income and racial characteristics of the loan recipients. The Federal Reserve Bank (FRB) also includes small business loan data in this analysis, while the other regulatory agencies devote a separate sub-section to small business loan data. The lending section concludes with a short narrative describing the CD lending

activities of the bank. The narrative usually includes the total amount of CD loans issued during the reporting period and a generalized description of what types of organizations received the loans. In addition to new loans issued, banks receive credit for loans made in prior report periods that remain in their portfolios.

The HMDA loan amounts vary widely and do not correspond directly with the institution's asset size or assessment area (Table 3). For instance, ING granted the fourth lowest amount in HMDA loans in its assessment area, but was the second largest bank in terms of total assets. On the other hand, Chase Bank had the most assets and provided the highest amount in HMDA loans. The lowest HMDA loan total, posted by AIG in its second exam, is a reflection of the shorter than usual exam period and its smaller assessment area for that exam. The total CD loan amounts were equally varied. The amounts of AIG and Citicorp's CD loans were substantially higher than their HMDA loans, while the other banks' CD loan amounts were lower than their HMDA loans. The level of detail as to what organizations these loans were made, their amounts, and their stated purposes varied by exam as can be seen in the description of how each bank's CD lending is rated below.

Table 3 - Lending

Bank Name	Asset Size (billions)	Total Assessment Area HMDA Loan Amount	Total CD Loan Amount
AIG Federal Savings Bank	$1.3	$215,783	$3 million
AIG Federal Savings Bank	$11.5	$30,606	$1.3 million
Chase Bank USA, N.A.	$ 87	$1.2 billion	$16.6 million
Citicorp Trust Bank, FSB	$18.6	$80,718	$22.3 million
Discover Bank	$31	$55.8 million	$21 million
ING Bank, FSB	$79	$739,097	$700,000
PNC Bank, Delaware	$3.2	$87.3 million	$14.4 million
Wilmington Trust Company	$9.7	$375 million	$16.3 million
Wilmington Savings Fund Society, FSB	$3.2	$341 million	$45.8 million

Note: Small business lending not included because this data were not always enumerated separately. Data from: FDIC, 2007; FRB, 2008; FRB, 2009; OCC, 2009; OTSa, 2008; OTSb, 2008; OTSc, 2008; OTSa, 2009; OTSb, 2009.

In its first exam, AIG Bank (AIG) was credited with a total of $3 million in CD loans. That $3 million was in the form of a line of credit to the Delaware Community Investment Corporation (DCIC), which is a CD financing organization funded by several Delaware banks to provide financing for affordable housing projects in Delaware. In the exam period, $1.6 million of that line of credit was provided to DCIC (OTSa, 2008).

In its second exam, AIG was credited with providing $1.3 million in new CD loans. This time, the loans were for eleven projects through a housing loan fund. At the time of the assessment, AIG had previously committed $5 million to this fund, and $1.3 million of the $5 million was advanced during the exam period. The date when AIG committed the total $5 million was not included in the report. Unlike the previous AIG report, this report does not specify the recipient organization

(OTSa, 2009).

Chase made $16.6 million in CD loans that qualified for CRA credit. The regulatory agency, OCC, reported that this amount was double the amount of CD loans that Chase had made during the previous assessment period. The $16.6 million in CD loans resulted in nearly 80 units of affordable housing. In addition, Chase issued a letter of credit to a nonprofit institution for $4.6 million. Finally, Chase made an additional $13.2 million in CD loans statewide, with a potential to benefit the assessment area, meaning the loans were made outside the assessment area, but spillover effects could positively impact the assessment area. OCC rated Chase's CD lending as "good," but "not strong enough to impact the lending score (of High Satisfactory)" (OCC, 2008, p. 3). This exam was the only one to report the purpose of any CD lending.

Citicorp provided $22.3 million in CD lending. Its exam itemized the amounts and the agencies that received loans, but did not report what activities or projects these loans funded. In addition to the $22.3 in CD loans in the assessment area, Citicorp was credited with $302 million in CD loans to the Broader Statewide or Regional Assessment Area (BSRA) which had a potential to benefit the specific assessment area (OTSb, 2009).

Discover Bank, with a total of $21 million in CD loans, according to FDIC, "is a leader among credit card banks in the assessment area for community development lending" (FDIC, 2007, p. 3). The loans were used for the creation of affordable housing, community services targeted to LMI populations, and agencies that work to revitalize communities. Examples from each of these categories are included, but not every loan is included in the summary. The report also notes that Discover purchases every first-time homebuyer mortgage issued by the Delaware State Housing Authority (DSHA) in Kent and Sussex County.

ING made one CD loan of $700,000 during the assessment period. This loan was used to refinance the mortgage of a nonprofit agency that provides financial literacy courses to students in elementary, middle and high schools. The organization, which was not specified, is located in an LMI area in Delaware (OTSb, 2008).

PNC Bank made nine loans totaling $14.4 million in its assessment period. Rather than summarize the organizations or types of organizations to which the loans were made as the other regulatory agencies did, FRB broke the loans down by county in which the loans were made. FRB noted that CD lending by PNC enhanced its overall lending score, which was Outstanding (FRB, 2008).

Wilmington Trust Company provided $16.3 million in CD loans. This amount consisted of nine loans: $12.6 million for affordable housing; $3.7 million for economic development; and $84,000 for CD services. The specific recipients of these loans were not reported, nor was a generic description of the types of agencies receiving these loans (FRB, 2009).

WSFS provided $45.8 million in CD loans for a variety of programs in affordable housing, community services and economic development. OTS, the regulatory agency, listed select loans with "unique characteristics" in its report, but outcomes resulting from those loans are not included (OTSc, 2008).

Recommendation

This summary of the type and use of CD loans demonstrates the vast differences between CRA exam reports, which is partly attributable to the fact that regulatory agencies themselves do not maintain a consistent format. For example, OTS, which regulates AIG, Citicorp, ING and WSFS, summarizes AIG's loans, lists each of Citicorp's loans, and provides examples of loans with "unique characteristics" on WSFS's loans. The lack of consistent data makes it difficult for third parties to verify and analyze the data in the report. Therefore, the four regulating industries should establish uniform reporting standards and formats to rate lending activities. The reports should clearly state how the agency devised its rating of the bank. Finally, at a minimum, the reports should list the amounts of each qualifying CD loan and the purpose of the loan. This level of detail would help CD organizations, which are charged with helping enforce CRA, in measuring the level of CD lending, and its impact on the community.

Investing

Similar inconsistencies are apparent in the Investment test section of the exams. See Table 4 for a list of the CD investment amounts and contributions amounts, when contributions were reported separately from investments, as well as the banks' asset size for comparison. As with lending amounts, investment amounts do not correspond to asset size.

Table 4 - Investing

Bank Name	Exam Agency	Asset Size (billions)	CD Investments Amount (millions)	Contributions Amount
AIG Federal Savings Bank	OTS	$1.3	$38.05	$831,000
AIG Federal Savings Bank	OTS	$11.5	$14.3	$23,000
Chase Bank USA, N.A.	OCC	$ 87	$15	n/a
Citicorp Trust Bank, FSB	OTS	$18.6	$272.1	n/a
Discover Bank	FDIC	$31	$114.5	$3.3 million
ING Bank, FSB	OTS	$79	$112	$3.1 million
PNC Bank, Delaware	FRB	$3.2	$20.2	$412,003
Wilmington Trust Company	FRB	$9.7	$24.7	$695,000
Wilmington Savings Fund Society, FSB	OTS	$3.2	$8.5	n/a

Data from: FDIC, 2007; FRB, 2008; FRB, 2009; OCC, 2009; OTSa, 2008; OTSb, 2008; OTSc, 2008; OTSa, 2009; OTSb, 2009.

In three exams, contributions were not distinguished from other investments. The difference between investments and contributions is that the bank generally receives a return on investments through interest accrual and/or fee generation, but no return is received from contributions aside from their tax deductibility. Like CD lending, regulatory agencies are inconsistent in their reporting of investment activities. For example, OTS reports contributions for AIG and ING, but not for Citicorp and WSFS.

Like the CD Lending section, the Investment section is in narrative format, and each report varies regarding the level of detail provided. In all cases, the total amount of CD investments is reported. However, all the reports provide some breakdown of the investments, but they do not use similar formats or provide the same level of detail. In some cases, such as for AIG, Discover and ING, both amounts and investment types are provided. For PNC, the report provides the amount of new investments and the balance from previous investments and then gives a percentage breakdown of affordable housing, small business financing and community revitalization. The report on Chase's activities provides examples of major investment and contribution activities.

Every bank invested in the provision of affordable housing, usually through the purchase of housing bonds and low income housing tax credits. When investments are listed with greater detail, some common agencies and investment types appear. Delaware State Housing Authority (DSHA) housing bonds and mortgage backed securities were a common investment for each of the banks that listed investments. Each of the banks also invested in DCIC. However, investment in DCIC also illustrates the inconsistencies in CRA reports. AIG's participation in DCIC was listed in CD lending in its first report and in Investments in the second report. All other banks' participation in DCIC was reported in the Investments section.

Another frequent investment by most of the banks was in a small business investment

corporation. The specific corporation was not listed. Small business investments always targeted minority and women-owned small businesses, or businesses located in LMI areas. Like CD lending, no goals or outcomes of investments were reported.

When they were reported separately from other investments, contributions, or grants, they comprise a miniscule portion – around 1% or less – of a bank's total investment. As noted above, contributions are more costly than loans and other investments, because the bank receives no monetary return on its investment. As with CD lending and investing, reporting on contributions to nonprofits runs the gamut from breakdown of each grant, to summaries of general grant activities. The one commonality is that none of the descriptions of contributions includes a report on the outcomes or the impact of those contributions on the community, in which they are made. Examples of how each of the reports that distinguish contributions from investments are described below.

The AIG report includes a list of the agencies that received a portion of the $831,000 that AIG granted to Delaware nonprofits, but does not state how much each organization received or the purpose of the grant. Of the $831,000, AIG Federal Bank contributed $316,000 in grants, while parent company, AIG, Inc., provided $515,000 in grants to CD organizations in Delaware (OTSa, 2008).

In its second report period, which entailed only one year, AIG provided $23,000 to grantees in Delaware, including the Delaware Community Foundation, Wilmington Renaissance Corporation, First State Community Action Agency and the Interfaith Housing Task Force. Again, specific amounts, activities and outcomes are not included (OTSa, 2009).

The specific amount of contributions made by Citicorp is not distinguished from its overall investments, but the report notes that the bank made "significant" grants to the community (OTSb, 2009, p. 29). The report includes a list of some of these significant grants, their amounts and the agencies that received them (OTSb, 2009).

Discover Bank made 167 grants to 83 organizations totaling $3.3 million. The report includes examples of some significant grants, but not all grants. The examples note what project the grant funded with only a general description of the agency, for example "an organization that provides affordable housing" (FDIC, 2007).

ING gave $3.1 million in grants to nonprofits in Delaware. Of that amount, six grants totaling $1.048 million were granted to nonprofits providing affordable housing; 33 grants totaling $2.3 million were provided to organizations providing community services to LMI individuals; and $53,000 was given to four organizations to stabilize or revitalize a LMI geography. A general description of these grants is given in the report without providing names of organizations, or project details and outcomes (OTSb, 2008).

PNC gave 64 grants totaling $412,003. Of these grants, 56% supported a variety of statewide and local-area organizations and programs that provide services to LMI families and individuals, offer affordable housing and help stabilize or revitalize communities. The remaining 44% supported PNC Grow Up Great, a nationwide PNC initiative that supports Head Start programs (FRB, 2008).

Wilmington Trust made grants and contributions to "various organizations that routinely provide affordable housing, economic development, and community development services that benefit low and moderate-income individuals and areas" (FRB, 2009, p. 16). The report includes a breakdown of amounts by geographic area (Wilmington, Dover and Sussex County), but does not include information about grant recipients (FRB, 2009).

In all the reports, contributions were generally identified as supporting agencies providing affordable housing and CD services, but specifics of how these contributions fit into the larger picture of the provision of affordable housing and CD are not available. The most detailed reports included the name of the organization that received the grant, the amount of the grant and the general project the grant funded. In most cases, only the type of organization or the types of services the organization provides are included. There is no evidence that the banks are tracking the impacts or effectiveness of their contributions.

In addition to investments and contributions made in their assessment areas, some banks were credited with additional investment activity that benefited LMI households or geographies outside their assessment area or had the potential to impact the assessment area. AIG received credit for purchasing $45.4 million in Maryland affordable housing bonds. Also enhancing its exam results were investments by its subsidiary, SunAmerica, in low-income housing tax credits in supplemental assessment areas across the country. AIG's parent company also committed $15 million from 2007 through 2009 for financial literacy programs nationwide; $1.5 million of that commitment benefited organizations with offices in the assessment area, and $350,000 supported organizations with offices in the region (OTS, 2008).

Chase, Citicorp, and WSFS were also credited with additional investments made in adjoining regions to the assessment area, which had the potential to benefit the assessment area. For example, Chase purchased additional DSHA housing bonds outside its assessment area and committed $7 million to a housing fund that invests in low-income housing tax credits. Discover bank was credited with investments by an affiliate in New Market Tax Credits. Its report indicated that overall its new investments and grants increased by 203% from its previous CRA exam, which boosted its overall investment score.

Recommendation

As with the lending section, the four regulatory agencies should adopt a uniform report format for investing. The reports should all include the same level of detail of the amount invested and the purpose of the investment. The regulatory agencies should also describe the extent to which the banks' investments contributed to its rating. To this end, the agencies could also establish investing benchmarks based on asset size and/or assessment area to make the investing rating more objective.

Services

CD also plays a role in the Service test. The main function of the Service test is to ensure that banks provide the same services to LMI communities that are available elsewhere. So, if a bank has full-service branches in high-income areas, it should also have full-service branches in LMI areas. Banks can enhance their Service test scores by providing CD services. These services are most often in the form of volunteerism, leadership and technical assistance for CD and community services organizations. Every CRA exam in this study noted that several bank officers and staff served on multiple boards of directors of nonprofit service providers in Delaware. Most of the lending institutions have an officer on the board of DCIC. Other common organizations receiving CD services were the Delaware Financial Literacy Institute and the Delaware Community Foundation.

As in the other tests, reporting on CD services was inconsistent. While, every report included language, almost verbatim, mentioning that bank officers and staff serve on community organization boards, Chase, Discover, and PNC's reports enumerated the number of boards, on which bank staff served. The other exams simply reported that "several" staff served on boards. Some of the reports listed the positions, such as Treasurer, that staff held on the boards they served. Chase was praised for taking leadership on the response to the foreclosure crisis, and several of its community partnerships are described in detail in the report. Five banks' staff members taught financial literacy courses to LMI individuals or in LMI geographies.

Because there are virtually no benchmarks on which to rely, the CD service portion is arguably the most subjective portion of the CRA exam. The other tests, at a minimum, provide the total amounts of loans and investments. There are no equivalent numbers associated with the CD service test. It is up to the regulating agency to determine whether the boards, on which staff serve, show sufficient commitment to CD service. Only AIG received less than Outstanding on its Service Test, indicating that the varied levels of community service reported in the exam reports were indeed good enough, though there is no standard that defines what "good enough" is.

Recommendation

Similar to the Lending and Investment tests, the regulatory agencies should establish more uniform reporting formats for the Service test. The report should note the level of banking services offered in LMI communities, including location and number of branches. It should also report the number of volunteer activities that benefit LMI communities that bank officers and staff participated in and the nature of those activities (e.g. volunteered at community clean-up, Habitat for Humanity build, taught Junior Achievement courses, etc.). Finally, the report should include a list of the board or other volunteer positions held by bank officers and staff. The list should include the name of the organization, the position held by the staff member (board member, trainer, etc.), and any officer positions on the board they may hold. If each exam report included such a list of CD services, volunteer activities, and board or other volunteer positions, comparisons could be made between banks to ensure that they are graded fairly, and that their services and volunteer activities contribute toward CD.

Conclusion

The CRA was enacted to ensure that low-income families and communities have access to credit in terms of home mortgages, small business investment and other CD activities. As the home mortgage market has changed, banks covered by the CRA have decreased their home mortgage activities. At the same time, the federal government has continued to decrease its investment in CD organizations and activities. Banks can receive CRA credit for making such investments, but have little incentive to increase their CD grants, lending, investments, and services under the current regulations because home lending is still weighted much higher in the exam process.

Consequently, most research on CRA has focused on home mortgage lending to the detriment of research on the other aspects of CRA, including CD investments and services. One significant reason for this lack of research is the insufficient data available, as evidenced by the nine (above) CRA examinations of large banks in Delaware.

Changes should be made to the way regulators review and report lending institutions' CRA performance in the area of CD. First, uniformity in reporting these activities can provide more accurate comparisons among banks in a community or region. As each CRA report is unique, comparisons of banks' performance is difficult, at best. A more uniform reporting format would allow community groups to accurately assess banks' CRA-related performance. Toward this end, benchmarks for the Lending and Investment tests should be established. Benchmarks for the CD lending and investment tests based on the banks' total assets, and other lending activities would provide objective measurements of a bank's performance and allow community organizations to monitor activities more effectively.

Second, regulators should be required to report CD lending and investing at the same level of detail that HMDA lending is reported. Reports should include the number and dollar amount of loans and investments, and the agencies to which they are made. Moreover, they should also include specific details as to the purpose of the loan or investment. Again, this would make the test more objective and allow CD groups, who are supposed to be the enforcers of the CRA, to more accurately assess the CD performance of banks.

Finally, the CRA exams should report on outcomes of investment and contribution activities. If a contribution was made to assist in the provision of affordable housing, the report should include how many people that contribution benefited, or how many units of affordable housing it financed. Contributions for community revitalization should be reported with specificity so monitoring groups can verify that contributions indeed help revitalize communities and benefit low- and moderate-income households. And grant-making should be evaluated for higher impacts than lending to CD organizations.

As the banking industry continues to change and CD efforts evolve, these changes can make the CRA an even more powerful and effective tool in helping communities access credit and in helping

community organizations provide services in underserved communities. With access to more detailed information, community organizations would be better equipped to enforce CRA by challenging banks' mergers and acquisitions if their lending, investment, and services were not being adequately provided. Increased transparency in the CRA examination process would also lead banks to ensure that their lending, investment, and services that they are providing for CRA credit are being provided in areas of legitimate need.

References

Avery, R.B., Courchane, M.J., & Zorn, P.M. (2009). The CRA within a changing financial landscape. In Federal Reserve Banks of Boston and San Francisco (Eds.), *Revisiting the CRA: Perspectives on the future of the Community Reinvestment Act* (pp. 30–46).

Bostic, R.W., & Robinson, B.L. (2003). Do CRA agreements influence lending patterns? *Real Estate Economics, 31*, 1: 23–51.

Essene, R.S., & Apgar, W.C., Jr. (2009). The 30th anniversary of the Community Reinvestment Act: Restructuring the CRA to address the mortgage finance revolution. In Federal Reserve Banks of Boston and San Francisco (Eds.), *Revisiting the CRA: Perspectives on the future of the Community Reinvestment Act* (pp. 12–29).

FDIC (Federal Deposit Insurance Corporation). (2007). Community Reinvestment Act Performance Evaluation of Discover Bank. November 26, 2007.

FRB (Federal Reserve Bank of Cleveland). (2008). Community Reinvestment Act Performance Evaluation of PNC Bank Delaware. February 4, 2008.

FRB (Federal Reserve Bank of Philadelphia). (2009). Community Reinvestment Act Performance Evaluation of Wilmington Trust Company. July 20, 2009.

Immergluck, D. (2004). *Credit to the community: Community reinvestment and fair lending policy in the United States.* Armonk, N.Y.: M.E. Sharpe.

Ludwig, E., Kamihachi, J., & Toh, L. (2009). The Community Reinvestment Act: Past successes and future opportunities. In Federal Reserve Banks of Boston and San Francisco (Eds.), *Revisiting the CRA: Perspectives on the future of the Community Reinvestment Act* (pp. 84–104).

OCC (Office of the Comptroller of the Currency). (2009). Community Reinvestment Act Performance Evaluation of Chase Bank USA, N.A. November 2, 2008.

Olson, J., Chakrabarti, P., & Essene, R. (2009). A framework for revisiting the CRA. In Federal Reserve Banks of Boston and San Francisco (Eds.), *Revisiting the CRA: Perspectives on the future of the Community Reinvestment Act* (pp. 2–7).

OTSa (Office of Thrift Supervision). (2008). Community Reinvestment Act Performance Evaluation of AIG Federal Savings Bank. February 25, 2008.

OTSb (Office of Thrift Supervision). (2008). Community Reinvestment Act Performance Evaluation of ING Bank, FSB. August 6, 2008.

OTSc (Office of Thrift Supervision). (2008). Community Reinvestment Act Performance Evaluation of Wilmington Savings Fund Society, FSB. May 20, 2008.

OTSa (Office of Thrift Supervision). (2009). Community Reinvestment Act Performance Evaluation of AIG Federal Savings Bank. November 2, 2009.

OTSb (Office of Thrift Supervision). (2009). Community Reinvestment Act Performance Evaluation of Citicorp Trust Bank, FSB. November 9, 2009.

Quercia, R., Ratcliffe, J., & Stegman, M. (2009). The Community Reinvestment Act: Outstanding and Needs to Improve. In Federal Reserve Banks of Boston and San Francisco (Eds.), *Revisiting the CRA: Perspectives on the future of the Community Reinvestment Act* (pp. 47–58).

Rust, A. (2009). A principle-based redesign of HMDA and CRA data. In Federal Reserve Banks of Boston and San Francisco (Eds.), *Revisiting the CRA: Perspectives on the future of the Community Reinvestment Act* (pp. 178–184).

Schwartz, A. F. (2010). *Housing policy in the United States (2nd ed.)* New York: Routledge Press.

Schwartz, A. (1998a). Bank lending to minority and low-income households and neighborhoods: Do Community Reinvestment Act agreements make a difference? *Journal of Urban Affairs 20*: 269–301.

Squires, G.D. (Ed.). (2002). *Access to capital: Advocacy and the democratization of financial institutions.* Philadelphia: Temple University Press.

Taylor, J., & Silver, J. (2009). The CRA: 30 years of wealth building and what we must do to finish the job. In Federal Reserve Banks of Boston and San Francisco (Eds.), *Revisiting the CRA: Perspectives on the future of the Community Reinvestment Act* (pp. 148–159).

Willis, M. (2009). It's the rating, stupid: A banker's perspective on the CRA. In Federal Reserve Banks of Boston and San Francisco (Eds.), *Revisiting the CRA: Perspectives on the future of the Community Reinvestment Act* (pp. 59–70).

Health Care System Structure and Delivery in the Republic of Korea

Considerations for Health Care Reform Implementation in the United States

Rachel Linstead Goldsmith

As part of its plan for rapid economic development, South Korea achieved universal health insurance in 1988. In the ensuing years, the national government has continued to adjust health care system structure and care delivery mechanisms in response to social and political changes, culminating in a single-payer system in 2000. Further reforms have included improvements in pharmaceutical distribution, efforts to contain costs, and development of programs to care for older adults. This paper examines the underpinnings of health care system development in South Korea and offers lessons for the United States as it implements the Patient Protection and Affordable Care Act, which addresses similar systemic issues. These include the challenges of controlling growing expenditures, administering coordinated care in a decentralized provider system, and providing care for an aging population.

Introduction

In contrast to the many decades it took the United States to pass comprehensive health care reform, the Republic of Korea (hereafter referred to as South Korea) implemented universal health insurance coverage in just twelve years (Anderson, 1989). In 1976, President Park Chung-Hee passed a series of laws to provide coverage to a succession of groups, starting with beneficiaries of firms with more than 500 employees, with smaller firms soon following (Anderson, 1989). The next year, a program similar to the United States' Medicaid was created to provide coverage to the poor and unemployed (Anderson, 1989). Laws to ensure the coverage of public workers and the self-employed followed in 1979 and 1981. In 1988, coverage was extended to the remaining urban and rural populations (Anderson, 1989).

Dr. S. Kwon identifies Park's motivation for shepherding health coverage legislation as an attempt to gain political legitimacy: He was formally elected President in 1963 only after leading a military coup d'état in 1961 and had ambitious economic goals for the country (2007). Park's focus on industrialization informed the structure and delivery of health care for decades, and is implicated in the system's strengths and weaknesses. While passing health care legislation in the United States was a much more highly contested event, South Korea's evolving health care structure has many elements that are similar

to what was proposed in the 2010 Patient Protection and Affordable Care Act (PPACA), which is currently under review by the U.S. Supreme Court. An analysis of how these structures and the delivery of services have affected costs, quality, and health outcomes can be instructive for purposes of implementation planning for the PPACA, and for envisioning future policy pathways.

From the beginning, the three major characteristics of South Korea's universal coverage were 1) its provision as a mandate, 2) beneficiary contributions based on income, and 3) benefits offered not correlated with the amount of the contribution (Anderson, 1989). Mandated individual coverage is central to the PPACA as well, and is the keystone of the law. It increases the size of the risk pool so that costs are more likely to be balanced among the sick and the healthy. Without it, insurers may act on fears that only the sick would buy coverage by raising prices (Gruber, 2012). While beneficiary contributions generally will not be based on income in the United States under the PPACA, coverage will be subsidized according to income level in relation to the federal poverty line (Kaiser Family Foundation, 2011). However, benefits most likely will continue to vary according to contribution through employer plans and through the different state insurance exchanges.

Another important feature of the South Korean system is the delivery of health care through private providers, who account for more than 90% of health care services provided and represent a case of supplier-induced demand (Lee, 2003). Features that have consequently driven costs up include overuse of medical technology and pharmaceuticals, fee-for-service payment structures, poorly managed chronic care, and lack of care coordination. Because these are noted areas of concern in the United States as well, the effect of South Korean public policy interventions should be examined so as to suggest possible solutions and, more importantly, draw attention to the unintended negative impacts of these features.

Many challenges have tested the South Korean health system since 1988 and subsequently significant reforms have been made. One such challenge has been the aging of the general population, an issue facing many developed nations; however, this problem is especially acute in Asian countries (United Nations Development Program, 2005). In South Korea, the need for care assistance for the elderly has risen as the numbers of older adults living with their family members has dropped significantly and a substantial percentage of women have begun working outside of the home (Jones, 2010). Changing cultural values, evolving away from traditional Confucianism toward modernist and market principles, also have played a role.

Although South Korea has long lagged behind other Organization for Economic Co-operation and Development (OECD) member countries in its support for older adults (Yang, 2008), new programs are being developed to assist the elderly as the demographics shift, partially by building out the administrative structure of the health system, and in some cases, changing the face of health care delivery. In particular, the possibilities of technology in addressing the needs of chronically ill patients and older adults are being piloted in Seoul through its e-government[1] infrastructure. The results could hold great promise in the United States.

Health Reform Provisions in the United States

The PPACA is best known in the United States for its provision requiring most individuals to acquire health insurance by 2014, to significantly reduce the number of uninsured Americans. The Congressional Budget Office has estimated that of the roughly 50 million uninsured Americans, 32 million will be covered by 2019 (Kaiser Family Foundation, 2011). The PPACA will provide Americans with access to health insurance through state insurance exchanges[2] if no insurance is

[1] e-government refers to digital interactions between a government and its citizens, businesses, and employees; and also between that government and other governments.

[2] American Health Benefit Exchanges will be established in each state, allowing individuals and small businesses to purchase insurance, learn about different plan options, and access premium and cost-sharing subsidies.

available through one's employer (Kaiser Family Foundation, 2011). Subsidies will be available for those within 133% of the federal poverty line. If this provision were in effect today, a family of four would be eligible for a subsidy if the household income was $30,657 or less (Kaiser Family Foundation, 2011; Families USA, 2012). Small businesses with less than 50 employees also will be able to purchase coverage through an exchange. Larger employers could face a $2,000 fee per employee if they do not offer coverage (Kaiser Family Foundation, 2011).

The PPACA also includes provisions to address increasing costs, lack of care coordination, and support for an approach to caring for older adults called 'aging in place,' in which health care is delivered to older adults in their home communities rather than in institutions (MacGuire Woods, 2010). Approaches to addressing costs are focused mostly on changing reimbursement patterns to incentivize better health outcomes, costing less down the road. One popular provision designed for this purpose supports providers in forming accountable care organizations (ACOs) to care for Medicare beneficiaries. Similar to health maintenance organizations (HMOs) in their network structure, ACOs are physician-run instead of being operated by insurance companies, and thus patients are free to go out of network (Gold, 2011). Medicare historically has used a fee-for-service payment system, which is said to incentivize providers to order more procedures than is medically necessary, thus driving up costs (Gold, 2011). ACOs do not dismantle the fee-for-service system, but they do alter the incentives by offering bonuses when providers keep costs down through quality benchmarking focused on prevention and coordinated chronic care management (Gold, 2011). ACOs are also designed to promote better care coordination through the provider network structure.

Two provisions that promote aging in place are Community First Choice Option and Money Follows the Person, both of which facilitate home-based care. The Community First Choice Option is somewhat limited in that it specifically excludes assistive technologies and devices, and home modifications (MacGuire Woods, 2010). As the PPACA is implemented, it will be possible to adjust its provisions so as to heighten the efficiency of state health exchanges, consider additional cost containment mechanisms and their effects, and to assess opportunities for using information technology to support older adults through the aging in place approach.

The Structure of the South Korean Health System

Administrative Structure

Several years before universal health insurance was initiated in South Korea, legislation was passed that allowed businesses to offer health insurance to employees through medical insurance societies (Anderson, 1989). These societies were formed as subsidiaries of large firms or were incorporated by a number of small firms and existed to collect revenues, set benefits, and develop reserves (Anderson, 1989). Claim reviews and payments to providers were centralized (Kwon, 2009). For the next ten years, there was debate about whether these administrative societies should be further unified under the central government or remain decentralized (Lee, 2003). The structure of administration and its relationship to both the country's goals for efficiency and its political philosophies were at the heart of the debate, as they have been in the United States through the legislative process in passing the PPACA.

In 2000, South Korea's new president Kim Dae-Jung fulfilled promises to merge all of the medical societies into one single payer (Kwon, 2009). Now the insured are divided into two groups, the employer-insured and the self-employed (Song, 2009), and the health care system comprises three branches: the National Health Insurance Program (NHIP), Medical Aid Program, and the Long-term Care Insurance (LCI) Program (Song, 2009). The NHIP itself is divided into four parts: the Ministry of Health, Welfare and Family Affairs, which supervises operations and makes policy decisions; the National Health Insurance Corporation, which manages health insurance enrollment, collects contributions, and sets medical fee schedules; the Health Insurance Review Agency, which reviews fees and evaluates care; and the medical care institutions that provide health care and are

supervised by the Ministry (Song, 2009). Medical Aid covers the poor while LCI covers disabled older adults. Medical Aid is comparable to the United States' Medicaid program, but LCI is highly restrictive in comparison to Medicare.

The move to a single-payer system was partially driven by inequities in financing, whereby the self-employed in poor regions were paying a higher proportion of contributions than those in wealthy regions, even though the benefits themselves were identical (Kwon, 2009). This was due to differences in the administrative societies, which were often too small to pool risk efficiently. Consequently, administrative costs varied substantially (Kwon, 2009). With the introduction of the single-payer system, administrative costs were equalized across different segments of the population and dropped substantially overall. Before the move to a single-payer system, administrative costs ranged from 4.8% for government workers to 9.5% for the self-employed. By 2006, the rate was 4% for all workers (Kwon, 2009). A mixed system of tax-based financing and health insurance was established (Kwon, 2009), avoiding problems in assessing the income of the self-employed.

Although a single-payer system currently may not seem politically viable in the United States, South Korea's example could provide a roadmap for finding administrative cost savings and achieving more equalized coverage among consumers through a more tempered centralization process. For instance, states could combine health exchanges across regions. If the PPACA does gain broader political and public acceptance, South Korea could also provide an example for transitioning to one federally offered public option in the future.

Health Care Financing and Cost Containment

In comparison to other OECD member countries, which spent an average of 9.6% of gross domestic product (GDP) on health care in 2009, total health care spending in South Korea is among the lowest, at an estimated 6.9% of GDP (Health at a Glance, 2011). The United States leads OECD countries in health care spending by a wide margin, having spent 17.4% of GDP in 2009 (OECD 50, 2011). Two components that may help to explain this spending gap are the ways in which costs are structured for patients in South Korea and the limitations placed on physicians and pharmacists over time. These mechanisms have their own disadvantages that the United States would need to consider before implementing them.

The influence of the Japanese health care system can be seen in South Korea's payment model in which the employer and employee each pay half of the premium (Lee, 2003), resulting in much higher payments from the employee than generally paid by U.S. employees. Along with a co-payment structure also adopted from Japan, this mechanism provided enough revenue to provide financial stability for South Korean medical societies until the Asian Financial Crisis in 1997, when national health insurance began to run an operating deficit (Lee, 2003). The cumulative debt was paid off in 2004 (Yang, 2008), after the switch to the single-payer system. The NHIP now has three sources of funding: contributions, government subsidies, and tobacco surcharges (Song, 2009). Yet even with reduced administrative costs, the rate of health care spending has increased rapidly, from 4.5% of GDP in 2000 to 6.9% in 2009 (Health at a Glance, 2011). In response, a number of reforms aimed at cost containment were implemented.

One strategy was to end a provider practice, also borrowed from Japan, in which pharmacists and physicians were able to both prescribe and dispense medicine (Anderson, 1989). Profit margins were significant, thus incentivizing overprescribing (Health of Nations, 2011). In 2000, the South Korean government separated reimbursement for pharmaceuticals from medical care (Lee, 2003). Now, like in the United States, only doctors are able to prescribe medications and only pharmacists are allowed to fill prescriptions. However, South Korea went a step further in 2006 by using economic data in reimbursement decisions for newly introduced drugs (Yang, 2008). Furthermore, NHI regulates all prices for both treatments and medications (Kwon, 2009) and does not involve physicians in these decisions (Lee, 2003). Still these government regulations have not adequately prevented the physician from playing center stage in increased spending.

Yang (2008) considers the fee-for-service payment method the most important factor in cost increases in the South Korean system because it structurally ensures that the system's resource requirements are open-ended, as opposed to the 'global budget' used in Canada's National Health Insurance system, or the flat monthly fees paid per-member within managed care organizations in the United States. When added to the liberal provider choice given to beneficiaries, the resulting competition by private health care providers led to a high volume of services, exponentially raising costs under fee-for-service. This is often referred to as moral hazard in the United States. Reforms have limited consumer choice, but have not balanced out costs incurred by the high proportion of specialists that extensively utilize new medical technology (Lee, 2003).

The lesson for the United States from South Korea's experience is that even when controlling treatment and drug prices, fee-for service structures are problematic. Furthermore, focusing on cost mechanisms alone without any restraints on supply or regulation of care is ultimately ineffective. Although there is little worry that the free market–focused United States will attempt direct price-setting, the importance of concentrating on smart regulation of care itself through evidence-based guidelines is underscored here. Therefore, cost controls should continue to be designed in tandem with care coordination or other health outcomes goals, as exemplified in the ACO provision of the PPACA.

Medical Aid Program

For people unable to pay for their own health care coverage, the South Korean government offers the Medical Aid Program. The program was written into law via the Medical Aid Act in 1977 and was fully established two years later (Song, 2009). Like Medicaid in the United States, Medical Aid is jointly funded by the central and local governments (Kwon, 2007) and recipients undergo means-testing based on income to qualify for benefits (Kwon, 2009). Public demand for additional social welfare increased after the Asian Financial Crisis (Lowe-Lee, 2010) and part of President Kim Dae-Jung's 1998 campaign platform was an expansion of health care coverage (Shin, 2006). However, in 2009, Medical Aid covered only 3.7% of the entire South Korean population (Song, 2009); as a comparison, 15.7% of the U.S. population was covered by Medicaid in 2009 (U.S. Census Bureau, 2010). Park (2008) argued that the low percentage of coverage in South Korea is evidence of an underdeveloped social insurance system. Shin (2006) cited estimates of the poor in need of further coverage, additional benefits, and reduction of co-payments to be closer to 10% of the population.

In the United States, the PPACA will expand Medicaid to people living at or below 133% of the poverty level (Kaiser Family Foundation, 2011), leading to the 45% reduction in uninsured Americans by 2019 according to projections from the United States' Congressional Budget Office (Holahan & Headen, 2010). Funding Medicaid for Americans at or below 133% of the federal poverty line will also equalize beneficiary levels that currently vary widely among states.

President Kim took office soon after the onset of the Asian Financial Crisis. In response, his administration quickly changed the focus of their policy from expanding Medical Aid to containing costs. To accomplish this goal, the administration created the National Health Insurance Corporation (NHIC) (Shin, 2006). Attention was diverted from key campaign promises, such as ending the discrimination against Medical Aid beneficiaries by private medical providers (Shin, 2006), to projects that shifted financing away from general revenues (Song, 2009). Significant barriers to Kim's project were an immature civil society, anti-Communist values (Shin, 2006), and a 'growth-first' ideology (Park, 2008) that continually prioritized cost-containment over egalitarian values or public health measurements, particularly in a time of financial crisis.

Medical Aid serves Type 1 beneficiaries, who are children under 18 years old, seniors above 65 years old, and the disabled; and Type 2 beneficiaries, who are those able to work (Shin, 2006). One change implemented by the NHIC was to introduce cost-sharing for Type 2 beneficiaries, who comprise 43% of all Medical Aid beneficiaries. Another change was that it limited provider choice. Both changes were intended to reduce unnecessary usage of health care services (Kwon, 2007).

Opponents argued that costs were higher because Medical Aid recipients were in worse health: 25% were older adults and many suffered from expensive chronic conditions (Kwon, 2007). Another option would have been to focus attention on why costs for older adults and those with chronic conditions were so high, as these issues exist outside of the Medical Aid program as well. In the United States, over a third of expenditures come from long-term care. One goal for reducing these costs is to move the care setting from institutions back into the community (Kaiser Commission for Medicaid and the Uninsured, 2012). Better coordination of care across providers and the use of evidence-based standards are other potential solutions.

If the mix of recipients is truly to blame for high Medical Aid costs, then the NHIC's overemphasis on cost controls may eventually cause or contribute to further long-term problems both in terms of health status and costs, such as poorly coordinated care for those with chronic conditions and a population of low-income older adults that have had care delayed or withheld due to discrimination from providers. The PPACA in the United States begins to address some of the same issues that were created by underfunding health coverage for low-income populations, by setting up economic incentives for better care coordination through ACOs via Medicare (Gold, 2011). Close monitoring of this mechanism may outline a health-status–focused policy viewpoint, which can help avoid a similar public resistance to a perceived socialization of the U.S. health care system.

Long-term Care and Expanding Benefits to Older Adults

In South Korea, nearly 4 of every 10 Koreans is age 65 or older ("Medical Reform," 2010). Yet the urgent issue is the rate of growth of this population, which is higher than anywhere else in the world (OECD Factbook, 2011). In 2010, South Korea's senior population had a growth rate of 3.63%; the next highest growth rate among this population was 1.78% in Israel. The OECD average was 0.56% and the U.S. rate was 0.78% (OECD Factbook, 2011). In addition to the aging of the population, changes in family structure have created pressures on older adults and their familial networks. Historically the Confucian virtue of filial piety, respect for one's parents and ancestors, has promoted informal caregiving for elders in the extended family (Chee & Levkoff, 2001). Daughters-in-law have long been expected to serve as caretakers (Chee & Levkoff, 2001), yet as women have entered the workforce, family structures have been put under great stress because of the need to care for older family members.

The government responded to this burden by introducing the Long-term Care Insurance Program in 2008 (Kwon, 2009). It began as a pilot that provided services to older adults with severe limitations in the performance of daily activities (Song, 2009). Services offered include in-home nursing care and discounts of up to 20% on long-term care facilities (Lowe-Lee, 2010). The NHIC manages the system along with the Ministry for Health, Welfare and Family Affairs (Kim, 2011). After the introduction of the program, the Korean Longitudinal Study of Ageing found that 60% of adults ages 50–64 are still family caregivers (OECD 50, 2011). However, the portion of older adults living with their children fell sharply from over 80% in 1981 to 29% by 2008 as more women began working (OECD 50, 2011). If the program is able to grow at an adequate rate, its development will stand as a significant advancement in health care coverage. The program has been followed by others, some pioneered in Seoul by the SMG.

The older adult population is projected to increase substantially in the city of Seoul, from 5.4% to 20% in 2027 (Park, 2011). One of the goals of Seoul's Warm Life Welfare initiative is to create "an elderly-friendly city in the era of one million senior citizens" (Hi Soul web site, 2011), and the city operates 4,356 senior welfare facilities (Seoul Metropolitan Government, 2011). The initiative includes designing built environments that address the needs of senior citizens, assuring assistance to underprivileged and homebound seniors, and developing institutional support (Hi Soul web site, 2011). Two programs that exemplify Seoul's aims are the 9988 Senior Program and the Elderly Care Service. The "99" in the 9988 Senior Program is meant to indicate that all older adults in Seoul can live to the age of 99 by staying healthy. The program consists of services for seniors with

Alzheimer's disease, employment services, counseling, opportunities for social interaction, and a fitness program offered in over 40 city parks (Park, 2011). In 2009, the program expanded day-care for Alzheimer's patients to offer evening care ("Capital News"). The Elderly Care Service provides safety check calls for homebound seniors, which include video calling for those with limited mobility (Seoul Metropolitan Government, 2011). These initiatives provide case studies for the national government to consider in developing programs.

Many of OECD's recommendations to South Korea for improving social protections are also relevant for the senior care in the United States, including limiting long-term care costs by shifting from hospital-based to home-based care, using quality control in place of fee-for-service structures, and avoiding cost-containment initiatives that could further increase out-of-pocket spending and inhibit care access (OECD 50). Because these elements are limited in the PPACA, it will be important to measure outcomes carefully. South Korea is limiting its roll out of these services; future comparisons of results may provide both countries a wider understanding of how long-term care functions in aging societies.

Health Care Delivery

Access and Delivery

Doctors, dentists, nurses, and midwives are licensed with the Ministry of Health, Welfare and Family Affairs (Song, 2009). Health care delivery facilities are classified into three tiers based on the number of beds and degree of specialization: the first tier consists of clinics (0–30 beds); the second consists of small hospitals (31–100 beds) and general hospitals (101–700 beds); the third tier includes university hospitals and general hospitals with more than 700 beds (Choi, 2002). All South Koreans have access to these facilities, with a referral system for the third tier. In South Korea, the patient can go to any health care provider for the first consultation and must present a referral slip issued by the diagnosing provider to receive care in a third-tier center (Song, 2009). In choosing a specialist, a patient has a great deal of latitude as compared with a patient in the United States (Choi, 2002). Kwon (2009) suggests that a lack of gatekeeping leads to "competition rather than coordination among physician clinics and hospitals." The competitive nature of the field may affect quality of care, as will be discussed in the next section.

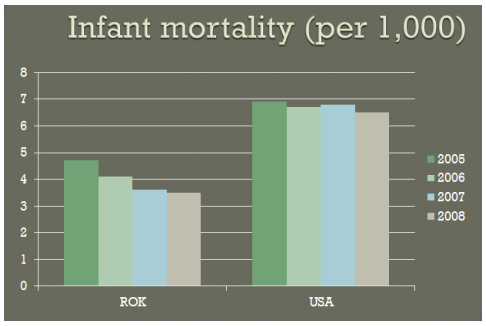
In 2007, the World Health Organization (WHO) and OECD reported that South Korea had 17.1 physicians per 10,000 people as compared to the OECD average of 30.7; 2004 WHO data showed that South Korea counted 43.9 nurses per 10,000 versus 95.4 in OECD countries overall (Health of Nations, 2011). Not only are there relatively fewer health care providers in South Korea, but 80% of doctors are specialists, with many holding degrees in two or more specialty areas (Lee, 2003). There are certainly cost implications here as specialists use more advanced technology for medical treatment and testing (Lee, 2003), and liberal consumer choice allows demand for these services to grow with the associated prestige of these practices. Yet the real concern is what affect this imbalance of providers has on the health of the South Korean populace.

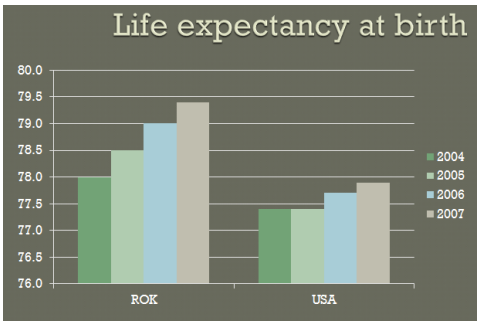
A recent OECD report by the Health Division of the Directorate for Employment, Labour and Social Affairs (2012) recommended that the South Korean health care system move from continually expanding acute care in order to proactively manage the specific needs of an aging population and patients with chronic conditions. As in the United States, the best consensual health care delivery strategy is to strengthen and reinvigorate primary care (OECD Health Division, 2012). The PPACA not only provides access to free preventive care in the form of blood pressure and cancer screenings generally applied through primary care, but primary care providers seeing Medicaid patients will receive temporary bonuses for seeing Medicare patients and increased reimbursement for Medicaid patients (Abrams, 2011). Similarly the OECD Health Division recommends raising reimbursement rates for preventive care in South Korea, increasing the primary care workforce, and improving coordination through privacy-minded electronic medical

record sharing (OECD Health Division, 2012). The SMG offers a useful case-study of the plans and possibilities for this technology in South Korea, as discussed below.

Health Outcomes and Quality of Care

Data show that the overall quality of medical care and the health status of its citizens have both improved in South Korea since the implementation of universal health insurance. This is demonstrated by the decline in infant mortality, which went from 61.0 per 1,000 live births in the 1960s (Song, 2009) to 3.5 per 1,000 in 2008 (OECD Factbook, 2011), and the increase in life expectancy from 51.1 years in the 1960s to 75.7 years in 2006 for men and from 53.7 in the 1960s to 82.4 in 2006 for women (Song, 2009). Health outcomes are worse in the United States, which had an infant mortality of 6.5 per 1,000 births in 2008, and an average life expectancy of 75.1 for men and 80.2 for women in 2006 (OECD Factbook statistics, 2011). However, health care coverage is not the only change in South Korea over the past thirty years. Yang (2008) points out that additional factors including "lifestyle, diet, income distribution, and environmental elements," contribute to health outcomes.





Source: OECD Factbook statistics, 2011

Jung (2011) reported that the delivery system of medical services is not fully established in South Korea, and "every doctor can run his private office regardless of specialty." This can lead to highly variable quality of care. Eight years earlier, Lee (2003) noted that South Korean medical professionals have practiced without public accountability, resulting in overuse of antibiotics, excessive testing, and a high rate of caesarean section deliveries. In 2008, Yang pointed out that quality-of-life measurement tools such as the EQ-5D (Euro quality of life) and the health utility index were available only from North American and European contexts, which may not correspond with Asian values. Recently, Jung (2011) has reported on a new validity and reliability measure, the Korean Primary Care Assessment Tool that assesses patient satisfaction with primary and non-primary care services.

The demand for this tool arose from professional discussion focused on primary care as a more efficient use of medical resources, improved cost containment, and increased equity (Jung, 2011). The resulting study found low satisfaction on health care coordination among both primary and non-primary groups, and suggested that self-owned clinic-based physicians may dismiss referrals because of competition for patients with other medical facilitates, short visits, and a loose medical service delivery system in which physicians' treatment boundaries are not as strictly defined as by licensure in the United States (Jung, 2011). The low scores given by patients may be correlated with a high demand for medical care, but also demonstrate an area for future attention.

Both primary care and quality improvement measurement are central to the PPACA. Provisions supporting the development of primary care include funding for primary care residencies in

underserved areas of the country, temporary increases in Medicare and Medicaid reimbursements for primary care, and financial assistance for students (HealthReform.gov). Health IT plays a key role in improving the health care system (Broadband.gov, 2011). In fact, "when appropriately incorporated into care, technology can help health care professionals and consumers make better decisions, become more efficient, engage in innovation, and understand both individual and public health more effectively" (Broadband.gov, 2011). The PPACA also encourages the use of health IT in its reimbursement methods for integration of electronic medical records and its envisioning of health information exchanges.

Expanding Health Care Delivery Through e-Government

One of the strategies employed by SMG to ensure access to quality care is to deploy advanced technological tools and services. In 2010, SMG was rated as the top global city in e-government worldwide (Hicks, 2010). The E-Governance Institute at Rutgers University-Newark and the Global e-Policy e-Government Institute at Sungkyunkwan University, South Korea, evaluate the digital governance of large municipalities annually, and rated Seoul's online e-government efforts as the best in the world in 2003, 2005, 2007, and 2009 (Holzer, Min-Bong, & Manoharan, 2009). E-government projects touted by SMG include the Imagination Bank, through which city employees can make suggestions; Seoul Oasis, through which citizens offer ideas for increasing public good; and interactive online meetings between citizens and city government (Kang, 2011).

Lee and his colleagues predicted in 2009 that South Korea as a whole would be a major center for the e-health industry due to its geography, advanced information technology, and high public consciousness about health (Lee et al., 2009). South Korea's u-Healthcare system started with a pilot in Seoul's Guro district in 2007 (Ramalingam, 2010). This was the first phase of the 'Ubiquitous City' project for the district, which went on to plan for the implementation of u-Seoul. u-Seoul was intended to facilitate the use of mobile devices to access public services "anytime, anywhere" (Hicks, 2010). Health care is just one of many public services u-Seoul efforts will address.

The u-Healthcare system is designed to increase capacity for managing chronic diseases, such as hypertension and diabetes. The Guro Public Health Center provides check-ups through the system, consisting of patient input of health indicator measures for diabetes, blood pressure, obesity, and respiratory diseases via mobile devices (Ramalingam, 2010). The center then monitors data for diagnosis and treatment as appropriate (Ramalingam, 2010). This promotes a focus on disease prevention and early intervention, which can greatly improve one's quality of life.

The larger u-Healthcare system is still under development, with a primary focus being the build-out of its Electronic Medical Records (EMR) system. Launching a comprehensive EMR system is also a goal of the PPACA. An EMR system can reduce administrative costs, duplicative services, and the number of medical errors, thus increasing quality of care (HealthReform.gov). In South Korea, the technology industry maintains that privacy laws are preventing more advanced use of the system, such as the sharing of medical information among doctors via cloud computing and electronic prescription ordering (Je-yup, 2011). Experts are now considering managerial issues, behavior perspectives, and the user's point of view for further policy modification (Yu, Guo, & Kim, 2011).

The national u-Healthcare system may also supplement the brick-and-mortar health care delivery system for the elderly because of its potential for better preventive care and early intervention. The national government is likely to look to Seoul to test the implementation of new components. The U.S. may also consider adding further e-medicine solutions in addition to the EMR requirements in the PPACA, which will better support aging-in-place efforts, patient self-monitoring of chronic care tests and measurements that can be done at home and reported to the provider, and technological decision-support for primary care.

Conclusion

The South Korean health system mixes single-payer administration with private provider delivery while managing universal coverage. As a leading global city, Seoul has a key role in developing and expanding health care structure and delivery in South Korea. The United States could follow the results of Seoul e-health care pilot programs to develop new policies for health care, particularly care for seniors.

In many ways, the South Korean health care system has met the goals it set for itself, with universal health insurance coverage, improved health outcomes, and overall costs that are a lower percentage of GDP compared with other OECD countries. South Korea was able to fairly quickly transition to a single-payer system without substantially altering the private provider market. Such a transition would not be so easy in the United States, as the PPACA leaves the United States' private health insurance systems in place. However, the fact that both countries built (or are building) health care reform around the free market—with insurance companies in the United States and medical providers in South Korea—demonstrates the two nations have similar values. These values offer useful comparisons and lessons in health care system strengths and weaknesses.

References

Abrams, M. (2011). How will the Affordable Care Act bolster primary care? The Commonwealth Fund Blog. Retrieved from: http://www.commonwealthfund.org/Blog/2011/Jan/Affordable-Care-Act-Bolsters-Primary-Care.aspx?view=print&page=all.

Anderson, G. (1989). Universal health care coverage in Korea. *Health Affairs, 8,* 24–34.

Broadband.gov. (2011). National Broadband Plan: Connecting America. Chapter 10: Health Care. Federal Communications Commission. Retrieved from http://www.broadband.gov/plan/10-healthcare.

Capital News. (2012). Hi Seoul web site. Retrieved from: http://english.seoul.go.kr/ gtk/news/news_view.php?idx=8150.

Chee, Y.K., & Levkoff, S.E. (2001). Culture and dementia: Accounts by family caregivers and health professionals for dementia-affected elders in Korea. *Journal of Cross-Cultural Gerontology, 16,* 111–125.

Choi, K.S., et al. (2002). The relationships among quality, value, satisfaction and behavioral intention in healthcare provider choice: A South Korean study. *Journal of Business Research, 57,* 913–921.

Families USA. (2012). 2012 Annual Federal Poverty Guidelines: 48 Contiguous States and DC. Retrieved from: http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html.

Gold, J. (2011). FAQ On ACOs: Accountable Care Organizations, Explained. Kaiser Health News. Retrieved from: http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx.

Gruber, J. (2012). Health care reform: The centrality of the individual mandate. American Constitution Society Blog. Retrieved from: http://www.acslaw.org/ acsblog/health-care-reform-the-centrality-of-the-individual-mandate.

Health at a Glance 2011: OECD Indicators. (2011). Key Findings: Korea. Retrieved from: http://www.oecd.org/dataoecd/12/60/49084295.pdf.

Health of Nations. (2011). South Korea. Retrieved from: http://www.healthofnations.com/countries/profile/south-korea.

HealthReform.gov. (2011). Key Features of the Affordable Care Act, By Year. Retrieved from: http://www.healthcare.gov/law/timeline/full.html.

Hicks, R. (2010). Seoul tops global cities ranking for e-govt. *Asia Pacific Future Gov*. Retrieved from: http://www.futuregov.asia/articles/2010/jul/21/seoul-tops-global-cities-ranking-e-govt/

Holahan, J., & Headen, I. (2010). Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Retrieved from: http://www.kff.org/ healthreform/ upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

Holzer, M., Min-Bong, Y., & Manoharan, A. (2009). Digital Governance in Municipalities Worldwide: A Longitudinal Assessment of Municipal Websites throughout the World. The E-Governance Institute, National Center for Public Performance, School of Public Affairs and Administration, Rutgers, the State University of New Jersey, Newark. Retrieved from: http://spaa.newark.rutgers.edu/images/stories/documents/ EGov/Digital_Governance_Municipalities_Worldwide_2009.pdf.

Je-yup, K. (2011, November 17). Regulations bar medical advances. *Korea Times*. Retrieved from: http://www.lexisnexis.com.proxy.nss.udel.edu/hottopics/lnacademic/.

Jones, R.S. (2010). Health Care Reform in Korea. Economic Department Working Papers No. 797. Organization for Economic Co-operation and Development. Retrieved from: www.oecd.org/workingpapers.

Jung, J.W., et al. (2011). Patients' assessment of community primary and non-primary care physicians in Seoul City of South Korea. *Korean Journal of Family Medicine, 32,* 226–232.

Kaiser Commission for Medicaid and the Uninsured. (2012). Medicaid 101. Retrieved from: http://www.kaiseredu.org/Tutorials-and-Presentations/Medicaid-101.aspx

Kaiser Family Foundation. (2011). Focus on Health Reform: Summary of Coverage Provisions in the Patient Protection and Affordable Care Act. Retrieved from: http://www.kff.org/healthreform/upload/8023-R.pdf.

Kang, B.H. (2011). Seoul's e-Government and World e-Government Organization. The Sixth Seoul Field Trip, Case Study: Policy Management in Seoul, sponsored by Economic Promotion Headquarters, Seoul Metropolitan Government and Graduate School of Policy Studies, Korea University. Lecture conducted from Korea University, Seoul, ROK.

Kim, S.H, et al. (2011). Long-term care needs of the elderly in Korea and elderly long-term care insurance. *Social Work in Public Health*, *2,* 176–184.

Kwon, S. (2007). Reform of the Medical Aid Program. *Health Policy Monitor*. Retrieved from: http://www.hpm.org/survey/kr/a10/1.

Kwon, S. (2009, February 20). Health Care System and Policy in Korea: Politics and Democratization. Power Point presentation from lecture delivered at Stanford University.

Kwon, S. (2009). Thirty years of national health insurance in South Korea: Lessons for achieving universal health care coverage. *Health Policy and Planning, 24*(1): 63–71.

Lee, J.C.L. (2003). Health care reform in South Korea: Success or failure? *American Journal of Public Health*, *93*, 48–51.

Lee, M.H., Kim, J.K., Lee, B.W., Min, S.D., & Shin, H.S. (2009). The e-health landscape: current status and future prospects in Korea. *Telemedicine and e-Health*, *15*(4), p. 362.

Lowe-Lee, F. (2010, July 12). Korea moving forward to mature welfare state. *Korea Times*. Retrieved from: http://www.lexisnexis.com.proxy.nss.udel.edu/hottopics/lnacademic/.

MacGuire Woods. (2010). Retrieved from: http://www.mcguirewoods.com/news-resources/publications/health_care/ProvisionsofHealthReformLawPromoteAginginPlace.pdf.

Medical Reform. (2010, June 17). *Korea Times*. Retrieved from: http://www.lexisnexis.com.proxy.nss.udel.edu/hottopics/lnacademic/.

OECD 50. (2011). Health: spending continues to outpace economic growth in most OECD countries. Retrieved from: http://www.oecd.org/document/38/ 0,3746,en_21571361_44315115_48289894_1_1_1_1,00.htm.

OECD Factbook 2011: Economic, Environmental and Social Statistics. (2011). Population and Migration: Population. Retrieved from: http://www.oecd-ilibrary.org.

OECD Factbook statistics. (2011, June). Better Policies for Better Lives: A Framework for Growth and Social Cohesion. Retrieved from: http://www.oecd.org/ dataoecd/ 37/2/48225033.pdf.

OECD Health Division. (2012). Healthcare Quality in Korea: Assessment and Recommendations. Directorate for Employment, Labour and Social Affairs. Retrieved from: www.oecd.org/ health/qualityreviews.

Park, C.H. (2011). 9988 Senior Project to Engage Over-65s in Seoul. *Human Kinetics*. Retrieved from: http://www.humankinetics.com/aaccnews/aaccnews/9988-senior-project-to-engage-over-65s-in-seoul.

Park, Y.S. (2008). Revisiting the welfare state system in the Republic of Korea. *International Social Security Review*, *61*:2, 3–19. Retrieved from: http://papers.ssrn.com/ sol3/papers.cfm?abstract_id=1112165.

Ramalingam, M. (2010). Digital Districts. myConvergence. Retrieved from: myconvergence.com.my/main/images/stories/PDF_Folderjan2011/MyC_07_pg14_ pg20_Digital_districts.pdf.

Seoul Metropolitan Government. (2010). 'Seoul Welfare Net Center' launched. Retrieved from: http://www.korea.net/detail.do?guid=46226.

Seoul Metropolitan Government. (2011, October 29). Lecture presented in Policy Management in Seoul Case Study. Seoul: Korea University.

Shin, Y.J. (2006). Policy context of the poor progress of the pro-poor policy: A case study on the Medical-Aid policy during Kim Dae-Jung's Government (1998–2002) in the Republic of Korea. *Health Policy*, *78,* 2–3, 209–223. Retrieved from: http://dx.doi.org/ 10.1016/j.healthpol.2005.10.004.

Song, Y.J. (2009). The South Korean health care system. *Japan Medical Association Journal*, *52,* 206–209.

United Nations Development Program. (2005). *UN Human Development Report 2005*. New York: United Nations.

U.S. Census Bureau. (2010). Income, Poverty and Health Insurance Coverage in the United States: 2009. Retrieved from: http://www.census.gov/newsroom/releases/archives/ income_wealth/cb10-144.html.

Warm Life Welfare. City Initiatives. *Hi Seoul Web site*. Retrieved from: http://english.seoul.go.kr/ gtk/cg/policies.php?pidx=2.

Yang, B.M., et al. (2008). Economic evaluation and pharmaceutical reimbursement reform in South Korea's national health insurance. *Health Affairs, 27*, 179–187.

Yang, B.M. (2008). Health care system and national health insurance of South Korea. *The Official News & Technical Journal of The International Society For Pharmacoeconomics and Outcomes Research*.

Yu, J., Guo, C., & Kim, M. (2011). Towards a conceptual framework of adopting ubiquitous technology in chronic health care pages. In J. Tan (Ed.), *Developments in Healthcare Information Systems and Technologies: Models and Methods*, pp. 214–232. West Hamilton, Ontario, Canada: McMaster University.