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San Franciscans and Their Hospitals, 1848-2013

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San Franciscans and Their Hospitals, 1848-2013

by
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San Franciscans and Their Hospitals, 1848-2013
Susan Miller

ABSTRACT

This dissertation presents findings from a qualitative study of hospitals and social activisms aimed at hospital transformation in San Francisco. Research questions address how hospitals have been geographically and socially placed in the city over time, and how this placement may have set up hospital administrators', local government's, and community groups' more recent actions around hospital social construction and geographic placement. Data include documentary and archival evidence as well as qualitative interviews. Findings are divided into two parts: the first follows the historical development of the city's hospitals from c. 1848 to 2001; the second explores the redevelopment of California Pacific Medical Center hospitals from 2001 to 2013. Key findings are as follows: Historically there have been few hospitals in the city's southern/southeastern corridor, relative to government constructions of area need and to distribution of hospitals in the city. This disparity has been produced in tandem with structural racism and classism in the city's urban development. Federal healthcare policy development and implementation over time in part exacerbated this healthcare inequity. In more recent years, hospital administrators, local government officials and members of community organizations have oriented to hospitals according to diverse constructions of the efficiency of care, healthcare disparities, and hospitals' relationships to communities. However, through a variety of social-structural and cultural contingencies, social movements have produced changes in hospital social boundaries and placement.

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CHAPTER 1. INTRODUCTION

When major news outlets cover problems in healthcare, they describe how expensive care is, Americans' worries about insurance coverage, and how unwieldy and complex the system is. What they discuss far less often, however, is how our healthcare is segregated by race and by socioeconomic class. One system exists for those who are wealthier and more likely to be white, and another for patients who are low-income and more likely to be people of color. Between the two systems, there are differences in the types of care available, their quality, and their accessibility, which contribute to very different life chances among those varied social groups.

The hospitals of San Francisco offer a case in point. The city is remarkable for its extensive healthcare infrastructure, of which its hospitals form the backbone – they are sites of care not only for local residents, but a destination for the broader region and beyond. As of 1999, the city boasted 13 hospitals, including a nationally renowned academic medical center, community hospitals that offered specialty care services, and one of the nation's leading county hospitals. But San Francisco is also remarkable for the inequality in this infrastructure, a distinction that quickly becomes evident when looking at a map: hospitals mostly can be found in the northeastern corridor and center of the city, near downtown's skyscrapers and some of the city's wealthiest neighborhoods. (See Figure 1.1.) These are also the neighborhoods where more white residents are likely to be found. Meanwhile, the southeastern section of the city, the historical site of industry and of its neighborhoods of low-income residents, many of whom are people of color, has in recent years held only two hospitals: San Francisco General Hospital, a public hospital run by the City and County of San Francisco, and St. Luke's Hospital, a small nonprofit.

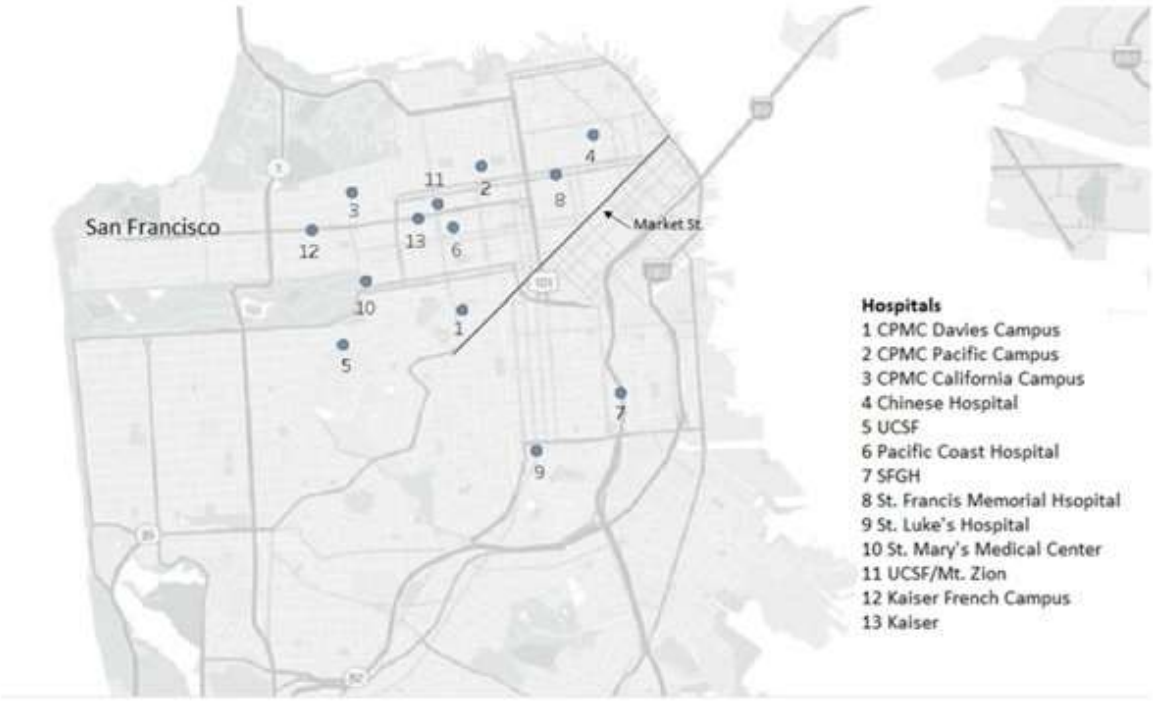


Figure 1.1. San Francisco Hospitals, 1999

The uneven distribution of hospitals across the city's geography tracks with health disparities – that is, hospitals are missing from some of the neighborhoods where they are most needed, those in the southeast. The southeastern neighborhoods rank behind others across a range of health indicators such as asthma, chronic obstructive pulmonary disorder, congestive heart failure, diabetes and homicides (SF Dept. of Public Health and SF Planning Dept. 2013). For example, a resident of Bayview Hunters Point, a southeastern neighborhood, can expect to live, on average, 12 years less than a resident of the Russian Hill neighborhood in the north (California Endowment 2018).

Given that these disparities are not typically newsmakers, it was a surprise to me to learn that, in the 2000s to early 2010s, a coalition of more than 90 San Francisco advocacy groups had

gathered together to save St. Luke's, which was known for its service to low-income patients and patients of color. Long financially strained, the hospital had recently been absorbed into the Sutter Health hospital system and its San Francisco operation, the California Pacific Medical Center (CPMC). Sutter/CPMC then planned to close the hospital's inpatient care and move these services into sites elsewhere in the city. In the midst of this process, groups from all over the city gathered in protest for years, through strikes, government hearings, community information gathering, media campaigns, and long negotiations.

These situations – of hospitals' uneven distribution, health disparities, and apparent divergent interests in hospitals' placement – raise the following questions:

1. Why are there so few hospitals located in southeastern San Francisco, relative to the city's center and northeast? More generally, how have hospitals historically come to be geographically and socially placed as they are in the city, and serving which patient groups? How might this process have conditioned more recent action by hospital administrators and community around hospitals' placement?
2. How do various groups of people with investments in hospitals, such as hospital administrators, local government, and community advocacy organizations, make meaning out of hospitals today? How do members of these groups think about and act toward each other? How does this action impact hospital placement?
3. How do responses to the foregoing questions illuminate how inequality in healthcare happens?

Southeastern San Francisco

This dissertation addresses these questions by exploring historical and near-present development of San Francisco and its hospitals. The geographic focus of this dissertation is the entirety of San Francisco, with the intent of showing how urban development across the city has mattered for the development of hospitals in the city's southeastern section. Southeastern neighborhoods include all of those south of Market Street, the historical symbolic divider between north and south, including Bayview Hunters Point, Bernal Heights, Crocker Amazon, Dogpatch, Excelsior, the Mission District, Outer Mission, South of Market (SoMa), Portola, Potrero Hill, and Visitacion Valley. (For a map of these neighborhoods, see Figure 1.2.) To distinguish the southern half of the city as a place, I use the terms "south of Market" or "southeastern San Francisco" to refer to these neighborhoods collectively and SoMa when discussing that neighborhood in particular.

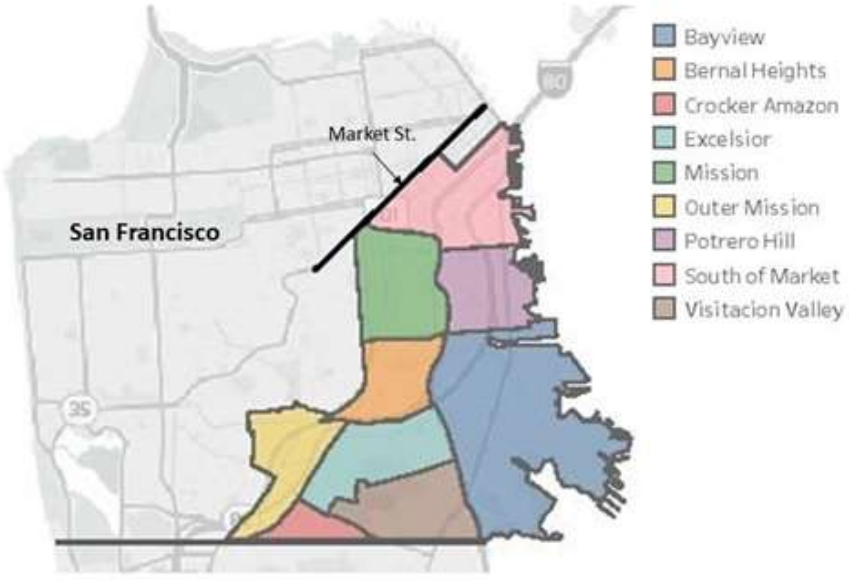


Figure 1.2. Neighborhoods of Southeastern San Francisco*
*Neighborhood boundaries on the map are defined by the San Francisco Planning Department.

Sociological Approaches to Hospitals in Their Environments

Sociological study of healthcare points to the importance of the relationship of residential segregation to healthcare disparities. However, relatively little empirical research or theoretical modeling describes how these relationships unfold. Scholars describe differences in access to care and quality of care by neighborhood as a major part of residential segregation's role in broader health disparities (Landrine and Corral 2009; Williams and Collins 2001; Williams and Sternthal 2010). Studies have shown, for example, that healthcare organizations located in low-income and minority neighborhoods are more likely to close than elsewhere (McLafferty 1982; Whiteis 1992).

This scholarship is part of a broader literature in the sociology of health and illness on "fundamental causes" of disease that addresses how structural racism and classism create disparities in health and healthcare (see, for example, Freese and Lutfey 2011; Metzl and Hansen 2014; Phelan and Link 2015). Where much work on health disparities points to "health behaviors" of individuals that adversely affect their health, the fundamental causes literature draws analytic attention up and away from the individual and toward more structural causes of disparities. Scholars point to such factors as socioeconomic status, and, more recently, racism, as fundamental causes of health inequity, and urge further research pointing to how larger-scale social structures impact individuals' health. These researchers ask, for example, how institutions, geographies, and policies have impacted disparities.

Yet attempts to model these more structural forces and their effects on disparities in healthcare access and quality lag behind. In the literature on access to care, the dominant model of access is Andersen and colleagues' (Andersen 1968, 1995; Andersen, Davidson, and Baumeister 2014). In this model, access is determined not only by the characteristics of

individuals accessing care, but also by "contextual characteristics" including healthcare organization and community characteristics. However, the variations on this model prioritize individual-level factors, such as whether patients have health insurance.

Elsewhere in the healthcare disparities literature, many scholars focus on characteristics of patients, patient-provider interaction, and disparities within healthcare systems, examining whether and how these result in disparate treatments for patients of different races and classes. Studies find that wealthy and white people are more likely to receive care in hospitals with higher quality services, while low-income people and people of color tend to receive care in hospitals with poorer quality services (Baicker, Chandra, and Skinner 2005; Gaskin et al. 2011; Hasnain-Wynia et al. 2007, 2010; Jha, Orav, and Epstein 2011). However, in this literature on "unequal treatment," geography is mentioned but often is given less attention. For example, in the Institute of Medicine report *Unequal Treatment* (2003), factors are divided into two main categories: the health care system and its legal and regulatory environment, and discrimination including biases and stereotyping. The bulk of this report, though, and much sociological literature, focuses on interaction between doctors and patients and what healthcare is provided as a result (e.g., Cooper and Roter 2003; Dubbin, Chang, and Shim 2013; Lo and Stacey 2008; Malat 2006; van Ryn et al. 2011; Shim 2010). The literature addressing how organizational and broader extra-clinic factors impinge on those relationships is much thinner. (Burgess 2010; Lutfey and Freese 2005; Stepanikova 2012). Altogether, these literatures provide valuable empirical insights and theoretical models (e.g., a focus on culture in the making of disparities), yet more could be said about the broader environment in which these interactions take place. There is, for example, relatively less inter-clinic comparison that could highlight this variation, and little on the action of healthcare administrators.

To respond to these works, I turn toward several literatures in medical and urban sociologies.

San Francisco's Racialized Uneven Development and Its Local Hospital Care Arena

The dissertation is primarily concerned with the social structuring of race and class, how such structuring is embedded in place and what impact it has on access to healthcare. To this end, I propose that we might see urban development in San Francisco as occurring through a *racialized uneven development*, arguing that this development is co-constituted with development of the city's *local hospital care arena*. I describe each concept and the supporting literatures in turn.

The term *racialized uneven development* builds on a few theoretical strands.[1]First, it draws on the concept of "uneven development," which can be traced in part to Engels' (1952) finding that different socioeconomic classes occupied different geographic spaces in the city of Manchester, England.[2] Study of uneven development has been advanced over time by Marxian theorists interested in how capitalism has developed differently in different times and places and, within this broader tradition, how geographic development is part of the process of social class division (e.g., Castells 1977; Harvey 1973; Smith 1979, 1990). To them, geography is a key site of the creation of surplus value, or profit, as capitalists invest in and build on land. Capitalist

[1] This concept is based in part on Miller et al. (2019). I thank my colleagues for their contributions to its development, and Adrienne Hall in particular for introducing me to work on racial capitalism.

[2] Here, social class is defined as people who share a common relationship to labor and to the means of production.

development also involves disenfranchisement, partly as capital develops differently in different places, and as capitalists move their investments from one place to the next, seeking to make new profit in new terrains. There is wealthy, developed land in some places, serving wealthier groups, and devalued places elsewhere, often allowed to deteriorate or organized as sites of pollution, where the working class is contained.

However, purely economic perspectives on inequality, including some Marxian theory, sometimes reduce the development of structural racism and other social processes to economic concerns. In so doing, they can miss other factors in inequality (e.g., culture and politics) which may matter as much or more than economic ones (Omi and Winant 1994). Economic valuations are made by people, and are therefore necessarily shaped by the other social concerns and social positioning that individuals making them have. What counts as value is fungible, and can potentially include any meaning or use of place. (See Pulido 2017 for a related argument.) Such meaning and use are achieved through the interaction of varied social groups and are co-constituted with any of a number of other social processes, such as the making of racial hierarchy. This is an interactionist approach to urban development, and of race- and class-based division within it, that leans on the interactionist, "power and politics" traditions in urban sociology, interactionist approaches to the study of race, and on more recent interactionist theory in situational analysis (Clarke 2005). I address each in turn.

As an interactionist approach, racialized uneven development attends to the social construction of meaning – in politics, culture and economic valuation. In urban sociology, pragmatist and interactionist urban sociologists include DuBois (1899), Drake and Cayton (1945) and McRoberts (2003). These scholars considered the historical and present-day political economic, cultural and historical making of residential segregation, and of people of color and

their organizations' response to the experience of segregation, as well as the importance of everyday interaction in their makeup. A related approach can also be found in urban scholarship that explores urban elites' actions to profit from development of cities (Beitel 2003; DeLeon 1992; Logan and Molotch 2007; Mollenkopf 1983). Such "power and politics" work stands in contrast to early Chicago School urban sociology, which conceptualized neighborhood and city development as somehow natural, efficient, and uncontrollable (Park 1936, 1965). Instead, the power and politics scholars named above saw urban development as *constructed*, rather than natural, and in their analyses they emphasized, among other things, discrimination in the making of neighborhood and organizational boundaries and interaction in the maintenance of the color line. Similarly, in geography, Pulido (2017) draws from the concept of racial capitalism (Robinson 1983), arguing that racism is foundational to capitalist development, especially as it is formed through the making of urban places.

To form an interactionist approach to the cultural, economic and political shaping of hospitals' roles in racialized uneven development, I conceptualize these together as part of a "situation," after Clarke (2005), arguing that hospitals are *social worlds* (Clarke 1991, 2005; Strauss 2011), and that together they are part of the *local hospital care arena* in the city. A social world is a "universe of shared discourse" defined by shared language and commitments of various actors to each other as they make meaning together (Mead 1972: 518; Strauss 1978). Discourse includes groups' historically specific constructions of their social world, and is also understood as sets of statements of what can be known about the world, and through which power operates, after Foucault (1980). That said, where Foucauldian analysis typically is concerned with a single, hegemonic discourse that organizes a scene, a situational analysis approach involves investigating the many discourses in a situation, to attend to the meaning-

making of oppressed groups. I also suggest that power operates in many ways, including some that are productive and some that are oppressive. For example, raced and classed segregation has been achieved not only as, say, city leaders took up new, financialized understandings of place, but also through forced migration of people of color. Further, discourse is organized in practices. These are everyday actions, such as medical diagnosis, as well as the practices of governance, studied with an eye to how they are organized, allowed and rendered understandable. Thus, racialized uneven development is made through the creation and maintenance of social worlds, as a wide range of social groups active in the city strive to make meaning of the urban environment and peoples in it.

The action of social worlds happens in a broader arena. An arena is a site of overlap of multiple social worlds where conflict between social groups, rather than commitment, is the norm (though, that said, social worlds are not conflict-free, either). The social groups active in a social arena can be any type of collectivity; here, we might imagine these to be primarily hospitals, but also local government, local elites (such as real estate developers and heads of major civic and business institutions) and the varied social groups that organized the first hospitals, as well as the patients who sought care in those hospitals. (For a conceptual map, see Figure 1.3.) Social arenas do not have to be delimited by geographic boundaries – in fact, the development of the social arenas concept was partly based on an attempt to move away from earlier, place-as-container-based models of urban sociality like that of Park and Burgess (1925). However, here, I consider San Francisco as the geographic boundary of this social arena to understand how groups involved in hospitals think about and act in relation to place, and to consider how the value articulated in hospitals is tied to place. By looking within San Francisco, and hospital care, as a social arena, we can understand how hospitals in the period related to each

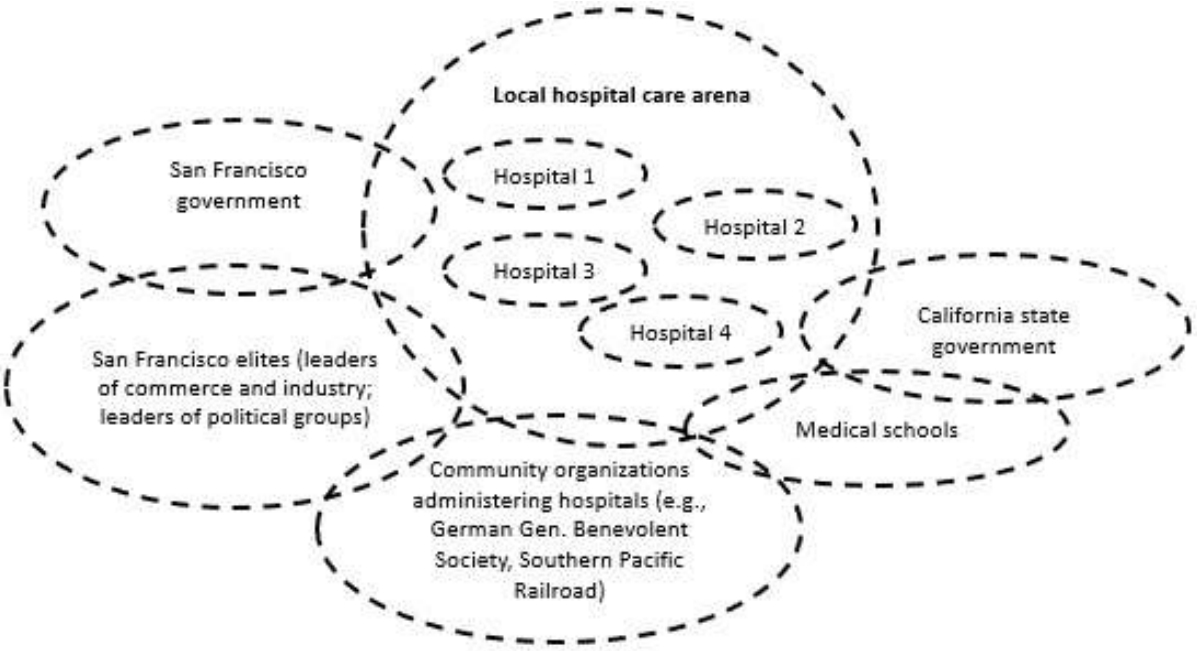


Figure 1.3. A Social Worlds Map of San Francisco's Local Hospital Care Arena, Mid- to Late 1800s*

*Exact overlaps of groups are not shown – the map is impressionistic and meant to give a rough idea of how groups are interrelated.

other, and what groups, including and extending beyond hospitals themselves, mattered for this process.

I draw, finally, from the recent neighborhood political ecology perspective in public health (Chitewere et al. 2017). In this work, Chitewere and colleagues urge analysis of the social determinants of health including "the varied components of the places people live, including the social, cultural, economic, political and environmental history and present engagements" (118). Such analysis draws attention to analytic levels above the individual in the making of place and health outcomes to point to social determinants of health. In so doing, it recognizes the actions of

varied social groups who make meaning of and use neighborhoods – including, for example, not only residents but also local, state and federal government; and local elites, including real estate developers. I draw from this model, examining how race- and class-based struggle in the city's urban development, at the levels of neighborhoods and the broader city, matters for the health of residents. Racialized uneven development could be said to characterize neighborhood political ecologies and the broader political ecology of the city, and the local hospital care arena could be understood as one part of the larger urban political ecology, stretching across neighborhoods.

I note three further engagements of this local hospital care arena. First, while there is a focus on discourse, racialized uneven development develops through the material bodies, places, and other things people use to make meaning. As Clarke concludes, "The social is relentlessly material, not 'merely' epiphenomenal" (Clarke 2005: 7). Here, I consider the city as a place – with streets, buildings and neighborhoods – that has a material, physical extension in space, and is tied to geographic location, yet also is invested with meanings, after Gieryn (2000). Also important are material goods that are valued and placed, such as hospital beds and bodies.

Second, to understand development of racism and classism, I draw from the concept of racial formation, through which racial categories are continually redefined and changing which Omi and Winant (1994) define as "the sociohistorical process by which racial categories are created, inhabited, transformed, and destroyed" (55). Racial formation unfolds in processes that both organize and represent human bodies and social structures. Such a process, which they call a *racial project*, is "simultaneously an interpretation, representation, or explanation of racial dynamics, and an effort to reorganize and redistribute resources along particular racial lines" (56). Racial projects exist at macro-and micro-levels of sociality, defining processes ranging from everyday experience to formation of the state.

Third, I describe development as occurring through particular eras. Each era is characterized by the presence of particular social worlds, discourses, practices and arrangements of the material environment. The idea of era draws on work of multiple theorists (Armstrong and Bernstein 2008; DuBois 2007; Klawiter 2008) who highlight the specificity of historical development, as opposed to other, more mechanistic historiographies. This historically specific conceptualization includes the Foucauldian notion of regime of practice – an era in which particular discourse is legitimated as true, together with the means through which this occurs (Foucault 1991). However, following the scholars cited above and situational analysis, the era does not only follow a hegemonic group producing a dominant discourse but looks at the multiple groups that make meaning in the era and take action. Here, I describe how hospitals have been given meaning and organized as places and as sites for care of specific groups of people, incorporating attention to how language and practice around race and class were embedded in place and in hospital development. I characterize ideas about race and class in each era, discussing how these are taken up by various social worlds and their members.

In sum, racialized uneven development, though it describes urban development generally, is also co-constituted with the local hospital care arena. This development occurs as social worlds compete to legitimate their social constructions within the arena and as they organize themselves within the material, built environment of the city, distributing people and things in place. The development of social worlds and the arena over time does not follow a predetermined path (as Marxian models sometimes emphasize), but rather is fluid and emergent. However, empirically the inequitable racialized and class-based structuring of places and healthcare has been durable in the US. Therefore, as a concept racialized uneven development explores shorter- and especially longer-term interactions to understand how this structuring

occurs. This interaction occurs as policy, economic interests and culture build and break down racism and classism, through processes that are historically specific. Further, racialized uneven development attends to the way in which meaning inheres in places and how places materially affect people, as buildings themselves are durable. Thus, hospital location, the meanings of hospital care and the people served there and the meanings of the places where they are related are all mutually constituted and reinforced. (For a similar argument, see Chang 2014). We might describe this as an emergent urban development, similar to the dialectical development of urban and social structuring that others have theorized (Castells 1977; Chang 2014).

I offer a final reflection on why one might make analyze the development of hospitals in this situation. Hospitals and others invested in them have a particular theoretical interest. Born from almshouses, organizations that historically were charitable in nature (or were meant to contain the poor, depending on one's perspective), hospitals might sit outside the development of structural racism and classism, mitigate them, or to prop them up by offsetting some of their exploitation. Therefore, if and how racism and classism become interpellated into hospitals becomes a point for exploration. A social arenas model can fruitfully explore this type of engagement as it attends to all of the commitments that various actors have in a given social world.

Hospitals' and Community Groups' Responses to the Past and to Each Other

The model above says little about extant theories of the structuring of medical institutions, or of social movements' attempts to change those institutions, or how these

processes may be raced and classed. Therefore, the second half of the dissertation draws from relevant literatures on medicine and capitalism and on health social movements.

Medicine and Capitalism. Mirroring Marxian approaches to urban theory above, the sociological study of medical institutions in their environments is a sometimes implicitly, sometimes explicitly Marxian one. This work has been concerned with the growth of capitalism, finding that, over time, medicine is increasingly "corporatized" and part of a "medical industrial complex" (Ehrenreich and Ehrenreich 1971; McKinlay and Stoeckle 1988). In this conceptualization, medicine develops through its relationships to governments and corporations as an instrument of profit-making. Some of this literature explores how the development of healthcare proceeds via an "uneven development" in which there is more healthcare in some places (Waitzkin 2000), leading to an "underdevelopment of health" elsewhere (Navarro 1974). That is, a lack of healthcare in some locales, leading to poorer health outcomes there, is relationally tied to excess healthcare and overdevelopment occurring elsewhere.

Further, in recent years, scholars have re-imagined how capitalism is unfolding in medicine in the neoliberal era. This era is the most recent era in the development of American politics marked by deregulation, privatization and a reduced welfare state (Clarke et al. 2003; Rajan 2006; Waitzkin and Jasso-Aguilar 2015). In some of this work, medicine is understood as being transformed through a process of biomedicalization. The concept of biomedicalization is an extension of earlier work on medicalization, which theorizes processes under which areas of social life become deemed medical issues (Conrad 2007). However, biomedicalization deals with "the increasingly complex, multi-sited, multidirectional process of medicalization that today are being both extended and reconstituted through emergent social forms and practices of a highly and increasingly technoscientific biomedicine" (Clarke et al. 2010: 47). The work is concerned

with how, since the mid-1980s, new technologies have been transforming medicine "from the inside out," creating new meanings and uses for it.

A part of biomedicalization's theoretical concern is an analysis of power, drawing on earlier work of Foucault. Here, knowledge is theorized to be a form of power, exercised as biomedicine produces, controls and optimizes patients' self-understandings. Where other theory, such as the Marxian theory discussed above, envisions power as *held* by the state over the populace, in this perspective knowledge *is* power (Foucault 1980). Power is not necessarily centered in the state or the action of elites; rather, it is exercised from everywhere, it is unstable, and it is multivalent.

Biomedicalization also addresses new relationships of biomedicine to capitalism and to inequality. Work using this concept considers, first, that changes in biomedicine proceed from a new relationship to political economy. That is, biomedicine is increasingly corporatized and commodified as the relationship of biomedicine and capitalism becomes closer. Biomedicalization is also stratified by varied axes of inequality, including race and class, in new ways as biomedicine is transformed. Medicine develops unevenly, and new forms of medical organization exclude some groups, while coopting others.

Such work is relevant to this dissertation because it focuses on the transformation of medicine in the neoliberal era, and especially on the ways in which biomedical language may operate to continue or address race- and class-based inequality. It is also valuable because it makes the relevance of the state – or any axis of inequality – an empirical question. However, to better understand the porousness of medical institutions' boundaries as varied groups engage with them, we might turn to health social movements literature.

Health Social Movements. Social movements might be defined as "collectivities acting with some degree of organization and continuity outside of institutional or organizational channels for the purpose of challenging or defending extant authority, whether it is institutionally or culturally based, in the group, organization, society, culture, or world order of which they are a part" (Snow 2004:11). Among social movements, health social movements are understood as "collective challenges to medical policy, public health policy and politics, belief systems, research and practice which include an array of formal and informal organizations, supporters, networks of cooperation and media" (Brown and Zavestoski 2004).

The foregoing definitions are in synch with recent work viewing social movements as challenging a broad array of authorities. This is a relatively recent turn in the literature as it has moved away from analysis of movements' actions on the state and toward an appreciation of movement activity as aimed at diverse targets (Armstrong and Bernstein 2008; Klawiter 2008), and informed by particular cultures. Armstrong and Bernstein (2008:82), for example, take a *multi-institutional politics* view of movements under which "society is composed of multiple and often contradictory institutions" that can be distinct and also can overlap and nest within each other. In this view, then, "the nature, power, logic and centrality of states... [is] historically variable and a question for empirical investigation." Culture and politics matter for the action of institutions and movements, and power is not held by the state, or by any group, after Foucault (1980). Rather, power is exercised relationally, with no person or group sitting outside of power. This position stands in stark contrast to a Marxist one – class relations do not determine shifts in power over time; rather these are variable and contingent in a way that a class model would not adequately capture. Similarly, Klawiter (2008) follows Foucault, addressing how power can be diffuse, rather than centered in the state, and exercised from everywhere. She also argues that

social movements can grow within particular cultures of action, a facet of movement development not adequately captured in older theorizing, which privileged analysis of the state.

This recent multi-institutional work on social movements synchs well with the arenas concept proposed above. A similar concept of *field* is already in use. Crossley (2006), refers to "fields of contention," after Bourdieu (1990), and Ray (1999) also takes up the concept of field. Such a field a site of social action, like a game, where actors on it have a "feel for the game." Social movement scholars' uptake of the idea of field have much in common with the arena – fields are nested and interrelated with each other, and power is diffuse.

This more recent work on social movements is driven by critique of older social movements interested in political process. In this older work, social movements have their success in relation to "political opportunities" (McAdam 1982, 1996). While conceptualized early on as anything outside a movement, political opportunities later were understood to be facets of the state, and in particular its longer-term social structuring. Agency, in the form of informal culture in the state or out of it, was de-emphasized, as were the grievances of movement members, or the action of entities outside the state, such as corporations. The state also to some extent lost its historically specific character and came to be seen in mechanistic terms. In contrast, work on multi-institutional politics and health social movements is not necessarily focused on the state, but rather may also focus on science, culture, corporations or any other facets of social life relevant to the progress of the movement.

Most recently, however, scholars have critiqued social movements literature, suggesting that it could go farther and analyze movements in relation to the larger racial and political economic structuring that they challenge (Bracey 2016; Hetland and Goodwin 2013; Moseby 2012; Richter 2018). For example, such work examines how racialized governmental

institutional structuring precluded detection of and response to environmental threats to a mostly Latino community (Richter 2018). Notably, this structuring included geographic conceptualization of health issues at a level too large to discern problems. Work in this vein also focuses on how governmental structuring of HIV prevention and social movement activism have shaped the racialization of HIV/AIDS from a white disease in the 1980s and early 1990s to a Black disease from the early 1990s through the early 2010s (Moseby 2012). Such work on health social movements is valuable to this dissertation because it allows a view into how hospitals are part of their broader social environment, and how hospitals' boundaries are impacted by social movements. The critique of social movements research in relation to race and class also points toward the need for analysis that will address how social movements do or do not challenge existing racialized and class-based structuring of hospitals.

Methods and Analysis

Below are details of methods and analytic procedures. These include descriptions of documentary and archival research; sampling, recruitment, and data collection for qualitative interviews; and analysis processes.

Documentary and Archival Research

Documentary research was used to trace the historical trajectories of San Francisco neighborhoods, especially those in the southern half of the city, to create historical portraits of the geographic and social positioning of hospitals within San Francisco over time, and to explore hospital rebuilding in the near-present. To capture as much of hospitals' trajectories as possible, this research included, first, a review of San Francisco city directories beginning in 1850 (the

year of the first available city directory) and continuing forward to 1999 to create a picture of what hospitals existed in San Francisco and where they were sited. Following this review, research included analysis of documentary data to understand how hospitals had become physically located where they were and how their social boundaries might have been shaped in critical eras. These materials included histories of hospitals written both by those working in them and by others, oral histories of prominent individuals working in or with hospitals, and government documents; hospitals' annual reports, histories, websites, City offices, and newspaper articles about hospitals. Care was taken to review newspaper articles from multiple perspectives, including, for example, the *New Bernal Journal*, *New Mission News*, *San Francisco Bay Guardian*, *San Francisco Bay View*, *San Francisco Business Times*, *San Francisco Chronicle*, *Sun Reporter*, and *El Tecolote*. I also reviewed historical city planning documents to understand how hospital planning was part of these processes, and I reviewed other primary and secondary sources on development of the city. Important sources of documentary data, used to follow the contours of the story of the St. Luke's/ California Pacific Medical Center hospital redevelopment, included notes, video and audio recordings taken at meetings and hearings with San Francisco city governmental bodies. Notes from more than 30 meetings and hearings were used, with hearings lasting up to seven hours. An important and highly problematic gap in this research is that much of the historical data does not include the perspectives of low-income people or people of color on their experiences with hospitals.

Qualitative Interviews

Semi-structured qualitative interviews were conducted with 20 people, ranging in length from 20 minutes to approximately two hours. Some individuals were interviewed more than

once. Respondents were selected to explore a range of social groups and institutions' relationships to and investments in the hospitals. These included individuals with long-term involvement with San Francisco hospitals who could inform a historical understanding of those organizations' development, as well as individuals involved in CPMC's recent re-organization. Interviewees were hospital administrators involved with strategic goal-setting for their organizations, other individuals working at hospitals, members of neighborhood and other community activist groups, and City government officials, as well as others involved in health care planning and health care strategic consulting. Interviewees were identified through document review and snowball sampling. Interviews were semi-structured to enable attentiveness to the interests of respondents, and to the terms and stories through which they described their world.

Analysis

Data were analyzed with constructivist grounded theory, the inductive and qualitative development of theories of social processes (Charmaz 2006). Grounded theory draws from pragmatist philosophy, symbolic interactionism and Chicago sociology. Chief among these theoretic foci is symbolic interactionism, which conceptualizes the social world as comprised of interactions between people (both individuals and groups), who act in the world as they take each other into account and make meaning of their interactions. Constructivist grounded theory also stands apart from earlier versions that argue that there is an objective situation to be understood (Glaser and Strauss 1967; Strauss 2011). Instead, here the analyst is recognized as actively positioned within the scene, constructing an interpretation of the situation at hand.

Analysis consisted of developing codes and memos to summarize and interpret data. A constant comparative method involved moving between data, codes and memos to develop a rich, thematic understanding of the situation. Qualitative analysis software facilitated coding data and visualizing relationships between codes. This process proceeded at the same time as data collection so that later data collection could be shaped to enrich and challenge understandings gleaned from earlier analysis. As part of this process, the interview guide and sampling strategy were systematically developed over time. Further, since constructivist grounded theory recognizes the analyst as an active participant in constructing an interpretation of the scene she is studying, memos included self-reflection on my place in the scene.

As noted above analysis also included situational analysis (Clarke 1991, 2005). Situational analysis "re-grounds" grounded theory after the postmodern turn. Drawing upon earlier work by Strauss (1987) and Charmaz (1995), situational analysis leaves behind grounded theory's early positivist roots. In positivism's place, situational analysis turns toward the partiality, situatedness, fragmentation and instability of the social world and what analysts can make of it. The unit of analysis becomes the situation, and analytic attention focuses on understanding the elements of that situation and their interrelationships. Here, the unit of analysis is the situation, the elements that make it up and their relationships.

In situational analysis, a series of maps are used to construct the situation, including situational maps "that lay out the major human, nonhuman, discursive, and other elements of the research situation and provoke analysis of relations among them" (Clarke 2005: xxii); social worlds/arenas maps "that lay out the collective actors, key nonhuman elements, and arena(s) of commitment and discourse within which they are engaged in ongoing negotiations – meso-level interpretations of the situation"; and positional maps "that lay out the major positions taken, and

not taken, the data vis-à-vis particular axes of difference, concern, and controversy around issues in the situation of inquiry." Use of these analytic processes, along with multiple methods proposed above, enabled me to triangulate organizations' constructions of their position and orientation with others' understandings of their position, as well as with documentary evidence. This process facilitated analysis of varied means of boundary-making and the impact of conflict and consensus between varied social groups, as well as the use of geographically situated resources in this process.

Overview

The chapters in this dissertation are arranged in two parts. Part I includes Chapters 2 and 3 and addresses the historical development of San Francisco's hospitals from approximately 1848 to 2001. Part II, including Chapters 4 and 5, examines how hospitals and the community responded to this past and to each other, from approximately 2001 to 2013.

To begin to address how San Francisco's hospitals developed historically, between 1848 and 1933, Chapter 2 argues that San Francisco experienced a racialized uneven development as described above. Co-constituted with this process, early hospitals developed as a set of social worlds in a local hospital care arena. I find the city's racialized uneven development was shaped through the action of white government, elites and populace to shape the land to benefit themselves, while containing the Chinese and poor whites. The white populace's discourse about particular places and groups of people was sometimes co-articulated with discourse about health, and was effected through technological advancement. At the same time, the local hospital care arena was shaped as hospitals distinguished themselves from each other by serving particular racial, ethnic and class-based groups and by orienting toward the "healthfulness" and

"unhealthfulness" of places and groups of people. This arena also grew through uneven white governmental support for and control of hospital development.

Chapter 3 considers how the local hospital care arena developed over time, and how in particular the birth of federal urban and healthcare policies influenced the growth of San Francisco's hospitals. I describe how San Francisco's hospitals evolved in the 20th century through two policy eras – a era of federal regulation and a neoliberal era, from about 1934 to 2001. In these eras, the loose coupling of healthcare policy language with its implementation and hospital response meant that existing racism and classism in the structuring of the local hospital care arena could be continued and even strengthened. Some groups resisted this development, but by the end of this century, there were even fewer hospitals located in the southeast than had been present in the previous century.

In Part II, Chapters 4 and 5 turn from Chapter 3's consideration of federal policy down to on-the-ground interaction and culture among hospital administrators, local government, and social movements. I follow the story of the struggle to save St. Luke's Hospital, a small nonprofit hospital serving San Francisco's southeastern neighborhoods. The hospital, which had long been financially strained, was threatened with closure of its inpatient services when it was taken over by the Sutter Health system of hospitals and its San Francisco outfit, the California Pacific Medical Center. Examination of its circumstances offers a window into the operation of biomedicine in the neoliberal era, and the ways in which its action would drive development of structural racism and classism, as well as public response to it.

Chapter 4 follows the discourse and practice of hospital administrators in response to past redevelopment as they begin a process of closure of St. Luke's and attempt to justify it before the community. In so doing, hospital leaders undertake a *selective regionalism* under which they

redesign the medical center to serve a broad region, but in so doing they plan exclusion of services to neighborhoods where there are patients who will be more likely to be low-income and/or people of color.

Chapter 5 unpacks the discourse and practice of community in response to the past and to hospital administrators' action. It describes San Franciscans' *community-oriented resistance*, under which a heterogenous group of community actors – including social movement organizations and members of local government – responded to CPMC. This chapter finds that these varied groups are able to contain hospital administrators' selective regionalism somewhat, in part through inroads that social movements have made in local government, but also through a series of contingent events and agentic interpretation that are not easily accounted for in older theories of social movements.

PART ONE

CHAPTER 2. SETTLEMENT AND EARLY HOSPITAL DEVELOPMENT, c. 1848 – 1933

In the midst of the Gold Rush, as newcomers from near and far converged on northern California, the city of San Francisco developed almost overnight. Chroniclers from the era described explosive urban growth:

> Every where in the city is the workman busy at his trade. Laborers of various kinds are still hewing down the rocky hills, excavating the streets, grading and planking them; they are levelling building lots, and rearing mammoth hotels, hospitals, stores, and other edifices; they are piling and capping water lots, and raising a new town upon the deep; gas and water works are forming; sand hills are being continually shifted, and cast, piecemeal into the bay… (Soule, Gihon, and Nisbet: 497)

But how did this expansion occur? What forces, political, economic and cultural, mattered, and how did they physically shape the city, its new houses, hospitals and neighborhoods? Somehow, the city and its hospitals grew.

The analysis below addresses this question in a manner that stands in contrast to work on organizations in medical sociology. Organizational medical sociology typically starts from a Weberian, functionalist, or Darwinian tradition (e.g., Fennell 1980; Laumann and Knoke 1987; Starr 1982). These scholars assume the perspective of the dominant social group operating within hospitals, physicians. Such an analytic perspective might be described as that of management (Clarke 1991), a positioning that goes unacknowledged, not only in organizational medical sociology but also in organizational sociology more broadly (Burawoy 1979: 5-6). Perhaps because of this social positioning, the work attends less to race- and class-based inequalities, tends to assume the market for health care is freer than perhaps it is (Navarro 1984), and attends less to actors not commonly deemed market actors, such as social movements. Furthermore,

when it does address space, space is seen as a container, rather than as a site of meaning-making. There is also little attention to neighborhoods. When space is part of an analysis, focus tends to be at larger geographic levels, washing out the relevance of neighborhoods.

In the analysis below, however, I find that hospitals are part of their neighborhoods and larger communities. Hospitals generate particular economic, cultural, social and political endowments as they are placed in the city. Furthermore, groups with investments in hospitals act to shape the boundaries of these social worlds, negotiating who will be served and how according to race and to class. This is a key contribution of the situational analysis. While in other theories (perhaps most notably, Darwinian theories of organizational history, where the social environment selects for the survival of particular organizations), here boundaries of organizations are socially constructed and fluid. Thus we see inter-relationships of some social worlds to each other, or the blurring of their boundaries, and the active negotiation of their boundaries. As noted in Chapter 1, the theoretical interest of hospitals in part is that they have their roots as institutions with some measure of support for low-income populations. These older meanings as sites of care of the poor persisted into this period, yet as we shall see, hospital leaders and those with investments in hospitals negotiated how and whether to serve patients of varied races and classes.

Below, I examine how the growth of hospitals was socially structured, and find that with it came social inequality as different groups of migrants settled – or were forced to settle – in different parts of the city, in what I have called "racialized uneven development." This urban development occurred as settlers arrived, transforming the land as they moved across it. Development was made uneven not only as white settlers developed capitalism, but also as groups contingently assigned other meanings and divided resources among to the land and

people there, especially according to race. Further, though racialized uneven development describes urban development generally, I focus attention on how the "local hospital care arena" and its "social worlds" grew in relation to broader urban development, with different hospital care afforded to different groups by race and class.

This chapter explores hospital development in the mid-1800s to 1930s, in an era of the growth of industry and early commerce, before significant federal legislation later reshaped cities' land use and hospital development. There are two sections. In the first, I explore urban development in this era. I find that, as the city grew, white elites split the city early on into physically and symbolically distinct northern and southern halves, choosing to live in the north and west while containing low-income groups and people of color in the industrial southeast and in Chinatown. In the second section, I show how hospitals' social divisions, made according to race, ethnicity and class, mapped onto geography, with wealthier hospitals for white ethnic groups concentrated to the north, and hospitals serving the poor and people of color located in the south.

Racialized and Class-based Settlement and Expulsion

In this section, I briefly describe racialized uneven development in San Francisco from the mid-1800s to 1930s. I argue that whites, especially white elites, applied capitalist commerce and industry, physical violence, the legal system, technology and medicine to force low-income residents and people of color into stigmatized spaces. Hallmarks of this era were rapid expansion of local commerce and industry, as well as the expulsion, exploitation and genocide of low-income groups and people of color. These practices were sometimes legitimated by, and sometimes themselves promoted, explicitly racist and classist language embedded in politics,

medicine and popular discourse. One of the most effective tools was invoking the threat of disease and tying it to class and especially to race. The consequence of these actions was that, by the 1930s, whites had effectively managed to control the space of the city by using several levers of structural and institutional power, as well as cultural beliefs, a process I have called racialized uneven development. In concluding, I note that the labeling of parts of the city and its peoples "unhealthy" helped shape the role of hospitals in their communities.

Before the Gold Rush, the area had been settled earlier by the indigenous Ohlone and by Mexican rancheros. However, in 1848 and immediately after, white settlers arrived en masse and used a variety of means to drive out or assimilate these residents, appropriating land and developing it for their own, often capitalist, purposes. Indigenous populations were made to assimilate, were forced into slavery, and experienced genocide (Madley 2016). Their place names and means of using the land also were obscured with new names (Field, Leventhal, and Cambra 2013). Meanwhile, rancheros, individuals who had been granted land by the Mexican government, often had to litigate to keep their land under the new US government (Almaguer 2009: 65-68). As a result, rancheros lost their land, as, for example, they sold pieces of it to pay for the lawsuits.

As white settlers wrested land from residents, San Francisco quickly grew from a small hamlet into one of the largest cities in the country. In 1847 only 500 people lived in the village of Yerba Buena, but after the discovery of gold at Sutter's Mill in 1848, the settlement – renamed San Francisco – grew into a city (consolidated with the county in 1856) of more than 230,000 (U.S. Bureau of the Census 1880). Arrivals came from the rest of California, the US, and other shores. By 1880, 70 percent of San Francisco's residents were born outside of California, and, at 44.6 percent of the population, foreign-born residents comprised the largest

proportion of residents of any major city in the US. The largest populations of foreign-born newcomers came from Ireland, China, Germany and England.

Migrating groups arriving in the new city initially populated a small area in the northeastern corner of the peninsula, in what is now the Financial District, as physical barriers, including sand dunes and hills to the west, hemmed them in (Tygiel 1977: 36). However, by the 1870s, San Francisco was expanding outward from this center and differentiating into neighborhoods attached to different socioeconomic classes and races. As the city grew, it effectively split into northern and southern halves, divided by Market Street. Of this, Jack London wrote,

> Old San Francisco, which is the San Francisco of only the other day, the day before the Earthquake, was divided midway by the Slot. The Slot was an iron crack that ran along the center of Market street [*sic*], and from the Slot arose the burr of the ceaseless, endless cable that was hitched at will to the cars it dragged up and down. In truth, there were two slots, but in the quick grammar of the West time was saved by calling them, and much more that they stood for, 'The Slot.' North of the Slot were the theaters, hotels, and shopping district, the banks and the staid, respectable business houses. South of the Slot were the factories, slums, laundries, machine-shops, boiler works, and the abodes of the working class. (London 1914)

That is, the city was divided partly by class. In the north, mostly, lived the wealthy. When the railroad arrived in 1869 in Oakland, railroad magnates settled in Nob Hill and other wealthy San Franciscans followed. Thus, development of the city proceeded partly as elites chose where they wanted to live. Meanwhile, elites developed the southern half of the city as the home of industry, placing shipbuilding, iron foundries, food processing and consumer goods production there. The working class settled there in houses, hotels and boarding houses. This split was not absolute, however: to the north, the Chinese, who were nearly all working-class, were only allowed to live in Chinatown (Kelley & VerPlanck 2010: 64), and in the south some wealthy families lived in the Mission District (Tygiel 1977: 39). In total, seven neighborhoods could be

distinguished as follows: 1) South of Market, a neighborhood for young, working class men as well as families; 2) Mission District, where families owned homes and were "skilled workers or small-scale entrepreneurs"; 3) Western Addition and nearby, home to middle-class families; 4) Nob Hill-Pacific Heights, "distinctly upper-class," 5) Chinatown, where working-class, single Chinese men lived; 6) North Beach, a largely working-class Italian neighborhood after 1900; and 7) Downtown, where maritime workers and professionals lived, as well as home to a "vice district" (Issel and Cherny 1986: 58). (See Figure 2.1 for a map.)

Early residential divisions were not just class-based but also racial and ethnic. The result was a racialized uneven development. This development was effected partly through the making of land use and property rights that were overtly racist. For example, like most other American cities, early on San Francisco lacked zoning laws (Carey & Co. 2009). However, by the 1880s, white San Francisco leaders attempted zoning in explicitly racist moves against the Chinese to give whites control over the growing city. In a series of ordinances, the city attempted to curtail Chinese business, banning Chinese laundries, for example, and proposing to move them out of white neighborhoods At the same time, the Chinese were denied the right to own property and were, as noted above, forced to live in Chinatown in the city's northern half (Kelley & VerPlanck 2010). Meanwhile, white political groups, including the Anti-Chinese Council and the Workingmen's Party, tried in the 1850s, 1880s and early 1900s to have the Chinese moved to southern San Francisco or out of the city (Kelley & VerPlanck 2010: 62; Trauner 1978: 74).

Racism and classism at the time were legitimated through language that was explicit and biologized. At the time, some white Americans subscribed to the social Darwinist view that races and ethnicities existed along a continuum from less to more "evolved" and that their success or failure in society was due to natural selection. For example, whites described the Chinese as

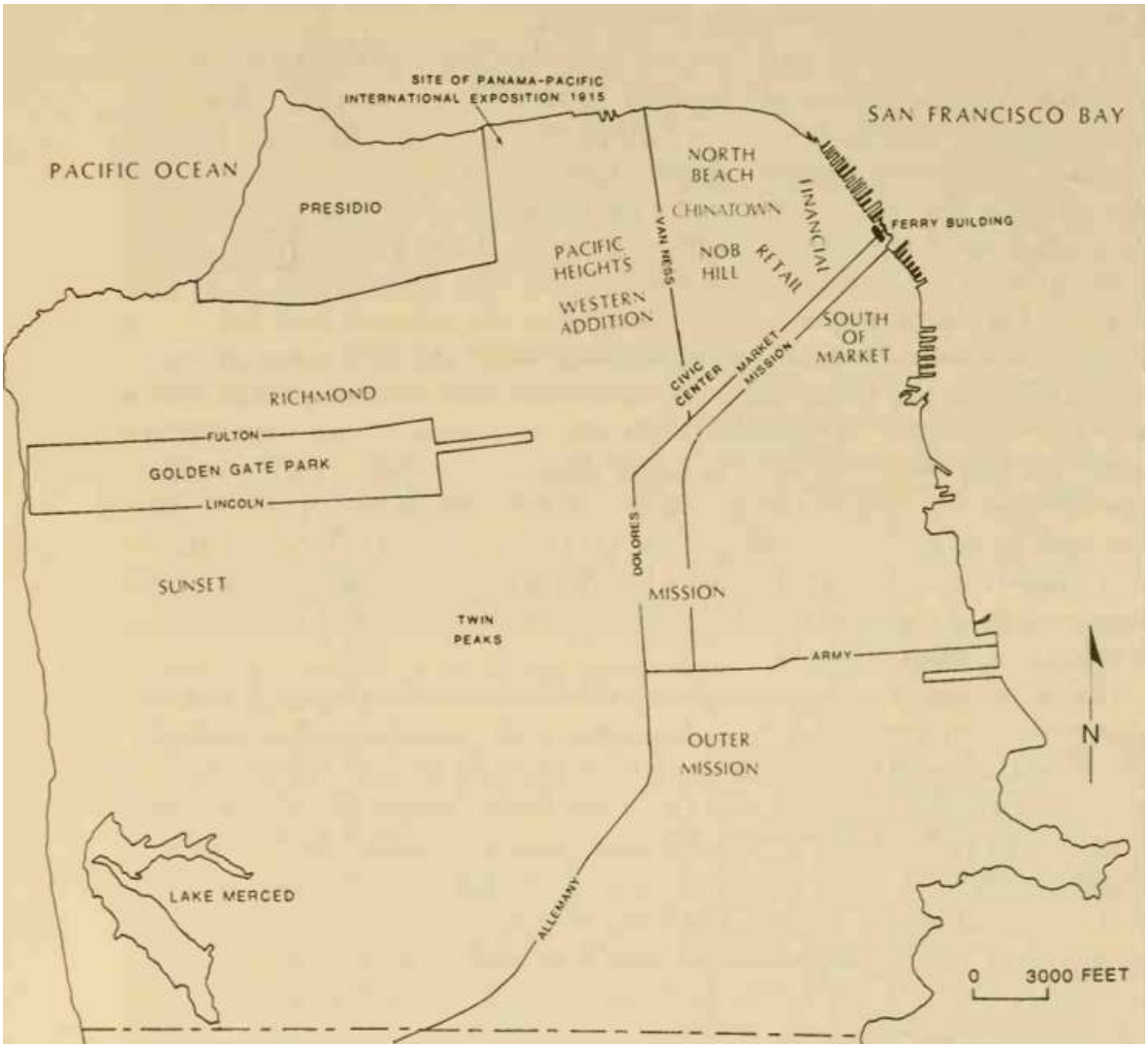


Figure 2.1. San Francisco, 1885*

*Image credit: Issel, William and Robert W. Cherney. (1986). San Francisco, 1865 – 1932. *Power, Politics, and Urban Development*. Berkeley, CA: University of California Press. Image used with permission of the authors.

"degraded" and "inferior" (U.S. Congress 1911, cited in Trauner 1978). Whites articulated this racism and classism in popular and government language about health as it intertwined with notions of place and the people who occupied those places. This language appeared around aspects of the city's rapid growth and industrialization. For example, residents of the southeast and Chinatown lived in crowded tenements, pollution emerged from industry in the southeast,

and a series of epidemics ravaged the city. Racist and classist language blamed disenfranchised groups for problems that often were caused by white and wealthy San Franciscans.

For example, classism is evident in popular language describing the southern half of the city. As noted above, one of the most prominent symbols of the city's class division was Market Street, which divided the city's north and south. "The Slot," as the street was called, was, one observer wrote, "the metaphor that expressed the class cleavage of society" (London 1914: 34). Stigmatizing discourse about the city's southern half developed. Observers referred to the south as "destined to hold the unenviable distinction which attaches to congested quarters of large cities" (Young 1912, vol. II: 574, cited in Tygiel 1977: 38) and as "ugly, crowded, sordid, undesirable…" (Wiggin 1923: 109, cited in Tygiel 1977: 38).

As disdainful as these attitudes were about the poor and mostly white southern half of the city, the stigma against the northern neighborhood of Chinatown was even stronger, likely because of anti-Chinese racism (Craddock 1995). And although attempts were made to move Chinese to the southern half of the city, thus linking racism with classism, white elites maintained a distinction between their views of poor whites and Chinese, as shown in Figure 2.2. The image portrays epidemics that ravaged the city. Both Butchertown, a poor, white settlement in the southeast, and Chinatown, a neighborhood in the north, are depicted. However, Chinatown appears as a tool in the hands of the wraith, while Butchertown and the 26th Street Hospital, the City and County's hospital for the poor (and later, San Francisco General Hospital), are only marked as destinations (Craddock 2000: 81). This imagery suggests that anti-Chinese sentiment in the city was greater than class-based antagonism.

This popular sentiment was also reflected in official government language and action. As epidemics struck in the mid- and late-1800s, white city leaders, including the Board of Health,

Figure 2.2. San Francisco's "Three Graces": Malaria, Smallpox and Leprosy*

*Image credit: Keller, 1882. "San Francisco's Three Graces." The Bancroft Library, University of California

declared Chinatown to be an incubator of disease. Pressure from white political groups grew, and the City's Board of Health declared,

> The Chinese cancer must be cut out of the heart of our city, root and branch, if we have any regard for its future sanitary welfare…with all the vacant and healthy territory around this city, it is a shame that the very centre be surrendered and abandoned to this health-defying and law-defying population.
>
> We, therefore, recommend that the portion of the city here described be condemned as a nuisance; and we call upon the proper authorities to take the necessary steps for its abatement without delay. (Anon 1880, cited in Trauner 1978: 74)

That is, racism toward the Chinese, and language about Chinatown as unhealthy, were ensconced in city government's plans to improve the health of the city by razing this neighborhood.

Finally, racialized uneven development was furthered through uneven distribution of technological advances and related state political support. This occurred as San Franciscans began to develop and settle into the western part of the city. The cable car, introduced in 1873, enabled residents to move into the hills lying to the west (Hittell 1878:429, cited in Tygiel 1977: 36-37). This also meant an increase in race- and class-based segregation as wealthy, white families headed in this direction. There was some ability, too, for middle-class families to move west, as the California state legislature sponsored the nickel fare for cable car use.

Thus, the meaning and value of place and its material manifestation mattered in city growth, with ideas around the health of places and of people living there having a special role. In what follows, I turn to hospital development, reviewing how hospitals were developed and how ideas about the healthfulness of the city may have mattered for their placement.

Early Hospitals: Organized for Racialized Mutual Aid, and for Charity

With expansion of the city came the growth of hospitals. These were situated along race- and class-based divisions, burgeoning as social worlds that mapped onto the racialized uneven

development of geography in the local hospital care arena. Below, I give a brief overview of the social construction of these worlds, followed by descriptions of how they extended geographically in the north and the south.

As noted previously, in the 1800s hospitals transformed from almshouses[3] into organizations that served the sick only (Engel 2006:11; Starr 1982: 149-50). Initially, the wealthy received care in their homes; only the poor went to hospitals. In San Francisco, even the working class avoided hospitals initially because of the institutions' dismal reputations as death houses (Trauner 1979: 19). However, by the second half of the 19th century hospitals were more in demand. This was perhaps partly because surgery was becoming safer and advances in nursing were being made, but possibly also because urban life was reorienting residents toward valuing professional facilities (Starr 1982: 146, 155). With these shifts, hospitals grew in their symbolic value, becoming sites of class- and race-based distinction as the wealthier and white groups gained easier access.

These services to varied groups suggest that hospitals developed as separate social worlds in part as negotiated those worlds' boundaries and in part as they were contained and shaped by members of other social worlds. That is, hospitals developed organizational boundaries according to the social distinctions emerging between the racial/ethnic and class-based groups migrating into and through the city. Groups based on ethnic or linguistic backgrounds banded together to create benevolent societies to care for their members, with activities including care

[3] Almshouses were charitable housing provided for the poor, initially run by religious groups and later by government.

for the sick and burial of the dead (Anon 1960; Trauner 1979). Society activities were funded through members' dues and donations. In the 1850s, benevolent societies provided most charity hospital care in San Francisco (Trauner 1979: 30). Further, while these divisions were the most pervasive, hospitals also developed along divisions by gender (e.g., the Lying-In Hospital[4]), profession (e.g. the Southern Pacific Railroad Hospital, established for the company's rail workers) and religion (such as St. Luke's Hospital, which was Episcopalian). This racial/ethnic and class-based division in health care coincided with a lack of a federal welfare state to provide care for the poor, and limitations in support from California state government. In San Francisco, care for the poor shifted between the City[5] and the state (Blaisdell and Grossman 1999:19-42), as each governing body offered funding and support at different times (more about this below).

Hospital Divisions Mapping onto Geography

Racial animus and class-based discrimination drove the uneven development of hospital care in San Francisco. As the wealthy and white migrated westward, hospitals such as the University of California's hospital and the French and German hospitals moved with them. Similarly, hospitals for poor whites and for people of color were established in the southeast, including the City and County's hospital, St. Luke's Hospital, and Mary's Help Hospital. That is, as noted at the outset of this chapter, hospitals organizational boundaries blurred with those of other social worlds, and hospital leaders negotiated those boundaries, typically in ways that reinforced race- and class-based segregation. (See for maps of the area, see Figure 2.3 and 2.4;

[4] The Lying-In Hospital was a maternity hospital.

[5] Throughout, I use "City" to refer to city government and "city" to refer to the city more generally.

hospital locations marked in 1860 and 1885 are marked.) Unlike the hospitals in wealthier communities, which could draw upon their own funds and had connections to the elite, these hospitals depended on government and charitable funding. Throughout, I note how understandings of the "healthfulness" of places and people in them drove hospital development. I close with an examination of the pre-history of the Chinese Hospital. Though the Chinese Hospital was not located near other hospitals serving the poor, I argue that its placement only underscores the impact of racial discrimination and the drive to contain people of color in stigmatized places. It also shows the agency of this group as they established their own healthcare, despite racist oppression.

Hospitals for the White and Wealthy – Located Downtown and in the West. A total of six hospitals that primarily served white patients were established downtown and were relocated westward within the city; below, I detail examples of two hospitals that originally were situated downtown and were moved west, the French Hospital and the German Hospital. Additionally, approximately 20 hospitals were originally built in the west of the city, where the populations they served had moved. I examine one such example, the University of California's medical center. These sites are chosen to be illustrative of hospital services that were either established in or moved to a location to be for particular social groups, because they show the birth of a hospital that did not originate in the northeast, and because they are sites for which abundant data exist. I describe each of their locations, financial means, and means of exclusion of nonmembers.

The French Hospital (Maison de Santé) was opened in 1853 to provide care to members of the French Benevolent Society, which in turn was set up to serve local French and French

speakers. The society was formed when French San Franciscans decided that the public hospital did not provide adequate service to speakers of their language (Trauner 1979: 22). A prepaid health plan, possibly the oldest such private plan in the country, was set up; members paid monthly dues and in return received medical care, surgery and hospitalization. Initially care was provided to nonmembers as well, but as it became financially difficult to do so, in 1853 the society limited its services to members, adding the word "Mutual" to its name to mark this shift in focus (La Société Française de Bienfaisance Mutuelle/The French Mutual Benevolent Society) (*SF Chronicle* June 30, 1895; Levy 1884: 170). Individuals would be admitted to the hospital only if they had been a member of the society for at least one month before becoming ill (Levy 1884: 172, cited in Trauner 1979: 23).

Like the French Hospital, the German Hospital was operated through a benevolent society. After the topics of such a society and a hospital were raised in local German newspapers and lectures delivered in German organizations, the German General Benevolent Society was established in 1854, focusing on aid for immigrants and the sick (Kaufman 1914; Kirchhoff 1878). All German speakers were eligible to join at a cost of $1 per month or $100 for a lifetime. Members and any immigrants who had not lived in the country for more than six months were eligible to receive care at the hospital. The society was able, Trauner (1979: 24) maintains, to perform charitable work throughout its existence, though elsewhere it is argued to have been operated on the basis of economic mutuality like the French Hospital (Commonwealth Club 1905: 6).

As noted above, the hospitals offered services in their members' native languages, delineated membership partly by language, and offered services that varied to some extent with the desires of their patients. Hospitals also drew upon the economic resources they were able to

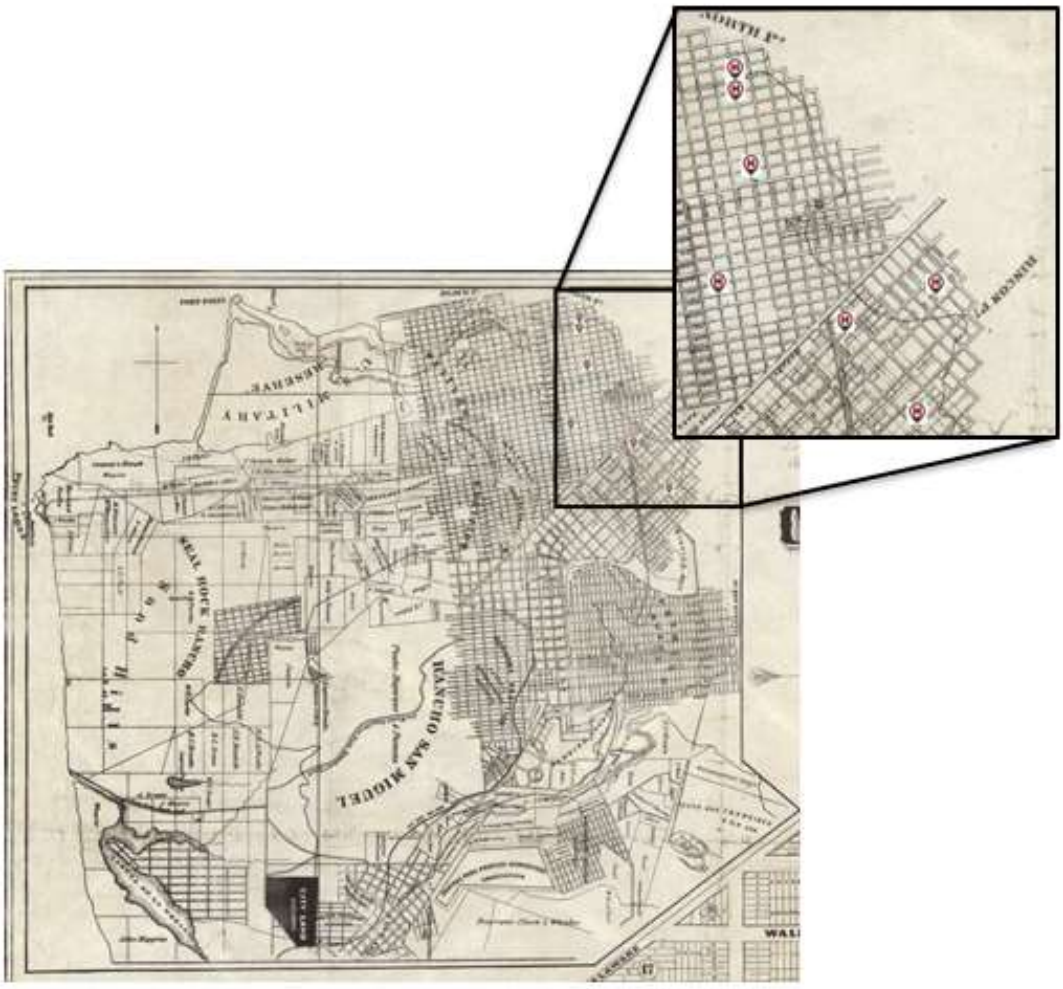


Figure 2.3. San Francisco, 1860, with Overlay of Approximate Hospital Locations*

*Image credit: City Land Association. 1860. Map of the Property of the City Land Association, Incorporated under the Laws of the State of California. Accessed via the David Rumsey Cartography Historical Maps Collection.

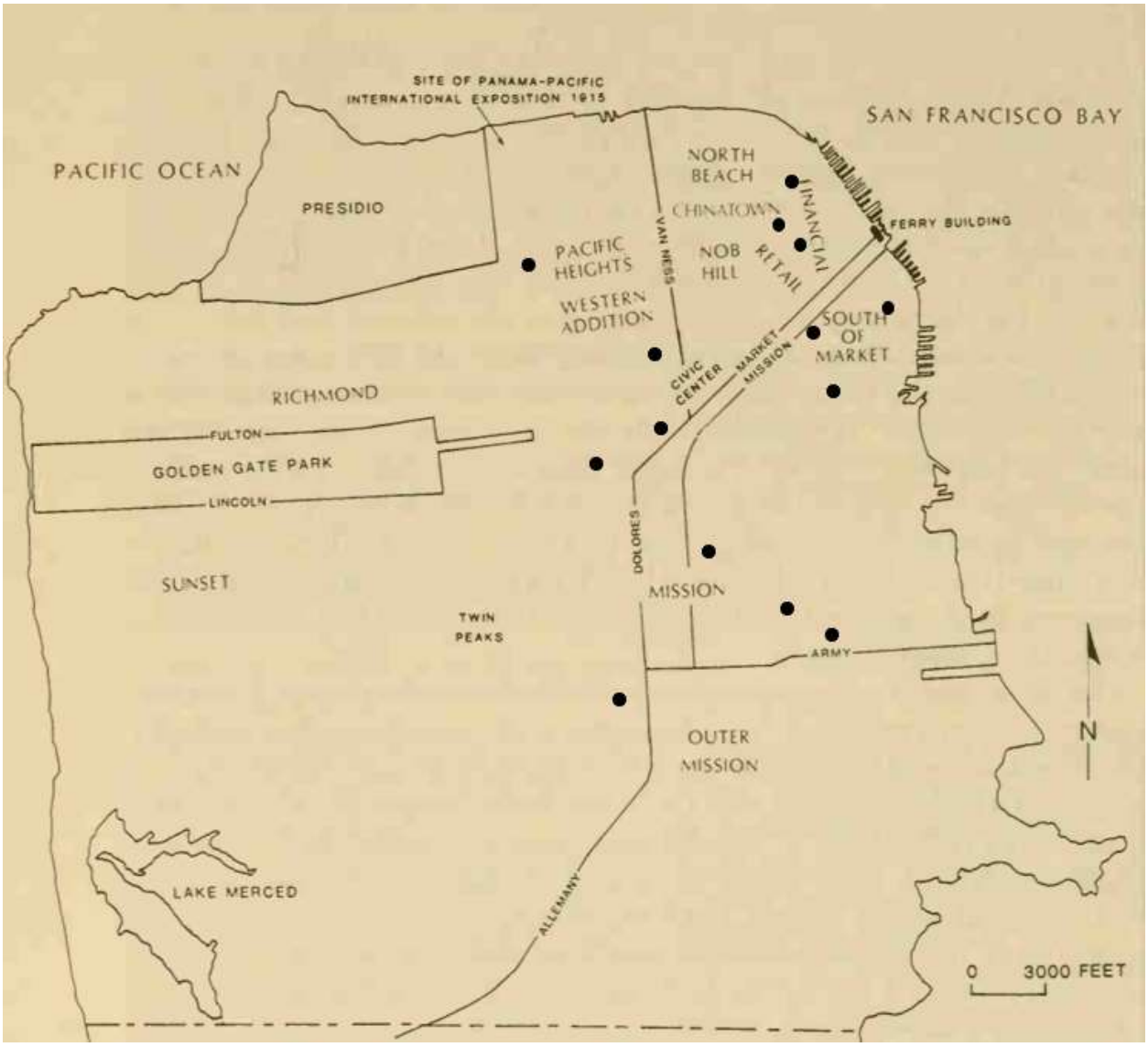


Figure 2.4. San Francisco, 1885, with Overlay of Approximate Hospital Locations

*Image credit: Issel, William and Robert W. Cherney. 1986. San Francisco, 1865 – 1932. *Power, Politics, and Urban Development*. Berkeley, CA: University of California Press. Image used with permission of the authors.

gather, and, perhaps most important, they were able to leverage varied social and political connections, or were contained by political and other boundaries imposed by members of other social worlds. These resources, connections and interactions created the raced and classed distinctions between the varied groups.

The social worlds of the varied hospitals mapped onto the growing city's space. As the city's white and wealthy populations grew and moved west, so too did their hospitals. The French Hospital was originally located on Rincon Hill, a wealthy neighborhood in the city's northeastern corner just south of Market, near the French Quarter (Chalmers 2007: 34). Recognizing the hospital's importance to the French community, the hospital was enlarged and relocated first to Bush and Taylor Streets, and then in 1857 to Bryant and 5th Streets (de Buren 2010; Levy 1884: 183). In the 1880s, the committee decided that the hospital needed to grow again and modernize its equipment, and they began to take up a collection (Anon 1887, Anon 1889; de Buren 2010). In 1894, the hospital was moved to Point Lobos Avenue (now Geary) between 5th and 6th Avenues (de Buren 2010). The German Hospital, originally located on Mission Street between 2nd and 3rd Streets, migrated to Duboce at 14th Street (Anon 1877).

Besides needing space to serve their growing communities and wanting to modernize the facility, another reason for hospital administrators to initiate these moves may have been to follow their members. A newspaper assessed the relocation of the French Hospital along these lines:

> The principal consideration which is said to have influenced the French Mutual Benevolent Society, under whose auspices the hospital is conducted, in moving their sphere of operations to the corner of Point Lobos avenue [sic] and Golden Gate Park, is that the usefulness of the institution will be really increased, since it is following the present exodus of population. Moreover the leading spirits in the French colony assert that the present building is not constructed in accordance with the requirements of modern medical and surgical practice, and that the major operations of surgery are now performed under conditions not dreamed of when the present structure was erected in 1858 (Anon 1891, emphasis added).

For the German Hospital, the move was at least partly based on discourse about healthfulness and southern San Francisco, as leaders sought to escape the increasingly industrial southern half of the city. When its old building burned down in 1876, the German Hospital was

moved westward to a site on 14th Street bounded by Noe and Castro. The new site was recommended by its location on the leeward side of the hill, and also by its distance from downtown (Kaufman 1914: 56). In a speech in 1904, the German Consul recalled, "Its [the first hospital building's] doom was a peculiar dispensation; fully twelve years before this time the removal of the hospital had been decided upon because of the annoyance occasioned to the patients by the noise of the factories which had sprung up round about…" The German Benevolent Society's chronicler described the virtues of the new site in similar terms, harkening to the distance from industry:

> What gives the new German Hospital an inestimable advantage over others is, besides its excellent hygienic arrangements, its beautiful and salubrious location. Standing high above the smoky business part of the city, in fresh, pure air, surrounded by stately trees, and with a beautiful view of the mountains, the city, and the bay, no better abode for the sick could be desired (Kaufman 1914: 78).

The growth of a third hospital, the University of California's site, suggests other another reason for hospital expansion to the west. That is, the development of the university's Affiliated Colleges of its health professions schools (later UCSF), which would eventually become the site for the university's hospitals, occurred not only due to discourse about the area south of Market but also through the hospital's connections to the city's elite.

Initially, there was talk of placing the university's medical school in the south on Potrero Avenue, near where university physicians staffed the City and County's hospital.[6] After the state refused a request for funds in 1891, however, medical school administrators advertised for philanthropists to give them a site. A site was offered in the southern half of the city on Potrero

[6] As with "City," I capitalize "County" to refer to county government and use the lower case to refer to the county more broadly.

Avenue between 15th and 16th streets, close to City Hall and the City and County Hospital. However, stigma is apparent in an evaluation of the site: "[D]etractors found a faulty title, the expanse of grading and retaining wall, a view of only Alameda County shores and Butchertown [the section of Bayview Hunters Point where the city's slaughterhouses were located], heaps of rubbish, bottles, tin cans, babies and goats" (Harris 1937: 7). A second site was offered by San Francisco's mayor, Adolph Sutro, on Mount Parnassus, 26 acres that he directed to be divided between his personal library and the university's Affiliated Colleges. In a letter to the University of California Regents, Sutro wrote that he chose this site for several reasons – among them, its proximity to the geographical center of the city and county and to the new City Hall (a 15-minute ride, in his estimation), its visibility given its location on a hill, its natural amenities, and his expectation that it would become a center of the city's population in time (University of Californa n.d.). Further, as above, a desire for healthfulness informed the choice of site: "The growth of the city is directly on this line, and the country to the west thereof, with its pure ocean air, diminished quantity of smoke, dust and bacteria, will rapidly build up." Sutro's statement also echoes the larger point that development of the city more generally was informed by discourse related to health. Whatever the case, with this gift, Sutro provided land in a desirable location, elite affiliation and funds that were unique privileges for the school.

Hospitals for the Poor and People of Color in Southern San Francisco. As white and wealthier hospitals were established to the north and west, hospitals for the poor and people of color were established in the southern half of the city or moved there from its center. As with development of some wealthy, white hospitals, local government and elite intervention played a role here, too. However, part of the goal for hospital development for other hospitals had been to optimize care, e.g., via providing new medical technology, here the establishment of hospitals is

based on drives to contain groups, or in some cases to offer some minimal mitigation of their circumstances. Below I describe the development of three hospitals: the City and County's hospital, St. Luke's Hospital, and Mary's Help Hospital. I find that these groups were not given the support needed to take control of their own health, as the groups described above were, but rather support was, especially at the City and County's Hospital, inconsistently provided and groups were further oppressed by the only options they were allowed. As above, I describe location, financial means, and means of exclusion of nonmembers, with attention to how City policy mattered for hospital development in this area. I note throughout that ideas about health of place and people influenced placement of hospitals and thus containment of their patients.

I begin with the City and County's Hospital (later San Francisco General Hospital). Here we see that, though there was some desire for care to poor San Franciscans, these groups were not provided consistent support, and they were sites of racialized oppression. Initially, residents and local leaders called for a city hospital in 1848 and 1849 (Blaisdell and Grossman 1999: 19-42). The City contracted out services to physicians, finally establishing a hospital in 1850 in what is now the Financial District. The building was damaged in a fire and was replaced by a State Marine Hospital, which was run by Catholic nuns. The state withdrew its support, citing an unfair burden placed by San Francisco on other counties, and the sisters bought the property, continuing to work for the City under contract. Shortly thereafter, the City refused to pay the sisters, who resigned and established their own private hospital there. Such difficulty with funding, and deferral of responsibility for care, demonstrates how reliant low-income residents were on financial support and how they lacked the connections that buttressed other groups. Afterward, shifts in the City Hospital governance, funding and location continued.

A more lasting site was chosen once the state legislature passed acts in 1863 and 1866 authorizing construction of the public hospital and purchase of part of the San Miguel Rancho in the city's southern half (City and County of San Francisco 1860). San Francisco municipal documents record the purchase of the property as "nearest that part of the city where the principal manufactories will be located eventually, and were accidents requiring immediate surgical attention will most frequently happen" (City and County of San Francisco 1867-68: 560). Also recommending the site were its sunshine, breezes, and drainage, among other things. Opened in 1872, the hospital was meant to provide care for all indigents. However, before 1900 this was not always the case. It was known for a time that one hospital worker would stand at the entrance to the hospital waiting for individuals seeking care to arrive and, if he "took exception to the physiognomy of the applicant" he would throw the individual down the front stairs (Commonwealth Club of California 1922: 309).

Racism against the Chinese also was institutionalized in the City and County Hospital (later San Francisco General): Chinese wanting care were sent to a segregated site (Chinn 1969: 22). Moreover, in 1878 and 1883, health authorities moved Chinese people with Hansen's disease (leprosy) from Chinatown to the City's Lazaretto in southern San Francisco, where they were physically isolated from the rest of the city. Of those 115 admitted between July 1871 and April 1890 who were classified as "Mongolian," 83 were deported (Trauner 1978: 75).

In 1869, after the City secured the land for its own hospital, the local government ordered much of the city not to include any new hospitals. The Municipal Record reads,

> [No Hospital or Infirmary to be maintained within certain Limirts [*sic*].]
>
> Sec. 12 No person or association shall keep, erect or maintain any hospital within that portion of the city and county bounded by a line commencing at the intersection of Lewis and Laguna streets [*sic*]; thence along the easterly line of Laguna street to Market street; thence along the line of Market street to Guererro street; thence along the

> easterly line of Guererro street to Twenty sixth street; thence along the northerly line of Twenty-sixth street to Potrero avenue; thence along the westerly line of Potrero avenue to Channel street; thence along the line of Channel street to the water front; thence along the water front to Laguna street, the point of beginning; but this order shall not prohibit the maintenance of hospitals established on or before the first day of May, 1869, or physicians from maintaining rooms for the accommodation and treatment of their private patients. …
>
> [Same Premises not to be let or transferred for Hospital Purposes.]
> Sec. 13 No person owning, occupying or having the control of any premises within the limits designated in section twelve of this chapter, shall let or transfer the possession of such premises to any person or association, to be used as a hospital, infirmary or place for the accommodation of the sick" (City and County of San Francisco 1868-69: 511).

It is not clear from historical records available why this ban on new hospitals was imposed or how long it lasted. However, the City may have impacted the future locations of hospitals, favoring established sites and preventing others. Notably, the proscribed area included that portion closest to the City and County's hospital. One has to wonder if the City was trying to keep down the burgeoning number of hospitals in the north while also protecting its own interests in the south. Another possible reason was the number of epidemics at the time – stigmatizing language circulating about institutions caring for the sick may have led to the moratorium.

In any case, shortly after the moratorium was decreed, other hospitals were built outside this area in the south. In 1871, St. Luke's Hospital, sponsored by the Episcopalian diocese, was established by Thomas Brotherton, a physician and Episcopalian priest, on Lundy's Lane, just outside the area proscribed by the municipality for hospital building. Brotherton established this site because he was "concerned about the lack of health care south of Market Street" (Grimes 2006: 9). The hospital's mission, established in 1871, was as follows: "'St. Luke's doors as a charitable hospital are open wide to our community for the reception of all colors, nationalities, and creeds. Its benefits, refused to none, will be limited only by its means'" (St. Luke's Hospital

1996). St. Luke's was also opened as a site of care to American Protestants in the area (Anon 1872). As its operations grew, the hospital was moved a few years later to its current location, San Jose between 27th and 28th streets (Anon 1879), on land purchased by four philanthropists (Grimes 2006: 90). Admission decisions were made once a week by a committee (Anon 1885). Supported by donations from local Episcopalians, St. Luke's struggled financially in its early years, closing for about five years, and offering varied amounts of free care in different eras, according to what its staff saw as the hospital's ability (St. Luke's Hospital 1907).

Also built just outside the city's hospital-building boundary, Mary's Help, a Catholic hospital, was incorporated in 1894 in the Mission "for the purpose of erecting and maintaining a free hospital for all sick women and children of the poor, without regard to religion, to be conducted by the Roman Catholic sisters of St. Vincent de Paul" (Anon 1894). The hospital was funded by a bequest of Kate Johnson, who had come into her money from family involved in iron and steel importing and who owned a local saddlery and harness business. Like the other hospital leaders and elites described above, Johnson subscribed to ideas about health being attached to place. She wanted patients to be exposed to abundant sunshine and for that purpose chose the site on Guerrero Street (Anon 1896; Mahoney 1985). It is interesting Mary's Help was located in the middle of a poor neighborhood; stigmatizing language about place did not play a role here as it did with the University of California's site, for example. The first building for the hospital was nearly complete in 1906 when it was destroyed in the earthquake, along with properties that had been owned by Johnson and meant to provide income for the hospital. The hospital was finally established as part-pay, and patients were admitted in 1912 (Mahoney 1985).

The Pre-history of the Chinese Hospital. A final example of the race-, class- and place-bounded development of hospitals in San Francisco can be seen in the pre-history of the Chinese

Hospital. This was the only hospital established in the northeast that served non-white, non-wealthy populations. Analysis of its establishment shows how perceptions of place are tied to perceptions of who belongs where and reveals attempts by whites to contain people of color. It also shows the agency of the Chinese, who succeeded in establishing care that included their own culturally specific health practices. As noted above, the Chinese were forced to live in Chinatown, and the neighborhood was stigmatized as unhealthy. The Chinese also were not allowed to access hospital care that was available to others. Chinese requiring the City and County's services were sent to segregated sites and sometimes deported, and they were barred from entry elsewhere. For example, the Southern Railroad Company Hospital (Short 1986) did not allow the company's own Chinese workers to participate in its prepaid medical plan or to receive hospital care there.

The Chinese began to establish venues for health care, though only after struggle against racialized oppression of the white government. Early on, the Chinese attempted to establish a hospital to provide care in Chinese, because this care was not available elsewhere (Chinese Hospital 1963). The Chinese Six Companies, the local Chinese benevolent society, and the Chinese Consul began to collect funds and purchased a site in southern San Francisco (Anon 1899). However, when the City learned that the Chinese planned to offer traditional Chinese medicine, they were not allowed to continue. Finally, the Tung Wah Dispensary was established in 1900 in Chinatown, employing both Chinese herbalists and Western-trained physicians (Quock 1978). This inclusion of allopathic medicine may have been made because the Chinese had some years earlier recognized that they would have to include white physicians in their service to gain approval from the Board of Supervisors (Trauner 1978: 83). It was on this site that the Chinese Hospital later was established, opening in Chinatown in 1925.

Conclusion

In this chapter, I have argued that San Francisco experienced *racialized uneven development* in its urban landscape according to race- and class-based social divisions. Furthermore, racialized uneven development was co-constituted with development of the city's *hospital care arena*. The social groups participating in this arena included not only hospitals but also such groups as the benevolent societies, religious groups and other groups that started and maintained hospitals; elites that funded hospitals and donated land; local and state government that regulated where hospitals could be placed and sometimes funded care; and the race- and class-based groups into which these organizations and their members fell.

Rather than developing in a purely economic fashion, racialized uneven development proceeded through several means. These means included sometimes violent expulsion of people of color out of the city; discourse distinguishing between the northern and southern sections of the city, with stigma accorded to poor groups living in the south and to the Chinese who lived in Chinatown; elites' choices about which neighborhoods they wanted to live in; overtly racist policies such as zoning laws and property rights, created by white city leaders and white political groups, partly as they regulated health; the uneven distribution of technology; and inconsistent political support from the state.

Racialized uneven development was co-constituted with development of hospitals as social worlds. Hospital leaders located their organizations in the neighborhoods that they wished to serve on the basis of the meanings that different places had for them – in particular, language about healthfulness and desirableness of white and wealthy neighborhoods and of the stigma attached to the southern half of the city and to Chinatown. This uneven availability also occurred partly as hospital leaders developed organizational boundaries according to the social

distinctions emerging between the racial/ethnic and class-based groups migrating into and through the city. Wealthy, white hospitals sometimes would only accept individuals who spoke particular languages, were from particular national backgrounds, or could afford to pay membership dues. Wealthier, white-serving hospitals also became unevenly available as they migrated across the city's developing landscape. These moves occurred as they followed the populations that they served, stigmatized the poor and industrial southern half of the city, and took advantage of the land, social connection and funds offered by elites. Meanwhile, hospitals serving the poor and people of color developed as they received (or did not receive) City and California state financial support, or the support of religious groups. Overt racism against the Chinese also shaped hospital development as Chinese were contained in Chinatown and initially were refused the right to develop a hospital based on traditional Chinese medicine. Yet, these groups also developed hospitals of their own, defined by their own understandings of healthfulness and who deserved health care. This is especially evident among the Chinese who developed a hospital providing Chinese and western medicine.

In the next chapter, I will examine how hospital development continued in the 20th century, responding to this emplaced, historical past and to new developing federal urban and healthcare policies.

CHAPTER 3. DEEPENED INEQUALITY IN THE 20TH CENTURY, c. 1934-2001

Introduction

In Chapter 2, I argued that San Francisco hospitals' placement in the city's landscape was part of the city's *racialized uneven development*. That is, urban development was co-constituted with the making of structural racism and classism, all of which unfolded contingently, emergently, and differently in different places. Development of the *local hospital care arena* was part of this process as varied social groups made meaning of hospitals and placed them in different neighborhoods.

But how did the hospitals' early arrangement in the city's landscape translate to their placement later in the 20th century, and how various groups made meaning of hospitals? This chapter's analysis continues that of the last, drawing from a few additional theoretical and empirical strands. First, I follow Quadagno's (1994) work on the development of 20th century federal welfare policy. In work that follows both Marxian dialectic and interest in racial structuring, Quadagno proposes that American social welfare history is driven by a non-linear, dialectical relationship between past and present, and between policy and the broader society in which it is worked out. Empirically, she finds that political compromises reached in the making of federal welfare policy meant that the policy effectively benefitted white people only. The racism of these policies prompted Black people to push for civil rights, and, through the Civil Rights movement, to expand and change the role of the state. In reviewing the relationship of health policy to urban implementation, I extend Quadagno's perspective to address structural

racism and classism in the creation of healthcare policy and its relationship to hospital development.

I also continue the situational analysis from the previous chapter, drawing on its incorporation of theorizing on assemblage (Clarke, Friese, and Washburn 2018; Deleuze and Guattari 1987) – a collection of things, ideas and people that is unstable and loosely coupled. The looseness matters, I argue below, because it enables certain structural features of the local hospital arena to remain – the structural racism and classism at the neighborhood level in the form of where hospitals are sited, relative to residential segregation – while obscuring that they do so. As a result, as change occurs in one part of the assemblage, other features can stay the same or even be reinforced. In San Francisco, the advent of federal policy deepened the structural racism and classism in the development of hospitals. It also produced response in hospitals' local environments. The value of such analysis, then, is that, where many theories of history focus on change, this assemblage-based perspective also allows analysis of the "changing sameness" of structural racism and classism (after Bonilla-Silva 2014: 9). Furthermore, where more Marxian analysis might see change as predictable, this type of analysis emphasizes the contingency of change.

Below, I make the argument as follows. I first describe racialized uneven development in the 20th century, including demographic shifts, followed by processes of redevelopment and white flight from the city in the mid- and late 20th century that increased residential segregation as federal and state policymakers, local government and local elites reshaped the city's built environment. Second, I move to the center of the chapter's analysis and consider how hospitals were part of the broader processes of urban development. In some cases, white and wealthy hospitals' leaders continued to grow existing organizations' operations in white and wealthy

neighborhoods, and, in other cases, they relocated to those neighborhoods and away from southern San Francisco, participating in white flight and gentrification. In this century, new actors, or social worlds – federal and state policymakers – expanded the local hospital care arena, and the interaction between these entities and local actors (hospital administrators, elites, and government) enabled legitimation and deepening of white and wealthy hospitals' privileges in new ways.

I follow changes in hospital care across two policy eras, one of federal regulation and a neoliberal one. For each era, I explore how this new federal and state health policy enabled hospital leaders to legitimate themselves and their existing uses of land, benefiting from their historically emplaced advantage while at the same time justifying it in ways that obscured how this occurred. I describe these processes as creating an *intergenerational drag*. The term is borrowed from Gee and Ford (2011) and related literature exploring how past racial structuring can matter for present disparities. Intergenerational drag refers to the transmission of privileges and debts from one generation of a social group to the next. However, relatively little of this research explores healthcare disparities. I define privilege as valued resources, such as hospital buildings, beds, and geographic proximity to well-insured patients, together with the discourse and practices under which those resources continued to be deemed valuable and which legitimated their unequal distribution by race and by class.

I explore processes that facilitated intergenerational drag. These included *creating policy language*[7] in the form of state and federal healthcare policy, which legitimated hospital action,

[7] I thank Laura Mamo for helpful discussion on policy's function as discourse.

and *policy implementation practices* under which government at various levels enacted (or failed to enact) policy. At the local level, processes included *organizational action* in terms of how organizations sited themselves geographically. Furthermore, though data are thinner here, some point to *hospital administrators' culture* as somewhat self-regarding in their choice of hospital placement, and increasingly financialized. I have noted in the previous two chapters that hospitals historically were created as sites of care for those in need, though often with racialized and class-based restrictions on which patients would be seen. Through policy implementation practices, racist and classist discourse under which hospitals had acquired their resources were removed in name only, while the maldistribution of resources deepened and redress for earlier inequities was not made.

Finally, I show how white flight, urban redevelopment and hospitals' participation in them occasioned response from community activists. Though the focus of this chapter is primarily on intergenerational drag as part of broader racialized uneven development, this last section is offered as a way of exploring how increasingly many social groups made meanings of San Francisco's hospitals.

Urban Development[8]: White Flight and Increasingly Financialized Containment, c. 1933-2001

In the 20th century, white-controlled federal and local governments, as well as local elites, reshaped San Francisco's land use. These groups created whiter and wealthier

[8] The data for this section are represented in part in Miller et al. 2019.

neighborhoods in the city's northeast and west and rebuilt the city for commerce, while containing low-income people and people of color south of Market Street. Below, I will briefly narrate the history of the implementation of selected new federal and state urban policy over time, from the New Deal through the end of the 20th century, including the profound demographic changes to which these responded, the creation and implementation of local-level housing policy, and white elites' and broader white populace's responses to these changes. In each of two policy eras, an era of federal regulation and a neoliberal era, inequality persisted as new housing policy language, its implementation and response of the middle-class, white populace meant that low-income people and people of color continued to be contained in San Francisco's southeastern neighborhoods. Policy language continued racism and classism by characterizing low-income groups, people of color and the places they lived as "unhealthy" and especially as "financially risky."

In the 1930s, New Deal housing policy language continued disinvestment in and stigmatization of southeastern San Francisco, using overtly racist and classist language. In 1937, the city was mapped by the Home Owner's Loan Corporation (HOLC) (Marciano, Goldberg, and Hou n.d.). This mapping process used a risk-rating system to delineate which geographic areas were safe for making home loans. Those areas deemed to bear the greatest risk were outlined in red, because they were the homes of low-income residents and people of color, and these "redlined" neighborhoods were almost never given loans from the newly created Federal Housing Administration (FHA). Thus policy language mapped onto, and exacerbated, existing segregation. Much of southern San Francisco was redlined, including what is now the neighborhoods of Bayview Hunters Point, Bernal Heights, Excelsior, the Mission, Potrero Hill, and Visitacion Valley. This occurred in contrast to development of the northern and western

parts of the city, where there was less redlining except in neighborhoods where people of color made their homes – Chinatown, the Western Addition (also known as the Fillmore) and the Haight. Such policy systemically disenfranchised residents, cutting off the flow of capital into those neighborhoods. (For a map, see Figure 3.1.)

Shortly thereafter, World War II and mid-century immigration federal policies altered the city's demographics, creating a population boom and influx of migrants. These events would make race a defining issue in San Francisco's politics and economy in a way that it had not been previously as white San Franciscans responded to new residents of color (more on this below). The Navy began to operate a base at Hunters Point in southeastern San Francisco, and migrants arrived to join in the war effort and take advantage of wartime employment, including San Francisco's first significant migration of Black migrants. San Francisco's population grew from 634,536 to 775,357 between 1940 and 1950 (U.S. Census 1940, 1950). Additional shifts in the city's demographics occurred as San Francisco's southern half became home to many groups of people of color. New Latino arrivals began to settle in San Francisco as early as the 1930s (Howell 2015). These populations centered in the Mission neighborhood, with groups tracing their roots to Mexico and Central America (Carey and Co 2009). The repeal in 1943 of the Chinese Exclusion Act, followed by the 1965 Immigration Act, also brought more migrants, especially from Asia and Latin America (Pamuk 2004; Sandoval 2002).

After the war, the California Community Redevelopment Act of 1945 and federal Housing Act of 1949 included new language authorizing redevelopment and, effectively, containment of low-income groups and people of color. This policy allowed local elites to direct the implementation of federal policy, as local redevelopment authorities were authorized to acquire and redevelop properties. And in this period, racism and classism became somewhat

more covert. For example, redevelopment under this act was often justified via use of the concept of "blight." This term, drawn from the study of ecology, referred to diseases of plants,

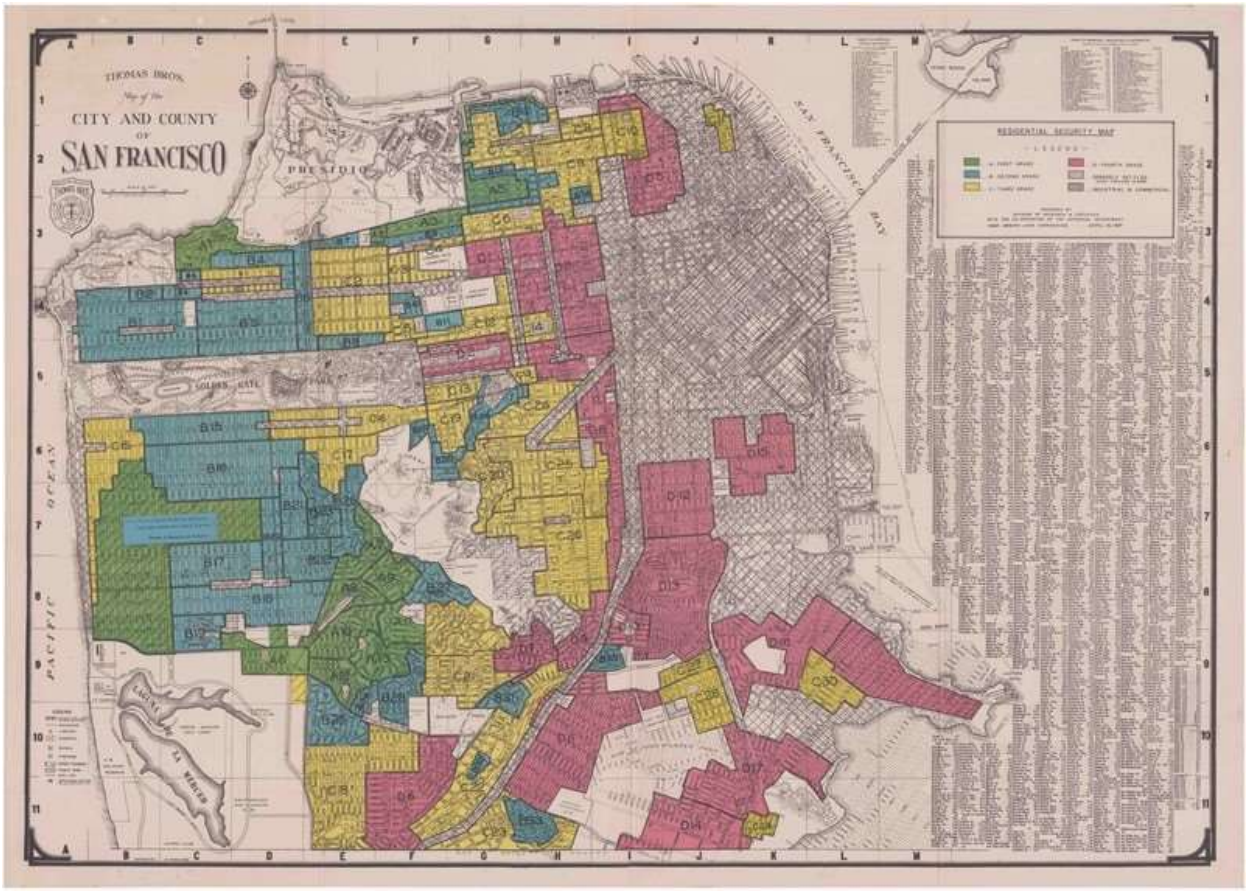


Figure 3.1. Homeowner's Loan Corporation Map of San Francisco, 1937

and naturalized race- and class-based disenfranchisement. Used in Progressive-era urban planning (Stanton 1918, cited in Fogelson 2001) and in sociology of the period (Reissman 1964, cited in Gordon 2004), the term was taken up in federal policy that allowed local redevelopment authorities to define what counted as "blighted." Local governments and white elites who worked with them then would flexibly apply the term to designate and redevelop areas that were desired for new uses, using language describing neighborhoods as "unhealthy" and "unsafe."

These new uses were typically private real estate, chosen to support the growth of commerce in the area. I give an example below.

Using the above-described policy and others, elites and government redeveloped San Francisco as an administrative center, partly redesigning the city to push manufacturing out of the city, contributing to southern San Francisco's economic decline. These groups also decided that a redesigned San Francisco would need to grow its downtown and to redevelop residential neighborhoods that would provide housing for those working downtown. Most prominent among the neighborhoods they transformed stood the Fillmore, a neighborhood filled with rows of old Victorian houses and proximate to downtown. A site of racial violence in World War II, the Fillmore had been emptied as its Japanese residents were removed and interned. In their absence, it was one of the few neighborhoods available to people of color arriving to participate in the war industry due to its lack of racial residential covenants.[9] The city's Redevelopment Authority used state, federal and local policy, as well as government and private funds, to then condemn, purchase, or claim eminent domain on desired properties. They were supported by local work, e.g., by a white, middle-class housing association, to interpret blight in their favor. A report produced at the time, *Blight and Taxes*, promoted redevelopment of the neighborhood with racialized language: "[The Western Addition] is not white. It is gray, brown, and an

[9] Racial restrictive covenants had been placed on housing throughout the city, preventing non-white groups from renting or buying homes in much of the northern and western sections (Horiuchi 2007; Johnson 1944). Therefore, much of migration by people of color was directed to the southern half of the city. Newcomers were confined to the southeastern neighborhoods of Hunters Point, Bayview, and Visitacion Valley (Howard 2014; Mason Tillman Associates 1996).

indeterminate shade of dirty black ... it is an unfortunate blot" (SFPHA 1945). (The report also characterized the Marina District, a white neighborhood to the north, as "clean and bright".) With this work, elites effectively claimed this neighborhood near downtown for expensive developments for themselves and as many as 21,500 Black residents lost their homes (Lai 2012). With racial residential covenants still in place, this forced the removal of many Black people living in the Fillmore to southeastern San Francisco and out of the city.

The FHA policy noted above also meant that people of color who had migrated to the southern half of the city were contained through racist exclusion as whites increasingly fled to the suburbs. In San Francisco, this white flight began from the southern half of the city as war workers and others migrated west to the Sunset and the Richmond neighborhoods (Carey and Co 2009). San Franciscans also left the city, and the counties around San Francisco swelled. To the south, San Mateo County grew from 235,659 in 1950 to 444,387 in 1960, and Marin County in the north grew from 85,619 in 1950 to 146,820 in 1960 (U.S. Bureau of the Census 1950, 1960). In the same era, San Francisco's population declined from 775,357 to 740,316. Similarly, segregation continued as people of color seeking homes in white-majority neighborhoods faced resistance including violence. In 1957, for instance, baseball star Willie Mays was initially prevented by white residents of the exclusive Sherwood Forest neighborhood from purchasing a home there. He later left San Francisco after a bottle containing racist hate speech was thrown through the window of his home.

The 1970s and 80s brought new processes of policy implementation. Policy was no longer overtly racist, but it supported existing structural racism and classism in a few ways. First, it failed to repair the damage of older policy (e.g., inequity in family wealth due to racism in FHA lending). Second, through new neoliberal language, policy obscured that such damage had

been done. A new a-historical, marketized approach to policy did not account for existing inequality and reduced welfare state supports such as taxation. Starting in the late 1970s, federal and state policy shifts included de-regulation, privatization of business and shrinkage in the welfare state. In California, this was manifested partly in the passage of state Proposition 13 in 1978, which capped property taxes and required a two-thirds vote of each house of the legislature for new taxes. Together with the continued exodus of manufacturing from cities, Prop 13 meant that cities re-oriented toward geography as they funded themselves through real estate. City governments did not choose types of real estate to meet community needs but rather supported the building of retail space so as to generate taxes and fees. As part of these shifts, San Francisco, already envisioned as a site for business, became the site for new corporate administration, biotechnology and the service industry.

As part of this process, development encroached on the southern half of the city in new ways. Since the 1950s, private regional planning groups representing major business interests, such as the Bay Area Council, had attempted to expand the downtown area toward the south. These groups had envisioned that this growth as necessary to expand San Francisco's use as an administrative center to the region. Some inroads already had been made (e.g., creation of the Yerba Buena Center just south of Market Street), but new ones were developed during this era. For example, developers converted buildings initially designated for light industry to use as living spaces by tech workers. When venture capital poured into San Francisco in the 1990s, with young, often white people following high-paying tech jobs, "no-fault" evictions rose as landlords sought to remove residents of rent-controlled units to replace them with higher-paying tenants coming in to work in tech (Capps 2014; Zuk and Chapple 2015). Neighborhoods south of Market became emblematic of gentrification nationwide as low-income residents,

disproportionately people of color, were forced out. As a result, by the end of the 1990s, inequality among San Franciscans had increased dramatically. Between 1990 and 2000, the number of households making $200,000 or greater more than doubled. By 1999, the average gross rent was $928 (U.S. Bureau of the Census 2000a) and the median cost for a home had more than doubled since 1990, from $270,161 to $518,146 (CA Assoc. of Realtors 2016).

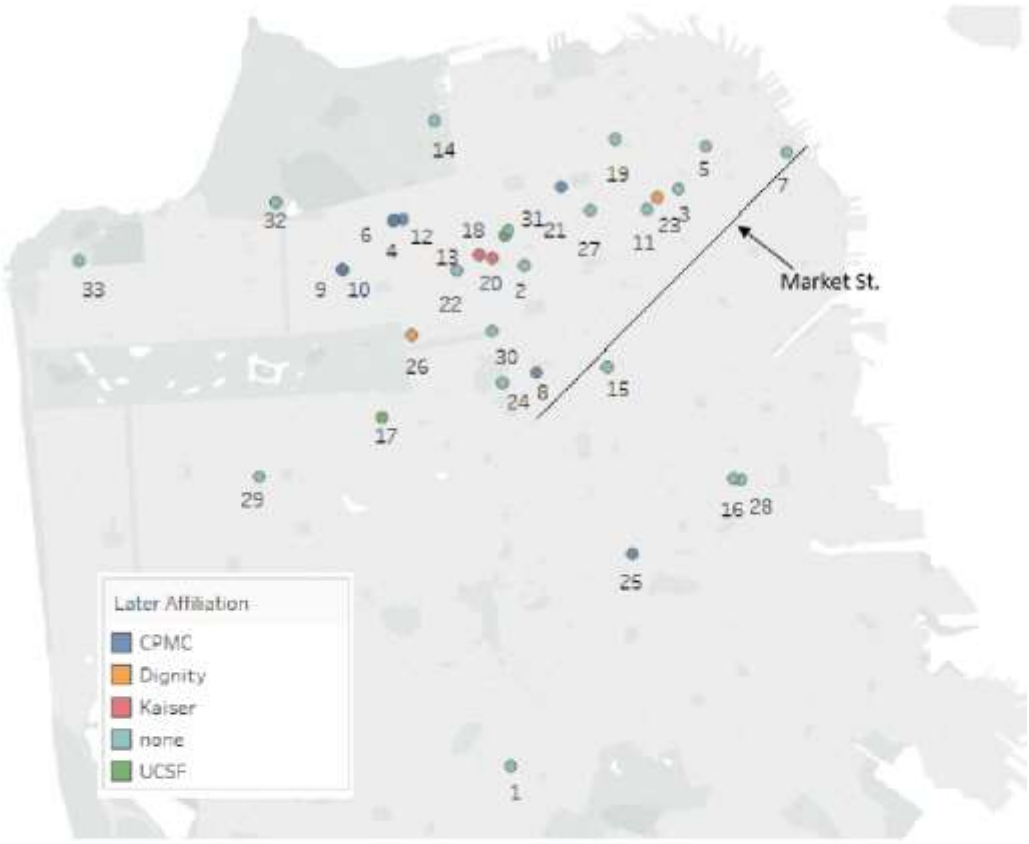
Hospital Development in Eras of Federal Regulation and Deregulation

White and wealthy hospitals took part in racialized uneven development discussed above in ways that continued and extended their privileges while deepening hospital maldistribution. As with racialized uneven development in the city more generally, intergenerational drag here was created through language that obscured past inequity, a lack of compensation for past damages, and processes of affording new privileges to those who were already privileged. (See Figure 3.2 for locations of hospitals in 1966.) Below, I examine how two eras of policymaking – specifically, an era of federal regulation followed by a neoliberal era – and their uptake by local hospitals – mattered for this process. In each of the two subsections that follow, I focus on moments of federal policymaking and local implementation most directly relevant to regulation of hospital geographical placement and deregulation so as to allow more detailed description of local implementation and response to federal healthcare policy and to urban development.

Mid-20th Century Regulation: Creating White Privilege among Northern and Western San Francisco Hospitals

In the mid- and late 20th century, the geographic placement and size of hospital services and sites changed during two eras of federal policymaking. The first era, one of new federal

regulation, included new policy language and implementation practices. In the 1940s, the Hospital Survey and Reconstruction Act of 1946 (or Hill-Burton Act) provided funding for hospital building, with support for new hospitals initially in non-urban areas and later in cities.



1. Alemany Emergency Hospital
2. California Podiatry Hospital
3. Callison Memorial Hospital
4. Childrens Hospital of San Francisco
5. Chinese Hospital
6. City and County Central Emergency Hospital
7. City and County Harbor Emergency Hospital
8. Franklin Hospital
9. French Hospital
10. Garden Hospital
11. Golden Gate Hospital
12. Hahnemann Hospital
13. Kaiser Foundation Hospital
14. Letterman Hospital
15. Mary's Help Hospital
16. Mission Emergency Hospital
17. Moffit Hospital
18. Mt. Zion Hospital
19. Notre Dame Hospital
20. Permanente Medical Group
21. Presbyterian Medical Center
22. St. Elizabeth's Infant Hospital
23. St. Francis Memorial Hospital
24. St. Joseph's Memorial Hospital
25. St. Luke's Hospital
26. St. Mary's Hospital
27. SF Eye and Ear Hospital
28. San Francisco General Hospital
29. Shriners Hospital for Children
30. Southern Pacific General Hospital
31. US Public Health Service Hospital
32. Veterans Administration Hospital

Figure 3.2. San Francisco Hospital Locations, 1966

This first period of increasing access did not, however, always increase access for everyone. By the mid-1970s, the cost of healthcare had continued to increase. In response, the National Health

Planning and Resources Development Act of 1974 was passed to control costs while also increasing access.[10]

Federal Hill-Burton Funding and San Francisco Hospitals' Responses. After the war, federal involvement in hospital building came in its first prominent form via the Hospital Survey and Construction Act of 1946 (Titles VI and XVI of the Public Health Service Act of 1946), also known as the Hill-Burton Act for the two senators who sponsored the bill. These Federal funds subsidized hospital and nursing home construction and expansion.

In San Francisco, it appears that Hill-Burton funds were generally not used to ensure that care was evenly distributed throughout the city. While Hill-Burton funding did go south of Market, funds primarily were used to support building at existing hospital locations in the northern half of the city or, in one case, to fund flight out of the south. In the south, no new hospitals or large expansions of hospitals were achieved. A listing of hospitals funded through Hill-Burton follows below in Table 3.1. Further, in this era Mary's Help Hospital used Hill-Burton funds to close its location in the Mission neighborhood in southern San Francisco and re-open in Daly City as it followed white flight out of the city (more about this below). Local hospital administrators' implementation of Hill-Burton thus maintained and increased hospital

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[10] Other policies mattered for hospitals' growth, for their relationships to each other, and for their ability to attract the patients they most desired. In the mid-1960s, Medicaid, and Medicare especially, were new sources of funding that led to hospitals' growth, while leading to some increased access to care. At the same time, federal policy also offered new funding for research and graduate medical education in specialty care. I note these policies here with the acknowledgment that I am not analyzing their effects to focus more on policies aimed specifically at hospital placement.

Table 3.1. San Francisco Hospitals Funded through Hill-Burton, By Region*

North and West		Southeast	
Hospital	Year(s) of Initial Hill-Burton Funding Approval	Hospital	Year(s) of Initial Hill-Burton Funding Approval
Children's Hospital (absorbed by California Pacific Medical Center [CPMC])	1968	San Francisco Medical Center (now San Francisco General Hospital [SFGH])	1970
Franklin Hospital (formerly the German Hospital, now the Davies campus of CPMC)	1965, 1966, 1968, 1969	St. Luke's	1967
Garden Hospital (absorbed by what became CPMC, then closed)	1954		
Mt. Zion Hospital (now part of the University of California, San Francisco [UCSF])	1962, 1964		
St. Francis Memorial Hospital	1957, 1968		
St. Mary's Medical Center	1958, 1964, 1968		

*U.S. Department of Health Education and Welfare 1970

maldistribution by supporting rebuilding of hospitals in white and wealthy neighborhoods and hospital flight out of the city as part of the broader process of white flight.[11]

[11] A quantitative analysis of Bay Area hospitals as a whole found that receipt of Hill-Burton funds increased hospital survival over time (Scott et al. 2000: 252-58).

Hill-Burton's contribution to hospital maldistribution seems to have been accomplished partly as the California Advisory Hospital Council, the state-level agency charged with determining how to distribute Hill-Burton funds, enacted policy and practice, and hospitals acted in response. Below, drawing in part on Feshbach's (1979) analysis, I describe ways in which Hill-Burton supported how whiter and wealthier hospitals produced value from the neighborhoods where they were located, while obscuring this process.

First, Hill-Burton policy language conceptualized geography in ways that obscured the neighborhood basis of hospital maldistribution and which shaped hospitals' orientations to geography. In San Francisco, the hospital service area was the entire county, which was co-extensive with the city limits (CA Advisory Hospital Council 1969). This meant that all hospitals were to use the need aggregated across the broader area to justify their planning. It also meant that hospitals in northern San Francisco could say that they were serving the southern half of the city without placing services close to those residents. Such regulations and hospitals' response to them together obscured neighborhood-level need. By the late 1960s, the City and County of San Francisco recognized the problem and tried to create a health service area for the southern half of the city. This request reached the State Advisory Hospital Council in 1969 (CA Advisory Hospital Council), but it did not succeed (Feshbach 1979).

Second, policy language of Hill-Burton regulations explicitly legitimated existing hospitals by favoring their expansion. The California Advisory Hospital Council stated its position as follows: "*Existing* general hospitals in convenient locations to serve the community and having a physical plant and service facilities capable of accommodating expansion will be encouraged to expand to an optimum capacity before new separate hospitals are established" (CA Advisory Hospital Council 1964: 10, emphasis added). This prioritization meant that it

would be more difficult for groups outside of existing hospitals to build new buildings (e.g., CA Advisory Hospital Council 1964; Feshbach 1979).

Third, policy implementation included weak economic structuring and a lack of enforcement. The economic structuring of this program was such that, to my knowledge, there were inadequate or no funds to assist poorer groups with applying for Hill-Burton grants. The average planning time for a Hill-Burton grant was long, lasting on average 6.5 years, meaning that poorer hospitals and groups would, without additional support, be more likely to lack funding necessary to complete their applications (Feshbach 1979). Further, government did not ensure community need was met. Though hospitals were required by the federal government to undertake planning processes that would determine what services their communities needed, hospitals did not have to take these groups' recommendations. Instead, hospitals could place their new sites and services as they wished, without responding to what planners deemed to be the need in the community (more on this below, in discussion of administrators' culture).

Fourth, while government policy and practice tended to favor hospitals and groups that were already better off, the culture of white, wealthier hospitals' administrators also may have mattered for hospitals' responses to policy. This seems particularly the case for the move of Mary's Help Hospital out of southern San Francisco to Daly City. Mary's Help, which had been located on Guerrero Street in the Mission, left San Francisco in 1965 when construction on a new hospital in Daly City was completed with Hill-Burton support. Writing of the hospital leaders' desire to move, a chronicler said that at the time the hospital had been strained to serve its existing clientele: "The growth of the Clinic – over 32,000 patients were seen each year – the range of services provided for low-income residents, and the substantial costs of nursing

education made heavy demands on the hospital services" (Mahoney 1985: 50). This orientation toward service was calculative, reckoning whether service would be possible based on cost.

Further, language about the move is implicitly raced and classed. A hospital consultant who had been hired to assist hospital leaders in thinking about their issues characterized the hospital's migration out of San Francisco as "simply following the movement of the population to the suburbs" (Anon 1962). That is, administrators prioritized following the existing patient population, in so doing identifying with that population and expressing a culture of organizational self-interest. The context around this statement reveals its relation to white flight. At the time, the Mission neighborhood was becoming increasingly Latino, while there was white flight out of the city described in the first section of this chapter. The hospital moved to San Mateo County, whose burgeoning post-war population was mostly white (U.S. Bureau of the Census 1960, 1970), and was finally placed near the new Westlake development, which was financed with racially restrictive FHA moneys. Thus, the language involved racialized and classed self-definition, and contributed to structural racism and classism.

This type of organizational self-interest is also apparent in ways in which hospitals acquired valued resources for their existing patients, rather than to expand where broader community demand indicated need. For example, a member of the governing board of Presbyterian Hospital, located in the northeastern neighborhood of Pacific Heights, recalled that instead of justifying the hospital's expansion based on need, the hospital decided first that it wanted 350 beds. After firing a planner who refused to commit to this conclusion ahead of his work, hospital leaders found another planner who would be willing to start from that number and work backward to justify it. Despite the board member's push that they undertake a study to ensure the need for the building (the board member was also part of the regional planning

council), Presbyterian refused to attend to the distribution of healthcare facilities in San Francisco at large as it planned its expansion in the mid-60s. The board member said,

> You had to… have surveys made to determine whether or not you need another hospital or an expansion of a hospital. People are very ignorant about these matters. That was one of the troubles we had, at least in ***my*** own opinion, with the Presbyterian [Hospital] board. I wanted a study made. They wanted to rebuild the old Stanford Hospital. They needed a new hospital. There was no question about it. I wanted them to go to seek the services of … the Bay Area Health Facilities Planning Association [the regional health planning council]. We covered nine counties and we recommended that studies be made whenever there was a need for more hospital beds or getting down to programs like pediatrics and obstetrics. …All of the administrators and the lay people we got in would always give you lip service and then they would go along selfishly on their own ways. It's in the nature of the beast. To get a person who could be community-minded and not parochial in his attitude is not so easy, if a person has been indoctrinated for many, many years and has loyalty to a certain hospital--it can do no wrong (Koshland 1981 [no page numbers in document], emphasis in original).

According to the board member, these administrators were "indoctrinated" – they had absorbed a particular culture, which as in the previous example suggests a particular conceptualization of organizational identity and an attention to maintaining an existing position.

Incomplete Reform in Regional Hospital Services Planning. With and after Hill-Burton came federal legislation creating regional planning for hospital services, the most extensive and enforceable of which was the National Health Planning and Resources Development Act (NHPRDA) of 1974. The act combined Hill-Burton and earlier planning programs that had been enacted to control costs and improve access to care, creating about 200 regional health systems agencies (HSAs) nationwide. Each HSA was to develop a plan for health services for its designated geographic area, and it was charged with determining whether proposed hospitals and services were consistent with area need and would not duplicate existing services. Once these plans were in place, any hospital planning to build was to submit an application to their local HSA. If the HSA agreed, it would issue the hospital a Certificate of Need indicating that the planned service was necessary. In San Francisco, the local health systems agency was the West

Bay Health Systems Agency (WBHSA), established in 1975. As with Hill-Burton before, federal policy regulating the regional planning generally enabled white and wealthy hospitals to maintain advantages while to some extent obscuring how this process occurred. I argue here that the specific ways in which policies were enacted, implemented, and enforced served to maintain racialized and classed distribution of healthcare facilities in San Francisco.

At the outset of this era, documentation guiding WBHSA work stated that hospitals were maldistributed across the city's landscape. For example, a 1972 report found the following:

> Hospitals are not well distributed for accessibility to all areas of the city as most are in the north and northeast sections. All except two of the general hospitals are within a two mile radius, leaving the western, southern and southeastern portions of the city without facilities. Public transportation from these areas without facilities to the hospitals which provide ambulatory care on a part pay basis is not as good as in some other portions of the city making travel times a barrier to ready access to care (SF Comprehensive Health Planning Council 1972: 25).

Yet under the WBHSA's tenure, no additional hospitals were built south of Market, and the number of hospital beds did not increase there. Figure 3.3 suggests that the WBHSA did at least partly achieve its goal of reducing duplication of services, as the number of beds declined 1971 and 1980, during which time the agency was active. Since hospitals would face review if they wanted to expand or develop new services, and that review would not allow duplication, hospitals began to buy each other out to reduce overall numbers of beds and allow expansion into

new service areas (interview, 3/30/2018). However, despite findings that perhaps need in

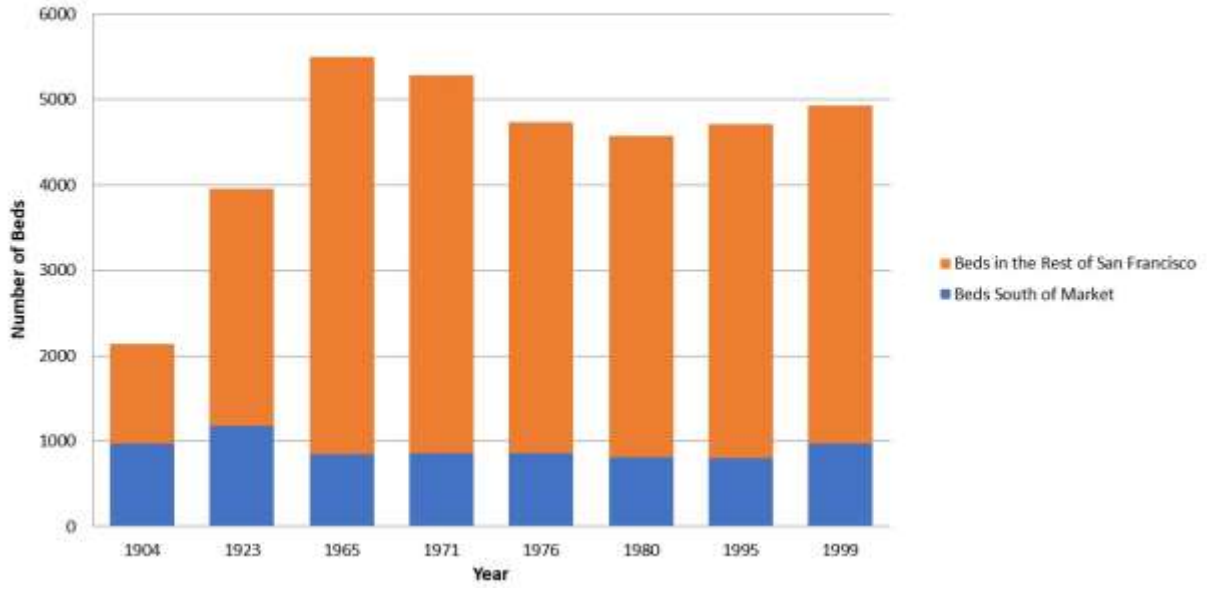

Figure 3.3. Geographic Distribution of San Francisco Hospital Beds Over Time*

*Sources: (CA OSHPD 1980-1999; Emerson and Phillips 1923; U.S. Bureau of the Census 1905; WBHSA documents n.d.)

southern and southeastern areas were not being met, the WBHSA did not raise the number of beds available to San Franciscans living south of Market Street.

The NHPRDA did not make a strong, positive change in access for several reasons. First, the language of the bill was vague, combining interests in access to care and cost control without discussing how to prioritize between them. The creation of planning guidelines that would harmonize these goals was left to the Department of Health, Education and Welfare, and ultimately the government relied on local HSAs to create plans for their communities.

Second, despite delegating authority to local HSAs, no federal provision gave the WBHSA authority to ensure area need was ascertained and met. The most the Agency could do

was refuse to allow a Certificate of Need; it could not proactively place hospital beds. Further, though HSAs were required to have a consumer-majority membership, the WBHSA became the site of disagreements among members that were not easily resolved. The agency included many community representatives, as well as representatives of hospitals, insurers, and businesses, and meetings among them were at times “acrimonious,” an interviewee said.

An example of conflict is as follows. In the late 1970s the WBHSA decided to embark on a patient origin study for local hospitals to assess need for care by geography. It attempted to gather this data with the cooperation of the West Bay Hospital Conference, the local hospitals’ professional association, which said that it would consider the request but wanted the use of the data to be limited. Not all hospital administrators felt that way – one former administrator was part of the planning group pushing for the patient origin study (interview, 5/30/2019). However, discussions went on for more than a year, and ultimately the requested data was not shared (WBHSA documents 1980). In 1980, the West Bay Hospital Conference and local medical societies made written complaints to the State Health Advisory Council that the WBHSA was too oppositional in their work and would not do what doctors and hospitals wanted (WBHSA documents, "WBHSA Complaints.")

Perhaps most important, the economic structuring of hospital planning under the NHPRDA reinforced white and wealthy hospitals’ existing privileges. Title XVI of the Act included provision for funding for carrying out plans that HSAs made. However, this funding was never made available. Thus, in area practice Hill-Burton funding effectively ended with the beginning of the NHPRDA.

Neoliberal Regulation in the Late 20th Century

In the early 1980s, inequality continued as a neoliberal era in hospital development began (Scott et al. 2000; Starr 1982). I argue that these shifts enabled intergenerational drag from previous eras, allowing administrators of whiter and wealthier hospitals to build on the resources they had already garnered. As there was no major federal policy aimed at hospital siting, in this era I focus on policy facilitating inter-hospital competition and network-building and their effects on continued maldistribution of healthcare in San Francisco. As above I consider the following means: policy language and practices under which it was implemented, including policy enforcement, economic structuring, and local organizational practice. In concluding, I demonstrate how hospital systems threatened the remaining hospital care in southern San Francisco that primarily served patients who were poor and/or were people of color.

First, in the 1980s and after, major shifts in policy included federal and state governments' moves to end health planning and instead increase support for managed care. According to its proponents, managed care was an arrangement of health care and insurance meant to create competition among providers and thus drive down costs, while improving quality. In a managed care plan, a managing company created a network of hospitals and providers that patients could access. The company also would set quality standards, require service-pricing agreements to lower costs, and review appropriateness of care patients received.

Federal and state policies supporting managed care included the 1973[12] federal Health Maintenance Organization (HMO) Act and California's 1982 selective contracting law.[13]

Second, the passage of policies supporting managed care ended regulation that could have been used to ensure new hospital services and sites met geographic needs. The 1981 OBRA allowed states' governors to end funding for local health planning and in 1984 California suspended its Certificate of Need program (Simmons 2006). With its funding and governmental authority ended, San Francisco's West Bay Health Systems agency officially closed its doors in 1982. The 1981 OBRA allowed states' governors to end funding for local health planning and in 1984 California suspended its Certificate of Need program (Simmons 2006). With its funding and governmental authority ended, San Francisco's West Bay Health Systems Agency officially closed its doors in 1982. Similarly, there was relatively little regulation in place governing how

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[12] An HMO can be defined as "an organization of healthcare delivery available to persons in an enrolled group who reside in a specific geographic area. The HMO provides a specific set of [contractually defined] health benefits to its members including the services of physicians and other health care professionals" (Zipperer and Pace 1993: 97).

[13] Another important component in the marketization of care was the creation of prospective payment. The Tax Equity and Fiscal Responsibility Act in 1982 called for "prospective payment" for Medicare, and in 1983 the federal Health Care Financing Administration began to use a new Prospective Payment System. Before this point, Medicare had funded services retrospectively, generally paying what physicians asked. With PPS, funding was set according to patients' diagnoses, which were organized into "Diagnosis Related Groups" (DRGs). This allowed the government more control over prices and incentivized physicians to reduce costs.

mergers could occur. By the mid-1990s, the law governing mergers or affiliations was Assembly Bill (AB) 3101, which only required the state Attorney General to review proposed conversions of nonprofit hospitals into for-profits. A similar rule for nonprofit hospital mergers, AB 254, would not arrive until 1999. Instead, the recourse available to challenge mergers was anti-trust law, and anti-trust lawsuits in the era tended to resolve in favor of regionalization. Similarly, the only regulator on HMOs, the California State Department of Corporations, was criticized for its lack of control over HMOs and was dissolved in the late 1990s (Anon 1998). Thus, hospitals could serve the populations they wanted to serve.

Ultimately, policies were a new means for creating new, network-based inequality, while continuing hospital maldistribution. In San Francisco there was no hospital re-siting toward the city's southern half or increase in beds available in the south. Instead, hospitals merged and joined systems beginning in the mid-1980s and extending into the 1990s, with benefits for white and wealthy hospitals as described below. As a result, by the mid-1990s, San Francisco's hospital scene was dominated by three groups: Kaiser, UCSF and CPMC (Rauber 1999). Further, by that time there were only two hospitals south of Market, St. Luke's and San Francisco General. Thus, inequalities became somewhat less about hospital siting and more about organizational networks. San Francisco mergers and affiliations are listed in Table 3.2.

Table 3.2. San Francisco Hospital Mergers and Affiliations, 1986-1999

Year of Merger or Affiliation	Hospitals Merging or Affiliating (System)
1986	St. Mary's (Daughters of Charity)
1993	St. Francis (Daughters of Charity)
1990	Mt. Zion (UCSF)
1991	Children's Hospital, Pacific Presbyterian Medical Center (CPMC)
1998	Davies Medical Center (CPMC)
1987	French Hospital (Daughters of Charity)
1989	French Hospital (Kaiser)
1997	UCSF, Stanford [merger ended in 1999]

Managed care and network-based inequality in San Francisco also grew in the form of independent physician associations (IPAs) after 1980.[14] Perhaps most notable of these was the growth of the IPA Brown and Toland. In January 1997 the California Pacific Medical Group, the independent practice association of physicians at California Pacific Medical Center, joined with some of UCSF's doctors to create Brown & Toland, which became the largest physician association in the city. New selective contracting law lacked provisions to ensure that hospitals serving vulnerable groups would be included. Brown & Toland, therefore opted not to include St. Luke's physicians in their network. By including some of the city's most prestigious physicians and excluding physicians at St. Luke's, the only nonprofit hospital serving the largest percentage of people of color and low-income patients, this arrangement further concentrated medical resources and expertise in the north and west of the city. The arrangement of hospitals in 1999 is depicted in Figure 3.4.

The number and placement of hospitals over time displays a tremendous shift in the shape of the city. In the late 1800s (see Figure 2.4), there were fewer hospitals overall, but a greater percentage in the southeastern part of the city. In 1966, there were far more hospitals, but by this point a greater proportion of them was located in central and western San Francisco than in the southeast. Finally, by the late 1990s, the number of hospitals had dropped and the proportion in the southeast had declined even further.

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[14] An independent practice association is an association of doctors who affiliate to contract with managed care organizations as a group. This practice gives physicians negotiating leverage with managed care organizations (Grumbach et al. 1998).

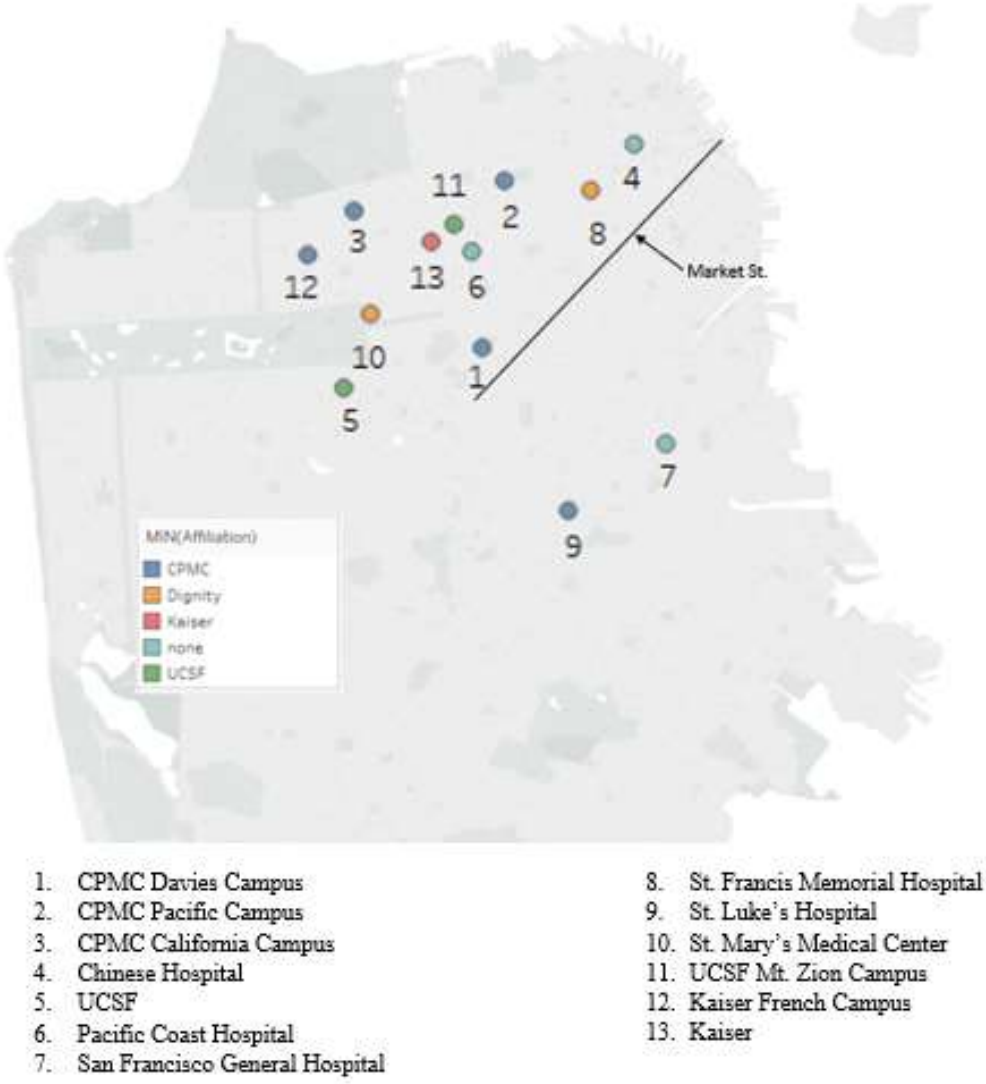

Figure 3.4. San Francisco Hospital Locations, 1999

What might be the only possible counterpoint to the overall racialized and classed maldistribution of hospitals in San Francisco is the 1998 approval of UCSF's Mission Bay campus, located in the city's southern half. However, the site was not initially conceived as an extension of care to patients in the southeast at all, but rather envisioned only as a site for biomedical research and teaching (Kirby 2006). UCSF, the City, and Catellus – the owner of the Mission Bay property – all wanted to redevelop the land for use by biotech companies in the

area. Only after UCSF's Chancellor recommended that the biotech project be located in Alameda, an island across the bay, did the parties come together to negotiate the donation of land to UCSF; UCSF got its new southern campus and city government got the economic boost they had been wanting (Brady 2002). Over time, proposals to locate some hospital services at Mission Bay were slowly incorporated into the development plan.

In the final section of this chapter I consider how hospitals' development occasioned development of new activisms and action among San Franciscans, altering hospitals' environment.

Responding to Redevelopment: New Activisms and Identities

Shifts in federal policy and the local hospital growth that followed did more than increase existing maldistribution of hospitals. They also occasioned the growth of community activism in response. As noted previously, hospitals had long been understood as sites of care for low-income groups. These activisms demonstrate the continuance of this belief, as well as beliefs about other meanings hospitals had for the communities in which they were located. By way of example I show how some social worlds in the local hospital care arena responded, developing identities and organizational structuring based on varied definitions of community and demanding that their interests be protected as such. Below I focus on how these emergent identities yielded changes to internal hospital organization and changes to the local environment with the establishment of new neighborhood institutions and local government regulation.

St. Mary's Hospital Expansion and Neighborhood Response

Shifts in hospital building led to the emergence of expressions of local identity and creation of neighborhood institutional structure as well as lasting changes in hospital organization and in the San Francisco Planning Department. These changes enabled communities to respond to hospital redevelopment and, to some extent, to mitigate it. One illustrative example is the response of neighborhoods to the expansion of St. Mary's Hospital.

In the 1970s, St. Mary's Hospital attempted to expand its campus with a new clinic site as well space for as medical offices and other uses. At the time, a California state law enabled hospitals to expand their sites by eminent domain. However, in this case, a neighbor, who would have lost his house had the expansion continued, pushed back and formed the Stanyan-Fulton Street Association to respond. I suggest that this action is indicative of desire to protect the neighborhood, and a sense of neighborhood-based identity, and is the beginning of some neighborhood-based institutional structure. Other neighborhood organizations joined in the fight, eventually winning not only limitations on how the hospital could expand but also putting in place an ordinance to ensure that hospitals and educational institutions would have to produce institutional master plans every two years for the San Francisco Planning Department. As a result, the City's Planning Code stipulated that Institutional Master Plans

1. provide notice and information to public agencies and the public so that early and meaningful involvement may occur prior to substantial investment by the institution,
2. enable the institution to make modifications in response to comments prior to more detailed planning, and
3. provide public agencies and the public with information that may help guide land use decisions. (City of San Francisco 1978)

Implementation of the Institutional Master Plan legislation gave the public a chance to respond to planned changes in hospitals (Checkoway 1981). Thus, community-based identity created a

meaningful shift the local hospital care arena in the form of creation of a neighborhood organization and a change in City policy.

Health Care Activism in Unions

Urban development also led to the emergence of identity and organizing from local healthcare unions. As mentioned above, San Francisco had been a union town for a long time, and it was one of the oldest sites of hospital unionization in the country. After the city's General Strike in 1934, San Francisco General service workers unionized in the same year. The group joined the Service Employees International Union (SEIU) as Local 250 and over time won contracts in other San Francisco hospitals. In time, the union spread to the East Bay.[15]

In the 1980s and 1990s, hospital competition and the growth of managed care meant that hospitals engaged in cost reduction strategies. California and Bay Area hospitals responded to shifts in payment by reducing expenses, and engaging in mergers and closures as described above (Zwanziger, Melnick, and Bamezai 1994). Hospitals began to implement more "lean" organizational practices, for example, cutting nursing jobs and raising nurse-to-patient staffing ratios. In San Francisco, CPMC (and UCSF) reduced their workforce in the mid-90s.

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[15] By 1999, Local 250 represented workers across Northern California and included approximately 45,000 workers, making it the largest union local in California and the second largest in the United States (Service Employees International Union (SEIU) 1999). Members included service workers, nurses, physicians, respiratory therapists, lab technicians, pharmacists, paramedics and others. Six divisions covered Kaiser facilities, hospitals, convalescent care, home care, physicians, and emergency medical services.

In response, many union members organized under what might be described as a discourse of caring for the community. It was widely believed by nurses, not just in San Francisco but nationally, that managed care involved cutting nursing jobs and harming patient care (Shuit 1996). When UCSF cut jobs, for example, the President of the California Nurses Association responded that UCSF "is one of the wealthiest hospitals in Northern California. But in the name of managed care, they are lowering the standard of care" (Russell 1995).

Possibly in response, San Francisco's health care union activism grew during the 1980s and 1990s. This was mostly accounted for by growth of the SEIU. In the 1990s, SEIU grew by six percent between 1991 and 2001-02, representing 16.5 percent of all California union members in 2001-2002 (Milkman and Rooks 2003). By 2002 it was the second largest union in California and the most rapidly growing union in the country. The California Nurses Association (CNA), while much smaller, is important in the Bay Area and accounts for 2.7 percent of the area's union members. In the late 1990s, the SEIU organized a "Stop the Sutter Scam" campaign to address patient care, worker treatment, and Sutter's practice of subcontracting service (SEIU 1999). The union also organized in favor of the 1994 California Proposition 186 for single-payer universal health care. Thus, this increase in union membership in response to increasing corporatization demonstrates how local response to hospital development creates shifts in the local organizational environment in the form of changes to hospitals' internal structures.

St. Luke's Responds

Response to shifts in policy did not just lead to new articulations of identity on the part of hospitals' neighbors and unions; they also led to shifts in how hospital administrators responded to their environment. At the end of the 1990s, hospital leaders at St. Luke's responded to its new

position as the last independent nonprofit in the southern half of the city, arguing that it, too, deserved to compete in the financial market.

As discussed above, hospitals' affiliation into systems and networks effectively excluded low-income patients and patients who were people of color, while also pursuing newly financialized competitive goals. Amid this process St. Luke's administrators attempted multiple times to affiliate and shore up the organization's financial position. However, because this position was weak, none of the local hospitals would merge with it.

Therefore, in what was seen as a novel solution to its problems, St. Luke's leadership sued CPMC and Sutter under anti-trust law. Its administrators argued that some of its most profitable physicians became excluded from admitting patients when CPMC created its exclusive contract. The lawsuit continued over two years. When the suit ended with a settlement, terms included Sutter's obligation to run St. Luke's for a period of five years, after which the chain could let go of the hospital. Sutter also was required to provide at least $2 million per year toward care for the poor and uninsured. A final agreement with the Attorney General was reached and the Attorney General approved the merger on June 26, 2001 (Martin and Colliver 2001). Thus, St. Luke's administrators continued to see the hospital as a site of non-economic value and fought to maintain that value.

Conclusion

In this chapter, I argued that the advent of federal and state hospital development policies was co-constituted with an *intergenerational drag* that enabled whiter and wealthier hospitals to expand the privileges that they had acquired in their early years. I followed the trajectory of hospitals' development through most of the 20th century, from about 1934 to 2001.

I first followed the continuance of racialized uneven development across the city. I found that new inequalities were piled onto those created in the past through policy development and implementation. Policy language at first overtly discriminated on the basis of race and class, later becoming more covert and financialized. Meanwhile, policy was interpreted flexibly to allow development of commerce and contain low-income residents and people of color in the city's southeast.

I find that hospital development was co-constituted with urban development. Initially, hospitals were maldistributed across the city, with more hospitals for the neighborhoods where white and wealthy residents lived. Then, two eras of federal and state policymaking enabled this maldistribution to increase. In each, policy language and practice enabled hospital administrators and elites to continue to drive hospital development at the local level in ways that deepened inequality.

A first era of federal regulation in the mid-20th century allowed whiter and wealthier hospitals to build on their existing wealth. Policy language of the Hill-Burton Act obscured the neighborhood basis of need for hospitals, while also legitimating whiter and wealthier hospitals' existing privilege and allowing them to expand, while ignoring their role in the community's racialized uneven development. Later, the National Health Planning and Resources Development Act was developed in part to attempt to ensure that some sort of access condition was met. However, this had only mild success, failing under similar implementation difficulties.

In a second, neoliberal policy era, hospitals developed as federal and state policy devolved and became more market-based. In this case, policy language continued to obscure community need, promoting exclusive contracting and network-based inequality in managed care instead, and means that had existed to ensure access were closed. Hospitals then affiliated as

networks, continuing to develop outside the south of Market area and to further disadvantage the single nonprofit hospital that remained there to serve people of color and low-income groups.

The research points empirically to the durability of healthcare inequality in San Francisco, and theoretically to how policy language and practices around implementation and enforcement, along with organizational culture, mattered in this process. Empirically, hospitals had been maldistributed in the city since the city's beginning, and by the end of the 20th Century, many hospitals in town stood in the same location where they had been since the 1800s or early 1900s. Theoretically, durability seems to have occurred at least partly on the basis of the creation of policies that enabled the continuation of previously existing inequalities; rather than the overt promulgation of inequality, such policies effectively contributed to its maintenance over time. This occurred through policy that overtly revalued past privileges, such as prioritizing support for existing hospitals, but also obscured distinctions between neighborhoods, thus masking inequality, and failed to mandate redress for past inequity. Further, policy implementation at times seemed designed not to ensure access, through failures of design or funding, while hospital organizational action suggests its importance in legitimating and creating the durability of inequality. At varied moments, administrators of whiter and wealthier hospitals had the choice to ensure that care was broadly accessible by placing their hospitals where needed, but they did not do so.

Finally, this chapter points to ways in which hospitals relate not only to governments and elites but also to community groups. Disenfranchisement by the existing power structure leads varied social worlds with investments in hospitals to develop identities and social structuring that allow them to respond, ultimately creating changes in the local hospital care arena.

In Part II of the dissertation (Chapters 4 and 5), I continue the discussion of St. Luke's and its fortunes as a part of CPMC, examining in more detail how culture and on-the-ground local action mattered for hospital development in the near-present.

PART TWO

CHAPTER 4. SAVING ST. LUKE'S: HOSPITAL ADMINISTRATORS' SELECTIVE REGIONALISM

Introduction

Where the last chapter focused more on how broader federal and state policy shaped hospital placement over multiple eras, this chapter and the next address hospital administrators' and community members' culture, local politics, and on-the-ground interaction in the neoliberal era. To do this, I analyze development of one medical center, the California Pacific Medical Center (CPMC) from 2001 to 2013. Analysis of CPMC's development reveals hospital administrators' orientation toward the historically marginalized southern half of the city, as well as the response of the community and local government to that process. This is because a key inflection point in CPMC's growth was its merger with St. Luke's Hospital. St. Luke's was the last private nonprofit hospital in southeastern San Francisco and was recognized for its care for patients who were low-income or people of color. In contrast, CPMC was known as a provider of care for white and wealthy populations. As noted in the previous chapter, in 2001 the settlement of a lawsuit between St. Luke's and Sutter Health, the health system of which CPMC was part, meant that Sutter was required to run St. Luke's until 2005. CPMC, as the local Sutter affiliate, took up this charge. Also around that time, hospitals were required to rebuild to meet a new state seismic safety law. How CPMC administrators would handle these issues would articulate the medical center's role in racialized uneven development in a new way.

In this chapter I ask how hospital administrators responded to the past, with attention to their language and action. I situate this question in relation to studies of medicine's relationship to capitalism in the late 20th century. Beginning in the late 1960s, scholars began to critique medicine as increasingly "corporatized" and part of a "medical industrial complex" supported by private corporations and permeated by those corporations' business cultures (Ehrenreich and Ehrenreich 1971; McKinlay and Stoeckle 1988). By the 1980s, medicine's corporatization was deemed to have shifted into a new era, along with major political economic changes (Clarke et al. 2003; Estes 1991; Navarro 1986; Rajan 2006; Waitzkin 2000; Waitzkin and Jasso-Aguilar 2015). In this new, neoliberal era, elites and capitalist governments supported unfettered free markets through deregulation of private corporations, privatization and a reduced welfare state. This included promoting the spread of capitalist enterprise across place such that as it strained against and surpassed political borders, creating cross-border capital flows. A part of neoliberal capitalism included expanded markets for medical products in some places (Rajan 2006; Waitzkin and Jasso-Aguilar 2015), resulting in an "underdevelopment of health" elsewhere, as maldistribution of healthcare contributed to poor health outcomes (Navarro 1974). Relatedly, scholars noted the growing prominence of healthcare consolidation in the neoliberal era as hospitals have formed systems and networks (Clarke et al. 2003; Scott et al. 2000; Wells and Banaszak-Holl 2000; Wright and Perry 2010). In tracing medicine's development at CPMC, then, I explore how capitalism was expressed – or not – by administrators at CPMC.

I also follow Clarke and colleagues (2003), who analyze these most recent shifts in capitalism, identifying medicine's increasing corporatization and commodification; its centralization, rationalization, and devolution; and its stratification, that is, its uneven availability to different social groups (e.g., races and classes). Critically, this conceptualization of the

expansion of medicine to new social terrains, or biomedicalization, also focuses on biomedicine's development as an instantiation of power, after the work of Foucault (Clarke et al. 2003). Analytic attention is given to discourse and practice constituting the growth of biomedicine. Particular emphasis is on ways in which medical knowledge is itself a form of power, producing, administering and optimizing particular kinds of bodies and people (Foucault 1978). Therefore I look to how administrators might craft knowledge in support of their position.

I note, finally, that this chapter contributes to this literature because it examines how biomedicine's relationship to capitalism and structural racism play out at the local level. The extant scholarship more often is engaged at the national or international level, or at the level of larger regions within a nation. Little literature discusses within-city variation and what forces propel it. Further, relatively less work has addressed how it is co-constituted with structural racism and classism, and how they are worked out in place (but see Rajan 2006 and Hansen and Roberts 2012). It is the intent of this chapter to explore hospital administrators respond to existing structural racism and classism in the neoliberal era.

I argue that CPMC's administrators would develop neoliberal biomedicine through a *selective regionalism*. This was language and action under which hospital administrators began to consolidate the medical center to serve a region (in this case, San Francisco and beyond), while planning to site its hospital proximate to neighborhoods that were wealthier, and not coincidentally, whiter. In this way, administrators would serve patients with higher-paying insurance plans, while also excluding patients without. Through this plan, biomedicine would be co-constituted with the city's continued racialized uneven development. Selective regionalism also included hospital administrators' discourses that oriented and obscured the organization's

relationship to place as they chose relatively placeless language to justify their hospital building plans. These discourses expressed administrators' power as producers of medical and bureaucratic knowledge and as civic benefactor.

In what follows, first, I address neoliberal policy shifts and historical racialized uneven development in hospital siting. I suggest how these processes conditioned hospital administrators' action as federal deregulation enabled hospital regional consolidation and CPMC's spread across San Francisco in a first expression of its selective regionalism. Second, I consider how CPMC administrators attempted to continue racialized uneven development through internal re-organization and consolidation of the medical center's hospital sites, in a second expression of its selective regionalism. This re-organization would enable administrators to build economic value. Third, I describe discourses that hospital administrators deployed that downplayed the medical center's regionalism and obscured its growing dominance or hegemony in a third expression of selective regionalism. Fourth, I discuss how CPMC's actions and language constituted structural racism and classism, engaging with the work of Bonilla-Silva (1997, 2014).

Producing Value in the Service of Selective Regionalism

In this section I briefly recall elements of racialized uneven development discussed in the last chapter, and then I detail elements of CPMC administrators' selective regionalism as hospital administrators initially acted to re-site their medical center in the early 2000s. I argue that these actions were attempts to create economic value as administrators redesigned the medical center.

As noted in the last chapter, at the end of the 20th century racialized uneven development in the local hospital care arena resulted in hospital maldistribution. This proceeded as healthcare

policy deregulation enabled hospitals to reorient to geography. That is, hospitals were no longer accountable to regional planning agencies to ensure equitable distribution of care. As a result, the city's neighborhoods south of Market Street, which were historically working-class and the home of people of color, were left with fewer treatment options than their neighbors to the north. Two hospitals served the southern half of the city, St. Luke's and San Francisco General, which were known as primary providers of care for these groups in San Francisco. However, St. Luke's had become financially troubled partly as other local hospitals consolidated into systems and networks in the 1980s and 1990s, excluding it from lucrative contracts. CPMC played a clear role in producing this situation: During the 1990s, three hospitals in San Francisco joined to create the medical center. Together, they became a dominant player in San Francisco's healthcare scene, with sites located primarily in the wealthier and whiter neighborhoods of the city. Then, to gain market share, CPMC administrators attempted to form exclusive contracts with St. Luke's more lucrative physicians, which would remove those physicians from St. Luke's and would worsen the hospital's already tenuous financial state. In response St. Luke's sued CPMC, with the end result that CPMC's parent hospital chain, Sutter Health, would be required to run St. Luke's for five years. Thus, in the 1980s and 90s CPMC's selective regionalism had begun as CPMC's management of physician contracts privileged wealthy and white neighborhoods and patients.

Afterward, CPMC's selective regionalism evolved as administrators mobilized the organization's resources in the early 2000s. At the time, new state law required California hospitals to meet new seismic safety codes. CPMC administrators used this moment to reorganize the geographic siting of its hospitals as part of their strategy to create economic and cultural value, maintaining and extending the medical center's historical and growing

advantages. As CPMC administrators began to contemplate the medical center's new siting, they rearranged the hospitals' services in ways that mapped onto existing segregation and intensified maldistribution of hospital services, continuing racialized uneven development through the medical center's internal organization. Below, I detail administrators' actions in selecting geography as well as how they reorganized the medical center's services to effect this shift.

When I first asked those who knew CPMC's functioning well how its administrators oriented to geography, my interviewees responded that the organization used a practice of geographic domination. As one interviewee put it, CPMC leadership and that of its parent chain, Sutter, saw geography "as their turf and…as part of their destiny." Geographic positioning would turn out to be key in the way CPMC leaders positioned the organization in relation to its environment. Specifically, its selective regionalism was accomplished not only through attempts at *geographic relocation* of its sites but also shifts in its internal *division* and *geographic distribution of labor*. By division and geographic distribution of labor, I mean which hospital services administrators chose to provide, and where these services would be located in the city. Administrators would consolidate care into a single hospital, removing inpatient hospital care from other CPMC sites. Together, these tactics comprised a type of opportunity hoarding, keeping valued resources for the medical center and its patients while excluding others. That is, it would derive profit from the wealthier and better-insured patients located in the northern half of the city, patients who were more often white, and it would draw such patients from distant locales to the city. Such division of labor has been described as a mechanism of structural racism

and classism in healthcare (Lutfey and Freese 2005).[16] In a similar fashion, changes in the division of labor of St. Luke's hospital would contribute to the city's racialized uneven development as it expanded in one site rather than in another.

First, CPMC administrators pursued a selective regionalism as they attempted geographic relocation of sites. In the early 2000s, administrators looked for possible new hospital sites. Government documentation from the period suggests that all the locations contemplated were located north of Market Street, in or adjacent to neighborhoods that were whiter and wealthier than others in the city. These included sites in the Presidio, located in the city's northwest corner – the former U.S. Public Health Service Hospital, Letterman Hospital, and Fort Scott District. Sites also included other places in the north along Geary Boulevard and Masonic Avenue, including an old shopping center and locations owned by the Catholic Church and San Francisco Unified School District.

In 2003, CPMC administrators settled on a new hospital site in the Cathedral Hill neighborhood in northeastern San Francisco, the site of the former Cathedral Hill/Jack Tar hotel. Located on the border between the Western Addition and the Downtown/Civic Center neighborhoods, and proximate to the Japantown and the Tenderloin neighborhoods, Cathedral

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[16] In an ethnography of two diabetes clinics – one serving middle- and upper-class white patients, and a county clinic serving working-class, minority and underinsured patients – Lutfey and Freese find that the variation in the division of labor between two clinics instantiates a race- and class-based disparity in care. In these clinics, medical residents have more autonomy in care of patients at the county clinic and appear to offer lower-quality care, while the more privileged patients at the other clinic are likely to receive more care from experienced attendings who provide better care.

Hill was a densely settled area home to high-rise apartment buildings and historic churches. With a location in this neighborhood, situated at the corners of two major streets (Van Ness Avenue and Geary Boulevard), the new hospital would be very close to the financial district and City Hall, where workers from those areas (who, again, as noted above, were more likely to be white and wealthy) could easily access its services. The hospital would also be close to a freeway exit such that patients traveling into the city would be able to reach the site. This proximity to the freeway mattered because regionally CPMC was growing a reputation for specialty services. As of 2007, approximately a third of its patients resided outside of the city and drove into town for its services, according to a CPMC official. With these shifts, CPMC was, some said, trying to grow its reputation as a "boutique" medical center that would become the "Mayo Clinic of the West" (Anon 2010). The new central hospital would include lucrative medical specialties that would draw patients from outside the city and the region.

This planned organizational shift would include changes in the hospitals' *division* and *geographic distribution of labor*. All of CPMC's inpatient services, which had been scattered at each of its sites located throughout the city, would be consolidated on one city block in Cathedral Hill. Of the four Sutter-controlled hospital campuses in the city, the California campus would close and the remaining three campuses, Davies, Pacific Heights, and St. Luke's, would be converted from inpatient hospitals into outpatient centers. Together with the main Cathedral Hill site, a 555-bed tertiary care hospital, these locations would form what administrators termed a "hub and spoke" model. (See Figure 4.1 for a map.) The plan also involved locating doctors' offices near the Cathedral Hill site. Notably, CPMC, like other hospitals, would charge its doctors rent for their offices at the new site, and the area where the hospital would be located had the potential for some of the highest office rents in the city.

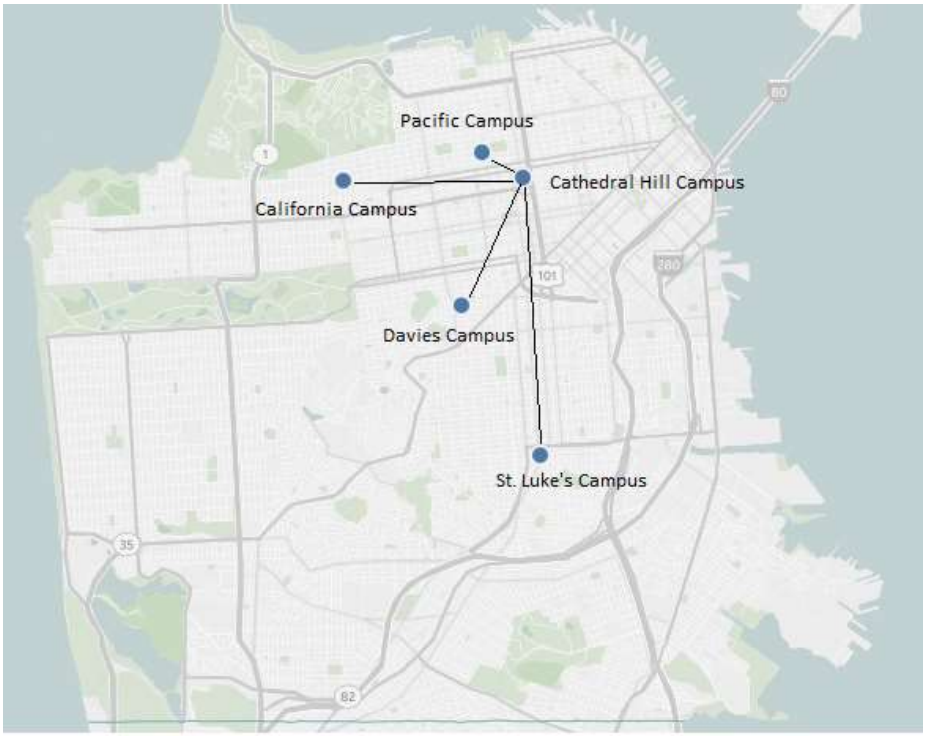

Figure 4.1. California Pacific Medical Center's Proposed Hub-and-Spoke Model for Its Hospitals

CPMC administrators began to position the organization for this change by making strategic shifts in the services available at St. Luke's via a *selective services attrition*. In moves that seemed designed to ensure the success of its initial plan, over time, Sutter and CPMC administrators began to remove services from St. Luke's. First, in 2005, St. Luke's announced closure of its inpatient psychiatric unit in fall 2005 for "financial reasons" (Colliver 2005). Second, administrators reduced pediatric services and removed the neonatal intensive care unit (NICU) from St. Luke's, keeping a NICU at its California campus, located in a wealthier and whiter northern neighborhood instead. NICUs are often deemed to be money-generating investments in hospitals (Lantos 2010), and the removal of this service from St. Luke's in

particular suggests that administrators desired not only to reduce duplication of services at multiple sites but also to shrink this site's financial base.

In 2007 CPMC administrators continued selective services attrition at St. Luke's, closing the pediatric and neonatal units. Shortly thereafter, there were layoffs of union-represented nurses at St. Luke's. The union in question, the California Nurses Association, met with CPMC leadership, who said they were going to close the 10th floor surgical unit at the hospital. This floor opened and closed on need and was being closed indefinitely. And, in Fall 2007, administrators let it be known that it planned to close St. Luke's acute care hospital services in 2009.

With these actions – a geographic relocation of sites, including shifts in division and distribution of labor – CPMC administrators enacted a selective regionalism that would allow them to say they were serving the whole city while siting their organization in a neighborhood proximate to white and wealthy patients.

In the next section, I turn to language that CPMC hospital administrators used to describe their plans and to persuade others, especially city government, to support them.

Hospital Administrators' Discourses: Obscuring Value Production

When hospital administrators revealed their plans, community response was immediate. Groups within St. Luke's and government officials called for hearings to address what was happening. The political and organizational structuring that facilitated these hearings and community response are addressed in the next chapter; here, I discuss the language hospital administrators used during hearings. Administrators argued for their project with a number of claims that they made at public hearings called before members of the City's Board of

Supervisors. I aggregate what was said by hospital administrators across years of hearings before City government, deviating a bit from the trajectory of the overall development of the story to give a fuller sense of administrators' responses and to highlight themes in their language that in part comprise selective regionalism.

In what follows, I describe the discourse that administrators used to persuade City government officials to let them re-site CPMC as they desired. I analyze this language as Foucauldian "discourse" or historically specific statements of what can be known. Discourse, for Foucault, enacts meaning and power partly through its connection to institutional structuring (1978: 100). Discourse exists within the broader historical assemblage of CPMC's institutional structuring and the structural racism and classism of which this structuring had been part – in this case selective regionalism and racialized uneven development.[17] Thus the racialized and class-based institutional past was still present, legitimating discourses.

We begin a look at language with an exemplar. In 2007, CPMC administrators were called for a hearing before the San Francisco Board of Supervisors (San Francisco's version of a city council) to respond to community concerns about CPMC's new master plan for its services, with its "hub and spoke" model. The hearing was contentious, with city supervisors intently questioning and challenging hospital administrators on their plans for the hospital siting. We can see this in the following exchange between an administrator and one of the supervisors:

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[17] That said, discourse's power does not just come from the past, nor is it exercised solely from above. However, in this chapter I will be concerned with how it is reproduced within hospital administrators' on-the-ground action.

Administrator: …the original design [for the new medical center] is to try and consolidate acute care hospitals that are difficult to run … It's expensive to run multiple hospitals and have a hundred patients here and hundred there. Ideally you would get them to a single location.

Supervisor: that gets to the crux of the redlining.[18] If you reroute St. Luke's [Hospital's] services, which is accommodating an underserved community in the southern part of the city, back to the sort of the center of our city, moving northeast in our city, then we have a significant shift of population trajectory. …

Administrator: …your comments about the population and the trajectory and needs of people south of Market Street is exactly what drove us to reevaluate the master plan [for the medical center].

Supervisor: Which is probably why you can understand, from a redlining perspective, things were one time established, say in the African American community, and then they [the business] shut their doors and decide to relocate facilities in another part of town that is not necessarily host to that same population …This is where the term redlining was beginning to grow through the real estate marketing practices. How would that be different in this analogy of redlining in the healthcare industry?

Administrator: I understand the application of the real estate term and using that in a healthcare analogy. The difficulty is asking private hospitals to build multiple locations around a city. It's like asking the General [the city and county hospital] to open up a second and third hospital. The economics are no different for the General than they are for anybody else. It's very challenging to try and do that.

Supervisor: I know there's an economic burden … that you're shouldering, and I don't make light of it, but I put the city in the driver's seat of this as to the future of St. Luke's. And I think the consequence of there not being vision or plan and asking the larger question about the distributive model of where our healthcare should be, taking care of [an] underserved hospital, and is why we're here today, is St. Luke's fell through the cracks…. You're trying to deal with your economic bottom line while maintaining a certain line of care and we're trying together to accommodate a population highly at risk and services seem to be more deficient than ever.

Administrator: It's happened across this country. Across California a hundred hospitals closed and for much of the same reasons. We talked about the economics of dying hospitals or hospitals on the margin and it is a tragedy of no universal healthcare in this

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[18] Described in the last chapter, redlining is a process under which a neighborhood or other geographic area is marked by a mortgage lender or other institution as untenable for business. Historically, areas were redlined according to explicit racist or classist criteria and contributed to the increase of inequality among residents of those areas.

> country. … [The hospital chief executive] speaks about universal healthcare in this country and unfortunately it is not. We all want it to be but it's not today and consequences of that are these.

Here, the administrator argued for a consolidated hospital design, justifying it on the basis of economic feasibility. Further, the administrator cast "economics" as some sort of natural and objective force that inevitably conditioned the medical center's response (for analysis of similar language by an administrator of another medical center, see Karlin 2013). Importantly, this talk of efficiency involved silence about the site's proposed location in the northern part of the city, and no discussion of possibly consolidating care in the south. Thus, this *efficiency discourse* was used to legitimate administrators' financial interests and approach to siting by normalizing a placeless economic market and obscuring the geographic placement of the hospital.

Below, I find that hospital administrators deployed multiple discourses to support their position, including some to legitimate themselves as authority figures and one to promote themselves as beneficent. First, administrators attempted to convey their authority to define the terms of the situation as business people and as medical scientists. In an *efficiency* discourse, administrators claimed the legitimacy of their project based on financial and medical models of efficiency. Second, in a *non-problematizing* discourse (Vess 2007), administrators claimed that inpatient hospital care at St. Luke's was not needed. Third, when administrators talked about race- and class-based variation in distribution of healthcare across the city they used a *health care disparities* discourse to engage with these issues in ways that addressed health equity, but

did so in a way that downplayed talk of historical racism and classism.[19] All of these moves relied on legitimating the hospital as a rational entity and producer of scientific and bureaucratic knowledge.

But administrators did not rely solely on legitimating their scientific and bureaucratic authority to make their case. A fourth discourse was a *civic interests* discourse. Through this language, administrators promoted themselves as a civic benefactor that motivated city administrators and other interested parties to act by describing benefits their hospital would provide to the city. Below I address each of the four discourses in turn.

The Efficiency Discourse: Placeless Consolidation

Below I describe aspects of the efficiency discourse. Administrators argued that consolidating the hospital would be efficient, while refraining from discussing that this consolidation prioritized wealthier and whiter neighborhoods and the better-insured patients these neighborhoods would produce. To walk this discursive line, administrators constructed the economic market for hospital care as normal, natural, and objectively real. This implicitly included prioritization of the hospital's self-interest within that market, as well as silence or minimization around what exactly administrators' goals were in terms of profit-making and what they would be willing to do to support the community. Such language included a vision of the hospital that was at times placeless, and which, in so doing, tacitly downplayed San Francisco's

[19] One would think that talk of disparities might create an opening to talk about and address the needs of patients who are low-income and/or are people of color; however, like the other discourses this one is primarily deployed in a way that describes the medical center as non-agentic in creating disparities.

history of racialized uneven development, including hospital maldistribution, and CPMC's role in creating and perpetuating that process.

This language was central to CPMC administrators' approach to finance, as it obscured how much profit the organization was making and where leaders wanted the organization to be sited. This obfuscation was accomplished in a few ways. A first tactic was strategic silence. CPMC was one of the wealthiest healthcare organizations in San Francisco (CA OSHPD 2006-2010), yet administrators did not volunteer information about its profitability relative to other hospitals in the Sutter chain or to other hospitals in the city.

Perhaps the most important tactic, however, was to claim the necessary primacy of finances over other interests and to attempt to normalize the economic market for hospital care. In the quote that began this section, an administrator claimed,

> It's happened across this country. Across California a hundred hospitals closed and for much of the same reasons. We talked about the economics of dying hospitals or hospitals on the margin and it is a tragedy of no universal healthcare in this country. … [The hospital chief executive] speaks about universal healthcare in this country and unfortunately it is not. We all want it to be but it's not today and consequences of that are these.

As noted above the administrator responded to a city supervisor's charge of institutional racism by saying that the medical center would, in the absence of a stronger welfare state, orient toward its economic wellbeing. I note a few components of this response. First, normalizing the market included a displacement of agency: "[The hospital chief executive] speaks about universal healthcare in this country and unfortunately it is not. We all want it to be but it's not today and the consequence of that are these." That is, the administrator implied the medical center must respond primarily to economic forces. Second, and more important to claims of efficiency, was that CPMC administrators would argue in favor of consolidation as if it were placeless – that is, they used this as a means to argue for consolidation as if that issue were divorced from the

question of where the centralized site would be located vis-à-vis patients who needed the care. In multiple cases, hospital leaders tacitly or explicitly promoted the importance of hospital consolidation for economic efficiency without attention to the importance of siting for patients' accessibility. In a hearing before the Board of Supervisors' Land Use and Economic Development Committee, the hospital chief executive officer characterized CPMC's position as follows:

> …one of the most difficult aspects in health care planning is how you deal with history and tradition. For example, we had obstetrics on the Pacific campus [of CPMC], that was the history of the Pacific campus. Then we merged with the Children's Hospital, now our California campus. And despite the objections of the obstetricians it was not the right thing to do to run two obstetric services and have two NICUs [neonatal intensive care units] – have neither be what it should be. So, you do what's right and put the entire thing on one campus and take the politics from the doctors straight in the neck but we get over it. One of the most difficult problems we've had with health planning for St. Luke's is it is an adored institution south of Market. It has a tremendous history, but it has been a severely financially distressed organization for close to 20 years. Five years ago, a decision had to be made should the rest of us allow St. Luke's to be bankrupted, which it was very close to being, or not? Should we preserve that component south of Market...

This particular example involved contrasting "history and tradition" – that is, St. Luke's history and tradition of caring for low-income patients and patients who were people of color – with thinking about the economic efficiency of consolidation. This talk also tacitly minimized St. Luke's history of providing accessible care to residents. As before, the notion of consolidation was placeless – there was no mention that the site would be consolidated in the whiter, wealthier neighborhood, or what that positioning might do to access to care. Furthermore, administrators justified their position by describing other orientations toward the situation as "political," tacitly contrasting these stances with their own, which they implied was neutral. Finally, the hospital CEO represented this moment in history as a "decision" to be made in relation to "politics" and "history and tradition" versus efficiency when in fact it was not their choice to make: the

California Attorney General had forced Sutter Health to preserve St. Luke's. However, by revisiting that decision and recasting it in terms of economic efficiency "or not," this statement elided and obscured alternative orientations and values of preserving access.

Administrators also argued for the efficiency of their plan by creating quality of care metrics. One example was a measure of physician care volume, or the number of patients a given doctor would see in a year. This metric was used to argue that physicians needed sufficient volume to keep up their skills so that they could adequately serve patients. Administrators said that the large hospital planned for Cathedral Hill, which consolidated many of the organization's inpatient services onto one site, was being created to ensure that physicians' volume would be high enough to ensure quality of care. Interestingly, the language justifying this claim shifted from being, in earlier stages of the hospital's planning, oriented toward financial responsibility, and, in later stages, toward data suggesting that increasing volume would improve quality of care. This shift suggests a possible change in administrators' understanding of how to couch their interests.

Non-problematizing: St. Luke's Inpatient Care as Unneeded

CPMC administrators argued that closing St. Luke's inpatient services would not be a problem. This type of "non-problematizing," as Vess (2007) calls it, is sometimes used by corporations involved in conflict with social movement organizations. In non-problematizing, corporations argue that what they are doing (e.g., producing chemicals alleged to be toxic) is not in fact a problem, despite social movement arguments to the contrary (see also McCright and Dunlap 2000). In the situation at hand, CPMC administrators argued that St. Luke's inpatient care was underused, and they made arguments deflecting attention away from whether there was

a need for inpatient care south of Market. Instead, administrators attempted to organize others' understanding of the hospital's work in relation to technological and scientific metrics that the hospital used and produced. In doing so, they promoted their credibility as producers of scientific – and therefore what would be deemed as authoritative, depoliticized – knowledge, thus re-inscribing CPMC's power, while obscuring the need for hospital care in southern San Francisco.

As part of non-problematizing, CPMC administrators used metrics to argue that inpatient care was under-used and therefore not needed at St. Luke's. One such metric was an inpatient census at St. Luke's (the number of beds filled per day, aggregated across a month). In a hearing, an administrator presented the inpatient census for a recent month, listing how many beds were occupied. The number was meant to show that St. Luke's was being underused. Notably, however, that month included a day when nurses were on strike, so the numbers were lower than they typically would be. Furthermore, as noted above CPMC administrators had been stripping away services from St. Luke's over time, which would reduce the number of inpatients that seen at the hospital.

Similarly, CPMC administrators used a number of metrics to support their argument that hospital care was not needed in the southern half of San Francisco. They highlighted, for example, the rate of preventable hospitalization in southern neighborhoods as depicted in a City report showing this rate was greater in southern San Francisco than elsewhere. CPMC hospital administrators used this data as they argued that outpatient care was more needed, implicitly drawing attention away from the issue of whether inpatient care was necessary. At another moment, an administrator drew attention to rates of outpatient care across CPMC:

> [I]f you look at where health care is going [at CPMC as a whole], there is a steady and steep conversion of inpatient hospital services to outpatient services. This is a statistic, 30,000 inpatient discharges, and over 500,000 outpatient discharges, CPMC-wide per year. And that statistic is telling and will continue to swing in the direction of outpatients.

These measures did not speak to whether inpatient hospital care was needed in the southern half of the city. Instead, they aggregated care across the city, obscuring local need.[20]

Health Care "Disparities" Discourse

Administrators spoke about differences in levels of care to different races and classes of patients as a matter of health care "disparities" that were framed in ahistorical terms. One might think that discussion of disparities would show CPMC's orientation toward making care accessible. And in fact this language did have this effect. Administrators offered some acknowledgment that there were differences in the level of care available in different parts of the city, and also that larger social forces mattered as part of this process. As one administrator said, "St. Luke's is the only private hospital South of Market and this fragile system is being strained by macroeconomic factors, including very few private physician practices South of Market, lack of specialists and inadequate Medi-Cal [Medicaid] rates."

However, while administrators acknowledged that there was less health care available south of Market, their focus on abstract "disparities" did not fully address how hospitals' historical and current placement in the city, including how CPMC and its member hospitals had been located over time in northern and western neighborhoods, and how it formed contracts,

[20] I note that this language echoed that expressed in healthcare policy described in Chapter 3, which aggregated need across the city and in so doing obscured neighborhood specificity of need.

were part of how this lack of care had been produced. As noted above, St. Luke's was in difficult financial straits partly because CPMC had, in the 1990s, formed an exclusive contract that took better paying doctors away from St. Luke's. Administrators' language about how these disparities simply were (as opposed to came to be) also deemphasized that the hospital would not be south of Market, and so would perpetuate disparities. Moreover, the idea of abstract, somehow unplaced "disparities" echoed in CPMC administrators' statements that St. Luke's patients would be transferrable to the new hospital. Administrators argued that the organization had the capacity to "absorb" patients from the South of Market area into its other campuses. However, they assumed that patients would travel for care and that this travel would not make access to care a challenge for them.

Civic Interest Discourse: CPMC as Civic-Minded Actor

Hospital administrators frequently described the medical center as acting to meet civic interests, in what I call use of a *civic interest discourse*. The civic interest discourse included meeting the demands of the City and community to provide a range of ends including not only health care but also supporting local jobs, providing housing, and beautifying neighborhoods where campuses were situated. This language implicitly directed city leaders' attention away from CPMC's action as medical provider and toward other meanings it would have for them as a driver of the local economy. That is, administrators wanted the City and community to know that the medical center did not just provide healthcare; it also employed many San Franciscans, affected how much housing could be available in the neighborhoods where it was located (by taking up space that could be so used), and affected the traffic and aesthetics of its

neighborhoods. Provision of these services, while beneficial, could ensure city leaders did not attend to the growing maldistribution of hospitals.

The civic interest directed attention away from removal of healthcare in the south in two ways. First, CPMC administrators addressed the City's interest in providing health care as they said that the medical center provided the most care. In a hearing, an administrator explained,

> Just a little about how the size of the contributions of California Pacific Medical Center to health care in the city. We have four campuses: Pacific, California, Davies. And we're proud to have St. Luke's as our fourth. We are responsible for 33 percent of the acute care discharges in the city, 56 percent of all of the babies who are born in the city, 32 percent of all emergency department visits, over half a million outpatient visitors, and we have the largest active medical staff with 1200 doctors on our active medical staff, an additional 400+ on our courtesy staff.

Likewise, medical center administrators' language responded to a civic interest in providing jobs and services to the neighborhood around where the new hospital would be located. Medical center administrators argued for their hospital plan to be adopted partly on the basis of the number of jobs to be produced not only in health care but also in construction, as the process of hospital building would take years. Administrators reminded the City that CPMC was one of the largest local employers, and that it its project would provide an economic boost to the city, saying, "We are the second largest private employer in San Francisco with over 6,600 employees, second only to Wells Fargo Bank." And hospital administrators described the revitalization of neighborhoods they would undertake, which would make the area more livable for residents and attract increased business to the area. This included changes in transportation, in the size and placement of the buildings, and in creating parks around the sites. Given CPMC's sizeable proportion of the healthcare and jobs provided in the city, as well as service to neighborhoods, it is possible that this language might lead leaders to think of the city's reliance on CPMC and the difficulty of opposing the medical center.

Second, administrators directed attention away from southeastern San Francisco by pointing to the broader region in which San Francisco was a part as they implied that they would help San Francisco be competitive. Administrators argued that it was a destination hospital for the region and the country, and that this served as a boost to San Francisco's economy:

> CPMC is predominantly a San Francisco-serving hospital institution. However, it's important to note that a third of our patients come from outside the city. They're attracted by our specialty programs and clinical excellence. If you look at CPMC and UCSF [the University of California's medical center] in combination, you will see those two institutions have created a health care destination for patients all over northern California and the entire country to come here for their care.

That is, specialty care could be thought of as distinct from other forms of care, and providing an economic and cultural draw for the city. Thus, by virtue of the specialty medicine it provided, CPMC was able to provide this cultural distinction.

In the next section, I consider some implications of this chapter's data for the study of structural racism and classism.

Structural Racism and Classism; Color-Blind Racism and Tacit Classism

Reflecting on CPMC's action and language, I argue that they continued racialized uneven development through means particular to the neoliberal era, and they instantiated tacit classism and color-blind racism, after Bonilla-Silva's work on institutional racism (1997) and on *color-blind racism* (2014). Bonilla-Silva argues that racism is structural, but the structuring process is under-theorized (1997). What we see in the neoliberal development of CPMC are particular forms of structural racism and classism. First, the uneven development of medical infrastructures across regions, which has typically been addressed in literature attending to larger areas, extends also to cities and neighborhoods. Second, we see that as medical organizations grow larger in the

neoliberal era, their internal, meso-level restructuring perhaps deserves more attention as part of the co-constituted advance of capitalism and structural racism.

Bonilla-Silva also argues that structural racism is continued in part via the language of color-blind racism in which whites argue that they do not see race but act in ways that reproduce racial structure through practices that are subtle and institutionalized.[21] These practices appear on the surface not to be racial, and overt discrimination against people of color appears to be less frequent. However, through such language people of color's attempts to address racism, or just get by, are not met with overt negative responses so much as silence or language that is misleading and obfuscating. Here, I want to suggest that the structural racism and classism implicit in CPMC administrators' selective regionalism was furthered through discourses that functioned much as Bonilla-Silva says.

CPMC leaders' discourses obscured the organization's interests, primarily its pursuit of its financial interests through its consolidation and relocation in space, and the health care inequity this would produce. CPMC administrators actively attempted to direct the interest of City government officials by drawing on shared cultural orientations toward the authority of the

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[21] Foucauldian discourse and Bonilla-Silva's approach to color-blind racism do not sit together easily. In describing discourse, Foucault is relatively uninterested in the intent of speakers. A speaker may or may not know whether they are deploying language in a racist or classist fashion, for example. In Bonilla-Silva's work, however, language works as Goffmanian framing (1974). Goffman's take is that a speaker appreciates their social positioning and is calculating. My focus is on the immanence of institutional structures in language, especially their history, whether speakers create this positioning intentionally or not, and I use the Foucauldian word "discourse" to emphasize this relationship.

market and of science while also legitimating desires on the bases of the city's civic interests. In this way, administrators attempted to craft the medical center's actions as somehow apolitical and in the best interests of the city at large. However, this language functioned as colorblind racism and tacit classism (after Bonilla-Silva 2014). As noted above, this included language in which whites spoke in ways that subtly enacted racism. Bonilla-Silva outlines four primary frames. These include abstract liberalism, using liberal political and economic principles in an abstract way that masks structural racism; naturalization, explaining racialized differences, like residential segregation, as natural; cultural racism, making statements that attribute racial issues to differences in culture; and minimization of racism, saying that racism is no longer an issue.

The discourses outlined above fit and extend Bonilla-Silva's analysis. CPMC administrators' naturalization of the economic market and its rational self-interest within that market is an example of abstract liberalism. Administrators marshalled principles of their rational self-interest within a placeless market, minimizing that in fact consolidating medical care as they planned would remove it from patients who need it. Administrators' minimization of the need for a hospital in southern San Francisco was in effect a minimization of the structural racism inherent in the maldistribution of hospital care. Under its plan care would become even less available to patients who were low-income or people of color, and who lacked that care partly due to CPMC and its constituent hospitals' past action.

The scene also suggests that, perhaps in addition to the frames Bonilla-Silva outlines, there are additional means of legitimating institutional oppression. The first is deflection of government attention toward meeting civic needs. Meeting civic needs is not a bad thing in and of itself – CPMC's planned hospital would, for example, provide jobs to low-income workers. However, the overlap of this process with taking away health care south of Market means that

addressing inequality is not a zero-sum game. In addressing one inequality CPMC administrators would exacerbate another. Second, institutional oppression is legitimated through scientific and bureaucratic knowledge production. In the scene at hand, this was manifested in metrics around whether hospital care was in fact needed south of Market, and around whether consolidation was in fact needed. CPMC administrators used science to make raced and classed arguments, while also masking their stance as a-political.

Conclusion

In this chapter, I described how CPMC administrators responded to the past via a *selective regionalism*. Selective regionalism was the organization's spread across a broad geographic area (in this case, San Francisco), but through an uneven process such that more resources were located in wealthier and whiter sub-areas (here, neighborhoods). Selective regionalism also included discourse under which administrators attempted to maintain and expand the advantages they had accrued, while obscuring how they did so. Together, this language and action would continue racialized uneven development, while also displaying a tacit classism and color-blind racism.

Part of selective regionalism was comprised of action and planned action. The primary planned action was geographic re-siting. Administrators would create a 555-bed hospital in downtown San Francisco, consolidating their services in a location more proximate to the city's wealthier and whiter neighborhoods and closing St. Luke's hospital in the city's southeast. Other elements were shifts in distribution and division of labor in the medical center's internal organization. Through these actions, administrators would maintain and expand the medical center's advantages, while disenfranchising residents in the southeastern part of the city.

Administrators justified their moves with a set of discourses. Through an efficiency discourse, administrators sought to convince the City of the efficiency of hospital consolidation, while a non-problematizing discourse cast the elimination of St. Luke's inpatient care as a reasonable course of action, seeking to convince the City that this care was unneeded and underused. These discourses drew upon administrators' credibility as medical scientists and bureaucrats, while normalizing the logic of the free market and the hospital's rational self-interest within it. A healthcare disparities discourse further acknowledged the existence of healthcare disparities in San Francisco but minimized the hospital's role in them. A discourse of civic interest sought to portray medical center administrators as good citizens who would meet needs of the city.

I suggested that in acting and speaking as they did, administrators attempted to continue racialized uneven development, while also displaying a tacit classism and color-blind racism. In attempting to build economic value, administrators shifted their organization in ways that would continue racialized uneven development. Further administrators' discourse was used to justify creating and perpetuating raced- and classed disparities in healthcare. Two aspects of this discourse – the use of scientific and bureaucratic metrics, and the promise of provision of desired social goods to displace attention – may extend Bonilla-Silva's catalog of aspects of color-blind racism. Furthermore, historical race- and class-based structuring, and present institutionalized relationships with local government, gave CPMC administrators' language a particular power. As producers of science and bureaucratic knowledge, and, as a large institution providing much in the way of services to the city, they would attempt to bend local government's ear.

These structural and discursive moves by CPMC administrators did not go unchecked, however. In the next chapter, I address how the community responded.

CHAPTER 5. SAVING ST. LUKE'S: SAN FRANCISCO'S COMMUNITY-ORIENTED RESISTANCE

Introduction

It was late on a Tuesday evening, and San Franciscans were still lining up at City Hall to voice their opinions about the proposed California Pacific Medical Center (CPMC) hospital rebuild. One after the other, community members spoke before the Board of Supervisors, representing a range of groups: contractors, electrical workers, seniors, neighbors, nurses, doctors, small business, healthcare nonprofits, and others. Those supporting CPMC administrators' vision for the rebuild, a "hub" hospital located in downtown San Francisco with "spoke" primary care campuses elsewhere in the city (see Figure 4.1, Chapter 4), sported buttons saying "Rebuild CPMC." Others, determined to increase community input into the medical center's redesign, wore buttons that urged, "Rebuild CPMC the Right Way." The meeting continued for five and a half hours as speakers expressed varied concerns:

> Based on CPMC's own numbers, their hospital project is expected to attract 1,419 new households to San Francisco, and most of them will be working class and low-income to moderate income families. So what will happen to our housing stock in the Tenderloin [neighborhood, near the planned hospital downtown]? These people will be competing for finding affordable housing in our community.
>
> We are looking at 28,000 daily additional automobile trips every day to Van Ness [Avenue] and Geary [Boulevard]. They [CPMC] propose to mitigate that by a 50 percent transit share. I am going to point out that in all of their years of operating in San Francisco, they have not reached any kind of [number] close to 50 percent transit share. The disparity between CPMC's claims [of economic hardship] and its economic windfall [in profits] highlights a sense of privilege that is the hallmark of CPMC. It is what allows CPMC as the second largest private sector employer to come before city officials for approval of this project while denying current [union-represented] employees the right to transfer to it, despite huge individual and community repercussions that would result from a loss of union jobs.

Together, community members' persistence through hours of this and other hearings revealed deep commitments to their varied interests embedded in the hospitals. These included community-centered healthcare, housing in and around the new hospital, and employment of healthcare and construction workers.

This array of actors with vested interests in the medical center speaks to literature on health social movements. Social movements are sometimes defined as "collectivities acting with some degree of organization and continuity outside of institutional or organizational channels for the purpose of challenging or defending extant authority, whether it is institutionally or culturally based, in the group, organization, society, culture, or world order of which they are a part" (Snow 2004:11). Among social movements, health social movements are understood as "collective challenges to medical policy, public health policy and politics, belief systems, research and practice which include an array of formal and informal organizations, supporters, networks of cooperation and media" (Brown and Zavestoski 2004). However, the health social movements literature largely does not address health*care* disparities (Epstein 2008). (Exceptions include healthcare disparities work of Nelson (2011) and Hoffman (2012).) Therefore, the movement around CPMC's redevelopment is of interest because it addresses less-examined topics of race- and class-based disparities.

The CPMC redevelopment also opens a window onto analysis of how social movements respond to structural racism and classism. Analyses of social movements that attend critically to race or to political economy have been less common, as Bracey (2016) and Hetland and Goodwin (2013) note (but see Moseby 2012 and Richter 2018 for analyses of race). Instead, older literature on social movements attends to the formal structuring of the state and of

movement organizations (McAdam 1982; McAdam, McCarthy, and Zald 1996). The literature therefore misses opportunities to understand movements and their targets fully. I note a few such moments: First, in focusing narrowly on the state as a target, the literature misses ways in which movements seeking racial or economic justice often focus on entities other than the state, such as healthcare organizations. Second, not only the formal structuring of the state, but also the informal discourse and practice of government officials, contribute to how the state is racialized or classed. Third, this literature misses contingencies outside the political realm that matter, such as economic events, that shape movement success. Fourth, in characterizing activist groups as entirely disempowered, it misses opportunities to describe movements of middle- and upper-class groups. Fifth, the literature is relatively a-historical, describing the structuring of the state in a fairly mechanistic way.

Since the 1980s, however, social movements literature has moved away from a primary focus on the state and toward analysis of diffuse expressions of power outside political opportunity structures, such as corporations (Armstrong and Bernstein 2008; Klawiter 2008). Armstrong and Bernstein (2008:82), for example, take a *multi-institutional politics* view of movements under which "society is composed of multiple and often contradictory institutions" that can be distinct and also can overlap and nest within each other. In this view, then, "the nature, power, logic and centrality of states... [is] historically variable and a question for empirical investigation." Culture and politics matter for the action of institutions and movements, and power is not held by the state, or by any group, after Foucault (1980). Literature has also focused on how power might be understood not as held by the state but rather as exercised from everywhere, after Foucault (Klawiter 2008; Moseby 2012).

In line with this more recent strain of work, I continue a situational analysis of action (Clarke 2005). Such analysis highlights a number of features that are less prominent in older theory but which mattered here, as listed above (i.e., the focus on a target outside the state, the informal discourse and practice of government officials, etc.). I examine how San Franciscans responded to CPMC administrators' plans for redevelopment, and shifts in the organization of the city. I argue that community groups and, to some extent, local government responded to CPMC with a *community-oriented resistance*. The logic of community-oriented resistance was heterogenous, comprised of discourse and practice of diverse groups, which together would partially contain capitalism and structural racism of existing hospital siting plans. Key to the success of this resistance were not only formal organizational structuring of social movements and government but also, importantly, the day-to-day discourse and practice of government officials, community members, and administrators – their culture. I have noted throughout the dissertation that hospitals have histories as organizations dedicated to serving the less privileged – and while this meaning of hospitals has been racialized, it remained in some form. I will suggest that this discourse – of hospitals' meaning as this sort of site – is still circulating, and in the end, it mattered, especially when the community was confronted with the financialized and racialized culture and action of CPMC administrators.

To make this argument, I first highlight shifts in historical conditions of action supporting community groups and hospital administrators, suggesting that these processes were racialized and classed. Specifically, past organizing meant government was to some extent structured in ways that diverse movement groups could use to their advantage. However, groups representing wealthy, white groups, like CPMC, still exerted disproportionate influence over government and in business.

I then argue that based on these conditions the community responded with a widespread and heterogenous community-oriented resistance, mobilizing to protect healthcare, housing and land use. This reflected the race- and class-based identities of participants, and gains that various groups had achieved in the structuring of their own organizations and in government. I describe how these are displayed in the discourse of community.

In the final section, I discuss how community-oriented resistance was contingently shaped. Tracing the development of the conflict, I outline the strategies of community groups, the interpretation of government actors, the informal discourse and practice of government and healthcare, and the continued discourse around who hospitals were supposed to serve.

Historical Processes Supporting Community Groups and CPMC Administrators

Historical raced and classed conditions unevenly supported community groups and CPMC. These conditions included the continued strength of the mayor's office, diversification of San Francisco's Board of Supervisors to include more people of color and representatives of low-income groups, limited democratization of local government related to urban planning and healthcare, and the growth of multiple advocacy organizations. Furthermore, key changes were outside the state, in the shape of healthcare itself, including the growth of unions and the growing corporatization of care as described in chapters 3 and 4. This historical structuring of government and institutions left the balance of power in the hands of parts of government and in organizations controlled by white and wealthy interests.

With a "strong mayor" form of government, the mayor's office had broad authority to shape the city's budget, to appoint heads of the executive branch of local government and to veto legislation passed by the Board of Supervisors. Given the city's past, the office was typically

concerned with increasing tax revenues through real estate development, a priority that privileged white and wealthy San Franciscans. The structuring of the mayor's office thus had some ability to contain the voice neighborhoods had through their locally elected supervisors, continuing the racialized character of decisions that were less responsive to San Franciscans who were low-income or people of color.

Meanwhile, advocacy to make the city's Board of Supervisors more responsive to neighborhoods gave neighborhood groups more power and legitimated resident discourses advocating for neighborhoods' rights. In the late 1970s community groups had fought for legislation that would enable them to elect city supervisors by local electoral districts. Previously, supervisors had been elected from the city as a whole, and supervisors tended to be elected if they were supported by white, wealthier voters. Passed in 1976, overturned in 1980, and re-instated in 1996, this legislation meant that supervisors became accountable to the neighborhoods they represented. Supervisors also became more representative of San Francisco's diverse constituencies, espousing more of the range of San Franciscans' views, with perspectives that varied by class and race and that were marked by past racialized uneven development of the city. Neighbors' heightened power to vote out supervisors meant that residents knew that they could speak in front of city government and expect to have their concerns about their neighborhoods taken seriously.

Activism yielded changes in the executive branch, as activist groups ensured that the city's Planning Department became more responsive to community concerns. For example, activism led to creation of the City's Planning Commission, a board that oversaw the work of the Planning Department and included some non-elected resident oversight. The Planning Commission included seven members, four nominated by the mayor and three nominated by the

president of the Board of Supervisors. Later, housing activists advocated for new legislation for hospitals and educational organizations. As described in Chapter 3, this legislation required educational and healthcare organizations to file institutional master plans with the department every two years, giving community groups warning to plan and respond in the face of hospital changes. It did not, however, require healthcare planning, allowing hospitals to do as they wished; thus, this legislation continued to tacitly support the racialized uneven development of hospitals.

At the same time, healthcare advocates had slowly incorporated a few new structures into city government to give the community more voice in local health care planning. For example, in the early 1980s health care activists, realizing that the city Department of Public Health's budget was typically allocated by the city's Chief Administrator without community oversight, won creation of a Health Commission. The Health Commission, which included elected members from the community and members appointed by the mayor, then gave the community input into City decision-making about the department's work. In the 1990s, passage of a proposition to inform city government about planned hospital service closure, known as Proposition Q, gave the City a mechanism to surveil and interact with local hospitals in the event of hospital services changes. None of these mechanisms gave the City and community control over local hospitals, but they did give the City means to monitor and to warn hospitals, and to plan for shifts in services.

Apart from changes in government, over time San Francisco had grown a dense set of advocacy organizations dedicated to lobbying local government, including groups representing varied races and classes of residents. Prominent among these were the neighborhood housing advocacy groups, which developed large organizations and effected shifts in regulations of the

city's Planning Department. These groups had been active in the city since at least as early as the 1950s when they fought the placement of freeways; they also responded to the devastation of the Fillmore in the 1960s, and continued their advocacy in the following decades. The largest of the housing organizations taking part in the action around CPMC's redevelopment was the city's Council of Community Housing Organizations (CCHO), which joined the organizing since many of its member organizations were already involved. The CCHO was to be a powerful influence – a long-term player in city politics supporting affordable housing, the CCHO had created significant shifts in local housing policy over time. For example, its advocacy led to the City's implementation of the local Jobs Housing Linkage Fee, a fee that real estate developers pay to offset the production of real estate with production of affordable housing.

Community structuring also included labor unions. San Francisco had a long history as a union town, and this meant that unions supported supervisors and mayors in elections and were in turn valued by them. Historically, there was an alliance between construction unions and developers, fueled by the desire for construction jobs that development would bring (Hartman 2002: 34). However, as discussed in Chapter 3, in response to neoliberal shifts in healthcare, healthcare unions had become larger in recent decades, and this meant that the unions that would counter hospital developers (and construction unions) had sway not only with hospitals but also with city government.

Perhaps most important, healthcare had changed. As noted above, CPMC had in recent years adopted a selective regionalism, a new neoliberal and financialized orientation toward San Franciscans and their health. Selective regionalism involved practices of consolidating and re-siting CPMC's hospitals so that more services would be located in a wealthier, and, as the previous chapters have argued, not coincidentally whiter part of the city. Selective regionalism

also involved producing colorblind discourse that legitimated this practice. Together, the practice and discourse of selective regionalism made for a new, corporatized medicine that was oriented not only toward care but also toward profitability, and in a way that stood to continue past structural racism and classism in the city's healthcare. Moreover, over time CPMC had grown to stretch across the city. By the mid-2000s, it was one of the largest employers in the city and served many residents, delivering, for example, a third of the babies.

Finally, economic shifts in the city would condition rising activism. The city was increasingly gentrified. Rent had become some of the most expensive in the country, leading poor San Franciscans, many of whom were people of color, increasingly to leave. The welfare state also had contracted, and business had shifted, with union jobs leaving. The city had had financial troubles for some time due to welfare state retrenchment as California government had cut funds and pushed responsibilities for social welfare provision to counties. Poorer San Franciscans were in a more precarious state vis-à-vis their healthcare options than they had been in decades. CPMC thus posed a threat not only to healthcare but also to housing, as its new siting would potentially influence the availability of affordable housing and it would likely drive gentrification of the area.

In all, these shifts represented uneven changes in the shape of the city, its government and its hospitals. Over time, activists had created avenues for protest within government in the form of political structures such as elected seats and legislation, legitimating certain discourses. Government became in some ways more responsive to residents, and thus able to address racialized and class-based structuring. Outside of government, advocacy organizations included the skills and resources to support their work on neighborhood issues. And extra-governmental shifts in healthcare and in the economic shaping of the city had created unique pressures that

would inform the movement. However, these structures also continued government leanings toward developers and other elites with significant lobby power, whose work would privilege wealthy and often white San Franciscans.

San Franciscans' Response – Community-Oriented Resistance

As noted in the previous chapter, when CPMC administrators proposed a master plan for a new hospital that would remove St. Luke's inpatient services, the community responded in protest. I argue that this was a *community-oriented resistance*. As many groups were disenfranchised, over time they banded together to advocate for healthcare, housing and employment. They attacked the growing dominance of CPMC, which they saw as a nonprofit in name only. This resistance was driven by racialized and class-based identities that groups had developed over time. It was also driven by ongoing, contingent strategy aimed not only at government but also directly at CPMC. Below, I describe identity of organizations as expressed in discourse. I then describe the remainder of the action in the negotiations with CPMC.

Race and Class-Based Discourses of Community and Labor

As noted above, the Board of Supervisors and other City governing bodies held hearings for presentations and arguments about administrators' proposed hospital siting. In these hearings, community groups and healthcare labor unions countered CPMC's discourses (explored in the last chapter) with their own. Arguably these discourses were made available by the historical conditions described in the last section. This process might be described as a spillover, which Meyer and Whittier (1994) define as the effect of one social movement on another, later movement through a diffusion of "ideas, tactics, style, participants …[or]

organization" (277). One such type of spillover occurs as social movements create political structuring that is responsive to them. I will describe the language primarily used, which included discourses from community groups of *neighborhood identity* (of *the family of St. Luke's*, *the "special nature" of Cathedral Hill*, and *the need for citywide health planning*), discourses from healthcare labor unions of *CPMC as unfair employer* and *uncaring civic actor*, and discourses from all groups of *CPMC as equivocal*. For all of these groups, discourses are ways of claiming rights to place, and to the organizations in it, and to basic other rights that varied by group.

Discourses of Neighborhood Identity: The Family of St. Luke's, Cathedral Hill's Special Nature, and Citywide Health Planning. As noted above, past community advocacy to ensure neighborhood representation on the Board of Supervisors meant that neighborhoods could demand that supervisors listen to their claims and expect a response, enabling diverse races and classes of residents to be heard. In line with this history, groups produced discourse on the basis of *neighborhood identity* that varied by race and class of neighborhood, including one on *the family of St. Luke's* and another on *Cathedral Hill's special nature*. Neighbors also leveraged their identity as neighbors to call for *citywide health planning*.

In neighborhoods south of Market Street, groups urged supervisors to preserve the culturally safe access to care that St. Luke's had historically provided for surrounding neighborhoods' low-income residents, many of whom were people of color. Near the proposed Cathedral Hill campus to the north, some neighbors' concerns were oriented toward the aesthetics of the neighborhood, while others were concerned about the potential loss of affordable housing with the building of the new hospital. One would think that these groups,

having such different interests, would not collaborate. However, together they espoused a shared interest in citywide health equity, arguing that CPMC leaders were not interested in such equity.

In the south, community members recognized the role St. Luke's played as the neighborhood hospital. Some individuals emphasized the lack of alternative services and the possible consequences of St. Luke's closure:

> My mom who lives in District 9[22], close to St. Luke's, had to be taken to emergency and luckily she lived so close that her life was saved. Currently she lives with me and I live in District 11, and I'm sorry that my supervisor isn't here so that he can hear firsthand what … what would be happening if St. Luke's closes to us as members, or people that live in District 11. My mom, if anything were to happen, if there is no St. Luke's, I'd hate to think…what would happen. Sorry if I get emotional. St. Luke's and San Francisco General Hospital are the only hospitals that are there, that would definitely make an impact on both District 9, 10, and 11. By closing St. Luke's… it would just be devastating to us. All of the hospitals seem to be on the north side… the majority of them are actually in District 2 [in the city's northeast]. …I had the opportunity to talk to a paramedic, who told me that by closing St. Luke's there are no guarantees. When you have to take someone from one district to another, you look at traffic and they're limited as to what they can do to keep someone alive or provide medical attention. So this would be a detriment. I surely wouldn't want to see anyone lose their life as a result of having to go across town, in traffic, to deal with. I really would like to ask that the Board of Supervisors must make a community benefit agreement, CPMC must work with the group of stakeholders in the community. A planning proposal healthier infrastructure, to get a hospital where we need it to be. We do pay a price. Patients pay a price and the price is our lives.

Residents valued St. Luke's in part because it met a desire for healthcare. Without the hospital, this resident argued, many residents would not have care near enough to their homes to be useful. Further, this was not just any need, but a basic one – residents argued on the basis of their embodied sense that their lives were at stake.

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[22] District 9 is a San Francisco electoral district including neighborhoods in southern San Francisco, as are Districts 10 and 11. District 2 is in the northeast.

But St. Luke's was not seen as a generic site for care and valuable only for its proximity; rather, it had a history of meeting the needs of low-income residents and people of color, especially those residing in the city's southern neighborhoods. A community organizer working in the Mission, the neighborhood where St. Luke's was located, elaborated:

> … we had one of our members give birth at St. Luke's, an undocumented immigrant from Mexico, working two jobs, was not being provided minimum wage from her employer, and her only choice was to go to St. Luke's to have her beautiful baby boy there. There's so many people in that same position who are underserved, don't have access to health care. We need a hospital that will cater to these folks in the Mission.

So important was St. Luke's to meeting local needs that many community members said it was integral to the identity of the Mission and San Francisco's other southeastern neighborhoods. They described the hospital as culturally safe, where Black, Latino, Filipino and other patients of color could be seen by staff from their own racial and ethnic backgrounds, who spoke patients' languages and were attuned to their concerns. As one provider put it,

> St. Luke's plays an important part of the people in the Mission and my patients are afraid to look [Inaudible] for medical needs…Here they are accepted and feel at home. … They have a health care provider and a safe place to rely on... And I implore to you keep open St. Luke's and help us to continue service to the community.

This feeling of safety and welcome meant St. Luke's was itself a community within the community, reflecting their own backgrounds, to the point that some called it "family."

Meanwhile, community groups serving neighborhoods north of Market Street, especially the Cathedral Hill neighborhood, had very different concerns about the impact of the new mega-hospital in their midst. Like the neighbors to the south, these groups made claims about neighborhood identity. However, while groups to the south expressed identity in terms of an embodied sense of need for care, northern groups were more concerned about aesthetics, or what they called "Cathedral Hill's special nature." A resident commented,

> I am concerned about noise disrupting the relative serenity of Cathedral Hill. If this proposal comes back to you, I urge you to impose special conditions and require the developer to adhere to a neighborhood-wide disruption avoidance plan. Construction noise should be prohibited after 8 p.m. With no exceptions from the building office, and any time on Sundays and during special occasions, and special events in the Cathedral Hill sanctuaries, such as weddings or funerals. The disruption avoidance plan should require posting of construction hours, posting of a phone number to call with complaints or requests to accommodate special events, communicating and cooperating with neighbors when scheduling exceptional disruptive work. The long-term disruption to the ambience of Cathedral Hill will be 24 hours a day forever, including sirens, delivery, waste removal, and lots of vehicles. Special conditions of approval should restrict times for deliveries and waste removals. We urge you, supervisors, to please respect Cathedral Hill's special nature. (emphasis added)

Neighbors expressed apprehension about possible traffic impacts; damage to existing buildings, especially a historic church; and changes in the view and shadows after the 555-bed, 15-story Cathedral Hill hospital would be built. Given these possible problems, some residents of Cathedral Hill and the neighborhoods around argued that there should be no hospital nearby or it should be reduced in size.

Other neighbors to the north also were concerned about impacts that CPMC's building would have on the local supply of affordable housing.

> I am a senior citizen and my sole support is from social security. I am a patient at the San Francisco V.A. Medical Center and it is important for me that I not leave the city. Since the meeting at the Cathedral Hill Hotel in August of this year notifying us that they want us to move, I have been looking around for senior housing and low-income housing. Each time I contact a housing complex I am told that not only do they no longer have any vacancies but that their waiting list is full and that they are no longer adding people to the list. In fact, if I were on the waiting list, it may be up to five years before I'd be able to have …an apartment. I talked to … the manager at the new apartments at the corner of Geary and Pope and he told me all of the units are filled and that 2,500 people are on his wait list and it is closed. Because it is so difficult to find housing for those with low income, I think it is essential that we are able to stay where we are until we are able to find another apartment even if that means that it May take up to five years. Another suggestion would be to have the hospital include housing in the new construction for those of us tenants who are being evicted.

For these neighbors, claims revolved around meeting basic needs, needs that hospital could threaten by occupying space that could otherwise be so used.

A third discourse of neighbors was one calling for *citywide health planning*. Under this discourse, even in early hearings, community members expressed a desire for equitable distribution of sites, so that there would be adequate access to care throughout the city. One Cathedral Hill resident argued, "We feel the city and county will best be served by commencing and instituting an acute care master plan. Having geographical medical equity for acute care throughout the city or the [city's] planning quadrants is something to be desired, more so than a concentration of facilities in a few areas." An argument for health equity would address both sets of participants' needs: downsizing or eliminating the Cathedral Hill Hospital and expanding St. Luke's Hospital would reduce aesthetic impacts on Cathedral Hill while preserving health care south of Market.

Residents' calls for health planning also highlighted CPMC's role in creating and addressing those health needs as residents argued that CPMC was engaging in redlining. Community members and their supporters argued that Sutter was systematically siting its operations to ensure that it primarily served the wealthiest neighborhoods in San Francisco. As one hearing attendee said,

> …redlining as a question and really, it's a matter of common sense… and apparent as racial segregation in the city and doesn't require more study. …we take the information that hospitals and healthcare providers provide the state by law on their population census by hospital. Let's look at what Sutter reported to the state about who they serve, just make clear the common sense of this medical redlining is in fact true.
>
> Who does St. Luke's ER serve? Sutter's numbers show that 54 percent of ER visits at St. Luke's are made by African Americans or Hispanic residents. Compare that to CPMC, it's eight percent. …Finally, is St. Luke's as community-based hospital? You bet it is. Our analysis of the data shows that the zip codes that produced most of the patients for St. Luke's are only three adjacent to the hospital. Look at CPMC, 50 percent or more come from 22 zip codes – much more broadly served.

Notably, these 22 zip codes included many that were white and wealthy and outside of San Francisco, while the demographics of the zip code in which St. Luke's was located was 46 percent Latino and 12 percent Asian (U.S. Census Bureau 2000). In the language of social movements research, this was an argument aimed at discrediting CPMC to reduce the "resonance" of its claims – that is, to reduce the effectiveness of a groups claims on the group at which they are aimed (Benford and Snow 2000). As noted in Chapter 3, CPMC administrators had made claims that they were acting as a civic benefactor by providing healthcare to many city residents. A charge of redlining effectively countered this claim. Moreover, this critique of CPMC was built atop neighbors' claims about rights conferred on the basis of their identity – they wanted to emphasize that what would be best for their neighborhoods would be equitably distributed healthcare.

Healthcare Union Discourses: CPMC as Unfair Employer and Uncaring Civic Actor. While neighborhood groups argued that CPMC leaders acted in poor faith toward the communities in which the organization was situated, healthcare unions, including the Service Employees International Union (SEIU) (and, later, the National Union of Healthcare Workers, which branched off from SEIU), and the California Nurses Association (CNA), argued that CPMC administration treated its own employees badly, which contributed to poor care for patients. In so doing they made arguments on the basis of their own identity as workers and on the basis of the identity of the hospital as part of the local community.

First, some union members argued that the CPMC/St. Luke's rebuild was in many ways about fairness toward employees. Union members called hospital administrators "union busters" who "don't care about the community or their employees," as one hearing attendee put it. At St. Luke's, one nurse said, "We are the lowest paid and have the worst benefits of all of the CPMC

hospitals. People like to work here but we have trouble retaining doctors and nurses." In this discourse union members argued, among other things, that CPMC failed to meet workers' needs across a range of issues as administrators cut jobs at St. Luke's, underpaid St. Luke's staff relative to employees at other CPMC campuses, and refused to allow union representation at the new Cathedral Hill campus.

Other union members drew upon their hospitals' identity as part of the community, arguing that CPMC's anti-union stance was uncaring toward patients. A nurse at CPMC pointed out that the nurse-to-patient staffing ratio in her unit was too low:

> We, in the post-acute [setting], do not have the ratio laws that acute care has. Our patients do not benefit from those [staff to patient] ratio laws. We are under the same auspices as a nursing home. We've been …[working] to achieve better ratios through the California Nurses Association. We now have on the day shift, five, to seven patients per RN. Our colleague RNs on the Davies and St. Luke's campuses [of CPMC], they have eight, nine on the day shift. They want patients to benefit from the RN patient ratios. CPMC will not meet with us for a single contract with the Davies or St. Luke's campus and we want that very much.

A Ubiquitous Discourse: CPMC as Equivocal

Beyond the substantive points community and union members presented to help supervisors understand and address community needs and identities, these individuals repeatedly argued for supervisors to attend to issues of procedural justice – that CPMC and Sutter administrators were, in community members' view, underhanded and did not have the community's interests at heart. I call this a discourse of *CPMC as equivocator*. Administrators were obscuring their true plans, community members said, and they would get out of their implied promises.

For example, community members said that CPMC administrators were attempting to make St. Luke's fail as a hospital. As noted above, Sutter began to remove CPMC's services

starting in 2005, CPMC administrators continued this process despite pressure from the community and City government, who said that the removal would negatively affect the community. This removal of services, one community member observed, seemed to be a form of "ratcheting": it would mean fewer patients could be served at the hospital, which would lead CPMC to remove more services. Furthermore, community members argued, to lower St. Luke's revenues CPMC administrators were refusing to collect bills from St. Luke's patients and pushing surgeons to do their surgeries at other campuses. Then, to cover up these processes, administrators' metrics, were manufactured to misrepresent St. Luke's patient population as lower than it was and to hide how CPMC administrators' action had led to that situation.

Most important, community organizations argued that CPMC administrators used St. Luke's as a bargaining chip. That is, they argued that administrators took on the campus to make the community believe that it had the community's best interests at heart and then to use the goodwill built on this relationship to pave the way to securing the Cathedral Hill campus. Meanwhile, CPMC would take the better-insured patients from St. Luke's, "creaming" them, in the language of the hospital industry, and dropping the rest when they shuttered the hospital. A union representative argued,

> When St. Luke's was bought in 2001, did they know that that Sutter corporate that it has this losing picture in front of it? Of course they did. It was acquired to obtain market share of covered lives – insured participants in health plans. When St. Luke's is out of the picture, the former owners of St. Luke's won't have that piece of the market or the ability to offer services in a health plan to help plan participants. Not everybody in southeast San Francisco is uninsured. Quite a few working people are insured. Their health plans direct them to Sutter Health facilities. They have captured that market but they do not want to pay the price of the expense of that particular market segment and as compared to a healthy population that is going to a hospital where there's not very many low-income uninsured consumers, St. Luke's is more expensive. Prove that. That does not justify purchasing it to plunder market and close it to evoke the community harm. This area is defined as medically underserved area and has been for years. It's a defined market. So in 2001 what was their intention? When in 2005 they affiliated St.

> Luke's directly within the licensed scope of, CPMC what was their intention? All along it was to shut down St. Luke's. Never having given you notice. Never.

In short, some community members decried Sutter as a "ruthless corporate health care predator" with no real interest in serving the neighborhoods south of Market.

As evidence for these claims, and as a warning to San Franciscans, community members invoked the experience of communities elsewhere. They argued that at Summit Hospital in Oakland, Eden in the East Bay, and Marin General, Sutter had used hospitals as profit centers rather than attend to community needs. For example, at Sutter Santa Rosa, a hospital north of San Francisco that some saw as "St. Luke's shadow" for its large number of under-insured patients, Sutter leased the hospital from the county with a 20-year contract to keep the hospital open. However, Sutter included a clause in its contract enabling it to sell the hospital if a large enough competitor could be found, and it did so, with the result that the city's capacity to care for the uninsured dropped. Such machinations in contracts were routine, community members argued, and the City should be wary of making one with Sutter.

Building Community-oriented Resistance

In the last chapter, I described how CPMC administrators' initial plan and early moves in consolidating their hospitals effected a selective regionalism in health care. This action constituted Phase One in the CPMC conflict. In the remainder of this chapter, I pick up the story with Phases Two through Four of the conflict's trajectory. I argue that, in line with the raced and classed historical structuring of Sutter/CPMC, social movement organizations and local government, those different groups took different lines of action. That is, local government was fractured along different lines, with the mayor's office offering somewhat more support to hospital administrators (representing white, wealthy groups), and supervisors split between

development and community interests. At the same time, CPMC administrators initially pursued selective regionalism with little concern for community demands. However, social movement organizations and some parts of local government's community-oriented resistance involved action to protect land use, employment and healthcare. This activism eventually constrained CPMC somewhat. This latter action, especially of government, was shaped by contingent events, ongoing informal practice and discourse, and by shifts in actors' action and interpretation over time. These are, as noted above, features of action that are less commonly accounted for in older social movements literature, and they speak to ways in which race and class mattered.

Phase Two. Standoff: Signaling, Economic Pressuring, and Non-Response, c. 2005-2007

Phase Two involved actions by government and community groups enabled by past conditions. Community representation in local government meant limited democratization, which was expressed in local government policy language and pronouncements. Past structuring of unions enabled the community to preserve rights to work at CPMC by threatening and carrying out union strikes. However, perhaps because of the raced and classed advantage CPMC administrators enjoyed, these actions did not produce a desired response, resulting in a standoff, with CPMC administrators continuing their plan to close St. Luke's. Furthermore, historical action by the community to democratize government did not create a uniform response – as noted above, representatives of different neighborhoods pursued varied interests according to their relationship to racialized uneven development.

The community groups' previous inroads into city government led to the inclusion of community members who represented their constituents. This spillover (Meyer and Whittier 1994) – which, as noted above, is the effect of one social movement on another movement –

produced some action by government on behalf of community constituents. For example, during this period government officials signaled to CPMC to act in the community's broader interests and drafted new legislation to monitor hospitals. In 2005, the Health Commission passed Resolution 17-05, acknowledging the planned merger of CPMC and St. Luke's, and encouraging CPMC to restore mental health services that the medical center had removed, noting that the loss of those services would particularly impact southeastern San Francisco. The Commission also recognized CPMC's commitment to revitalize St. Luke's and encouraged CPMC to engage in a public process related to any proposed changes. Meanwhile, the supervisor from District 10 (composed of the southern neighborhoods of Bayview Hunters Point, Excelsior, Crocker Amazon, Visitacion Valley, Outer Mission and Portola) began the process of creating new legislation for hospital institutional master plans. Under this new ordinance, the Health Commission would review institutional master plans for their health impact and would create a report before the plans were passed on to the Planning Commission. In both cases, however, government's actions would not have "teeth" – government would not actually be able to force CPMC's hand on the basis of any of this work. Thus, the Health Commission's action represented authority that was in this case symbolic, and supervisorial action suggested both the influence of community forces and (possibly) restraint in the face of local development.

In addition to political action enabled by past community organizing, the past structuring of San Francisco's wealth of community activist organizations enabled activists to signal their interests to the government, the broader public and directly to CPMC. For example, the labor unions' structuring enabled strikes. At the Service Employees International Union (SEIU-UHW), this included a membership of 800 at three CPMC sites, as well as nationwide support by the union for the local strike fund until the strike was settled. As a result, for 60 days in 2005, SEIU

workers struck at three CPMC sites. Similarly, nurses in the California Nurses Association (CNA) struck in late 2007, in concert with more than 5,000 CNA nurses striking at 13 hospitals across northern California. These actions economically pressured CPMC and communicated workers' experience to the broader public.

Furthermore, community inroads into local government meant that supervisors pursued conflicting agendas according to their neighborhood affiliations. In 2007, members of the Board of Supervisors undertook two sets of actions in a split between conservative and progressive members. On one hand, a supervisor from a historically poor neighborhood home to residents of color proposed asking the City Attorney to look into a redlining suit against CPMC. On the other hand, the supervisor for the city electoral district where CPMC's current main campus was located, and where its new hub campus would be located, together with the Director of the Department of Public Health and CPMC, proposed a "Blue Ribbon Panel" of local leaders and experts to be convened by CPMC and to give input to the fate of St. Luke's. A somewhat heated discussion before the Board of Supervisors followed about whether the proposed panel was political grandstanding aimed at heading off the redlining suit. Eventually, a majority of the Board voted to go ahead with asking the City Attorney to look into the possibility of legal action while also allowing the panel to move forward.

Despite these actions, in 2007 CPMC administrators continued to enact selective regionalism, closing service units at St. Luke's, and finally letting it be known that they planned to close the hospital's acute care hospital services in 2009 (SFGH JCC meeting minutes, Nov. 14, 2007). This situation points to the continuing importance of CPMC's raced and classed advantage – without, for example, regulations to require equity in hospital siting, hospital administrators were able to pursue other ends.

Phase Three. Asymmetrical Engagement: Responding to Community, Building Coalitions and Engaging in Circumspect Negotiation, Late 2007 – Mid-2012

The standoff over CPMC administrators' initial plan ended when the mayor met privately with the chief executive of CPMC, announcing afterward that St. Luke's must be saved and remain in operation as an acute care hospital. As described below, this change was contingent – it was perhaps occasioned by neoliberal welfare state retrenchment. In any case, the mayor's interpretation of the situation clearly shaped how action unfolded. After this decision, administrators, government and community organizations' orientation toward the situation varied. Community groups advocated for rights for housing, health care and jobs; different parts of local government sometimes supported movement organizations and sometimes did not; and CPMC administrators made some concessions. Again, perhaps because of their advantage in this situation, hospital administrators remained circumspect, expressing openness but, in community members' view, refusing to engage in negotiation. At the same time, supervisors took action to rein in CPMC administrators, continuing to employ strategies of pronouncement and surveillance. However, as in Phase 2 described above, they did not require CPMC administrators to act. Meanwhile, community groups began to coalesce, forming a coalition powerful enough to demand direct negotiation with CPMC.

Mayoral Responsiveness to Community. Neoliberal welfare state funding shifts at the California state level and the mayor's interpretation of the situation influenced what happened next. In a new turn of events, in 2008 the mayor said St. Luke's must be saved:

> [T]here is unanimity – …[St. Luke's Hospital] is fundamental to the success of our health care delivery system – that is why it is so critical that you [community leaders] come up with a solution to the problem of how we can maintain our acute care services in particular at …[St Luke's]. You know all of the facts about how critical it is to have south of Market support for that system. Even with the rebuild [of San Francisco General Hospital], …it will not substantially increase the number of beds, and will not

> be able to absorb the closure of …[St. Luke's]. So it simply cannot happen, and I have come to accept that. It will not happen, it cannot happen. We have to accept that it will remain open, and acute care will be preserved and enhanced.
> (Blue Ribbon Committee meeting notes, April 16, 2008)

This shift in the mayor's interpretation was perhaps due to neoliberal cuts in state funding for social welfare programs as noted previously. In accordance with California state law San Francisco had become, like other counties, the hospital care provider of last resort for patients on Medicaid. This placed increasing strain on the City and County's hospital, San Francisco General, the other hospital located in southern San Francisco. If St. Luke's closed, the General would not be able to take care of the low-income patients who would need its care. Further, San Francisco had experienced a rising number of uninsured residents (SF Mayor 1998: 1), with the number climbing to 17 percent of the population by 1998 (p. 15), and including approximately half of these seeking care at the General. Uninsurance was concentrated partly in neighborhoods south of Market St., and what to do about it had become the subject of local government discussion, as the City became increasingly concerned about the quality and availability of care for poor patients.

It is also possible, however, that the mayor's pronouncement was less a result of state government pressure and more due to a desire to "do the right thing," as a government representative put it. Long-known for its progressive politics, San Francisco's government believed in providing healthcare to all its residents. At the time of the activism around the CPMC rebuild, for example, the city was in the midst of implementing a new "Healthy San Francisco" program that would provide access to basic medical care for all San Franciscans, whether they were insured or not. The mayor's progressivism could also have been inflected by a certain level of pragmatism about how the process would unfold: because the public would give input in the

land use permitting process for CPMC, it would likely have been politically impossible for CPMC to move forward without keeping St. Luke's hospital open.

Whatever its motivation, the mayor's pronouncement marked an inflection point in the recent history of public welfare in the city. As noted throughout this dissertation, in San Francisco as elsewhere, hospitals had a culture and reputation as institutions dedicated to public welfare. Local government relied upon local hospitals to continue this tradition, and it supported them in this effort through tax breaks. When the mayor stated that inpatient care must continue at St. Luke's, he articulated the city's continuing reliance on this private system. However, due to CPMC's previously described history, this moment also differed from the past when the government had articulated reliance upon nonprofit hospitals. The medical center, which had grown to be one of the largest providers of health care in San Francisco, did not have a practice of providing extensive charitable care; rather, it was known as a site of care for wealthy, white patients. Relying on CPMC, but failing to strengthen provisions to ensure the requirements for charity care were met could mean in effect that the City was abandoning its commitment to charitable services provision. Indeed, as discussed below, the uneven penetration of neoliberal ideology into local government meant that the mayor would adopt an apparently open position, saying that St. Luke's should be saved but not attempting to dictate a structure under which this *would* happen. [23]

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[23] Such a moment is also problematic to describe in traditional social movements theory. In such theory, social movement action is conditioned on political opportunity structures – the formal structuring of the state (McAdam et al. 1996) -- and welfare state retrenchment does not fit neatly into this "contentious

Circumspect Negotiation. In the wake of the mayor's pronouncement that St. Luke's must be saved, CPMC administrators shifted their business practice with the community from their earlier pure market orientation to a stance of circumspect negotiation. That is, administrators solicited community input; however, they were not forthright about what they would in fact do on the basis of this input, and they continued to orient to negotiations in a manner consistent with profit-seeking. An example of administrators' apparent surface openness was the Blue Ribbon Panel, a series of meetings that administrators organized to solicit community input. In the first half of 2008, the panel met approximately six times. The meetings ostensibly were held to determine what the new St. Luke's services would look like, and they were to be inclusive in design. The community representation was broad, including physicians and staff at St. Luke's; members of neighborhood and community activist groups; unions, local foundations, hospitals and local government. Individuals and groups came from diverse racial and socioeconomic groups. And, in addition to the full panel's meetings, a Community Outreach Task Force interviewed 20 stakeholder and neighborhood organizations and held public discussions in Bayview/Hunter's Point and the Excelsior and Mission neighborhoods in southeastern San Francisco, meeting with more than 500 people.

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politics" theorization about what those structures are. Furthermore, the ambiguity of the mayor's position and analysis of possible interpretations of the situation is also difficult to describe in political process theory, in which analysis is more apt to rely upon more or less stable structures. A situational analysis faces no such limitations, and in fact is best suited to describing such states where a variety of conditions of actions – and interpretations of their effects -- pertain.

Despite its impressive roster of attendees and named purpose, the Blue Ribbon Panel's outcomes might be characterized as ambiguous. Some outcomes seemed positive: recommendations offered by the Panel promised some structuring of the new hospitals that would include community input, with a resolution in support from the Health Commission and acceptance by CPMC's board. These recommendations included, among other things, that St. Luke's be rebuilt and "fully integrated" into CPMC's broader service system, with services to meet "the greatest need of the surrounding community," that existing workers be employed at the new hospital, and that new services be added which would improve the hospital's financial situation. However, the panel was described by some as "a face-saving device" for the decision that had already been made to keep St. Luke's alive (Prentice 2011). Further, the Panel's power was limited as it was told not to enumerate how many beds the hospital should have, and CPMC leadership was not required to act on Panel recommendations. Thus, the meetings appeared to achieve openness but did not create a binding structure for rebuilding St. Luke's. Like administrators' obscure discourse described in Chapter 4, this orientation toward St. Luke's is suggestive of the advantage that CPMC administrators enjoyed, which enabled the hospital not to take a firm stance.

Creating Legislation. Meanwhile, supervisorial action continued to be not merely restrained but ambiguous. For example, one supervisor acted initially to promote citywide equity in healthcare planning and acted later out of other interests. This supervisor, representing the electoral district in which St. Luke's was located, proposed Health Care Master Plan legislation that was passed in 2010 after about seven months of work. All new health care uses in the city of 10,000 square feet or more, as well as expansions of existing medical uses of 5,000 feet or more, required approval by the Planning Commission and Health Commission for compliance with the

plan. This plan would potentially affect the rebuilding of many of the hospitals in San Francisco that were slated to occur. However, in a surprise move, the sponsoring supervisor proposed exemption of current hospital projects from the legislation, arguing that unions were concerned about earthquakes. Others surmise that he was motivated to fold by construction unions, who long supported development, so as to keep those votes in their next election. The legislation was passed on November 16, with eight supervisors for and three against, and was not signed by the mayor (meaning that the mayor passively dissented, but the legislation went into effect).

Community Activist Organizing: Coalition Building and Consciousness-Raising. Activist organizations responded by building coalitions and continuing to push for protections on land use, health care equity and employment. This action was in line with San Francisco's rich activist history, in which community organizing was common across many varied groups of different races and classes.[24] In addition, the size and diversity of the coalition was perhaps unique to the neoliberal era, occasioned as it was by Sutter/CPMC's expansion across much of the city and its impact not only on typically disenfranchised groups, but also on wealthier groups, and not only on healthcare but also on housing and employment. Older social movements literature typically theorizes that movements are made entirely of groups that are outside power structures. However, this heterogenous coalition emerged from a sense of disenfranchisement

[24] Such alliances are not well-described in the older social movements literature, however, as it typically theorizes social movements to be made entirely of groups located outside of power structures. Here, however, many groups were disenfranchised, including doctors, nurses and other healthcare workers who organized on behalf of their patients. Such boundary-blurring is perhaps better described with situational analysis.

shared by many groups, as well as by allies such as doctors, nurses, and other healthcare workers who organized partly on behalf of their patients. It also likely emerged from past action of movements. In early organizing there had not been union-community partnerships. In this era, however, groups learned from the past, and ensure there was a community-labor alliance.

Initially, these groups organized independently, forming three main coalitions. In the Mission, Save St. Luke's, a group including staff of St. Luke's and others, was born to protect the hospital from closure. In the north, the Good Neighbor Coalition was created by the Tenderloin Neighborhood Development Corporation, along with other organizations serving the Tenderloin and neighboring areas, to ensure CPMC's support of their neighborhoods. A third coalition was formed through the local affiliate of Jobs with Justice, a labor advocacy group. Over time, these coalitions finally merged into a larger coalition, San Franciscans for Healthcare, Housing, Jobs and Justice.

As a result of the history and strength of their organizing, the groups managed an array of actions aimed not only at government but also directly at CPMC. For example, the Good Neighbor Coalition undertook multiple community information-gathering events, surveying more than 700 people in five languages on the CPMC project and then organizing a Citywide Healthcare Summit at a local church, in which approximately 120 individuals participated (Welch 2013). Coalition members also contacted supervisors to inform and persuade supervisors and other government officials, and CCHO members and UC Hastings Community Economic Development Clinic staff met with City Planning staff to advise them.

Coalition and Mayoral Negotiation with CPMC. In time, community groups' coalition-building emergently yielded a qualitative shift in the type of power that they could exert in the negotiations. Initially, advocacy started with unions and neighborhood groups organizing around

the proposed Cathedral Hill campus and St. Luke's, with some collaboration, but no overarching coalition. There were at this point perhaps less than 10 organizations involved. By 2008, this number grew to 18. However, the community coalition became so large, with so many diverse interests involved (and more than 90 groups), that the group, now called San Franciscans for Healthcare, Housing, Jobs and Justice, was able to call for CPMC administrators to negotiate with them. This power yielded more concessions from administrators. It still was not enough, however, as neoliberal ideology continued to be evident in administrators' action, guided the format of the development agreement over which the groups negotiated, and contingently shifted the mayor's and supervisors' decision-making.

The Coalition began to meet with medical center administrators to discuss goals for housing, health care and employment in February and March 2011, with the City Office of Economic and Workforce Development acting as host. These goals would be expressed as part of the terms of a broader development agreement detailing the rights and obligations of the City and CPMC. The agreement would, however, constitute a public-private partnership, a mechanism of development that was increasingly used in the neoliberal era and which articulated neoliberal ideology. In response to neoliberal cuts to welfare states, increasingly governments relied upon private organizations like nonprofit hospitals to provide services that previously had been considered public benefits. Such partnerships involved multiple actors, including government, business and nonprofits, and were billed in neoliberal language as participatory (Beitel 2003; Mayer 1994, 2000). However, in actuality, public-private partnerships could mean that community groups were then burdened with the tasks of countering business interests and ensuring that social welfare needs were met.

These partnerships are examples of the increasing contractualization prevalent in neoliberalism. In such situations, corporations hold technology and contract out rights to their use, on a time-limited basis, to others. Such contractualization gives the contracting organization a new kind of control over the goods and services. In this case, CPMC would enter into a development agreement to meet residents' desires for healthcare, housing and jobs; however, community groups would have to watch them to ensure that these desires were in fact met.

Thus, the coalition found itself having to push for welfare state provisions. Through its advocacy the coalition was able to tie interests together, to address its diverse constituency's needs. Unions tied their contracting process to the development agreement, for example, and as a result they were able to secure more supervisors' interest in ensuring an agreement responsive to community needs than otherwise would have been possible. Furthermore, coalition action emergently yielded new means of control. Concerns about health were embedded in the development agreement, as, for example, CPMC promised to provide healthcare to one third of the city's new Medicaid enrollees.

However, as these meetings wore on the Coalition found that not enough was achieved. Moreover, some activists said, it seemed that the City sometimes seemed to be more on CPMC administrators' side than an impartial mediator. In March and May 2011, the coalition met with new mayor to review their and the City's requests for CPMC. Afterward, the mayor announced his "City Asks of CPMC." These included, among other things, housing requests, including that St. Luke's would remain open as an acute care hospital with an emergency room for at least 20 years; and that CPMC would provide charity care and Medi-Cal to patients at levels comparable to other non-profit hospitals in the city. Other requests addressed housing, workforce development, public transit, and streetscape and public safety investments.

Despite the increased power of coalition members, CPMC persisted in its circumspect negotiation. In July 2011 CPMC made a counter offer to the mayor, refusing to make a promise to keep St. Luke's open for 20 years and proposing to offer less than half the dollar amount of the mayor's request for public housing and transit improvements. Furthermore, CPMC requested several caveats on the development agreement. Among them was an escape clause on the deal allowing hospital administrators to close St. Luke's if CPMC's profit margin as a whole dipped below one percent.

In February 2012, economic contingency again turned the tide of the negotiation. Development deals important to the mayor went south, including a scrapped plan by America's Cup (a yacht race) to redevelop city piers and efforts by the 49ers football team to move to Santa Clara, about 46 miles southeast. In response the mayor promised the city's Chamber of Commerce to make the CPMC deal happen (Cote 2012b). A draft development agreement was released, including the escape clause, with the staff of the mayor's Office of Economic and Workforce Development confident that the clause would not kick in. A deal was finally announced, though supervisors would be allowed to weigh in (Redmond 2012). Local newspaper editorials urged rejecting the deal, but the Planning Commission voted to approve it. In April 2012 a draft development agreement was sent to the mayor, with no co-sponsorship by any supervisor and on April 26 the Planning Commission approved the development agreement. An appeal was filed by the coalition.

Phase Four. Active Engagement: Shifting Scale and Engaged Negotiation

In the previous phases of action, raced and classed historical conditions shaped what community activists were able to achieve, and the trajectory of action also developed emergently

through actors' interpretation, contingent events and the influence of larger socio-structural conditions. In the last phase, informal discourse and practice in government and in CPMC (their culture) emerged as new, critical ingredients. More specifically, hospital administrators' technical discourse around economic projections and government discourse around hospitals' roles as providers of community care, came to shape action.

In mid-2012, it seemed that planning for CPMC's rebuild was nearly settled. The medical center would have a 555-bed hospital at Cathedral Hill and an 80-bed hospital at St. Luke's. However, at a Board of Supervisors subcommittee hearing in late June it was revealed that, given new financial data from CPMC, the rebuild process might come close to triggering the development agreement's escape clause. According to leaked documents, CPMC administrators had envisioned a financial scenario in which construction costs would eat away the medical center's profit.

This situation is theoretically interesting. Social movements literature typically analyzes culture – in the form of "collective action frames" that movements deploy to make sense of the world and achieve their ends – but such culture is afforded little weight in describing the success of movements. Further, culture, in the form of organizational practices (like ways in which hospital administrators conceptualize and carry out their business), and government decision-making processes, are typically under-examined. However, here, culture might be understood to include CPMC's financial projections – the organization's discourse around its financial state. Such language clearly mattered for the trajectory of the conflict. Culture also mattered in the way it was embedded in local government's commitment to provision of care for less privileged San Franciscans. This latter form of culture can be understood as part of the agency of individual members of government, and also perhaps as the continued vision in government of hospitals as

providers of some measure of charitable care, carried over hospitals' long existence. Thus discourse around hospitals as entities designed to care for those in need arguably persisted over time, in the end mattering as much as any formal structuring of government.

We can see the workings of culture in language from multiple city groups. Four supervisors wrote a letter to CPMC's CEO, calling the medical center's behavior "outrageous and completely inexcusable" (Cote 2012a). And even the more development-friendly mayor's Office of Economic and Workforce Development offered a reserved but negative response in a hearing: "These new 2012 projections, while still showing CPMC will not breach the one percent margin, do not offer the same comfort level we previously had." These statements underscore that hospitals have long had practices of remaining as stable members of communities, and as acting as providers of charitable care, rather than acting as business entities. This historical cultural practice among hospitals of acting as caregivers, and local government's expectation of and reliance on this practice, were key to how this story unfolded, and violation of this expectation was cause for response. Thus, culture, in the form of economic projections and expectations of hospitals, shifted the action of the story.

As a result of this discourse, in August of 2012, coalition members began to renegotiate with CPMC administration. Here San Franciscans for Healthcare, Housing, Jobs and Justice's emergent power was most plainly seen. Members decided to go to Sutter leadership (rather than CPMC administrators) and the Board of Supervisors (rather than the mayor) to get the deal. The coalition approached an individual known as a mediator in the community, and secured the agreement of three supervisors to negotiate with Sutter. A tentative deal was reached in March, with the new Cathedral Hill hospital reduced in size from 555 beds to 274 and St. Luke's

increased from 80 beds to 120, and on June 25, 2013, the Board of Supervisors unanimously passed the development agreement (Ordinance 138-13).

Conclusion

This chapter responded to social movements theory by examining how movements might be racialized and classed. Drawing upon situational analysis I was able to explore facets of movements that are underexamined in older theory, such as the informal culture of government actors, and how they negotiate responses to their environment, and the importance of contingent economic events not typically explored, such as the importance of a city business deal.

I found that, though it appeared CPMC administrators would advance capitalism and white domination through participation in racialized uneven development, some San Franciscans responded with a community-oriented resistance that addressed the needs of diverse San Franciscans related to land use, healthcare and employment. This resistance was moved forward partly through historical conditions providing foundations for action, as well as through contingency, and interpretive processes, and in ways not addressed by older theory of social movements.

Several historical conditions mattered for the action of social movement organizations and CPMC. Hospital administrators had a racialized and classed advantage in the city's historically white elite-dominated, "strong mayor" form of government, as well as in some representation on the Board of Supervisors. However, movements also managed to grow strong organizations over time. San Francisco was home to a raft of social movement organizations dedicated to various causes. Their historical inroads into city government and skills in organizing meant that movement organizations would call for the city to attend to their needs,

using discourses of identity, and city leaders would listen. Neighborhoods could call to city supervisors, and so could union organizations. At the same time, economic shifts in the city that strained the welfare state, the growth of healthcare also conditioned action.

Such historical actions gave rise to discourses among community members that spoke to their racialized and classed interests, including desires for equity. These were discourses of neighborhood identity, where residents argued for the importance of healthcare and housing, as well as discourses of labor, through which community members argued for their rights to employment. Discourses included, too, warnings not to trust CPMC, which spoke to rising distrust of CPMC's orientation toward the community.

However, community-oriented resistance was not only influenced by historical political and organizational structuring but also was emergently shaped by contingency, various actors' interpretation, and entrenched cultural expectations about hospitals. Possibly responding to neoliberal welfare state retrenchment, the City decided that St. Luke's must be saved. This formed a *de facto* public-private partnership as CPMC administrators would be effectively relied upon to ensure that adequate welfare state protection would be provided. This choice led to an initial period of negotiation over the hospitals and coalition-building as advocacy groups mobilized. Throughout, CPMC administrators maintained a circumspect involvement. This included gestures of openness coupled with fierce negotiation and contractualization of the development agreement. These actions meant that CPMC administrators were allowed multiple escape clauses on the deal. Meanwhile, community members and their representatives in local government responded by holding strikes, broadcasting their views to the community, and propagating legislation. Ultimately, however, these methods did not produce the community's desired result. Community members feared that the proposed replacement for St. Luke's would

fail. Likewise, the healthcare master plan legislation, though the first of its kind in the country, exempted the hospitals from compliance.

In the end, historical structuring as well as cultural beliefs about the role of hospitals as charitable service organizations influenced the trajectory of action. When it was revealed that CPMC would not meet its profitability requirements with the rebuild, and therefore would be able to pull out of the project, the City and the community demanded renegotiation, ultimately securing a larger hospital. Thus, culture – in the form of CPMC's language around its day-to-day business – how it calculated profitability – and cultural beliefs about hospitals as sites that care for the less privilege – ultimately influenced the outcome of the action.

CHAPTER 6. CONCLUSION

Introduction

The American healthcare system remains segregated by race and class, with disparities in health outcomes for different social groups as they access healthcare at varied sites. Yet sociological research into race- and class-based healthcare disparities has tended to focus on other issues. Literatures on healthcare disparities often focus on the endowments of the patient, on interactions between patient and provider, and on disparities within a single clinic or system. While valuable, these studies tend to leave out the importance of geography. Responding to this gap, and to follow recent direction to better understand the relationship of residential segregation to health outcomes (Williams and Collins 2001), this dissertation examined how the hospitals of San Francisco have been socially and geographically placed, with attention to how this process was related to the actions of social groups with investments in hospitals, as well as broader healthcare policy and to the city's urban development. In this concluding chapter, I summarize key findings, propose some implications for sociology, discuss limitations of the study and propose future directions for research.

Summary of Key Findings

In analyzing how various social groups, including hospital administrators, members of local government, and community members make meaning of and attempt to place local hospitals, I arrived at the following findings.

First, the city of San Francisco has grown through a *racialized uneven development*. The term draws from Marxian attention to "uneven development," and variation in the growth of capitalism in different places, as well as interactionist work to emphasize not only the economic in the growth of places but also culture and politics as varied races, ethnicities and socioeconomic classes of people settle – or are forced to settle – in different areas. This process is larger than the growth of healthcare, but it is in part co-constituted with development of the city's *local hospital care arena*, an arena comprised of varied *social worlds*, including the city's hospitals and all the social groups with investments in their development. I have focused in particular on the social worlds of hospitals, community advocacy groups, elites (including real estate developers and business leaders), and local government, with attention to how the composition of these varied groups are raced and classed.

Second, racialized uneven development proceeded through a variety of cultural, economic and political means, including symbolic distinctions made between the northern and southern sections of the city, elites' choices about which neighborhoods they wanted to live in, and white city leaders' and political groups' overt racism as they created local policy that contained stigmatized groups of people, especially the Chinese. Development of the local hospital care arena mapped onto this process as hospital leaders gathered and deployed cultural, social and economic resource to place their organizations, and, in some cases, as they were constrained to be placed by white politicians of the day. As a result, more hospitals developed in the northeastern part of the city and in its center, but not in the stigmatized southeast.

Third, federal urban and healthcare policies of the 20th century continued racialized uneven development across the city. In eras marked by policy that was at first overtly racist and classist, and later tacitly so, urban development and development of healthcare continued and

deepened inequality. This included an intergenerational drag was produced as white and wealthy hospitals unjustly acquired more privileges over time, such as hospital beds. This occurred partly as federal and state policy were loosely coupled to policy implementation, allowing local implementation to deepen disparities.

Fourth, in the near-present, neoliberal understandings of place and action upon it continue to obscure how value is made, while making it in new ways. Some hospital administrators orient toward the past, and toward geography, with a selective regionalism. That is, they deploy discourse and action that constructs place to create new value, while obscuring how this process deepens inequality as it draws from raced and classed past privileges.

Fifth, community members respond to neoliberal constructions of value and place through a community-oriented resistance. In it, they construct understandings of rights to land use, fair employment and healthcare. Community members, too, draw from strengths they have developed through partial democratization of local government, and it is partly through these that they are able to contain neoliberal hospital development. However, encultured understandings of the meaning of hospitals, and other contingencies shape activism's outcomes in ways not predicted by older social movement theory.

Implications for Sociology

Fundamental Causes

As noted in the introduction to the dissertation, scholars of health disparities have become increasingly concerned with understanding structural causes of disparities. For example, work in this vein has addressed fundamental causes of disease, redirecting analytic focus upward from

individuals' health behaviors and toward factors such as socioeconomic status (Link and Phelan 1995), residential segregation (Williams and Collins 2001), and racism (Phelan and Link 2015)**.** This dissertation responds to work on fundamental causes. It shows how structural racism and classism are fundamental causes of healthcare disparities in San Francisco, and points to means through which inequality is generated and continued over time.

On an empirical level, means through which inequality is generated have included the relationship of hospital placement to processes of residential segregation; the making and implementation of healthcare policy by federal, state and local governments; hospitals' generation of valued resources over time, such as hospital beds; the language and action of hospital administrators; and the lack of redress for past inequities. These processes have also included medical and bureaucratic abandonment, as government agencies repeatedly demonstrated over time that they knew the southeastern part of the city lacked necessary healthcare but did nothing to address the problem.

Theoretically, a number of themes were present in the data. One theme has been ways in which healthcare inequalities were co-constituted with other inequalities, for example as residential segregation tracked with hospital segregation and as healthcare inequalities persisted through intergenerational drag. Intergenerational drag appears to have been produced by the explicit and tacit continued valuing of resources that were valued in the past, such as particular hospitals, as well as affording new privileges to those already privileged. This valuation also appears to have been produced through a lack of redress for past harms, and through the making of healthcare administrators' identities. The finding of hospital movement with particular populations and the concept of selective regionalism suggest that hospital administrators over

time identify with the raced and classed social groups that initially formed their hospitals' patient populations.

A consistent theme in this dissertation has been one of discourses circulating among policymakers and hospital administrators that obscure value production. This obfuscation has been not only about classism but also about racism as language, in different eras, explicitly or tacitly legitimated racialized inequities. Further, a key means of obfuscation has been through language that is increasingly regionalized and/or placeless. Throughout the 20th century, geographic boundaries have been delineated in healthcare policy as regions. These regions annul the distinct sub-areas that exist within them. This boundary-making thus elides healthcare disparities that form between sub-areas. A similar finding is present in the work of Richter (2018). In this study, Richter finds that residents of Kettleman City, California, were not able to make claims about environmental inequities because environmental monitoring data were aggregated in reporting into a region. This boundary definition washed out the presence of disparities in the sub-region in which those residents lived. This situation thus points to the need for understanding of how these regional aggregations of health data are made and interactively sustained over time, and with what effect for continuance of health and healthcare disparities. Further, as Richter's study makes clear, my findings are not limited to hospital care.

Theories of Access to Care

Scholars often write about access to care using via Andersen's Behavioral Model of Health Care Access (Andersen 1995). First developed in the 1960s (Andersen 1968), the model's most recent (sixth) revision describes characteristics of individuals and their social environment that impact whether individuals access health care (Andersen et al. 2014). (For a

visualization, see Figure 6.1 below.) The authors define access as "actual use of personal health services and everything that facilitates or impedes their use" (33-34). Whether individuals access health care is determined by "contextual characteristics" that include "health organization and provider-related factors as well as community characteristics" measured at the level of the collective (35) and by "individual characteristics" that are measured at the level of individuals. Each set of characteristics is further divided into "predisposing characteristics" that make services use more likely, "enabling characteristics" that make services use more feasible, and "need characteristics" that are measures of healthfulness.

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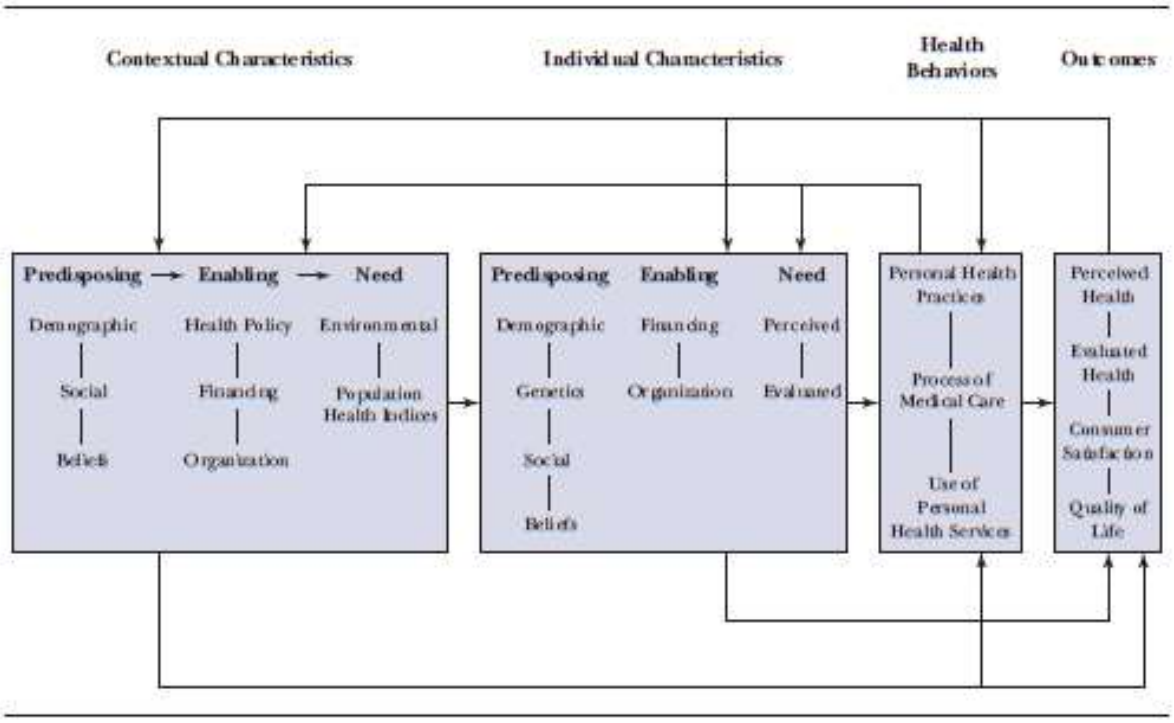

Figure 6.1. A Behavioral Model of Health Services Use Including Contextual and Individual Characteristics*

*Image credit: Andersen, Ronald M., Pamela L. Davidson, and Sebastian E. Baumeister. 2014. "Improving Access to Care." Pp. 33-70 in Changing the U.S. Health System: Key Issues in Health Services Policy and Management. Ed. G. Kominski. Hoboken, NJ: Jossey-Bass.

While the social context in which the individual seeking health care is located matters in Andersen and colleagues' model, the primary focus of the model is on the individual and on "individual characteristics" that matter for access to care. These include predisposing characteristics such as the demographics of the individual; enabling characteristics including whether the individual has health insurance; and need characteristics such as how the individual understands their need for health care

Though the model's conceptualization of social context has expanded over time, it does not describe a few elements I will list here. First, it assumes that health care access is first and foremost determined by individuals' preferences or pursuits. However, social context may matter more than individual behavior. Another model might place theoretical emphasis on group-level determinants. For example, a model that emphasizes structural racism and classism in the health care system might assume that these are operating and that individual-level choices matter rather less.

Second, the Andersen model does not describe the historical circumstances that have led to the current social context. These may include, for example, the past organization of the health care system. Elements of such organization could be whether certain hospitals have been wealthier, or have had more hospital beds, more specialists, or more prestige, and how such differences may have mattered for varied groups of patients' access to care. Such history could include the local and national shaping of healthcare policy over time, and how this has mattered for local care. This history may matter by affecting the effectiveness of current policy or the availability of health care providers of various types. The model also focuses on health care policy, but it could include the history of other policy that shapes places. For example, housing policy has, as this dissertation has suggested, intertwined with access to care.

Third, the Andersen model includes consideration of power by including health policies (such as the Affordable Care Act), but it could elaborate further on the political structuring of health care. How do local government leaders orient toward health care policy and planning? What kind of structure does the local government have in place to support health care policy and planning? How democratized is it? It also could include urban policy related to access to care. (Notably, it does include neighborhood measures, such as spatial segregation).

Fourth, the Andersen model addresses neighborhoods but could do more to address their political shaping. This may be an important intervention, as urban sociology, and work in public health that takes up the Andersen model, has not always recognized the raced and classed shaping of politics that make neighborhoods. Historically urban sociology has followed an "urban ecology" model under which segregation has been deemed efficient and social groups have been imagined to assimilate and move out of the city. A model of neighborhoods and access to care might go beyond this to point to the political shaping of neighborhoods.

Fifth, though Andersen and colleagues discuss social movements in their work, the model itself does not discuss social movements. Social movements shape health policy and health services over time. Movements also shape the individuals accessing care and members of their networks who in turn influence people accessing care. Thus, movements might appear in the model as contextual or as individual characteristics that make health services use more feasible or more likely. In San Francisco, for instance, movements have shaped local health policy and have directly affected hospital placement. As such, movements could be described as enabling characteristics that have made health services use more feasible for some patients, by placing hospitals close to them. Movements could also be described as predisposing characteristics by sensitizing members and their networks to the importance of care.

Limitations

First, an important limitation of this research is that much of the historical data does not include perspectives of low-income people or people of color. This means that key narratives of identity-making, healthcare structuring and possibly resistance to oppression are not present.

Second, San Francisco is a unique place in which to study health politics. When I described my findings to a health systems policy expert and wondered how San Francisco's social movements might be like those of other cities, she laughed. She then said that in healthcare San Francisco is so uniquely progressive, relative to other places, that the generalizability of findings about it really is limited. And so it may be. Yet communities have fought hospital placement in other places, both to improve healthcare options and to speak to other meanings embedded in hospitals (McKee 2016; Waitzkin 2001; Waitzkin, Wallen, and Sharratt 1979). It may be that San Francisco's experience speaks to theirs.

Third, it may appear that this dissertation assumes that more healthcare is better. Similarly, some fundamental causes literature makes the same assumption. Such perspectives can contribute to a biomedicalized view of health. I note here that more is not always better. First, the presence of healthcare has not been shown to be the most important determinant of health outcomes. More importantly, it is key to conceptualize what counts as "good" or "better" around patients' desires for what treatment they receive, and how. However, I suggest that, in this case, the question is not of whether more healthcare should be put on top of enough; it is of ensuring there is a baseline of accessible care.

Future Directions

One direction in which the study points is to analysis of how healthcare geographies are defined and used by hospital administrators, managed care organizations, and other key entities. Such study could elucidate how these definitions may reify or address existing healthcare inequalities. The importance of the topic was brought home to me not only by the data in this study, but in part by what data I was not able to collect: At one point during data collection, I went to gather the pleadings of the 1999 lawsuit between St. Luke's and Sutter Health. In that visit to the courthouse, l learned that information crucial to my understanding of this process - how hospitals defined their markets geographically - was in fact under seal and I would not be allowed to review it. This was because some parts of market definition are legally deemed trade secrets. And yet understanding these aspects of administrators' thinking would likely be invaluable in illuminating the relationship between the commodification of care and healthcare disparities. Therefore, a study addressing how geographically bounded market models are defined, how market models may be legally defined as trade secrets, and what effect these processes have on how hospital administrators define their target markets could address our understandings of inequality. It could also explore the theme of obfuscation that has been so prominent in this dissertation's data.

A second project could explore hospitals' biomedical particularism, that is, their creation and provision of varied services, through which they reach different population segments who vary by race and by class. To foreground the importance of geographic placement of hospitals, I forewent discussion of the growth of different types of hospitals (e.g., whether private, non-profit, for-profit, academic or community-based). Yet this growth matters for what types of care are provided, and to whom. This type of question has been explored ethnographically before

(Lee 2003; Reich 2014), and it has been noted to contribute to uneven development in hospital growth (Waitzkin 2000). Yet this type of growth, especially among academic medical centers and new accountable care organizations, has been less explored. Further, a movement is growing to center hospitals as "anchor institutions" that support their communities, and this movement, and the changes it makes in available care, deserves further study as well (Pinderhughes 2019; Zuckerman 2013).

A third geographically-oriented project could examine in more detail how hospitals contribute to neighborhood change. Though this study's focus was primarily on how the placement of hospitals was affected by neighborhood changes, the reverse also happens. In San Francisco, for example, UCSF has been studied as an anchor tenant, an organization that drives the formation of an organizational field – in this case, the development of life sciences in the Bay Area (Powell, Packalen, and Whittington 2012). Less studied, however, are the ways in which the growth of the university and its hospitals have impacted racial segregation and gentrification in the neighborhood, and what effects these processes might have on residents' health.

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