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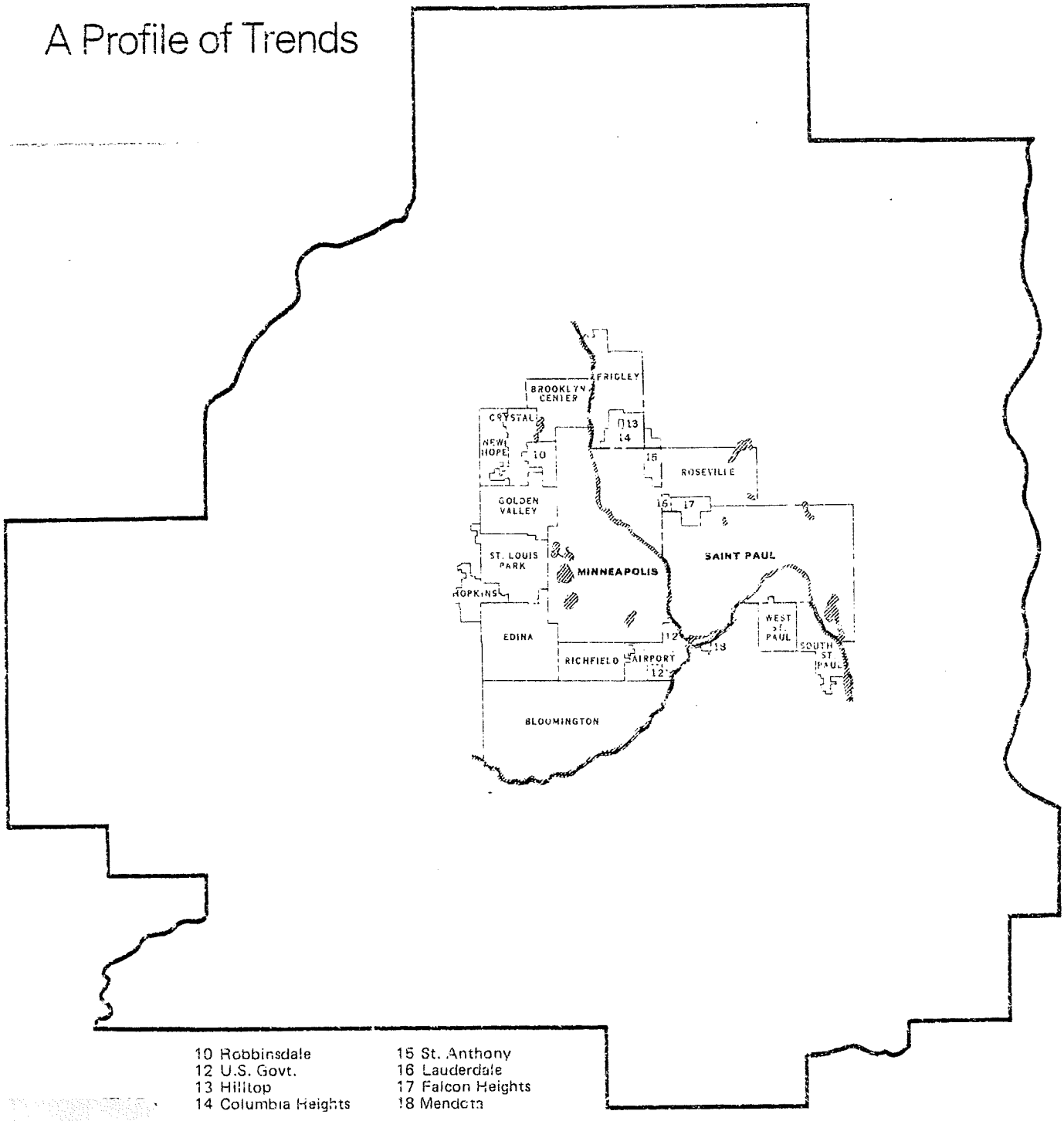
The Fully Developed Area

A Profile of Trends



10 Robbinsdale
12 U.S. Govt.
13 Hilltop
14 Columbia Heights
15 St. Anthony
16 Lauderdale
17 Falcon Heights
18 Mendota

Metropolitan Council
State of the Region Conference
Landmark Center, St. Paul
April 28, 1979

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THE FULLY DEVELOPED AREA

A Profile of Trends

April 1979

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STATE OF MINNESOTA

Metropolitan Council
1979 State of the Region Conference

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1. INTRODUCTION

This is a profile of trends in the older, built-up part of the Twin Cities Metropolitan Area--the part the Metropolitan Council calls the "Fully Developed Area (FDA)." It includes the central cities of Minneapolis and St. Paul, and 20 surrounding older suburbs that had less than 15 percent vacant land remaining for development in 1975.

The 20 FDA suburbs are: Bloomington, Brooklyn Center, Columbia Heights, Crystal, Edina, Falcon Heights, Fridley, Golden Valley, Hilltop, Hopkins, Lauderdale, Mendota, New Hope, Richfield, Robbinsdale, Roseville, St. Anthony, St. Louis Park, South St. Paul and West St. Paul.

A Fully Developed Area that is healthy socially, economically and physically is vital to the continued high quality of life in the Twin Cities Area. More than half the Area's population lives in the FDA. It has nearly two-thirds of the housing stock, and about 80 percent of the Area's employment and its commercial and industrial firms.

The process of urban aging is moving all FDA cities into more reinvestment activity, which involves reuse of existing urban structures or redevelopment. Generally, the older a city is, the greater its need for reinvestment and renewal. Unfortunately, a city's need and its ability to provide for renewal through public and private investment do not go hand-in-hand.

Metropolitan Council policy is aimed at maintaining and improving the FDA's ability to attract people who will live, work and invest in FDA cities. The Council's planning emphasis for the FDA is to monitor changes and plan improvements to ensure the long-term viability of each city. This involves modifying the effects of adverse trends while enhancing the beneficial ones.

This profile focuses on the direction of change in the FDA and its implications for future planning and policy-making. The profile begins with major findings. Then it discusses five aspects of the FDA cities that the Council considers important for planning, because they show how the FDA cities' needs, abilities and problems differ from those of cities in the other policy areas.* The five aspects are demographic trends, public investment, private investment, employment, and citizens' attitudes. The profile concludes with a section on differences among FDA cities.

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* The other policy areas in the Council's Development Framework plan for the Metropolitan Area are the Area of Planned Urbanization, Freestanding Growth Centers and Rural Service Area.

II. MAJOR FINDINGS

DEMOGRAPHIC TRENDS

The demographic profile of the FDA is changing. Population is decreasing and households are increasing, bringing a dramatic change in household character. There are fewer families, fewer children, more small households, and more single-person households of both young adults and elderly people.

FDA suburbs are facing more dramatic demographic changes that will pose problems; problems the two central cities have experienced for some time. The stabilizing cities-changing suburbs trend suggests that long-standing urban trends do "bottom out," and that recycling, rather than death, is a possibility for aging cities.

PUBLIC INVESTMENT

Public spending by the FDA cities for capital improvements and major maintenance is presently at a level that does not indicate disinvestment. As the number of households in the FDA continues to grow, however, the demand for services will grow, too, increasing operating expenses. As the FDA cities continue to age, their need for capital improvements will also increase. Competition between service demands and capital needs for increasingly tight city dollars will become more intense and capital needs may suffer. This would result in gradual public disinvestment.

With many state and federal aid formulas based in part on population, FDA cities, which now average 39 percent of their revenues from intergovernmental sources, are likely to face declining revenues following the 1980 census.

PRIVATE INVESTMENT

The private investment picture in the FDA is a mix of concerns and hopeful signs. The concerns are mostly for the older FDA cities. While they do not show private disinvestment now, their annual rate of private investment is low enough to become a problem if it continues at this rate into the 1980s.

The hopeful signs are that throughout the FDA, including the oldest cities, commercial-industrial building vacancies are down. Residential values are up, and the demand for FDA housing is sufficient to have available units rented or sold.

EMPLOYMENT

The FDA remains the primary location of employment in the Metropolitan Area. The trend among residents in the FDA suburbs is toward a broader

variety of occupations, i.e. blue collar, clerical and sales, as well as professional and managerial occupations. The central cities' loss of residents with professional and managerial occupations to the suburbs appears to have stopped in the 1970s.

CITIZENS' ATTITUDES

Residents are satisfied with their neighborhoods in the FDA, and most expect their neighborhoods to get even better in the next few years. Families with children in the Metropolitan Area still prefer locations in developing suburbs or the rural areas, however. This is a concern, since families are needed in the FDA to maintain a balanced population profile.

NATIONAL TRENDS/ LOCAL IMPLICATIONS

Several national trends and situations will affect the FDA's future. Each raises significant questions that have implications for government policy in the next decade.

Lifestyle: Beyond the Baby Boom

Currently, the post-World War II baby boom generation is passing through the public secondary schools and colleges, leaving empty school buildings in the FDA in its wake. Its members are competing for entry-level jobs and housing. Many have postponed marriage and children in favor of pursuing a career and "the good life." They have chosen to live in the central cities and older suburbs, where there are more rental units and lower-cost single-family homes.

FDA cities must be concerned not only with meeting this generation's current needs. The cities must be careful not to duplicate what happened with their schools. They must ask where this group will choose to live when it decides to settle down and raise children. It remains to be seen whether the FDA will continue to serve this age group, or whether its members will move to the developing suburbs, as many of their parents did. Will it be economically feasible to abandon the housing no longer needed by this group, as FDA cities are doing with schools?

Government Programs: The Population Numbers Game

Many state and federal aid programs to cities are tied to population, although households would be a better indicator of need. Following the 1980 census, which will show population declines in the FDA, the FDA cities will likely receive less revenues from state and federal programs. Also, redistricting of state and federal legislative districts will occur following the 1980 census. Developing suburbs will receive increased representation, and the FDA will have fewer representatives in the state legislature and in Congress. Can the FDA expect the amount of aid it will need for reinvestment following the 1980 Census?

Back-to-the-City?

The rapidly increasing cost and scarcity of energy, and the soaring cost of new housing, have generally been viewed as having favorable impacts on the FDA cities. Their central location, higher density of development, and older, less expensive housing are bringing some people and business "back to the cities." People have reawakened to the market of the central cities and FDA suburbs as viable options for residential and business locations, as evidenced by the strong housing market and reduced commercial-industrial building vacancies in the FDA. Will this trend continue if the current strong economic development situation takes a downturn? In recent periods of economic slowdown, the FDA has been the most adversely affected in terms of private investment.

III. DEMOGRAPHIC TRENDS

Demographic data helps in making decisions about a city's future needs and resources. A population's age composition relates to housing, schools, health care and most other community services. It is also important to know whether a community's households are made up of single people, old people, childless couples, or large families. Income is another concern, because it relates both to need for city services and to ability to pay for them.

POPULATION TRENDS

The Fully Developed Area (FDA) cities had an estimated 1978 population of 1,146,350, well over half the Region's population (see Table III-1). This is, however, 100,000 fewer people than in 1970.

This population loss is due mostly to large losses in the central cities, a continuation of trends that began in the 1950s. Other FDA cities estimated to have lost population since 1970 are Bloomington, Brooklyn Center, Columbia Heights, Crystal, Falcon Heights, Golden Valley, Mendota, New Hope, Richfield, Robbinsdale, St. Anthony, St. Louis Park, South St. Paul and West St. Paul (see Table III-2). Of the 22 FDA cities, only six added population between 1970 and 1978.

The trends in FDA suburbs of little growth or decline are, however, of fairly recent origin. Between 1960 and 1970, Bloomington added over 30,000 people. This is more than the population of most of the current developing suburbs, and more growth than is likely to occur in any other suburb, given the lower regional future growth expectations. Similar rates of growth were experienced in many other FDA suburbs in both the 1950s and 1960s. The transition from a rapidly growing suburb to an older declining city has sometimes been quite abrupt.

Metropolitan Council projections for the FDA cities show little change overall. This assumes central cities' losses will stop, and continued infilling in the FDA suburbs will offset their losses from shrinking family size. These forecasts, although reasonable in light of recent housing cost trends and energy concerns, are more a reflection of Council policy than of past trends. Forecasts for the FDA suburbs also reflect policies that would encourage a more balanced population, so that these cities will not face the problems of continued massive population loss and ever-changing demand for services.

Household Trends

The population declines that most FDA cities experienced in the 1970s are not reflected in their number of households. All FDA cities continued to add new households in this period (see Tables III-3 and III-4). The FDA's current share of the Region's households is estimated at nearly

Table III-1
FULLY DEVELOPED AREA POPULATION

	1950		1960		1970		1978 Estimates		1990 Forecasts	
	Population	Percent of Region	Population	Percent of Region	Population	Percent of Region	Population	Percent of Region	Population	Percent of Region
Fully Developed Area	978,980	82.6	1,162,917	76.2	1,260,316	67.2	1,156,350	58.1	1,144,950	50.6
Minneapolis-St. Paul	833,067	70.3	796,283	52.2	744,380	39.7	640,900	32.2	645,000	28.5
Rest of Fully Developed Area	145,913	12.3	366,634	24.0	515,936	27.5	515,450	25.9	499,950	22.1
Seven-County Region	1,185,694	100.0	1,525,297	100.0	1,874,612	100.0	1,990,760	100.0	2,261,000	100.0

(Source: 1970 U.S. Census and Metropolitan Council estimates and forecasts.)

Table III-2
POPULATION OF FULLY DEVELOPED AREA CITIES

Fully Developed Area Cities	1950	1960	1970	1978	1990
Bloomington	9,902	50,498	81,970	78,790	81,800
Brooklyn Center	4,284	24,356	35,173	33,700	33,500
Columbia Heights	8,175	17,533	23,997	21,300	20,000
Crystal	5,713	24,283	30,925	27,840	26,000
Edina	11,443	30,413	44,046	48,920	51,800
Falcon Heights	3,884	5,927	5,507	5,480	5,200
Fridley	3,796	15,173	29,233	33,450	34,500
Golden Valley	5,551	14,559	24,246	23,230	23,500
Hilltop	461	607	1,015	1,030	900
Hopkins	7,595	11,370	13,428	15,180	16,000
Lauderdale	1,033	1,676	2,419	2,460	2,400
Mendota	243	259	266	260	250
Minneapolis	521,718	482,872	434,400	370,210	375,000
New Hope	691	3,552	23,180	22,630	21,500
Richfield	17,502	42,523	47,231	42,250	39,000
Robbinsdale	11,289	16,381	16,845	14,850	14,500
Roseville	6,437	23,997	34,518	39,450	36,000
St. Anthony	1,406	5,084	9,239	9,070	8,900
St. Louis Park	22,644	43,310	48,883	44,540	42,800
St. Paul	311,349	313,411	309,980	270,690	270,000
South St. Paul	15,909	22,032	25,016	22,200	22,000
West St. Paul	7,955	13,101	18,799	18,820	19,400
Fully Developed Area Total	978,980	1,162,917	1,260,316	1,156,350	1,144,950

Table III-3
FULLY DEVELOPED AREA HOUSEHOLDS

	1950		1960		1970		1978 Estimates		1980 Forecasts		1990 Forecasts	
	House-holds	% of Region	House-holds	% of Region	House-holds	% of Region	House-holds	% of Region	House-holds	% of Region	House holds	% of Region
Fully Developed Area	291,009	84.0	360,350	79.7	414,529	72.2	444,474	63.9	450,900	62.9	474,660	55.6
Minneapolis-St. Paul	251,504	72.6	264,489	58.5	265,267	46.2	271,811	39.1	273,400	38.1	283,500	33.2
Rest of Fully Developed Area	39,505	11.4	95,861	21.2	149,262	26.0	172,663	24.8	177,500	24.7	191,160	22.4
Seven-County Region	346,563	100.0	452,276	100.0	573,834	100.0	695,529	100.0	717,300	100.0	853,400	100.0

Table III-4
FULLY DEVELOPED AREA HOUSEHOLDS BY CITY

	1950	1960	1970	1978	1980	1990
Bloomington	1,950	12,035	21,824	26,140	27,000	30,300
Brooklyn Center	1,140	5,869	9,151	10,551	11,000	12,400
Columbia Heights	2,186	4,632	6,861	7,127	7,250	7,500
Crystal	1,591	5,899	8,296	8,825	9,000	9,100
Edina	3,289	8,314	13,005	17,369	18,000	20,000
Falcon Heights	1,100	1,584	1,766	1,864	1,900	2,000
Fridley	1,020	3,745	7,855	10,026	10,200	12,100
Golden Valley	1,544	3,876	6,534	7,459	7,600	8,400
Hilltop	174	233	465	476	500	500
Hopkins	1,851	3,245	4,667	6,245	6,900	7,100
Lauderdale	284	460	856	909	900	950
Mendota	68	73	87	91	100	110
Minneapolis	159,345	165,791	161,141	161,710	164,000	171,500
New Hope	157	810	6,019	7,240	7,500	7,900
Richfield	4,611	10,893	14,801	15,101	15,200	15,400
Robbinsdale	3,082	4,717	5,290	5,618	5,700	5,900
Roseville	1,761	5,991	9,584	12,525	12,500	13,300
St. Anthony	432	1,410	2,754	3,127	3,350	3,400
St. Louis Park	6,554	12,204	15,781	17,296	17,900	18,600
St. Paul	92,159	98,698	104,126	110,101	109,400	112,000
South St. Paul	4,455	6,268	7,518	7,520	7,700	8,000
West St. Paul	2,256	3,603	6,148	7,154	7,300	8,200
Totals	291,009	360,350	414,529	444,474	450,900	474,660

two-thirds, and is expected to remain well over 50 percent by 1990.

Trends in Household Size

The loss of population despite gains in households in FDA cities occurred due to a reduction in household and family size. This was caused by a number of factors, including reduced fertility rates, older children leaving home, more single people living alone, later age at marriage, an increasing divorce rate, and out-migration of some families to newer suburbs or rural areas. The 1978 persons per household estimate for the FDA was 2.6, a drop from 3.0 per household in 1970. Region-wide, persons per household was 2.9 in 1978 (see Table III-5). Continued, although less steep, declines in household size are forecasted to 1990 in both the FDA and the Region as a whole. Both central cities had smaller household sizes than the overall FDA household size in 1978, but they are not expected to drop much lower (see Table III-6).

Household Composition

A 1974 census survey revealed a number of significant differences between the central cities and the rest of the five county SMSA* (the FDA suburbs were not separately identified). With 26 percent of the five-county SMSA households, Minneapolis had only 18 percent of the husband-wife families, but 37 percent of the Area's female-headed households. St. Paul had similar, although less pronounced, differences.

Recent data from the R. L. Polk Company** indicates that while husband-wife families have continued to decline in their share of central cities' households, they declined even more rapidly in their share of households in the FDA suburbs and the developing suburbs. The current share of husband-wife families is 47 percent in Minneapolis, 54 percent in St. Paul, 68 percent in the FDA suburbs and 73 percent in the developing suburbs.

The share of households with children has dropped, too. Minneapolis and St. Paul had only a one percentage point drop between 1974 and 1978, however, while households with children in the FDA suburbs and the developing suburbs dropped six and four percentage points respectively. For 1978, the percentage of households with children in Minneapolis was 27 percent; in St. Paul, it was 34 percent; in the FDA suburbs, 42 percent; and in the developing suburbs, 55 percent.

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*Standard Metropolitan Statistical Area:
Anoka, Dakota, Hennepin, Ramsey and Washington Counties.

**The Metropolitan Council recently purchased R. L. Polk's profiles of change data, which provides several key social and demographic indicators at the census tract level. Both current data and trend data are included. The data was developed from Polk's city directory canvasses.

Table III-5
PERSONS PER HOUSEHOLD IN THE FULLY DEVELOPED AREA

	1950	1960	1970	1978	1990
Fully Developed Area	3.36	3.23	3.04	2.58	2.41
Minneapolis-St. Paul	3.31	3.01	2.81	2.36	2.28
Rest of FDA	3.68	3.83	3.46	2.93	2.62
Seven-County Region	3.42	3.37	3.27	2.86	2.65

Table III-6
PERSONS PER HOUSEHOLD BY FULLY DEVELOPED AREA CITY

	1950	1960	1970	1978	1990
Bloomington	5.08	4.20	3.76	3.01	2.70
Brooklyn Center	3.76	4.15	3.84	3.19	2.70
Columbia Heights	3.74	3.79	3.50	2.99	2.67
Crystal	3.59	4.12	3.73	3.15	2.86
Edina	3.48	3.66	3.39	2.82	2.59
Falcon Heights	3.53	3.74	3.12	2.94	2.60
Fridley	3.72	4.05	3.72	3.34	2.85
Golden Valley	3.60	3.76	3.71	3.11	2.80
Hilltop	2.65	2.61	2.18	2.16	1.80
Hopkins	4.10	3.50	2.88	2.43	2.25
Lauderdale	3.64	3.64	2.83	2.71	2.53
Mendota	3.57	3.55	3.06	2.86	2.27
Minneapolis	3.27	2.91	2.88	2.29	2.19
New Hope	4.40	4.39	3.85	3.13	2.72
Richfield	3.80	3.90	3.19	2.80	2.53
Robbinsdale	3.66	3.47	3.18	2.64	2.46
Roseville	3.66	4.01	3.60	3.15	2.71
St. Anthony	3.25	3.61	3.35	2.90	2.62
St. Louis Park	3.45	3.55	3.10	2.50	2.30
St. Paul	3.38	3.18	2.98	2.46	2.41
South St. Paul	3.57	3.51	3.33	2.95	2.75
West St. Paul	3.53	3.64	3.06	2.63	2.37
Fully Developed Area	3.36	3.23	3.04	2.58	2.41

Five-person households showed even sharper declines. The greatest declines were again in the FDA suburbs, where five-person households dropped from 20 to 14 percent of their total households. Minneapolis and St. Paul five-person households each dropped two percentage points, to 8 and 13 percent respectively. The developing suburbs went from 26 to 23 percent.

Declines in the share of family households in the FDA suburbs and the developing suburbs from 1974 to 1978 were offset by increases in one-person households, from 17 to 20 percent in the FDA suburbs, and 14 to 17 percent in the developing suburbs. One-person households in the central cities remained nearly constant, however, at about 32 percent. Minneapolis dropped slightly, to 33 percent, while St. Paul increased slightly, to 30 percent.

The percentage of female-headed households also increased in the suburbs, but it dropped in the central cities. Minneapolis went from 33 to 31 percent and St. Paul remained constant. The FDA suburbs increased from 15 to 17 percent and the developing suburbs went from 11 to 13 percent. Female-headed households with children increased slightly in all areas, generally from only one-half to one percent. Overall percentages of female-headed households were also very similar; they ranged from 6.5 percent in St. Paul to 4.5 percent in the FDA suburbs.

The Polk data indicates that between 1974 and 1978, home ownership remained stable at 53 percent in Minneapolis, while declining in all other parts of the Region. St. Paul dropped from 63 to 59 percent, the FDA suburbs went from 70 to 68 percent, and the developing suburbs dropped less than a percentage point, to 73 percent.

These statistics generally correspond to expectations based on the cities' stage of development, with Minneapolis furthest along, followed closely by St. Paul. Their rates of change are, however, nearly stable, while the FDA suburbs almost always show more rapid trends in the direction of the central cities. This suggests that long-standing urban trends do "bottom out," and that recycling, rather than death, is a possibility for aging cities.

Age Distribution Trends

Age distribution is especially important to individual cities within the FDA, because they typically are much more homogeneous than the Region as a whole. This typically leads to continual change in the age composition in the city that results in continual shifts in the needs of the population. The typical suburb grows rapidly, adding families with young children. As the families age, the children pass through the school system, and eventually, they leave home. The parents frequently remain in the home alone. The need for schools drops greatly in that city, while increasing in areas that are in an earlier phase of development. As the city matures, more residents become elderly, generating a new set of needs. Housing turnover increases and new residents occupy the housing.

So far in the Twin Cities Area, this stage has been reached only in the central cities. Their new residents have not been families with children, in most cases, but smaller households of single people and childless couples. The new Polk data indicates that these trends may be stabilizing or changing in direction. Several FDA suburbs are nearing this point and all of them are well into the stage of shrinking family size.

Despite their similarities, each FDA city has its own unique attributes, depending on its development history. Some FDA cities added substantial numbers of multi-family housing units as they began filling up. Although not always welcomed, this housing may prove of great value in providing a source of potential buyers of housing in the community, as well as providing appropriate and affordable housing options to the city's elderly residents and to its children as they mature. Providing such "life cycle" housing not only serves the city's residents, but should result in a more balanced age distribution and less fluctuation in demand for services.

The Polk data reveals several recent trends reflecting age distribution in the FDA cities. This data shows that numbers of households with children are declining, but less so in the central cities than elsewhere. Polk data also indicates shifts on the other end of the age spectrum, by estimating the number of retired heads of households. This provides one of the clearest indicators of turnaround in the central cities. Retired heads of households in Minneapolis dropped from 29 to 24 percent between 1974 and 1978. In St. Paul, the decline was a little less steep, from 28 to 26 percent. In the FDA suburbs, on the other hand, retired heads of households increased from 10 to 14 percent, and a number of FDA cities exceeded this average substantially. Robbinsdale increased from 21 to 26 percent. Others with high percentages and large increases (at least four percentage points) were South St. Paul and West St. Paul, at 23 percent, and Richfield, Columbia Heights and St. Louis Park, at 18 percent.

The developing suburbs, although increasing slightly, were well below the rest of the Region, with only 7.5 percent retired heads of households in 1978.

Shifts in age composition are also shown in school enrollment. The regional data in Table III-7 shows the post-war babies moving through the system. These shifts have been especially dramatic in individual cities.

To illustrate the aging process and how it affects individual cities, age distribution "trees" are provided for the Region, Minneapolis and Richfield (Figures III-1, III-2, III-3). The legacy of past demographic trends--the depression of the 1930s, World War II, and the post-war baby boom--is seen not only in past age trees, but is evident until the end of the century. The shifts in the regional age distribution will have significant impacts on the individual cities. Minneapolis, for example, has been losing population in all age groups

Table III-7
REGIONAL PUBLIC SCHOOL ENROLLMENT

	Kindergarten	1-3	4-6	7-9	10-12	Totals
1967-1968	37,889	108,701	94,119	89,280	84,786	414,775
1970-1971	34,482	107,471	104,686	101,553	93,255	441,447
1973-1974	32,958	92,645	101,525	109,243	101,998	438,369
1976-1977	31,154	91,674	87,911	104,331	109,851	424,921

except the young adults and elderly since 1950. The young adult group has been growing regionally (and nationally) through the 1970s as the post-war babies reached adulthood. In the 1980s, however, this age group will begin to decline and will continue to decline through the 1990s.

As the post-war baby boom bulge moves out of the schools, some of which are now being closed, and into adulthood, it will place increasingly heavy demands on the housing supply and job market. This is initially reflected in increased needs for entry-level jobs and apartments, but this, too, will shift. Care must be taken to meet current needs without overbuilding for a short-lived market. The age group following the post-war babies is much smaller, especially the group born in the 1970s.

The FDA cities met the school needs of post-war babies and have provided most of the apartments for their initial housing needs. The Richfield age trees in 1950 and 1960 show the large numbers of children born in the post-war baby boom. On the 1970 age tree, the impact of the addition of numerous apartment buildings is evident in the increase shown in 20 to 29 year olds.

It remains to be seen whether the FDA will continue to serve this age group, or whether its members will move to the developing suburbs, as many of their parents did. It is unlikely that it will be economically possible to abandon the housing when this group no longer needs it, as FDA cities are doing with schools.

Figure III-1
REGIONAL AGE DISTRIBUTION TREES

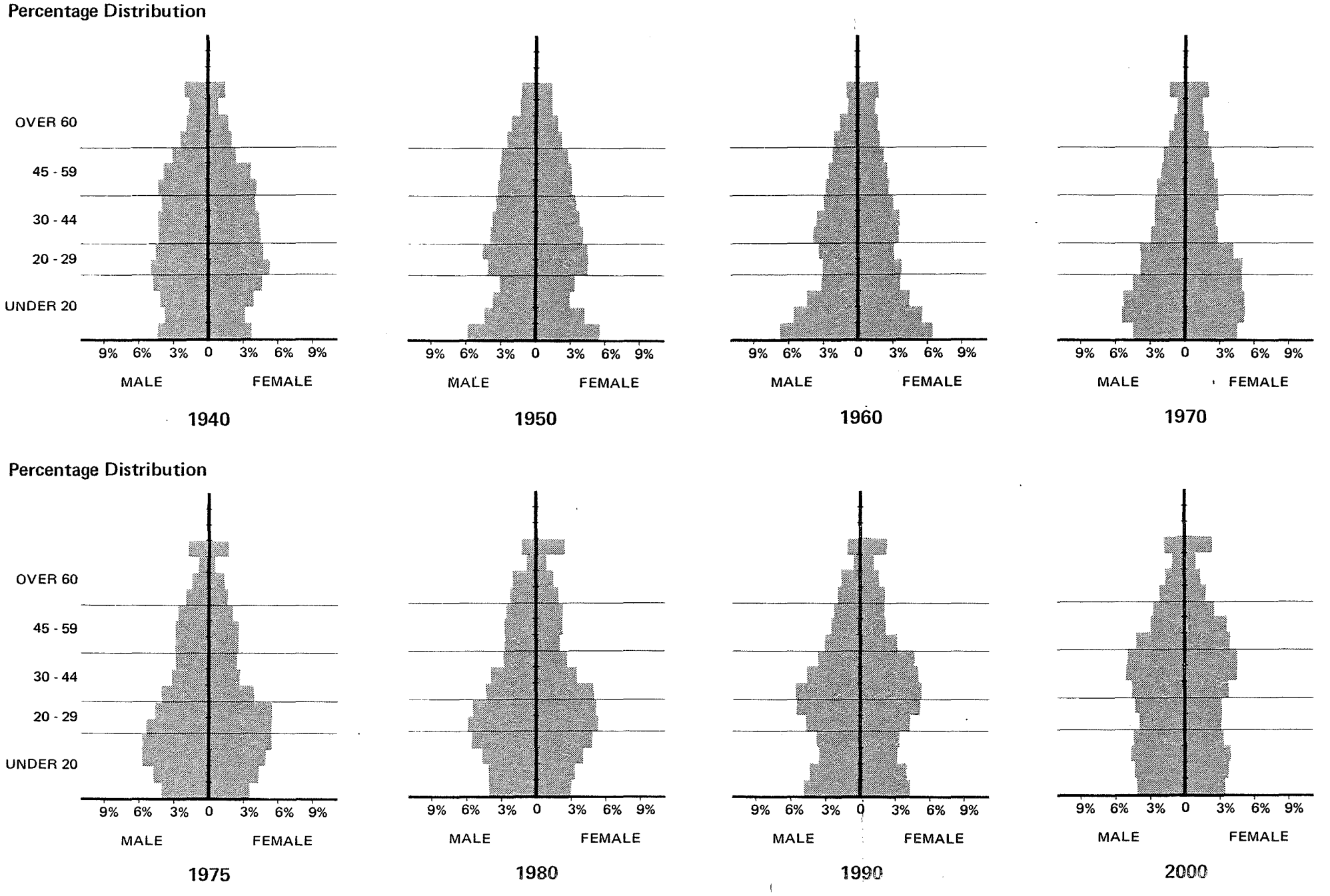
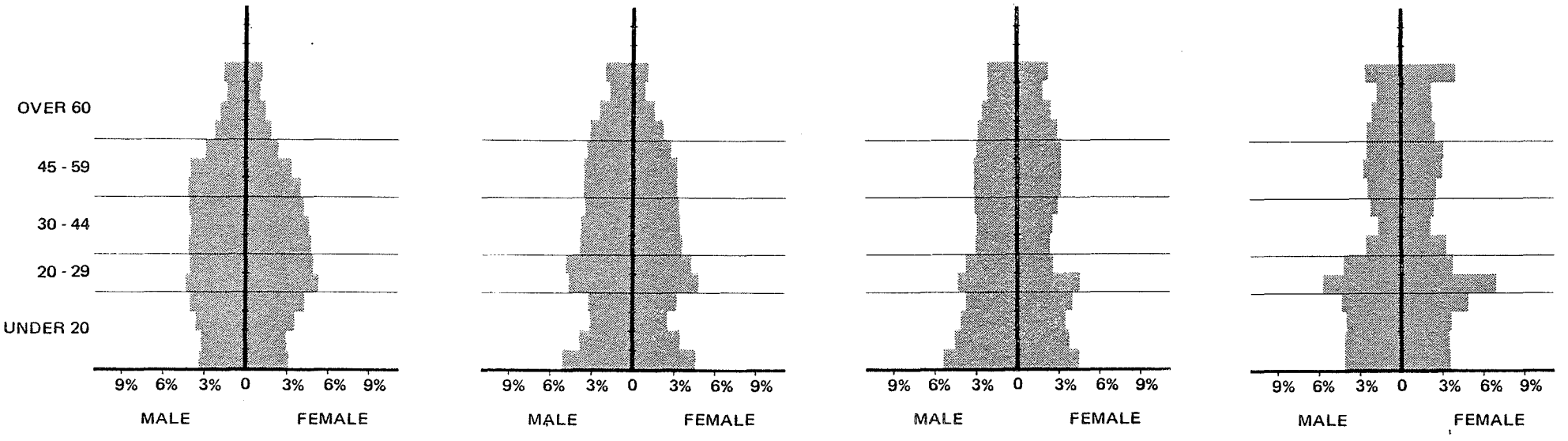


Figure III- 2

MINNEAPOLIS AGE DISTRIBUTION TREES

Percentage Distribution



1940 1950 1960 1970

Number of People

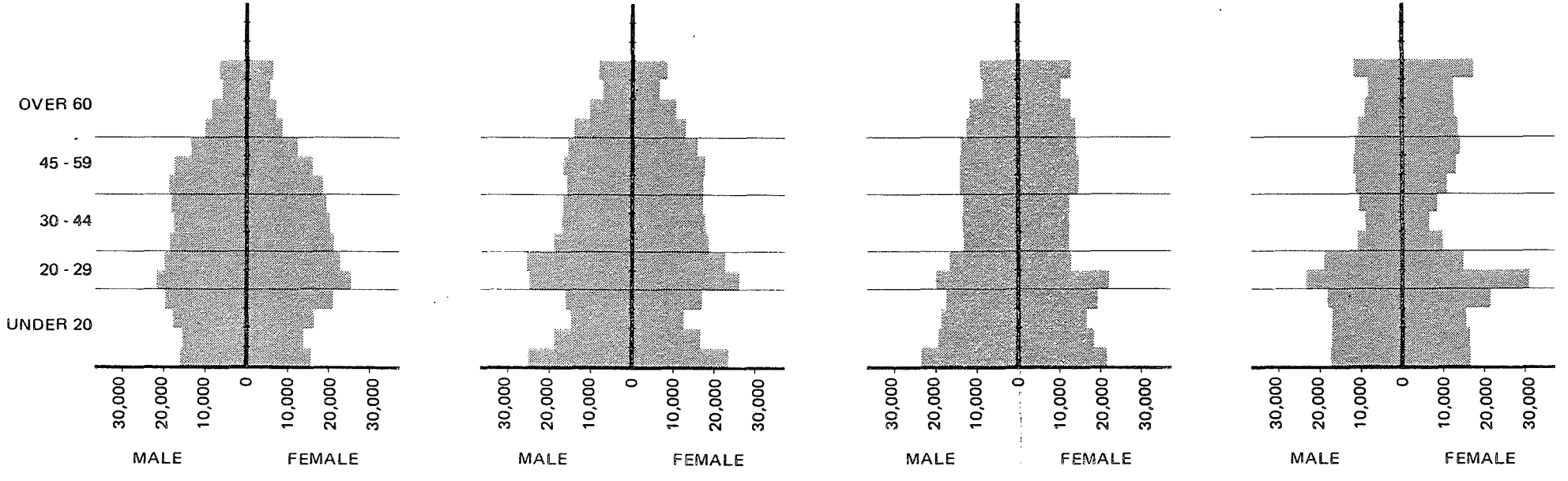
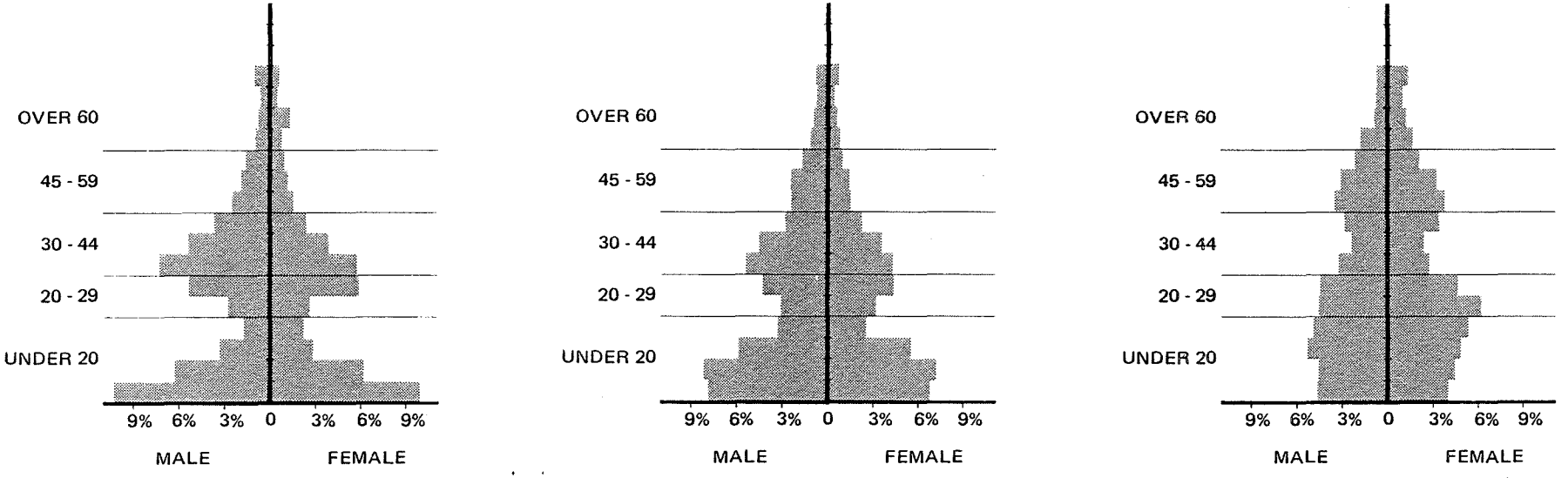


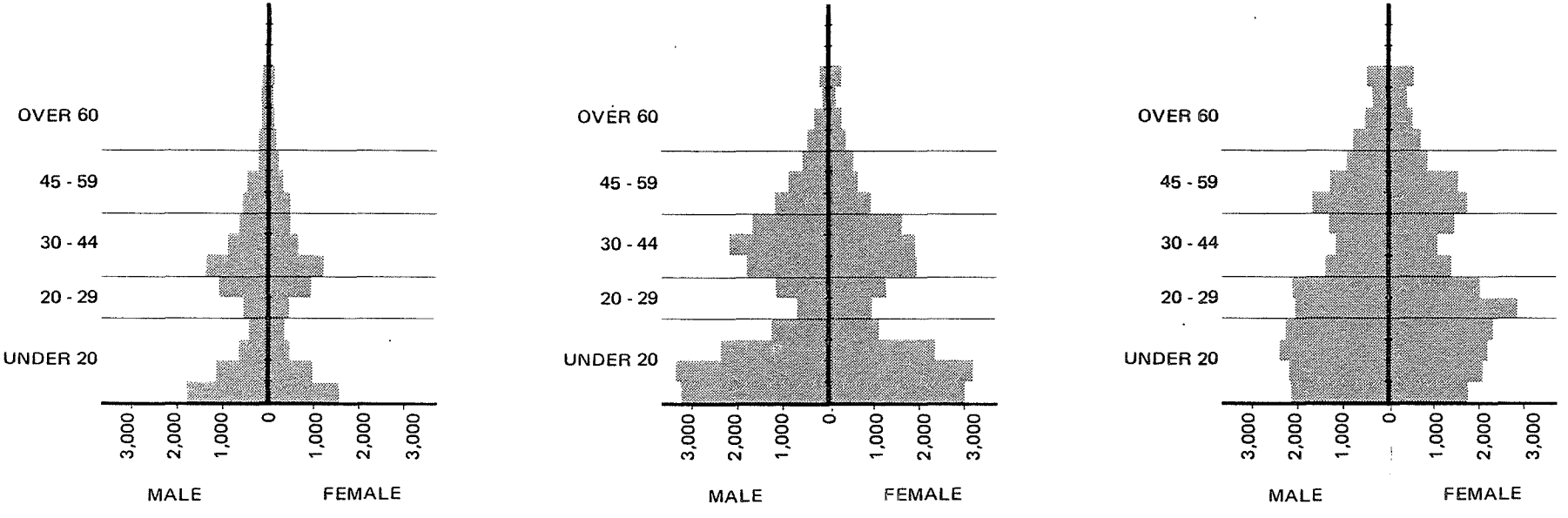
Figure III-3
RICHFIELD AGE DISTRIBUTION TREES

Percentage Distribution



1950 1960 1970

Number of People



IV. PUBLIC INVESTMENT

The quality of life in the Fully Developed Area (FDA) depends largely on the ability of the 22 FDA cities to raise enough revenues to do two things: (1) maintain the public infrastructure, and (2) provide adequate services to residents and businesses.

This section provides a brief overview of expenditure and revenue trends in the FDA cities.

EXPENDITURES

Public Investment in Capital Improvements

Metropolitan Council policy for the FDA emphasizes the importance of encouraging private sector investment and reinvestment. But continued private investment is contingent on maintenance of an adequate public infrastructure (buildings, streets, sewer and water systems) through public investment in capital improvements. Disinvestment by the public sector will precipitate disinvestment by the private sector.

The FDA cities do not show evidence of public disinvestment. From 1971 to 1976, they averaged 23 percent of total expenditures for capital outlay, evidence of continuing public investment. A general indicator of public disinvestment is a capital outlay of less than 15 percent of city expenditures.

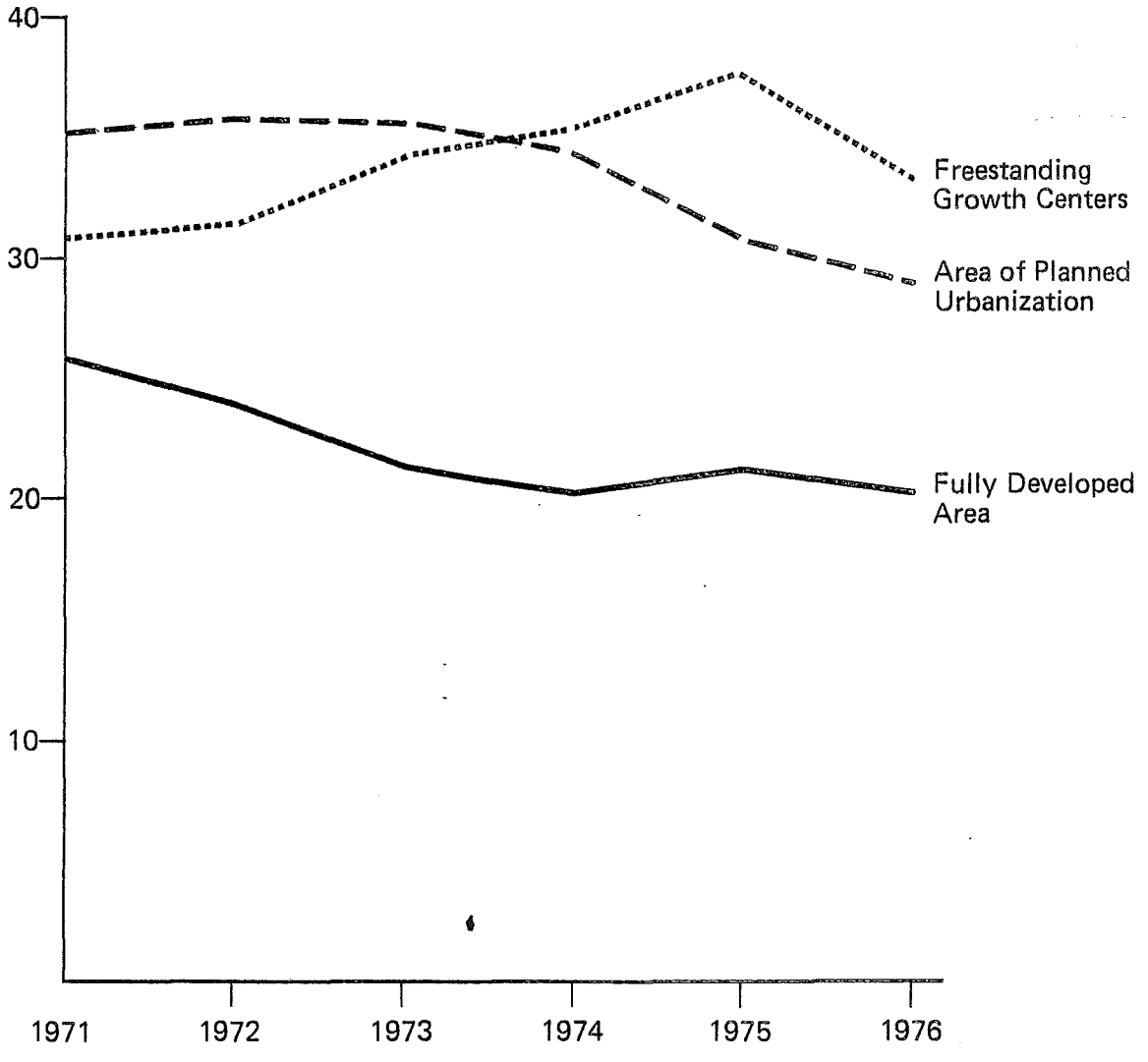
As their public infrastructures age, however, FDA cities will need to increase their level of expenditures for maintenance and replacement. This could result in intensive competition for limited public dollars between service needs and increased capital needs. Without continued public investment in infrastructure, the FDA cities are likely to encounter private sector disinvestment, too, making it increasingly difficult for them to maintain adequate local tax bases.

Figure IV-1 compares the ratio of capital outlay to total expenditures in three of the Region's policy areas from 1971 to 1976, using three-year averages. Both the Freestanding Growth Centers and the Area of Planned Urbanization spent higher percentages of their budgets for capital outlay than the FDA, averaging about 34 percent compared with the FDA's 23 percent average. Comparable data for the Rural Service Area is unavailable.

Public Incentives for Private Investment

Cities in the Metropolitan Area can encourage commercial or industrial firms to locate on redeveloped sites or marginal land by leveraging the development in either of two ways. They can use funds from commercial and industrial revenue bonds to aid private developers in financing major

Figure IV-1
RATIO OF CAPITAL OUTLAY TO TOTAL EXPENDITURES BY POLICY AREA*, THREE YEAR AVERAGES, 1971-1976



*Data on Rural Service Area is not available.

(Source: Reports of the State Auditor on the Revenues, Expenditures and Debt of the Cities of Minnesota, 1970-1977.)

projects. And they can use tax increment financing, usually to assume costs of preparing land for development. The expected results are an increase in the city's tax base, additional employment for residents, and retention of local firms when they are expanding.

These tools are especially useful for FDA cities, which by definition have limited vacant land. The FDA cities have issued 55 percent of the total dollar value of all commercial and industrial revenue bonds issued in the Region from 1970 to 1977. Cities in the Area of Planned Urbanization have issued 25 percent of the dollar value of these bonds, and the Freestanding Growth Centers have issued about 20 percent.

Tax increment financing has been used almost solely by the FDA cities (99.6 percent) for areas in need of redevelopment from 1968 to 1976. Minneapolis projects account for 79 percent of the dollar value of these projects.

Public Operating Expenditures

The FDA cities spend more of their budgets for operating expenses than the other policy areas. A major reason is that older FDA cities have higher concentrations of elderly, single-person and low-income households that require costly special services.

Figure IV-2 shows the breakdown of average city expenditures by policy areas. The FDA cities average 56 percent for operating, 23 percent for capital outlay and 22 percent for debt service. The Freestanding Growth Centers and Area of Planned Urbanization spend 46 and 40 percent respectively on operating expenses. Both spend 34 percent for capital outlay and they spend 20 and 26 percent respectively for debt service.

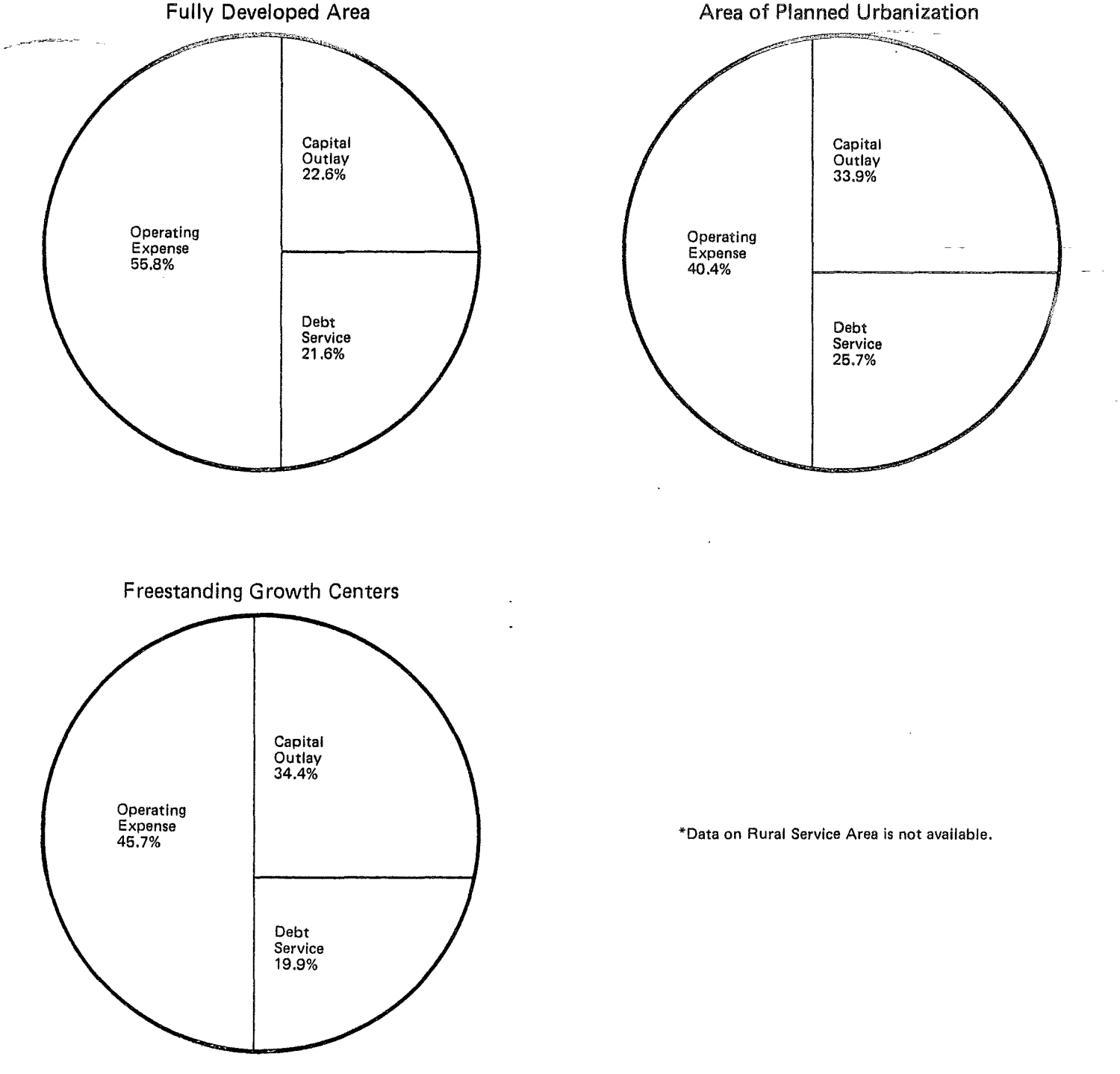
REVENUES

Intergovernmental Sources of Revenue

The FDA cities get an average of 39 percent of their total revenues from federal, state and county aids, as shown in Figure IV-3. Their other major revenue sources are local property taxes, 30 percent, and special assessments and user fees, 19 percent. The remaining 12 percent comes from various sources, such as fines, license fees, public service contributions and interest.

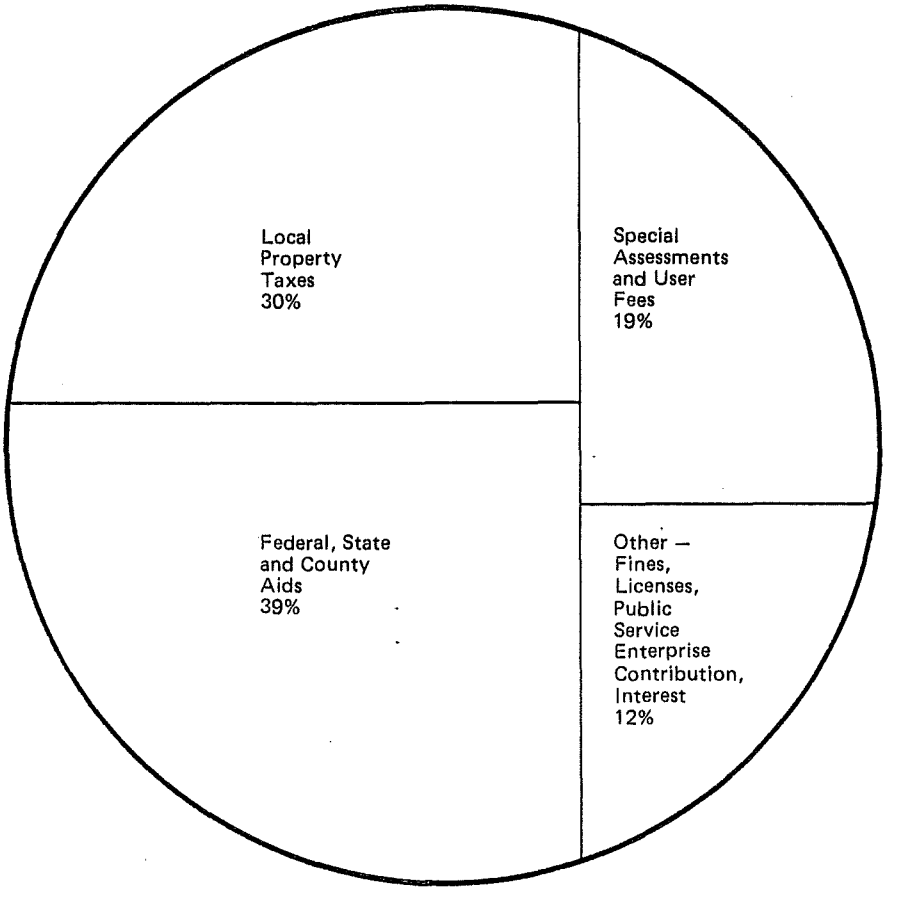
Reliance on intergovernmental aids varies significantly among the FDA cities. St. Paul, South St. Paul, Minneapolis, Lauderdale, Columbia Heights, Robbinsdale, Falcon Heights and Hilltop receive 37 to 46 percent of their revenues from these sources. The remaining 14 FDA cities receive less than one-third of their revenues from intergovernmental sources. Edina, at 22 percent, receives the least.

Figure IV-2
AVERAGE EXPENDITURES BY POLICY AREA,* 1971-1977



*Data on Rural Service Area is not available.

Figure IV-3
SOURCES OF REVENUES FOR FULLY DEVELOPED AREA CITIES, 1974-1976



State and county aids provide more revenues to FDA cities than the federal government does. The FDA cities receive between 21 and 34 percent of their budgets from state and county sources. Seventy-four percent of all state and county aid to the FDA goes to Minneapolis and St. Paul. Most federal funds go to Minneapolis and St. Paul, too, which together receive 91 percent of all federal aids to FDA cities.

Property Tax Revenue

The property tax base of the FDA has declined, while the need for revenues to service an increasing number of households has become greater. The FDA's adjusted assessed valuation decreased seven percent from 1970 to 1976. Its number of households increased six percent in the same period. Valuations of the newer FDA suburbs increased, but Minneapolis, St. Paul and the older FDA suburbs lost valuation.

A balance between regional share of valuations and share of households would indicate a policy area's ability to provide services relative to the other policy areas. Table IV-1 shows that the FDA's share of the Region's valuation is lower than its share of households, and that the gap is widening. In 1970, the FDA had 68 percent of the valuation and 72 percent of the households; in 1976, it had 59 percent of the valuation and 66 percent of the households. This indicates that the FDA is losing ability to fund services relative to the other policy areas, all of which have larger or equal shares of the Region's valuation than they do of its households.

State Tax Levy Limit

The state-imposed levy limit of six percent annually on property tax increases may constrain cities from maintaining existing levels of service at a time when the inflation rate exceeds six percent. The FDA cities may have to choose between providing fewer services and collecting additional user charges for such services as parks and rubbish collection to raise additional revenues.

Fiscal Disparities Program

By sharing the Region's commercial and industrial growth since 1971, the Fiscal Disparities program is beginning to reduce city-by-city differences in per capita tax bases. It's also beginning to make tax rates on commercial and industrial property more uniformed across the Region.

Eleven percent ($258 million) of the Region's commercial and industrial valuation was placed in the fiscal disparities tax base sharing pool in 1977. The FDA contributed 41 percent of the pool, and in return received 56 percent.

Eleven FDA cities had net gains from tax base sharing and the other 11 were net contributors. The three oldest FDA cities, Minneapolis, St. Paul and South St. Paul, were all among the 11 gainers, while most newer FDA cities were net contributors.

TABLE IV-1

REGIONAL SHARE OF VALUATIONS AND HOUSEHOLDS BY POLICY AREA
1970 to 1976

Policy Areas	% Share Adjusted Assessed 1970 Valuation*	% Share Region's Households 1970	% Share Adjusted Assessed 1976 Valuation	% Share Region's Households 1976
Fully Developed Area	68	72	59	66
Area of Planned Urbanization	22	19	28	24
Freestanding Growth Centers	4	4	5	5
Rural Service Area	5	4	8	6

*Adjusted assessed valuation: assessed valuation (value used for tax purposes) adjusted to approximate market value.

(Source: Minnesota Department of Revenue.)

V. PRIVATE INVESTMENT

In looking for indicators that the Fully Developed Area (FDA) is an attractive place to invest or reinvest, the key question is - is private disinvestment occurring?

While there is no clear indication that private disinvestment is occurring in the FDA, some indicators show cause for concern. Total assessed valuation is declining. The annual ratio of commercial-industrial activity to assessed valuation is low enough to pose problems if it continues. There is still strong competition from the developing suburbs for industrial activity, and there is high commercial-industrial vacancy in older, poorer neighborhoods in Minneapolis and St. Paul.

There are some positive signs, too. The overall vacancy rate for commercial-industrial structures is down, particularly in the central cities. The housing situation is generally positive. Long-term vacancy, which indicates abandonment, is not a major problem. The housing stock is maintaining its value in constant dollars. The sales prices of homes are up and there are sufficient buyers for the homes for sale. These very hopeful signs drawn from new data may portend greater private investment and reinvestment in the FDA in the next few years.

DISINVESTMENT INDICATORS

Private disinvestment is indicated when the assessed value of commercial, industrial, and residential taxable property is not increasing or at least remaining stable. When property values are not increasing, it is a result of one of four general conditions:

1. As buildings age, maintenance is being delayed;

2. Replacement of worn-out structures is not occurring;

3. Conversion or major rehabilitation of existing structures, which is necessary to keep them economically competitive, is not occurring; or

4. The small amount of open, developable land is remaining vacant.

This section examines assessed valuation and construction activity in the FDA, the two major indicators of whether or not private disinvestment has been exhibited.

Assessed Valuation

Total adjusted assessed valuation in the FDA dropped seven percent between 1970 and 1976 in constant 1976 dollars. Valuation in the Region as a whole increased seven percent during the same period. The rapid inflation of the 1970s has had an adverse impact on the FDA.

Residential valuation decreased one percent in the FDA between 1973 and 1976, using constant 1976 dollars. Commercial-industrial valuation decreased 11 percent in the same period.

As a result, the FDA has increased its reliance on residential valuation for generating local revenues. Also, the FDA has moved toward the regional ratio of commercial-industrial to residential valuation. This indicates the effect of the decentralization of commercial-industrial activity to the developing suburbs. It also indicates that the developing suburbs are relying less on the FDA for services and employment opportunities.

Ratio of Commercial-Industrial Building Permit Value to Commercial-Industrial Assessed Valuation

The FDA had a two percent annual increase from 1973 to 1977 in the ratio of commercial-industrial building permit value to commercial-industrial assessed valuation. The Region had a 3.3 percent annual increase and the developing portion of the Region had a 7.4 percent annual increase. Eleven FDA cities had annual increases under two percent.

A national study of cities concluded that city increases of two percent or above were generally healthy. Since the reinvestment cycle is longer than the five years studied (1973-1977), economic problems are not imminent for the FDA or individual FDA cities. However, if a lower rate continues into the 1980s, some FDA cities will face economic problems.

Commercial-Industrial Building Permit Value

Annually, $208 million in commercial-industrial building permits was issued in the Region from 1973 to 1977. The FDA accounted for 44 percent of the activity. In the 1975 recession, the FDA dropped to under 30 percent of the Region's permit activity (Figure V-1).

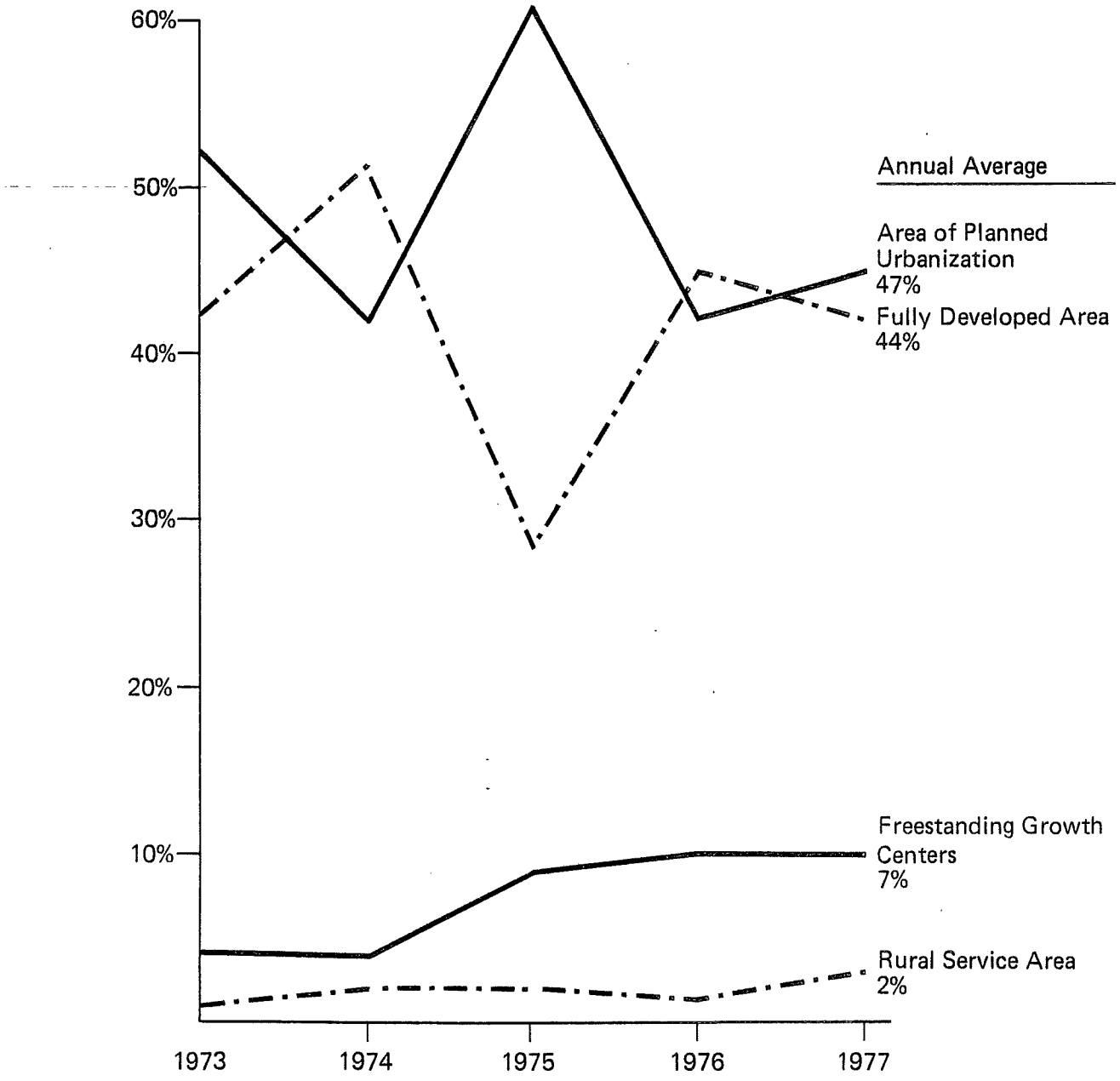
The FDA had 50 percent of commercial activity and 37 percent of industrial activity in the Region. The difference between commercial and industrial activity indicates that the economic and employment roles of the FDA are changing.

Industry has continued to move out of the FDA. In the 1960s, the central cities accounted for 84 percent of the firms in the Region which moved to another community. In the 1970s, the FDA suburbs have accounted for 50 percent and the central cities for 40 percent of the out-migration.

Industrial building permit values dropped 46 percent between 1968-1972 and 1973-1977 in the FDA. Only five FDA suburbs that had vacant industrial land had increases. Since vacant land is limited in the FDA and cost of redevelopment is high, industrial growth will likely remain in the developing suburbs where land is available and cheaper.

The FDA had 57 percent of the office building permit value and only 34 percent of the retail building permit value from 1973 to 1977. Office developers have a strong preference for central locations, which favors the FDA. The central cities have 60 percent of the Region's office space.

Figure V-1
PERCENT SHARE OF REGIONAL COMMERCIAL-INDUSTRIAL BUILDING PERMIT VALUE, 1973-1977



In the 1973 to 1977 period, Minneapolis and St. Paul accounted for only six percent of the office space added in the Region. However, in 1979, several million square feet is under construction in the downtown areas of the two cities.

Commercial-Industrial Building Vacancy: R. L. Polk Data, 1974-1978

In 1978, 7.9 percent of the commercial-industrial units in the FDA were vacant. Minneapolis had a vacancy rate of 9.3 percent; St. Paul had an 8.4 percent vacancy rate, and the FDA suburbs had a 6.8 percent vacancy rate. Vacancy rates declined between 1974 and 1978 in the central cities; in the FDA suburbs, they did not change much overall.

Commercial-industrial vacancy is decreasing in parts of the central cities where it has been highest--North Minneapolis, Central Minneapolis south of the downtown, Summit-University in St. Paul and the East 7th Street area in St. Paul--but the vacancy rate in these areas was still high in 1978 (over 10 percent). This raises concern about the level and type of services and employment opportunities available to residents. Also, high vacancy rates in older areas indicate possible blight caused by vacant or abandoned stores and factories.

Some older suburban shopping strips, smaller shopping centers and older mixed industrial areas had high vacancy rates in 1978 (over 10 percent). The trend in these suburban locations was toward higher vacancies, which is cause for concern.

Age of Housing

Nearly 40 percent of the housing units in the FDA were built before 1940; another 37 percent were built between 1940 and 1960. With housing units needing major maintenance every 20 years, housing rehabilitation should be a major program concern in the FDA.

The FDA accounted for 86 percent of housing unit demolitions in the Region between 1971 and 1977. Most of the activity was in the two central cities.

New housing unit construction in the FDA is limited by the availability of vacant land. In the 1971 to 1977 period, 35 percent of the Region's new housing construction was multifamily units. However, since 1975, single-family construction has increased as a ratio of all housing construction.

Housing Value and Turnover

The average adjusted assessed valuations in the FDA increased 24.6 percent for single-family homes and 27 percent for multifamily units during the 1973 to 1976 period. These increases were less than the rate of inflation as measured by the Gross National Product Implicit Price Deflator.

The average sales price of single-family homes increased 44 percent in

the FDA from 1973 to 1977, according to Multiple Listing Service (MLS) data. The central cities had a 49 percent increase and the FDA suburbs experienced a 44 percent increase. Both increases were above the rate of inflation. All existing housing has appreciated in value; however, within the central cities, the gap between the MLS districts with higher average sales prices and those with lower average sales prices increased from 1973 to 1977.

Long-term vacancy, which indicates abondonment or a bleak housing market, is very low in the FDA. So is the single-family housing turnover rate, which was only five percent in 1977. The low turnover and low long-term vacancy rates indicate a strong housing market throughout the FDA.

Housing Unit Vacancy: R. L. Polk Data, 1974-1978

In 1978, the vacancy rate for housing units for sale was 1.4 percent in the FDA. Higher vacancy rates for sale units (above 2.5 percent) in 1978 were in North Minneapolis, Central Minneapolis (neighborhoods adjacent to downtown) and the Summit-University area in St. Paul. Several suburban areas had higher vacancy rates in areas of new construction or condominium conversion.

In 1978, the vacancy rate for housing units for rent was 4.4 percent in the FDA. The areas of higher vacancy (above five percent) were central city and suburban locations with concentrations of rental housing.

VI. EMPLOYMENT

Employment is an important indicator of a city's economic well-being. Jobs and housing are closely interrelated. Generally, where there are jobs, there is a stronger demand for housing and vice versa. Employment concentrations do demand public services. But they also stimulate development of related commercial enterprises, such as banks, shopping areas and personal services, that improve the tax base and level of services available to city residents.

Cities with high blue collar occupations are generally more attractive for industrial development. Cities with high professional and managerial occupations are generally more attractive for commercial development, particularly office and more fashionable retail activities.

The type and cost of housing is also affected by the residential occupational profile. The combination of employment opportunities, resident occupational profile, and housing quality and cost have a significant impact on a city's future.

EMPLOYMENT TRENDS

Trends in employment in FDA cities follow.

The FDA had 79 percent of the Region's employment in 1977. This was down five percent from 1969, when the FDA had 84 percent of all employment (Table VI-1).

The FDA had 692,000 jobs in 1977. This was a 6.6 percent increase over 1969. The Region had an increase of 13.3 percent. Four FDA cities had employment losses between 1969 and 1977.

Manufacturing employment dropped 12 percent in the FDA. This decline, and the decentralization of manufacturing jobs to the Developing Suburbs and Freestanding Growth Centers, follows a national trend.

Service employment increased dramatically in the FDA, rising 33 percent from 1969 to 1977. Service employment, in contrast to manufacturing employment, is continuing to concentrate in the FDA.

OCCUPATIONAL BREAKDOWNS

The Polk data on occupations of FDA residents in 1974 and 1978 indicates that diversification is taking place. The occupations of people who live in the central cities and FDA suburbs are changing. The central cities have more people with professional and managerial jobs today, and the FDA suburbs and developing suburbs have more blue collar workers than they did 10 years ago. The effect of industrial movement to the suburbs and the increase of service employment in the central cities is clear.

TABLE VI-1

PERCENT OF REGIONAL EMPLOYMENT BY POLICY AREA
1969 - 1977

Policy Area		Total Employment	Manufacturing	Wholesale Retail Trade	Services
Fully Developed Area	1969	84.1	77.8	87.4	84.9
	1977	78.9	74.3	77.4	87.3
Area of Planned Urbanization	1969	11.7	16.9	8.9	11.6
	1977	14.0	18.6	17.3	9.5
Freestanding Growth Centers	1969	3.5	4.9	3.1	2.7
	1977	5.0	6.6	4.0	2.7
Rural Service Area	1969	0.7	0.4	0.5	0.7
	1977	2.1	0.5	1.3	0.5

(Source: Minnesota Department of Economic Security.)

Since 1974, the central cities have increased their share of the Region's professional and managerial occupations, nearly matching the percentage in the FDA suburbs, as they did in 1950. Conversely, by 1978, 40 percent of the employed heads of households in developing suburbs had blue collar occupations, compared with 35 and 36 percent respectively in the FDA suburbs and central cities.

The central cities have a diverse resident occupational profile, although it is high on occupations with lower salaries. The FDA suburbs also have a diverse resident occupational profile. However, there is much more stratification of occupational types in individual suburbs. Golden Valley, Edina and Falcon Heights have more than twice as many professional and managerial occupations as blue collar occupations, for example. Columbia Heights, Hilltop and South St. Paul have the opposite.

The professional and managerial occupations are concentrated in Edina, St. Louis Park-Golden Valley, Minneapolis lakes area, East River Road in Minneapolis and St. Paul, Highland Park in St. Paul, and the Roseville-Falcon Heights-St. Anthony area. Areas that are increasing in professional and managerial occupations are downtown St. Paul, Ramsey Hill in St. Paul, and the Loring Park-Minneapolis lakes area.

The blue collar occupations are concentrated in East Bloomington, North Minneapolis, Northeast Minneapolis, Columbia Heights-Fridley, Brooklyn Center-Crystal-New Hope, South St. Paul, North Central St. Paul and St. Paul Eastside. Areas with increasing numbers of residents in the blue collar occupations are North and Central Minneapolis, Hopkins, and St. Paul Eastside.

VII. IMAGE AND ATTITUDE

One important determinant of the future of the FDA cities that is not revealed by objective measures is their image--people's attitudes about them. Although it is difficult to measure and interpret attitudes, they do influence where people choose to live and how they respond to their environment.

In a recent Metropolitan Council survey, residents of the Region were asked four questions relating to residential preference and neighborhood satisfaction. The responses were broken down by place of residence, age, income and family status.

ATTITUDES BY PLACE OF RESIDENCE

Neighborhood Ratings

Neighborhoods throughout the Region were rated very high in 1978, although the suburban and rural areas were rated even more favorably than the central cities (see Table VII-1).

TABLE VII-1

NEIGHBORHOOD RATINGS BY RESIDENTS, 1978

Question: How would you rate this neighborhood as a place to live?

	Excellent	Good	Fair	Poor	Unsure
Minneapolis	27%	51	16	7	-
St. Paul	22	51	20	6	1
Fully Developed Suburbs	60	30	10	-	-
Developing Suburbs	49	39	8	2	-
Rural Area	53	40	7	-	-
Seven-County Region	41	42	13	3	-

Future Neighborhood Ratings

Optimism about the future of their neighborhoods was also high in all parts of the Region. Residents of the central cities and rural areas expressed the greatest optimism. For central city residents, this

was a significant increase in optimism over residents' responses to the 1974 Council attitudinal survey (see Table VII-2).

TABLE VII-2

RESIDENTS' VIEWS OF NEIGHBORHOOD FUTURE, 1978

Question: Over the next two to three years, do you feel your neighborhood will become a better place to live, or a worse place to live?

	Much Better	Slightly Better	About Same	Slightly Worse	Much Worse	Unsure
Minneapolis	16	39	26	11	5	3
St. Paul	22	26	26	17	1	8
Fully Developed Suburbs	5	35	44	11	2	4
Developing Suburbs	12	36	24	13	7	7
Rural Area	20	40	33	3	3	-
Seven-County Region	13	35	31	12	4	5

Residential Preferences

The results showed that the greatest number of people preferred to stay in their present neighborhoods if they moved to another house or apartment (about one-third). Exceptions were St. Paul residents, more of whom would prefer a suburban location to their present location, and residents of the FDA suburbs, who more often preferred a location elsewhere in the suburbs. Rural residents displayed the greatest preference for their present neighborhood (see Table VII-3).

ATTITUDES BY INCOME

In 1978, a majority of people in all income categories rated their neighborhoods as either "excellent" (40 percent) or "good" (43 percent). As might be expected, the higher the income, the higher the neighborhood rating. But even respondents in the lowest income category (under $8,000) rated their neighborhoods "good" or "excellent" 77 percent of the time. In terms of future expectations for their neighborhoods, the responses did not vary much by income, although the lowest income group appeared to be the most optimistic.

Residential preference by income showed that the lowest income group had the greatest preference for staying in the same neighborhood, while those in the upper income category were least likely to want to remain in their present neighborhood if they moved. The central cities were preferred more often by the lower-income respondents than other income groups.

TABLE VII-3

PREFERRED LOCATION FOR A NEW PLACE TO LIVE, 1978

Question: Suppose you decided to move to a different house or apartment. Which one of these areas would be your first choice?

	Present Neighborhood	Mpls.	St. Paul	Mpls. Subs.	St. Paul Subs.	Rural Area	Unsure
Minneapolis	33	27	2	18	1	17	3
St. Paul	26	3	23	3	30	12	2
Fully Developed Suburbs	30	2	2	42	5	18	-
Developing Suburbs	31	-	-	21	17	29	3
Rural Area	60	3	-	7	-	27	3
Seven-County Region	32	9	5	22	11	19	3

ATTITUDES BY AGE

The youngest (under 30) and oldest (over 65) age groups tended to rate their neighborhoods somewhat lower than the middle groups. The 50 to 64 age group expressed the highest degree of satisfaction with their neighborhoods, although neighborhood ratings were quite favorable for all age groups.

In terms of optimism about the future of their neighborhoods, the responses by age were similar. The youngest age group was slightly more optimistic and the 50 to 64 group was the least optimistic. With respect to where people would want to live if they were moving, the present

neighborhood was most popular for all age groups except the youngest, and popularity of the present neighborhood increased with age. Minneapolis and St. Paul were most popular with the youngest age group, although they were still far less popular than the suburbs. St. Paul showed its strongest popularity among the elderly.

ATTITUDES BY FAMILY STATUS

Neighborhood ratings did not vary significantly between families with children and those without children. The responses regarding future conditions of neighborhoods were also very similar between households with children and those without. There were, however, differences by family status in locational preferences. People without children more often preferred the central cities than those with children, while the reverse was true for rural areas.

VIII. DIFFERENCES WITHIN THE FULLY DEVELOPED AREA CITIES

This section discusses the major differences among the 22 Fully Developed Area (FDA) cities. These differences are in their need for and ability to accomplish reinvestment or redevelopment.

The 22 FDA cities have reached the point in their development where they have little vacant land remaining. Thus, the urban changes that they experience in the future will involve reuse of existing structures and redevelopment.

An individual FDA city's need for reinvestment or redevelopment is largely a consequence of the age of its development, while its ability to have reinvestment or redevelopment occur is largely dependent on the value of its development. Generally, the higher the value of its housing, businesses and factories, the better able a city is, and more likely its citizens and businesses are, to carry out reinvestment or redevelopment in areas that need it.

FDA CITY GROUPS

Besides their short supply of vacant land, how alike are the FDA cities? Their main similarities and differences depend on when their major growth occurred. The first group of cities experienced major growth before 1940, the second group during the 1940s and 1950s, and the third group in the 1960s. A data overview of the three FDA city groups is provided in Table VIII-1.

Group 1, the older developed cities,need reinvestment and are experiencing changes in their demographic character and ability to attract private investment. They are Minneapolis, St. Paul and South St. Paul.

Group 2 cities do not yet have a major need for reinvestment, but they are beginning to show change in their demographic character and in their ability to attract private investment. They are Columbia Heights, Falcon Heights, Hilltop, Hopkins, Lauderdale, Mendota, Richfield, Robbinsdale, St. Louis Park and West St. Paul.

Group 3 cities, which became built-up most recently, are not experiencing the need for reinvestment. They are showing only beginning signs of change in their demographic character and in their ability to attract private investment. They are Bloomington, Brooklyn Center, Crystal, Edina, Fridley, Golden Valley, New Hope, Roseville and St. Anthony.

DIFFERENCES BETWEEN FDA CITY GROUPS

The following summarizes some of the major changes occurring in the FDA and their implications for the three groups of FDA cities.

Table V111-1

DATA OVERVIEW OF FDA CITY GROUPS

	Fully Developed Area City Groups		
	Group 1	Group 2	Group 3
Population Change 1970-1978	-13.8%	-6.9%	1.5%
Household Change 1970-1978	2.4%	9.1%	21.5%
Unit Change 1970-1978			
Single-Family	.6%	1.7%	12.2%
Multifamily	5.1%	26.5%	55.3%
Residential Assessed Value Per Household 1977	$17,636	$30,801	$39,052
Percent Developed 1975	96.6%	91.3%	86.0%
Employment Change 1969-1977			
Total Employed	2.9%	8.9%	31.7%
Manufacturing Employment	-13.9%	-24.6%	13.2%
Service Employment	25.3%	23.1%	64.7%
Industrial Building Permit Value per Household 1977	$ 222	$ 160	$ 648
Commercial Building Permit Value per Household 1977	$ 312	$ 472	$ 914
	$ 534	$ 632	$ 1,562
Municipal Expenditure Patterns Operating Expenses per Household (1976 dollars)			
1950	$467	$304	$145
1960	506	367	716
1970	660	417	465
1976	725	368	361
Capital Outlay per Household (1976 dollars)			
1950	$ 80	$280	$118
1960	154	273	755
1970	199	250	288
1976	269	156	122
Ratio of Capital to Total 1976 Expenditures	24%	25%	18%

Population and Household

The oldest group of cities has experienced the greatest population loss in the 1970s. Group 1 lost 106,182 people between 1970 and 1978. The second group of cities has begun to lose population, while the third group of cities has had a slight increase. All three city groups have added households in the 1970s, but the most dramatic increases were in the third group of cities.

Residential Activity

The FDA added 33,159 housing units between 1970 and 1978. Group 1 has added more multifamily units, while Group 3 built mostly single-family units. Since 1975, housing construction has slowed greatly in all FDA cities. The drop-off was greater in the oldest FDA city group. The older a FDA city is the lower the residential assessed value per household is likely to be.

Land Use

The relatively small amount of vacant, developable land, particularly in FDA Groups 1 and 2, may deter development because of the scarcity of large sites and the actual or perceived higher costs of development through infill and redevelopment.

Employment

Employment patterns indicate a shift of industry out of the FDA, primarily from FDA Groups 1 and 2, which traditionally had the locational advantage of rail and river access. This shift leaves vacant or underutilized land and structures. Manufacturing employment dropped in both Groups 1 and 2; Group 2 had the greatest percentage loss.

Wholesale and retail employment is becoming decentralized with negative impacts on the older FDA cities, which traditionally had the locational advantages. Service employment has increased substantially in all FDA cities, however.

Private Investment

Industrial firms continue to leave the FDA and new industrial development is more likely to occur in the developing suburbs. The FDA relies more heavily on commercial investment. Annual amounts of commercial-industrial investment in the FDA are close to the point where private disinvestment may be a problem if the lower rate continues into the 1980s.

Housing values are increasing more rapidly in the older parts of the FDA. However, the highest housing values are in the Group 3 cities.

Municipal Expenditures

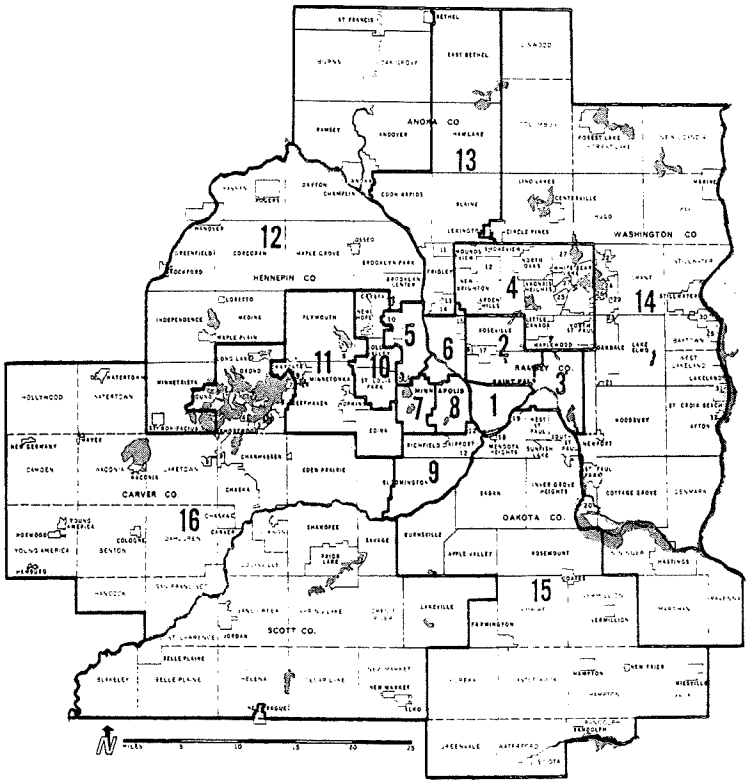
Municipal expenditures for the FDA cities follow similar patterns over time, with capital and operating expenditures increasing as cities age. It appears that Group 1 cities face the most difficult situations. So long as cities have sufficient vacant land to accommodate new growth, their tax base will likely grow or remain stable. The tax base can remain stable if new growth offsets depreciation in existing structures. Only in cities where there is a strong market for housing and business, which encourages continual improvement of existing property, will there be a constantly growing tax base without new construction on vacant developable land.

The tax base is shrinking substantially in the Group 1 cities. Group 2 cities are also beginning to lose valuation. Only the Group 3 cities have been able to increase their valuation as a result of new development. This change in tax base has broad implications for the ability of the older cities to raise local revenues and still be attractive for development.

Although the costs of government are increasing, the Group 1 cities have kept their local revenue effort* increase to 11 percent while their tax base has decreased 16 percent. This means that in constant dollars, they spent less in 1976 than in 1970. The Group 2 cities have increased their spending slightly. The Group 3 cities, where most of the growth has occurred since 1960, have increased their spending 15 percent. This means that as the cities age, become fully developed and experience losses in tax base, the services they provide will likely decrease. This has implications for future city vitality. The problem has been compounded by high inflation, coupled with the state-imposed levy limit on property tax increases.

There has been no indication of public disinvestment in the FDA. None of the FDA city groups spends less than 15 percent of its budget for capital outlay. However, operating expenditures in the older developed cities have gone up at the same time capital outlay has. The questions are, can this continue? And if municipal budgets are cut, will capital or operating expenditures be curtailed? If it is capital outlay, disinvestment may result. The Group 2 cities have not started any major capital infrastructure replacement yet. Currently, they are experiencing higher operating expenditures and decreasing tax bases. They may be facing problems similar to those of Group 1 cities within the next decade when their infrastructures need replacement.

*Local revenue effort is the ratio of locally raised revenues to the property tax base.



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