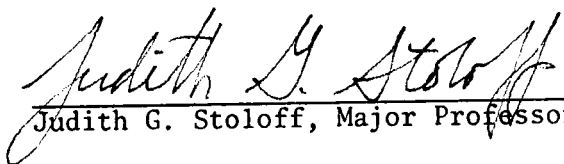
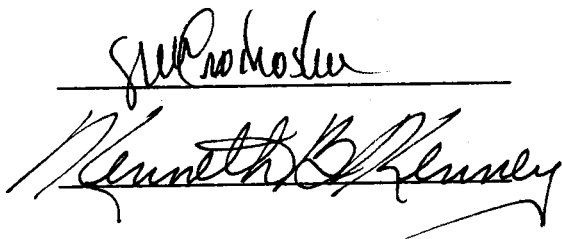


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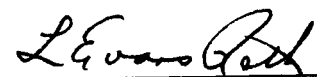
I am submitting herewith a thesis written by Richard W. Hails entitled "The Urban Housing Rehabilitation Industry in Knoxville, Tennessee." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science in Planning.


Judith G. Stoloff, Major Professor

We have read this thesis and
recommend its acceptance:


Kenneth B. Kenney

Accepted for the Council:


Vice Chancellor
Graduate Studies and Research

THE URBAN HOUSING REHABILITATION INDUSTRY
IN KNOXVILLE, TENNESSEE

A Thesis
Presented for the
Master of Science in Planning
Degree
The University of Tennessee, Knoxville

Richard W. Hails

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ABSTRACT

The purpose of this study was to better understand the nature and problems of the urban housing rehabilitation industry in Knoxville, Tennessee, through direct interviews with industry members. The interviews included sections about the background, procedures used, and problems of being in the housing rehabilitation industry. A total of 17 contractors and five other professionals active in housing rehabilitation activities in Central Knoxville were interviewed. Data compiled through the interviews was compared with information from a review of literature related to the topic.

Results emphasized the ongoing importance of and need to support the small housing rehabilitation contracting firm within the industry. This was found to be important due to the close supervision and great flexibility required by rehabilitation work. A growing amount of professionalism and standardization is also being seen in the industry, a trend that is supported by the nature of some government rehabilitation programs. Most industry members, however, still remain oriented toward general construction and carpentry skills, with most specialty work still subcontracted.

Few problems and corresponding solutions for the industry were proposed by industry members, something which appeared to be due to the low status and hope for improvement seen by many of them. Some of the newer industry members held a more optimistic view of the industry. Although the urban housing rehabilitation industry in Knoxville was

seen as an active one, the local industry had not yet taken on many of the characteristics of other, more organized industries. Although better communications and stronger professional groups will probably continue to emerge, the nature of the rehabilitation work itself was seen as a limiting factor in this trend. Lastly, the report points to some future directions for research and considerations for planners in relating to the housing rehabilitation industry.

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CHAPTER I

INTRODUCTION

A. Background

Housing rehabilitation activity in U.S. cities has increased substantially in recent years. From 1971 to 1977 alone, total residential improvement expenditures in the U.S. increased by more than \$3.3 billion constant dollars, a 27 percent increase (U.S. Department of Housing and Urban Development (HUD), Goals Report, p. 35). The increase seen in large central cities has been even more dramatic. From 1970 to 1975, residential expenditures by homeowners in these cities increased by almost a billion dollars, from \$2.5 to \$3.4 billion (Black, p. 1). The fact that these increased expenditures were in addition to the large amounts already spent each year on normal property maintenance means that many people are now reinvesting in their homes in major improvements that were simply not being made a few years ago.

Publicly-supported rehabilitation programs aimed primarily at lower-income urban families have also seen large increases in funding in recent years. Expenditures for rehabilitation loans and grants made from the Community Development Block Grant program (CDBG) have more than doubled between 1975 and 1978. Likewise, use of the Section 312 rehabilitation loan program and Section 8 Substantial Rehabilitation program have each more than tripled since 1976 (Ehrmann, p. 1).

In comparing these figures to the area to be investigated in this study, the city of Knoxville, Tennessee, appears to maintain these same trends. City building permit records indicate an increase in "additions, alterations, and repairs" from 613 permits totalling \$975,000 in 1968 to 1,052 permits totalling \$2,840,000 (in constant dollars) in 1978 (City of Knoxville, Permits). Likewise, during 1978 and 1979, the city's Community Development (C.D.) Rehabilitation program carried out assisted rehabilitation work on several times the number of homes as received rehabilitation assistance during the first two years of the program (1975 and 1976).

The increase in residential improvement expenditures has also substantially increased the amount of rehabilitation work carried out by contractors in the business. Between 1971 and 1977, the expenditures by single-family homeowners for repairs made by contractors supplying their own materials increased by \$2.6 billion, from \$8.1 billion to \$10.7 billion (constant dollar figures) (HUD, Goals, p. 41).

B. Statement of the Problem

It seems quite clear that there is an increasing reliance on housing rehabilitation as a key to urban revitalization efforts being carried out around the country.

Aside from a brief period in 1968-1972 when new construction surged, rehabilitation and conservation now have gained a top priority in government housing programs. The Housing and Community Development Act of 1974, creating the community development block grant program, committed the government to "the revitalization of the community, including the restoration and rehabilitation of stable neighborhoods to the maximum extent possible."

(Bureau of National Affairs, p. 14:0012)

This fact is some cause for alarm of itself, since publicly-supported rehabilitation efforts have generally been disappointing in recent years. Of a goal of one million housing units estimated to receive rehabilitation assistance in the ten year period from 1969 to 1978, less than one third (325,000 units) of the goal was achieved (HUD, Goals Report, p. 27).

Much has been learned about many of the pitfalls of past rehabilitation programs, however, and the current increased use of rehabilitation stands a good chance of success. Many writers on housing and public programs dealing with housing revitalization are developing more realistic frameworks within which to carry on rehabilitation.

Since neighborhood conditions, amenities, sociological and other human resources, and the availability of publicly provided services are crucial to successful rehabilitation of deteriorated units, each community's rehabilitation efforts with housing subsidy programs must be carefully dovetailed with their community development and assistance plans and programs . . .

(Nenno, p. 84)

In addition, considerable research on many rehabilitation-related topics has been carried out over the past years. Rehabilitation topics dealing with financing, governmental regulation, housing codes, and consumer rights have been the subject of new studies and programs recently. Better statistics on rehabilitation activity are also now available.

One area of the urban rehabilitation field, however, which seems to have received very little attention or research is the rehabilitation industry, those private contractors and other professionals who plan for and carry out the actual rehabilitation work that is done on urban

housing. The availability of skilled rehabilitators is often taken for granted by city officials and citizens with no knowledge of the actual situation of the local rehabilitation industry.

But the reality of the situation can be very different. One writer stated that "in most cities reliable rehabilitators with the required skills and experience are few and far between. American homebuilders have shown little interest in residential rehabilitation" (McFarland, p. 34). About the rehabilitation process as a whole, another writer stated, "Little is known about private rehabilitation activity except that there is a lot of it" (Mandelker & Montgomery, p. 461).

These comments hardly sound like a well-defined and understood element of our major urban revitalization tool for the 1980's and beyond. The lack of information about the urban housing rehabilitation industry poses an ongoing problem for further public policymaking and development of programs using rehabilitation. This is the problem that will be addressed in this study.

C. Purpose and Research Questions

The purpose of this study is to gain information through personal interviews about the individuals and firms who are involved in urban housing rehabilitation activities in Knoxville, Tennessee. In order to understand how and why they function within the larger rehabilitation system, the study will concentrate more on how and why they carry out their work than on how many do how much work. With this in mind, the study will attempt to answer four research questions. They are as follows:

1. Who is carrying out urban housing rehabilitation in Knoxville, Tennessee, and what is their background and experience in the industry?
2. What processes, procedures, and activities does a member of the industry in Knoxville follow in carrying out a rehab job?
3. How does the industry member in Knoxville view his business, what problems does he encounter from both public and private sources, what remedies can he suggest, and what plans does he have for rehabilitation involvement in the future?

The final research question is a more general one and answering it should serve to summarize much of the study. The question is:

4. To what extent does an active urban housing rehabilitation industry exist in Knoxville and what form does it take?

Upon these four questions we will focus our investigations in this study. The setting for the case study (Knoxville) is described in more detail in Chapter III.

D. Importance of Study to the Planning Field

This investigation into the urban housing rehabilitation industry in Knoxville should assist planners by increasing the knowledge available to them about rehabilitation industry members and about rehab programs as related to the industry. As public expenditures in rehabilitation continue to increase, so the need for planners to better know and understand this important tool for urban revitalization also increases. Three particular areas where more specific information about members of

the rehabilitation industry could assist housing planners include the following: (1) a better understanding of rehabilitation problems and goals, through a more direct knowledge about the problems of industry members, (2) the development of rehabilitation policies and programs that remain sensitive to the organization and processes used by industry members, and (3) more effective implementation of rehabilitation programs through increased knowledge about the capabilities and limitations of industry members in these programs.

E. Definition of Terms

A number of the basic terms used in this study have often had different and conflicting definitions when used in various contexts. It is important to clearly define these terms for use in this study before we go further. Due to the conflict about different uses of these terms, these definitions are necessarily quite lengthy. The terms most needing definition at this time are the words in the study's title: the urban housing rehabilitation industry.

Urban—This term is used to refer to the central or inner-city portions of a city, in contrast to both suburban and rural areas. Most of the housing and other structures in urban neighborhoods are at least 40 years old and often require significant improvement in order to reach current living standards. The repair of many urban homes has traditionally been of a different nature than the repair of many newer suburban homes, though similar to repairs of older homes in suburban and rural areas. Repairs to all older homes have tended to serve

essential housing needs (e.g. leaking roof replacement) and to involve many different parts of the home. Suburban repairs to newer homes tend to focus more on nonessential housing needs (e.g. room additions) and to involve just a few parts of a home. The growing amount of substantial repairs to many older homes in urban areas of the U.S. sets this type of repair effort apart from similar repairs to older suburban and rural homes.

Housing Rehabilitation—Many terms are used to describe home repair activities related to rehabilitation. Many standards and guidelines also exist in order to point out the extent and type of rehabilitation activities that should be carried out on a rehabilitation job. We shall look briefly at four different definitions of housing rehabilitation to gain a perspective on common use of the term.

National Association of Home Builders (NAHB) officials have recently stated that, "We consider remodeling and rehabilitation to be the same activity but on a different scale. Remodeling is a less extensive alteration of an existing structure than rehabilitation." This definition of rehabilitation attempts to separate it from home repair jobs involving smaller, less essential repair activities. This type of definition would also appear to be in response to two different types of home construction activity involved in remodeling and rehabilitation, for the benefit of NAHB's members.

The Bureau of National Affairs' Housing & Development Reporter defines housing rehabilitation as "the repair of a deteriorated building." The Reporter also goes on to mention the criteria used by HUD in their

own rehabilitation programs. The Section 8 Substantial Rehabilitation program defines rehabilitation as "improvements requiring more than routine repair work to make a property decent, safe, and sanitary" (Housing and Development Reporter, RF-95, p. 14:0011). The introduction of a general standard to which a house must be rehabilitated under this HUD program is an additional element in the rehabilitation definition.

The U.S. Census Bureau has been keeping statistics relating to housing rehabilitation activities (Construction Reports: Additions, Alterations, and Repairs) since at least 1919. During that time the Bureau has never recognized rehabilitation as a separate type of home repair activity. The relationship of rehabilitation to the repair activities described in the Census figures is described by researchers (Brune, p. 5) as part of a scale entitled "the Housing Conservation Continuum" (see Table 1). The purpose of this continuum is to place the three types of home repairs summarized in the repair-related Census figures in relation to each other: maintenance and repairs (Minor Repairs), major replacements (Principal Replacements), and additions and alterations (Major renovations).

Table 1
The Housing Conservation Continuum

Level 1	Level 2	Level 3	Level 4	Level 5
Routine Maintenance	Minor Repairs	Principal Replacements	Major Renovations	Massive Rehabilitation

Source: Brune, p. 5.

In the continuum, rehabilitation (Level 5) is seen as a combination of many activities from Levels 2, 3 and 4. This type of definition also seems to place lower limits on the amount of improvements required on a home in order to qualify as rehabilitation work (e.g. in Table 1, any home improvement activity with less than "massive" rehabilitation was assigned a different name).

Finally, Nathaniel Rogg gives us another approach to the definition of rehabilitation: "The goal is to bring existing structures into conformity with current standards of housing livability" (Rogg, p. 2). Once again, a standard of improvement is a part of the rehabilitation concept, but the specific nature of the "livability standard" and the amount and type of repair activity to be carried out as rehabilitation is broadly and not narrowly defined.

The spirit of this broader concept of housing rehabilitation is what we will use to define the term for the purposes of this study. All activities, large or small, public or private, that involve bringing homes up to this "livability standard" shall, in this study, be referred to as housing rehabilitation.

It should be noted that due to the wide-ranging use of a simplified version of the term housing rehabilitation by people associated with such activities, the study will often use the term "rehab" in place of the full name of the activity.

Rehabilitation Industry—there exists considerable controversy over whether a rehab industry exists at all in the U.S. It appears, however, that much of this disagreement is based more upon previous conceptions

of what an "industry" should be than upon the actual economic functioning of rehab-related groups.

Those that maintain that a rehab industry does not yet exist point to various guidelines on the degree of organization as compared with other industries. Nathaniel Rogg pointed to the homebuilding industry to make his point:

The study found that for many reasons, we have today no urban housing rehabilitation industry as such, in the sense that we have a new home construction industry.

(Rogg, p. 7)

Adrienne Levatino-Donoghue sees the lack of a unifying sense of structure for rehab-related activities as a problem:

An industry can be defined as the aggregate of technically productive enterprises. For rehabilitation, an industry could be the sum or collection of professionals operating or contributing to property rehabilitation. As such, a rehabilitation industry has not emerged as yet in the United States. While there are certainly professionals in the rehabilitation field skilled in a number of critical areas of expertise, there is not yet a sense of organization pulling these skills—and rehabilitation professionals—together.

(Levatino-Donoghue, p. 4)

Finally, Robert Tebbel draws direct comparisons between the auto manufacturing and the entire housing construction and rehab industry. Although falling short of declaring it a nonindustry, he makes the point that the general lack of coordination, modernization, and mechanization of all parts of the larger housing construction industry is intolerable and out of touch with other industries in the national economy (Tebbel, p. 178).

It should be noted that all of these observations seem to be based upon an unstated assumption that all industries should have similar

amounts of central organization, technological research, and major entrepreneurs within their ranks. We need to take a closer look at the relevance of this assumption to the rehab industry.

There appears to be a growing recognition of the economic integration and functioning of a rehab industry in the U.S. Economists Julian Lange and D. Gordon Bagby lay out some general observations for such a claim.

Construction, one of the most important parts of the American economy, is often referred to as an industry but is more accurately described as a sector of the economy . . . It is not a single activity, but a group of activities loosely related to one another by the nature of their products, technologies, and institutional settings. (Lange, p. 1)

Thus, there is not one construction industry. Rather, there is a hierarchy of construction industries, with new construction entrepreneurs at the apex and rehabilitators along the base. (Bagby, p. 29)

The issue of whether a rehab industry exists was not even addressed by Genevieve Brune in her recent study of the home improvement industry. Her main concern was in trying to analyze the makeup of such an industry:

Increasingly, new construction firms have been entering the realm of the home improvement industry due to the crunch on new construction in the national economy . . . The bulk of the industry, however, could be viewed as consisting of many small and independent contractors who offer specialty work or a range of housing conservation services. (Brune, p. 19)

Likewise, Daniel Mandelker and Roger Montgomery also note the relationship between the nature of rehab work and the inherent small-scale of operations within the industry:

Rehabilitation rarely provides opportunities for significant economies of scale . . . Because most rehabilitation is done on a custom basis, the rehabilitation industry is presently dominated by small firms, often one man operations, which tend to specialize in remodeling work.

(Mandelker and Montgomery, p. 463)

This study will utilize a concept of a rehab industry similar to these last two observations. Though the nature of rehab work has not developed into a highly organized industry, the fact that a large and increasing amount of specialized rehab work is being carried out within our economy indicates the existence of an industry of some kind. The emphasis of our definition of rehabilitation industry, therefore, is more upon actual economic functions and relationships than upon a well-defined and traditional image of a distinct, centralized industry.

Other Terminology—an effort has been taken to maintain a relatively uncomplicated and nontechnical vocabulary in the presentation of this study. Probably a larger terminology problem than the technical jargon used within the rehab industry is the untangling of the "alphabet soup" of abbreviations and acronyms that represent government agencies and programs and other organizations active in the industry. The study has attempted to explain such references when used throughout the report.

F. Limitations of Study

Due to the fact that so little previous research exists on the subject of the housing rehabilitation industry, a number of limitations upon the accuracy of the survey and relevance of the study as a whole

were unavoidable. Although a good cross section of rehab industry members appeared to be obtained in the interviews conducted, the difficulties of locating interviewees (see Chapter III) and the limited time available for conducting the interviews led to a somewhat smaller and less-scientific sampling of possible respondents than was originally hoped.

Several other limitations on the relevance of the data and conclusions for other places had to do with the setting for the study itself. Knoxville, Tennessee, is a moderate-sized (approximately 210,000 population in 1978) Southern U.S. city which serves as an urban center for East Tennessee and parts of adjoining states. Although the city maintains large amounts of aging, deteriorated housing in many of its central neighborhoods, there has been a relatively small amount of urban housing rehab going on in the city until recently. In particular, the relative lack of suitable multi-family housing and of interested moderate- to large-scale construction firms led to little urban rehab activity beyond single-family jobs with small-scale contracting firms. This was the type of rehab activity described in the interviews carried out for this study.

No direct information was received during the local interviews dealing with multi-family rehab efforts or with rehab carried out by moderate- or large-scale construction firms. Although this is not an unusual situation for many Southern U.S. cities, it is a quite different one from many of the cities from which rehab literature has emerged in recent years.

A final limitation to the study should be noted in the relatively nonquantitative approach to the industry taken by the author. During initial organization of the study, it appeared that, in order to narrow the scope, the focus of the study should be either upon the volume and type of rehab activity being carried out or upon a profile-type of examination of those carrying out the work. The author has chosen the latter direction and, as a result, has bypassed examination of some of the more quantitative aspects of the local industry.

G. Outline of Study

This study has been organized into a traditional research format of four basic sections in order to assist in easy orientation and reference to the study's contents on the urban housing rehabilitation industry. The study begins with an introductory Chapter I, including rather long sections on Statement of the Problem and Definition of Terms. Chapter II reviews available literature on the topic, beginning with a Methodology and Introduction, and following with a chronological analysis and summary of literature sources. The actual survey of rehab industry members in Knoxville, Tennessee, is contained in Chapter III, which includes a Methodology, Analysis of Results and Summary sections. Finally, Chapter IV is entitled Conclusions and Implications, and includes a section on each of these items as they relate to the entire study. A bibliography and several short appendices complete the study.

CHAPTER II

REVIEW OF LITERATURE

A. Methodology of Review

The process of searching for and reviewing different pieces of literature for this study involved a number of problems and undertakings that need to be described prior to the presentation of the literature itself. After settling upon the topic for this study, the author proceeded to carry out a complete literature search at The University of Tennessee, Knoxville. Several problems immediately arose that remained present throughout the remainder of the study.

The first problem encountered during the literature search had to do with trying to categorize the urban housing rehabilitation industry itself. No preexisting definitions, categories, topics, etc. seemed to encompass this title, and, necessarily, the literature search often split into several very unrelated directions. General references relating to housing rehabilitation and construction seemed to be plentiful, and the research for the study often became a matter of extrapolating information from such general sources to the actual rehab industry in order to describe some particular aspect about it. This was particularly true in trying to separate out information on the rehab industry from the plentiful sources dealing with the entire housing construction industry.

A second problem encountered in the literature search was the rapid changes occurring within the rehab industry at the time of researching this study and the resultant lack of availability of important and current information on many of these changes. Since so many of these changes dealt with the impact of many of the new public programs related to rehab, an information gathering trip was made to Washington, D.C. in October 1979. Interviews and library research sessions were held at the national headquarters of HUD and the National Association of Home Builders, with stops made at the Urban Institute and the National Association of Housing and Redevelopment Officials (NAHRO) offices in order to pick up additional information.

Results of this trip included discoveries of totally new studies relating to the industry, updated information on the status of different rehab programs, and much more in-depth historical sources on the development of urban rehab activity in this country. In addition, it was noted that many of the top researchers and staff persons in the rehab field seemed to have little knowledge of the existence of certain studies or of the activities of different groups involved in the rehab field. The fact that the study involved an essentially private sector topic within the context of many public sector programs also seemed to confuse some of the persons that the author contacted. Nevertheless, the trip proved extremely valuable by providing insights into the rehab industry.

Much of the information obtained in Washington was more detailed than what the author had uncovered in Knoxville and was substituted for

much of the initial research materials. As a final research effort to fill in gaps in the literature obtained thus far, the author conducted a supplementary literature search at the libraries of the University of North Carolina at Chapel Hill during February and March of 1980. This effort, in particular, yielded some good historical data that rounded out the literature search.

A final comment is needed for a particular report uncovered during the visit to Washington. In conjunction with HUD in 1976, Genevieve Brune had carried out a study for the Urban Institute about the "Housing Conservation Industry." This study was the only piece of literature discovered by the author that provided similar data to the data coming from the survey carried out as part of this study. Because of the level of detail provided by this report alone, the entire review of literature has taken on a two-tiered quality. The first tier of literature provides a broad range of indirect information about the industry, arranged over a fifty year period of time. The second tier of literature is Brune's study itself, with its own summary on the makeup, activities, and problems of the urban rehab industry. Although these parts are quite different, it is felt that they ultimately provide this review with two complementary viewpoints on the nature of the rehab industry.

B. Introduction

Probably less is known about housebuilding than about any other major industry. Myths, dogmas, and pat solutions of the housing problem have been offered in place of facts.

(Maisel, p. 4)

The current conception of rehabilitation in urban renewal areas also rests on the assumption that property owners will be able to find reliable contractors prepared to do the work. The private rehabilitation industry, or lack of it, is probably one of the weakest links in the chain [of the housing rehabilitation process]. (McFarland, p. 34)

These two quotes provide a suitable introduction to reviewing literature related to the urban housing rehabilitation industry. In the first place, there is an extremely small existing body of knowledge about any type of housing construction industry, either new or rehabilitation, upon which to base in-depth research and analysis. The tendency to include rehab construction activities as a large and indistinguishable part of this huge "housebuilding" industry is also a common trait among many looking at the housing rehabilitation industry. The emergence of distinctly rehab-oriented jobs and processes must be remembered as still being a relatively recent phenomena.

In second place, there is a ready assumption made by many persons that the urban rehab industry has a great supply of skilled practitioners who efficiently and automatically carry out the rehab work required the instant that a willing homeowner and suitable financing are arranged. In fact, there has been an ongoing shortage of experienced contractors for this work, as well as innumerable problems and disincentives associated with the carrying out of urban rehab activities. Greater understanding of this situation is becoming increasingly important as the total amount of urban rehab carried out continues to increase.

The growth and development of a distinct urban housing rehabilitation industry in the U.S. is directly linked to the many public programs and

private efforts that have emerged in recent years. This literature review will relate the evolution of the urban rehab industry and related rehab programs into three basic periods that have been mentioned by several urban researchers: (1) urban renewal, the strategy of the 1950's; (2) housing rehabilitation, the strategy of the 1960's; and (3) neighborhood preservation, the strategy of the 1970's (Greendale, p. 26). These three time periods can also be seen as emphasizing (1) FHA and private rehabilitation efforts, (2) multiple public rehabilitation efforts, and (3) C.D. and a public/private partnership for rehabilitation. While this division of rehab activity into three "eras" is extremely simplified, it gives a basic framework within which to examine and analyze the changing nature of the urban rehab industry. A lengthy review of the Urban Institute study by Brune concludes this section, followed by a brief summary of the chapter. This literature review, refers closely to the study's research questions as set out in Chapter I.

C. Urban Renewal, the Strategy of the 1950's

Background

The first urban housing rehabilitation programs in the U.S. were related, in part, to the urban housing reform movement of the early 20th century. Much of the impetus for 19th and 20th century urban housing reform came from public fear for the unsanitary conditions produced by tenement housing at that time. Gradually, however, sanitary conditions improved to the point where

voters lost their fright and with it their enthusiasm for aggressive public-health measures. Housing reformers were forced to fall back more and more on appeals for public support on the grounds that overcrowding led to drink, crime and prostitution, rather than urging a community of interest on safety and disease. (Warner, p. 219)

Some of the later housing reform efforts were concentrated on empowering public health departments to carry out inspections and condemnations of urban dwellings through the establishment and enforcement of minimum housing codes (Veiller, p. 137). These activities became known as code enforcement programs and are still considered essential elements in neighborhood housing rehabilitation programs.

During the 1920's and 1930's, reformers began to point to the growing urban areas of slum and blight requiring clearance and redevelopment (Wright, p. xi). There appeared to be widespread support for the notion that slums were too far deteriorated to permit any treatment but near-total clearance. The term "rehabilitation" began to be applied to the treatment of blighted neighborhoods at this time, in the context of repairing all aspects of the environment within these "declining" areas. While the concept of neighborhood rehabilitation did not preclude the demolition of much substandard housing, it did introduce the idea of more sensitively approaching urban housing needs than did slum removal.

The First Public Rehabilitation Programs

The first government-supported housing rehab programs came into existence with the establishment of the Home Owners Loan Corporation (HOLC) in 1933 and the Federal Housing Administration's (FHA) Title I

Home Improvement Loan Insurance Program in 1934. The popular FHA program was seen to serve a dual purpose at the time of its passage—both to encourage improvements in housing standards and condition and and to provide a short-term stimulus to the depressed housing construction industry (Colean, p. 265).

Since its passage more than 45 years ago, the FHA Title I program has been the mainstay of both consumers and rehab contractors alike in encouraging repairs, rehabilitation, and remodelling to homes throughout the country. Both the size of loans available under this program and the restrictions on use of these funds have been dominant factors in determining the nature of the rehab firms and activity that began to develop during these years. No other major government program for rehab would be put into effect for almost 30 years after the inception of the Title I program.

Beginning in about 1940, two types of activity began to take place that influenced the practice of rehabilitation in this country. The first was some initial efforts to carry out research related to the housing rehab industry while the second was the growth of a movement to make privately-sponsored rehab the major tool for dealing with urban slums and housing deterioration.

Research on Rehab as an Industry

Early research into the housing rehab industry seemed to concentrate on contrasting the housing rehab industry with the new residential construction industry. Miles Colean appears to be the first researcher (in 1944) to make significant use of statistics on residential alterations

and repairs, which had been available as a component of the overall residential construction statistics since 1919. In addition to noting the relative stability in annual expenditures for home repairs, Colean also commented upon the rehab industry problems of relative unprofitability and contractor inconvenience in comparison with new construction work. Finally, he mentioned that the establishment of special maintenance and repair organizations could effectively deal with these problems (Colean, p. 167). Colean and Robinson (1952) together later extended this research, noting the growing trend in rehab expenditures, the very small-scale of rehab firms, and the flexibility of these firms in planning and responding to business opportunities.

Maisel's research (1953) into the entire homebuilding industry delineated small, medium, and large firm classifications by number of employees and amount of annual business. He also separated builders into two categories of contractors and merchant or operative builders (Maisel, p. 19).

These categories were picked up on by Nash (1959) in his descriptions of the housing rehab industry. In addition to noting the small-scale of many rehab firms, he divided rehabilitators into contract remodelers and operative remodelers. In general, the contract remodelers can be seen as providing rehab services to separate property owners on request, whereas operative remodelers engage in acquisition, rehabilitation, and either sale or management of residential properties on a more entrepreneurial-type basis.

Nash also stated that "since the end of World War II, rehabilitation has emerged as a recognizable form of business activity . . ." (Nash, p. 56). He went on to show the different processes and groups involved in what he termed three different types of rehab: prestige, middle-income, and low-income housing rehabilitation.

Private Rehabilitation

The movement toward use of private rehabilitation as an answer to urban housing deterioration appears to have been in great part a response by several national professional organizations involved in the housing construction industry to the growing use of federally-sponsored public housing and urban renewal programs around the country. Both the National Association of Real Estate Boards (NAREB) and the National Association of Home Builders (NAHB) promoted private rehab activities, beginning in the 1940's but most actively during the 1950's. The basic model program promoted in most major cities at this time incorporated four major elements as an alternative to total demolition through federal urban renewal: (1) block-by-block rehab through code enforcement to safe and sanitary standards, (2) demolition of individual structures when required, (3) new construction and investment on vacant sites, and (4) upgrading of the neighborhood environment through municipal improvements (Burns, p. 5). In 1954, the Housing Rehabilitation Department of NAHB even went so far as to issue "Rehabilitation Kits" to members and interested groups which provided copies of brochures, newspaper clippings, contact persons and other materials (NAHB, Rehabilitation Kit, p. 1).

Industry Activity

The implications of this type of movement for the rehab industry as a whole were to encourage more builders to get involved in inner-city housing rehabilitation activity. This was true for both operative remodelers and for contract remodelers, especially appealing to builders to switch over from either new construction or FHA-type remodelling work. Probably the most significant aspect of these efforts for the rehab industry was the direct involvement of bankers, realtors, and city officials in urban rehab activities for the first time. Based on the limited success of such programs in most cities (Baltimore being an outstanding exception), it is doubtful that this movement caused a substantial increase in the size of the urban rehab industry.

This period also appears to have been a time of growth for home repair specialty vendors, many of whom rapidly gained very unsavory reputations. Single home improvement features such as aluminum siding or carports, new roofing, or porches were often sold door-to-door by manufacturer representatives. Although such home improvements do not constitute rehabilitation in the normal sense, the general public viewed such activities as a large and suspicious part of the rehab industry. Major magazine articles such as "Beware of the Home Repair Racketeers" (Saturday Evening Post, 7/21/56) rightfully warned consumers of the \$500 million per year in fraudulent sales by "fly-by-night" operators that was occurring around the country at this time. Despite a variety of additional safeguards available to consumers today, these practices continue and remain a problem and nuisance for the entire rehab industry.

Toward the close of the 1950's both the nation and the rehab industry seemed well aware of the need and probability of increased urban rehab activities in the years to come. One author wrote that "the salvage of rehabilitation areas constitutes one of the most pressing and rewarding tasks facing communities today" (Beyer, p. 228).

D. Housing Rehabilitation, the Strategy of the 1960's

The 1960's ushered in a period of increased urban deterioration and urban unrest that demanded increased federal governmental action in the housing rehab field. Many spokesmen talked about housing problems and about the many types of solutions available that could be implemented. Comments such as the following indicate the amount of unrest that stirred up so much change in the housing field during this decade: "The need to remove ancient methodology from this [the housing] industry is imperative to protect the national economy" (Tebbel, p. 178). "Broad public and private programs are necessary to encourage better maintenance and rehabilitation at standards far above those enforceable under the police power" (Meyerson, p. 179). The real need for changes in housing rehab programs, however, can be seen in the following statement by M. Carter McFarland (former FHA Administrator) where he says that early rehab programs such as FHA Title I were not

well adapted to the far more difficult job of rehabilitating properties in areas where the natural forces of spontaneous renewal have been arrested by the highly contagious virus of decay, and all the social, economic, and political forces combine to reinforce and perpetuate "the descending spiral" to blight and slum. If rehabilitation is to be accomplished at all in such infected areas, it requires a more elaborate arsenal of weapons and, indeed, a substantially different concept of the job to be done. (McFarland, p. 5)

Public Rehabilitation Programs

And so, the government rehab programs changed to meet this challenge. Both Presidents Kennedy and Johnson made strong commitments to increasing rehab activity in the cities. The approval of Section 203(k) in 1962, allowed for larger home improvement loans and longer payback periods on loans similar to the FHA Title I type program. This new program, however, never received much use, due mostly to the rehab industry's familiarity with and attachment to the Title I program.

The passage of the 1964 Housing Act included the first low-interest, long-term payback rehab loan program, in the form of the Section 312 loan. The program became widely used during the late 1960's and involved many contractors in urban housing rehab projects for the first time. Other rehab programs begun during the 1960's included rehab for both multi-family and elderly units.

Major Public Rehabilitation Efforts

Beginning in 1967, HUD undertook a series of experimental residential rehab projects to test the feasibility of rehab, improve the agency's operating procedures, and develop new techniques (HUD, Report F-22, p. 1). The largest and best known of these efforts was the Boston Rehabilitation Program (BURP), which rehabilitated 1400 multi-family units in three neighborhoods of Boston during a one year period and nearly 2000 units overall. The project involved a large corporation directing the overall rehab activities. Several different evaluations carried out about BURP point out a variety of problems encountered by the project: the high

costs of the rehab work, the large amount of relocation and the lack of sensitivity in dealing with relocated residents, the lack of local participation in rehab training and work activities, and the lack of ongoing input and direction from resident groups during the actual rehabilitation phase of the project (Keyes, p. 156).

Another large urban rehab program undertaken and documented during this time was the Camden (N.J.) Rehabilitation Program. A number of specific problems related to the rehab industry's participation were summarized as follows: contractors were initially reluctant to work in many of the urban neighborhoods, qualified contractors were very difficult to locate, FHA standards and paperwork were a problem for contractors, it was difficult for many contractors to obtain surety bonds (Listokin, p. 42).

In 1969, HUD launched its largest rehab program ever, a 14-city effort to carry out large-scale rehab in a closely-monitored effort. This effort was entitled "Project Rehab." The project's goals were to avoid the major problems of BURP and to carry out 38,000 units of urban rehab during a two year period. Despite lags in rehab start-ups in many cities, the project clearly demonstrated "that the capacity for large-scale rehabilitation can be generated" (HUD, Report F-22, p. 3). The project also showed that many different types of sponsorship and development setups could be used to administer rehab programs. In terms of rehab industry involvement, different cities involved in Project Rehab utilized rehab firms or developers ranging from a limited number of large rehab developers (used in Buffalo, Washington, D.C., and Detroit)

and to a large number of small developers and contractors (used in Cincinnati, Seattle, and Indianapolis).

Project Rehab produced a monitoring report (HUD-F-22, 1973) that made several interesting conclusions relating to the urban housing rehab industry and to the experience gained by working in the 14 cities in which the project functioned. The first conclusion was the discovery that large-volume rehab was not more efficient than small-volume rehab work in the majority of cases. The fact is that often each structure and household affected by rehab is so different from other household situations and requires such different rehab treatment, that significant economics of scale are often impossible to achieve. Small contractors maintained much smaller overhead costs that allowed for needed flexibility on most rehab jobs.

A second conclusion of the Project Rehab effort was that there were many advantages to rehab programs and activities that involved a large number of smaller contractors to carry out the rehab work needed. Quicker and easier response time to changing situations on rehab jobs give a large number of small firms many advantages over the several, inflexible large rehab developer firms.

A third and final conclusion of Project Rehab related to the rehab industry was that rehab work offers special opportunities to minority contractors and workmen to become involved in urban rehab projects, particularly in small-volume rehab work within their own communities. Problems blocking minority construction firm involvement in rehab work can be dealt with by local rehab program staff, for instance, in helping to gain adequate bonding or extension of credit.

There would appear to be several general impacts of the newer rehab programs upon the urban rehab industry. Moderately-increased amounts of rehab work, additional contractor confusion over the names and regulations of many of the new rehab programs, and maintenance of FHA Title I loan activity are some of the impacts that occurred.

Nonprofit Groups

The active involvement of nonprofit organizations in urban housing rehabilitation activity beginning in the late 1960's has proven to be a relatively unsuccessful yet informative effort in urban rehabilitation. Two particular case studies of nonprofit groups involved in rehab are quite revealing. Beginning in 1966, ACTION-Housing, Inc. of Pittsburgh, Pennsylvania, launched a pilot program to rehabilitate a group of deteriorated row houses on Cora Street in Pittsburgh and documented the entire project in a 1969 publication entitled simply Cora Street. The report highlights many of the problems associated with finding and keeping a suitable contractor for the project. Numerous cost overruns and interim financing problems forced several contractors off the job on Cora Street. The report calls on the "contracting industry" to undertake rehab training programs to prepare contractors for the many problems of carrying out rehab work (ACTION-Housing, P. 51).

The rehab efforts of Micah, Inc. with row houses in Providence, Rhode Island, are also documented in a 1969 report. The group coordinated rehab work on older row house dwellings within a deteriorated neighborhood in South Providence. Due to significant, unanticipated cost overruns

encountered during the construction process on these units, Micah was unable to market the rehabilitated homes after they were complete (Kenower, p. 7). The group soon ceased all rehab activities and issued both their first and final report.

The lessons to be learned from these and many other unsuccessful nonprofit groups involved in urban rehab are often found in the evaluation of their problems. Both of the groups mentioned suffered severe problems as the result of their contractors not being able to carry out rehab according to initial costs and plans. The somber lesson that carrying out successful urban rehab is harder than it initially appears is found throughout the nonprofit groups' experiences.

Research on Rehab as an Industry

The 1960's and early 1970's also produced a limited amount of good research on the housing and housing rehab industry. Two studies were carried out by urban economists who asked the question "Is housing rehab cheaper than new construction within urban areas?" A. H. Schaaf developed some mathematical models of capital investment in housing at different repair levels in order to determine "Optimum Renewal Standard." He concluded that several different levels of home improvement/renewal costs would normally be considered long-term cost-effective in comparison with new residential construction. In particular, interestingly, of four different rehab "standards" that he defined for his model, the "modernization" standard (between "prestige" and "structural repair") was determined to be the most cost effective level of investment. This

finding would support the notion of encouraging relatively large amounts of rehab investment per unit where possible (e.g. with the Section 312 loan program).

Another researcher, D. Gordon Bagby, carried out a similar study on rehab costs in Philadelphia urban renewal areas. He also attempted to include some of the more intangible costs involved in rehab, such as relocation, time delays, neighborhood improvements, the quality of rehab workmanship, etc. He noted many of the generic problems of rehab in relation to new construction. He concluded that the low profitability, capital expenditures, and wages paid were much less for rehab than for new construction. He continues: "Thus, there is not one construction industry. Rather, there is a hierarchy of construction industries with new construction at the apex and rehabilitation at its base." (Bagby, p. 29).

Bagby also developed a model for relating rehab costs to new construction costs. Though determining that rehab costs were indeed slightly lower than new construction costs, he questioned whether the rehab product and process to be gone through really made the technique more desirable overall. He also pointed out several aspects of the rehab industry in Philadelphia that were of interest. Seventeen percent of all building firms in the area did rehab-related work only. Capital expenditures as a percentage of gross receipts for rehab firms were considered to be quite low in comparison with new construction firms. Lastly, in answering the question of who carries out rehab work, Bagby pointed to rehab as a construction employer of last resort: "... they

are those contractors and workers who for want of capital, union cards, business acumen or capabilities, cannot find employment elsewhere"

(Bagby, p. 30).

Michael Stegman, in his study on inner-city housing investment in Baltimore, provided detailed information in entrepreneur-type rehab activities carried out by another part of the urban rehab industry, a large-scale investor in urban rental housing.

the schedule does not reflect the substantial savings he realizes through dealing with more than 75 firms which charge him less than retail prices for their products and services.

Another part of the business side of good management of inner-city real estate, which seems to come only with extensive experience, pertains to the ability to judge how much work a potential acquisition requires in order to make it attractive to good tenants, how much that work will cost, and the rents that the renovated units can command.

(Stegman, p. 123)

Two other brief research articles address the issue of internal efficiency of housing construction techniques, both for new construction and rehabilitation. Arthur Stinchcombe commented upon the lack of bureaucratic administrative systems within the entire construction industry as compared with other industries, showing that construction relied on a "crafts" administration with little centralized planning and communication processing by clerical workers. This was an indication of the relatively low technology and productivity status of the industry.

Christopher Sims, on the other hand, pointed out that the entire construction industry had definitely been improving its techniques and overall productivity in recent years. He stated that the entire industry maintains an image of having introduced little change in techniques over the past 30 years that just is no longer true.

A final comment on industry research during the 1960's and early 1970's comes from Mandelker and Montgomery. They noted two characteristics of rehab work that are central to an understanding of the activity and industry. The first characteristic was the inherent uncertainty of rehab work that tends to always slow down all aspects of the rehab process. The second characteristic was the domination of the rehab industry by small firms. Only 3 percent of all rehab/remodeling jobs undertaken by builders were by "large" building firms (e.g. firms that build more than 75 units of housing per year). The one-man rehab firm was the most common set-up of all rehab contractors (Mandelker & Montgomery, p. 463).

Industry Activities

The level of activity among groups related to the urban housing rehabilitation industry has increased somewhat during this period, though not substantially. Though the enthusiastic activity of the private rehabilitation movement of the 1950's had slowed down, a higher total amount of rehabilitation was being carried out by private contractors with public assistance. The major shift in rehab industry activity during the 1960's and early 1970's was the organizing efforts of groups involved in the supply of housing rehab materials. In 1961, NAHB sponsored a "Conference on the Manufacturer's Stake in Urban Renewal and Remodelling," featuring a full day of "perspectives" on remodeling from the builder, lender, and realtor's point-of-view.

Another conference with materials suppliers that was held in Washington in 1962 published a report entitled, Home Improvement Financing Conference. Co-sponsors were the Douglas Fir Plywood

Association and the National Home Improvement Council. The purpose of this conference was to promote use of the new FHA Section 203(k) and other financing programs in stimulating the use of rehab. Despite the increased amounts and time period permitted by the 203(k) program, bankers' and contractors' allegiance to the FHA Title I program was limiting use of this program.

A book combining reprints of articles from the Building Supply News was published in 1964 and authored by Joseph Berne. Entitled How to Make Money in the Remodeling Business, these articles relate information primarily on how rehab material suppliers can increase their sales through the education of contractors on the best and newest rehab tools/materials/etc.

The other major industry-related activity that this review noted as occurring during this time was membership research activities by NAHB. Both in 1959 and 1969, NAHB researchers carried out a survey of their members, indicating information on the type and amount of work and on personal information about NAHB members, in both new construction and remodeling. The summary of the 1969 survey was published by NAHB in 1970. On many of the comparative statistics, there had been little change. Sixty-five percent of all builders were still small-volume, building 24 or less units per year. The average number of years of contractors in the building business had increased, from 11 to almost 14 years. The average age of the head of a building firm increased from 41 to 45 years. The average builder had had a small amount of college education. Few (3.7 percent) of the builders carried out remodeling or

rehabilitating as their primary work activity, while more (12.7 percent) did remodeling or rehabilitating in addition to their primary work activity. The most significant problem of construction firms, noted by 26.7 percent of the builders, was housing costs, with labor problems noted by 13 percent of the builders (Sumichrast, p. 15).

This ends our look at the housing rehab industry during the 1960's and early 1970's. Public rehabilitation efforts in the recent past have evolved into an era of public/private partnership for the housing rehab industry.

E. Neighborhood Conservation, the Strategy of the 1970's

The early 1970's marks the beginning of a new period in urban housing rehabilitation. Whereas rehab during the 1960's had been characterized by the dominance of new federal programs in repairing large numbers of houses in different cities, a new type of rehab effort was now underway. The effort was alternately known as neighborhood preservation and neighborhood revitalization, but came to be known most often as neighborhood conservation. Neighborhood conservation "refers to the general improvement of an area including housing repair but going beyond just that one activity" (Bureau of National Affairs, p. 9).

Neighborhood conservation efforts are often characterized by the utilization of every possible resource and tool available to a neighborhood. Turning around the economics of a neighborhood from decline to improvement is seen as a job requiring the formation of an active public/private "partnership" in order to coordinate use of the many

different tools and resources within an area. Most neighborhood conservation projects include an overall strategy with six major components: (1) target neighborhoods identified, (2) public sector involvement and investment, (3) code enforcement program to force the rehab and upgrading of substandard homes, (4) low-cost financing for rehab of lower-income persons' homes, (5) citizen involvement in all aspects of the project, and (6) financial institutions to promote neighborhood reinvestment (Ahlbrandt, p. 2).

One of the leading models of this public/private partnership in action first began in Pittsburgh in 1968. Neighborhood Housing Services, Inc. (NHS) was a nonprofit corporation formed and directed by local citizens, bankers, and city government officials in order to coordinate an early neighborhood conservation effort. The success of this particular type of effort has resulted in the formation of NHS projects in many other cities.

Some neighborhood conservation projects can emphasize much more private sponsorship than others. Particularly in the case of projects based in very historically-significant areas with many large homes intact, strategy components such as low-cost financing and code enforcement programs are not as important to the economic revitalization of an area (Black, et al., p. 1). Needless to say, these efforts can also result in the massive displacement of lower-income persons to other deteriorated urban areas.

Community Development Programs

Passage of the Housing and Community Development Act of 1974 (C.D.) and of related legislation has proven to be a major stimulus and guide to neighborhood conservation and housing rehabilitation efforts. The program committed the federal government and HUD to "the revitalization of the community, including the restoration and rehabilitation of stable neighborhoods to the maximum extent possible" (Housing & Development Reporter, RF-14:0010).

The large amount of rehab that has been carried out recently under various HUD programs such as the Community Development Block Grant (CDBG) and the Section 312 loan programs, in particular, has required increased amounts of paperwork and formal procedures on the part of persons involved in the carrying out of housing rehab. A good example of this is A. William Benitez's book on municipal housing rehab programs, which contains more than 100 pages of standard forms needed to administer a normal rehab job utilizing public funding (Benitez, p. 7). From formal job writeups and bidding procedures to fund drawdown procedures and final inspection certifications, rehab processes and activities under these programs are becoming increasingly formalized and complex.

Furthermore, as HUD has been encouraging increasing amounts of rehab in recent years, they have adopted an attitude of actively trying to support and encourage participation of the existing housing rehab industry in their programs (HUD, Status and Strategy, p. 5). The 1978 reorganization of rehab programs within HUD to form the Division of Rehabilitation Policy and Assistance has particularly aided the coordination and emphasis of these efforts.

Specific HUD efforts to assist the rehab industry have included research and training contracts with industry organizations (e.g. NAHB) and the hiring of industry personnel for HUD positions. The development and co-sponsorship of the Community Rehabilitation Training Center (CRTC), with courses held for rehab professionals throughout the country on topics such as "How to Recruit, Evaluate, and Maintain Good Rehabilitation Contractors," represents a significant commitment by HUD to building a stronger relationship to the rehab industry (University Research Corporation, p. 1).

Industry-Related Organizations and Literature

Since the 1960's, there has been a tremendous growth in the direct involvement and rehab publications of different groups in the housing rehab industry. The NAHB, which is the nation's largest professional organization involving rehab contractors, has both formalized and expanded its activities in the rehab field in recent years. Since 1970, the group has issued numerous publications, bibliographies and articles about builders organizing to form and carry out a more effective "remodelling and rehabilitation" industry (NAHB, p. 1). NAHB's recent contract with HUD to produce a guidebook on how to recruit and work with rehabilitation contractors demonstrates a closer relationship between private and public rehab forces than had ever been seen previously.

NAHRO's traditionally close relationship with low and moderate income housing programs was dramatically extended into the urban rehab field with the publication of a series of "operational guides" on housing

rehab beginning in 1976. This series of books represents the most comprehensive attempt to define, analyze, and educate about the public program side of urban rehab that has yet been seen. Furthermore, one of the books in the series, The Rehabilitation Profession, initiates a novel effort to discover and define the growing number of rehabilitation professionals involved in administering local public rehab programs. Whereas in the 1950's and 1960's the rehab industry referred primarily to contractors and entrepreneurs carrying out rehab work, the concept and reality of urban rehab now is seen to include staff persons in public rehab programs.

Financial institutions also seem to be taking strides toward more direct involvement in the rehab industry. Recent occurrences such as the passage of the Community Reinvestment Act and active rehab support from the Federal Home Loan Bank Board (co-sponsor of NHS programs) have encouraged involvement in rehab activities. The commissioning of Nathaniel Rogg by the United States League of Savings Associations in 1977 to carry out a study of urban housing rehab in the U.S. was a very visible and supportive effort by a large organization of financial institutions. Likewise, the efforts of the National Savings and Loan League in 1979 in carrying out a rehab training program with HUD was a notable achievement. This program, entitled Urban Ventures, was aimed at encouraging middle-sized development groups to carry out urban multi-family rehab work.

Research on Rehab as an Industry

Despite all of the increased activity described earlier in this chapter, there still remains surprisingly little research about the actual persons, processes, and problems that comprise the urban housing rehabilitation industry. Two information sources provide material about actual rehab processes and techniques used in the industry. The Building Research Advisory Board summarized, from the building trades' perspective, an "action flow chart," showing the sequence of activities generally undertaken on a rehabilitation job. It should be noted that this chart includes all the formal steps often associated with the "red-tape" of C.D.—administered rehab jobs—formal bids, bonding, accounting, and inspections.

The National Institute of Building Sciences carried out in 1979 a study for HUD on "model guidelines and options for rehabilitation work." These guidelines include clear definitions of different components of the rehab process and should prove helpful in defining housing rehabilitation as a separate and distinct economic activity.

Actual case studies or profiles about rehab industry members are almost nonexistent. The only three known literature sources providing direct information on this subject include publications by Mayer, Rogg, and Brune (Urban Institute Study). The last of these is included in the following section of this chapter. Martin Mayer, in his recent book, The Builders, provides several brief vignettes about outstanding urban housing rehab persons and projects. A director of a large rehab program in Florida complains about not being able to find contractors to bid on

large jobs, some of which are as expensive as new construction; neighborhood contractors and other residents do most of the rehab work in an inner-city Baltimore neighborhood; a St. Louis nonprofit group uses Mennonite Church volunteers for much of their rehab labor, and two ex-electricians run a large rehab corporation in Hoboken, New Jersey, that "learns from the maintenance man" in carrying out rehab work.

Nathaniel Rogg visited ten U.S. cities during late 1977 and summarized information about the successful rehab industry efforts he encountered. "First, and perhaps foremost, is the fact that a great deal more is going on in cities than is generally realized" (Rogg, p. 3). Major rehab industry problems also identified included a lack of a separate clearcut, rehab industry as such and a preference of the existing industry members for new construction work in suburban areas. In Chicago, four different rehab projects were showing signs of success, with non-profit groups and financial institutions initiating the work. In Cincinnati, the service corporation of a savings and loan institution coordinated for-profit rehab work in a half dozen inner-city neighborhoods. Both Oakland and Cleveland carried on active NHS programs with few additional active rehab projects within the cities. In Houston, large amounts of ongoing suburban growth have discouraged any active urban rehab projects from being carried out.

Rogg pointed out that Boston maintained the nation's largest C.D.-oriented rehab program, which, along with NHS provides a wide variety of rehab technical and financial assistance. A combination of C.D. loans, private loans, urban homesteading and NHS efforts keep active

rehab activities within many of Baltimore's neighborhoods. In St. Louis, builders and nonprofit groups have taken the lead on rehab projects where a city C.D. program has been almost nonexistent and troublesome. The original NHS program in Pittsburgh dominates traditional and new directions in rehab activity there. A three-pronged housing revitalization effort in Dallas includes an HNS, a private rehab effort in a historical area, and a new construction, infill development program that functions privately. Finally, a large private inner-city rehabilitator from Washington, D.C. pointed to the problems of timid lending practices, site security, and city hall politics as the biggest problems he encounters in urban rehab.

F. The Urban Institute Study

A pilot study carried out for HUD by the Urban Institute in 1976 represents the only broad, formal research effort on the housing rehab industry that is known to exist at this time (Brune, p. 31). Authored by Genevieve Brune, the study includes a literature review and results of interviews of ten rehab contracting firms, six consumer agencies, three local government agencies, and three banks within the Washington, D.C. metropolitan area. The study attempted a "market conditions" orientation, that is, a study that relates important interests and problems between both the rehab industry and its consumers.

The study stated several basic limitations as to its accuracy and applicability to other rehab (i.e. housing conservation) industry research. The short amount of time permitted for the study, the very

small, nonrepresentative sample utilized, and the lack of sufficient data base with which to compare results were mentioned as important shortcomings.

The study dealt with all types and degrees of housing improvements, as described in the housing conservation continuum mentioned in Chapter I of this report.

Results of the study were presented according to the four different types of rehab-related groups interviewed, with a section on proposed remedies at the end. The interviews maintained a strong focus on investigating the issue of industry versus consumer interests—how they were different or the same, what problems arose, and how problems were dealt with.

Contractors—of the eight contracting firms with tabulated interviews, five offered all types of home improvement services, while the three others engaged in specialized improvements. The firms averaged eight years in the business and twelve employees per firm. Five of these employees were either clerical, professional, or sales personnel. The study notes that the national average is only four employees per repair firm.

In terms of the type of work carried out by the different firms interviewed, there were remarkable similarities. Seven of the eight firms did at least 80 percent of their work on single-family homes, while the other only worked on multi-family dwellings. Seven of the eight firms also did rehab work only, while one firm did only 10 percent rehab. Seven of eight firms subcontracted an average of 30 percent of

their rehab work (with the other firm "subbing" nothing), and five of eight provided emergency repair services.

With regards to service quality, six of eight firms offered one year warranties on labor, while two of eight had their own warranties on materials. All considered their reputations to be very important and claimed to "give in" to consumers when complaints were made.

On consumer relations, five of eight firms used word-of-mouth referrals as their most common form of initial customer contact, and seven of eight firms always completed a working agreement by signing a detailed written contract on work to be carried out. Many firms mentioned many of their problems arising from consumer ignorance about the entire rehab process.

On management of a rehab firm, employee supervision was considered to be a problem, more so for the bigger firms. No firm thought that there was a shortage of firms in the business. Only one firm planned to expand its rehab activities. The three highest priority problems mentioned by the firms were (in order of priority) (1) finding skilled employees, (2) finding enough work to keep busy, and (3) obtaining sufficient working capital.

Consumer Agencies—All six agencies interviewed had basic housing improvement literature and maintained complaint services about home improvement firms. The quality of the literature and the agency's ability to pursue complaints depended on its budget situation. No information on the number of complaints for each home improvement firm was available. Many difficulties were involved for an agency pursuing legal action against a firm with complaints filed against it.

Other Government Agencies—Two contractor licensing agencies and one public housing improvement program were interviewed. Each group had very different forms of controls over contractors and firms, and each stated that small budgets did not permit much policing or legal action. All the groups maintained a complaint service and tabulated complaints received, but they did not actively pass these complaints along to any other agency.

Banks—Three banks provided information on lending to home improvement contractors, either for capital expansion or for carrying out repair jobs. All the firms stated that credit and work references and available assets were the main criteria affecting lending decisions by their institutions. They also mentioned that inflation seemed to hurt the small contractor more than the large contractor.

Analysis and Findings—After the study reviewed results of the interviews, it went on to propose remedies and future research that HUD could undertake to deal with problems that the study identified. An overall finding of the report was that businesses interviewed tended to see major industry problems as internal while national organizations tended to see the industry's problems as being more external (e.g. a shortage of skilled labor versus restrictive governmental regulations). The report also noted that all respondents maintained a large degree of consensus regarding problems within the home improvement business.

In summarizing problems raised during interviews and research, the report divided the problems into five categories: business management, consumer relations, government and quality control, interagency

coordination, and work type. In the area of business management both primary and secondary problems were noted from the study. Primary problems included (1) finding trained, skilled, and stable employees, (2) having enough work to keep a steady work flow and stable employment, and (3) acquiring enough working capital to stay in business and expand. Secondary problems noted in the study included difficulty in (1) sticking to a work schedule, (2) finding good customers, and (3) coping with high employer and business taxes.

Consumer relation problems centered around the poor communication occurring among contractors, consumers and consumer agencies. Contractors felt that consumer agencies were worthwhile but that they discriminated against contractors. Consumer agencies often agreed and felt that basic information and education was needed for all parties involved.

Problems related to government and quality control were divided into consumer protection and industry registration problems. Within the consumer protection problems category, many businessmen felt that government regulation was going too far and that consumer protection activities needed a full reappraisal. In particular, many groups felt that preventive actions were more desirable than legal prosecution in this field.

Within the category of industry registration problems, the study indicated industry support for current registration controls, but sought more uniform interpretation and enforcement of controls. Lack of resources for policing registrants and minimal bonding requirements were also seen as problems. Finally, industry businessmen stated that because

of the government restrictions and controls placed on their work, they should receive several types of government assistance, particularly in the field of business management.

A number of interagency coordination problems were also pointed out in the study. There was very little communication of any kind occurring between consumers, consumer agencies, businessmen, industry organizations, and government. This fact has produced a wide variety of ongoing problems. There were also jurisdictional problems seen in licensing and regulatory enforcement activities. In addition, there were significant problems in the lack of collection, sharing, and communication of data to the public and to other government operations. Finally, there were special problems noted between businesses and government in some of the government-sponsored housing rehab programs.

The final category of problems noted in the study were related to the type of work involved in housing rehab. It was pointed out that the unpredictable nature of rehab work often caused extraordinary expenditures of time, money, and frustration in attempting to carry out rehab work. This is seen as an important yet ongoing problem for action.

Remedies to Market Problems—Remedies proposed by the study concentrated on actions that could be taken by HUD to assist the problems noted above. The development of three model training programs by HUD to assist different parties involved in rehab was the first type of remedy proposed. The first program topic was consumer education, to assist in the training and broad circulation of rehab education materials. Management training programs were also proposed to aid small firms and

large organizations involved in the industry. Finally, a training program in arbitration was proposed, to bring consumers, the industry and regulatory agencies to a position of better understanding and respect for each other.

The second type of remedy proposed by the study was in the increased collection and application of information about the rehab industry. The first remedy of this type was a proposed labor force training and education effort, based on needs and priorities identified with information gathered from the industry itself. The second remedy was an interagency information dissemination program designed to improve understanding within the industry through improved data collection, analysis, and distribution.

The final type of remedy proposed was a thorough evaluation of the regulatory mechanism for the rehab industry. This effort would examine the efforts of governmental regulations at all levels.

G. Summary of Literature Review

There is much agreement in the literature reviewed in this chapter about the urban housing rehabilitation industry and the problems facing it. The conclusions of the important Brune study can serve as a basis for comparison with the views of the rest of the literature. Most of the literature supports the five industry problems described by Brune. Business management problems were stressed by Brune and other sources, including the Project Rehab report, the experiences of nonprofit groups, Mandelker and Montgomery, Martin Mayer, et al. This was particularly true on the subject of finding sufficient numbers of trained rehab workers.

Though less attention has been focused on the problem of consumer relations in the general literature than was shown by Brune, there are references to such problems among the literature. Both Rogg and Black, for instance, talk generally about the need for homeowners to be able to find counselling assistance in dealing with contractors and maintenance of a home following rehab work.

There has been much attention given in the other rehab industry literature to Brune's stated problem of government and quality control. The increasingly formal and standardized rehab procedures that have been introduced through many C.D. rehab programs (e.g. see Benitez's book) represent additional quality control measures now required by the government. Other HUD and NAHRO literature and efforts have also been aimed at insuring good quality rehab work in a preventive rather than an after-the-fact manner. Less attention has been given in the literature to industry registration issues than to consumer protection efforts.

Rehab industry literature has shown concern with the interagency coordination problems mentioned by Brune. Recent efforts by HUD, in particular, to more actively involve national organizations related to the rehab industry with the rehab activities sponsored by the federal government is probably the best example of this concern. The NHS organizational model being used throughout the country also places heavy emphasis upon coordination of all activities with all related agencies.

The work-related problems of frustration and uncertainty talked about by Brune also received much attention by other rehab industry literature. Both Bagby and the Project Rehab report testify to the

frustration and unpredictable nature of rehab work and point to the need for small, flexible rehab firms to deal with it. In addition, efforts like these of the Building Research Advisory Board are helping to better define the entire rehab process and thus to develop possible solutions to some of these work-related problems.

Finally, this literature review support Brune's overall contention that businesses in the rehab industry tend to emphasize the internal problems of the industry (labor shortages, high material costs, etc.) while national industry organizations tend to point toward external problems (inflation, government policies, etc). Literature dealing with actual rehab case studies (e.g. Mayer, Project Rehab, Stegman, etc.) often point directly at business management issues as being the key to successful rehab. The literature from groups such as NAHB, NAHRO, and the U.S. League of Savings Association stress far more the interagency coordination problems of rehab work.

Although Brune's findings appeared to be generally consistent with the other literature reviewed, there were several important differences that should be noted. First of all, Brune did not really discuss the issue of proper scale for rehab work and business firms that was so central to much of other literature (e.g. Mandelker & Montgomery and Project Rehab). Second, Brune's emphasis on the consumer and consumer protection side of rehab work sometimes tended to distract attention from the rehab industry itself and some of the more qualitative insights and proposals for industry action that other literature contained. For example, the chronological evolution of public rehab programs as discussed

in this literature review reflect important relationships between changing rehab efforts and the makeup of the industry itself. Lastly, the Brune study was published in August 1976 and already shows some signs of being outdated. The recent formation and actions of HUD's Division of Rehabilitation Policy and Assistance in actively dealing with many of the problems described in Brune's report is probably the best example of this.

It seems clear that the rehab programs and movements that produce urban housing rehabilitation in this country continue to have a direct effect upon the industry carrying out the work. While the FHA Title I loan insurance program has developed a strong network of rehab contractors and banking officials over 45 years, so do five-year-old C.D. rehab programs develop a stronger and more experienced following each year. Likewise, the young owner who directed the restoration of his 1890 urban townhouse through private efforts is now more experienced and skilled in doing it all over again. As urban revitalization trends in the future continue to define the programs used to maintain and improve our urban housing stock, we will again see many changes in and new directions for the rehab industry.

This review of literature provides valuable insights into the amount and type of change that the urban housing rehabilitation industry has been involved in in recent years. Amid the many claims that a rehab industry does not really even exist, groups and businesses involved in rehab appear to have taken several important steps toward becoming a more professional, stable, and respected entity within the U.S. urban

revitalization movement. The increased complexity and amount of public/private efforts for urban housing rehab by both businesses and professional organizations show some of the confidence and maturity of an industry that is finding a sense of ongoing cohesion and purpose.

CHAPTER III

SURVEY OF THE URBAN HOUSING REHABILITATION INDUSTRY

IN KNOXVILLE, TENNESSEE

A. Survey Methodology

Purpose

The original problem statement in the introduction to this study stated that persons actively involved in the housing rehabilitation industry are largely unknown and their activities and problems are misunderstood by government and consumers alike. The purpose of this survey is to better understand persons working in the industry through the following means: (1) by finding out what kinds of experience and background these persons have had and what types of rehab they are carrying out; (2) by examining the process by which they carry out rehab jobs, from start to finish; and (3) by investigating problems encountered in their work, their views on the role of government in rehab, and their general satisfaction with being in the rehab business.

Objectives

The objective of the survey itself was to select a representative cross-section of persons in the industry and to carry out a personal interview with such persons at a site of their own choosing. During the interview, the aim was to move through a series of questions, beginning with specific, closed-ended questions on facts pertaining to their business and moving to more general, open-ended questions on attitudes

about being in the rehab business. It is felt that this would help to draw out answers from the respondents and to receive more in-depth responses from persons generally quite unfamiliar with being interviewed about their work. The topic of this survey was chosen as having particular relevance to the urban housing rehabilitation efforts being carried out around the country today. The specific content of questions and format utilized were in accordance with the issues being raised within the limited literature available in this field. As such, it is felt that the findings from this research could have limited applicability to the housing rehab industry in some other cities in the United States.

The Interview Setting

Knoxville, Tennessee, is a medium-sized city of about 210,000 persons (1978 estimate) with a relatively well-defined central sector composed primarily of older homes built previous to 1940 (See Map, Appendix A). The housing stock of this central section of town is the subject of the local urban housing rehabilitation industry's efforts, about which this survey is concerned.

Prior to the start of rehabilitation activity under the Housing and Community Development Act of 1974, Knoxville's housing rehabilitation industry appeared to be primarily a collection of small home improvement contractors that specialized in simple residential additions and remodelling jobs. Some of these contractors worked almost exclusively on jobs covered by the loan insurance offered local financial institutions by the FHA Title I Home Improvement Loan program. These

loans were generally for small amounts, with the maximum amount generally loaned out by Knoxville financial institutions in 1979 being \$10,000. A few had participated during the early 1970's in some Section 312 rehab jobs that were part of the Morningside and Mountain View Urban Renewal projects.

Beginning in 1975, the city's Community Development Department began to target some of these older residential neighborhoods for intensive rehab activity. Since the C.D. Department's Housing Rehabilitation office began administering its Community Development Block Grant, loan/grant and Section 312 loan programs in 1976, about 600 homes have been rehabilitated within the Central Knoxville area under these programs. This activity, in turn, has stimulated considerable additional privately-sponsored housing rehabilitation. It was within this setting that we set out to discover the nature of the urban housing rehabilitation industry in Knoxville.

Selection of Interviewees

Two types of interviews were carried out during this survey, the first type being with general contractors doing rehab work, and the second type being with other professionals related to housing rehab activity. Due to the fact that many more contractors than other professionals were engaged primarily in rehab work, considerably more effort was spent on selecting and surveying the contractors, the largest component of the local rehab industry. In selecting contractors to be interviewed for the survey, a special concern was to obtain a good

cross-sections of all the types of contractors carrying out rehab work in the older residential neighborhoods of Knoxville. With this in mind, three separate techniques were utilized in order to identify as many contractors active in these areas as possible.

The first technique used involved the review of city building permit records of residential alterations and repairs, from August 1976 to August 1979. The names of contractors that had carried out multiple repairs (e.g. more than just a repaired roof) totalling more than \$1,000 within three Central Knoxville census tracts (See Map, Appendix A) were recorded. These three areas had been targeted by a 1975 study of the Knoxville/Knox County Metropolitan Planning Commission as being areas of "high housing rehabilitation potential," and were thought to be among the areas of greatest urban housing rehabilitation activity within the Central Knoxville area. A compilation of 54 rehab jobs from these areas yielded a list of 31 contractors or firms, many of whom had carried out more than one job in these areas during this period.

The second technique for obtaining names of contractors to be interviewed involved reviewing those listed in the yellow pages of the 1979 South Central Bell phone book for Knoxville, under the heading of "Home Improvements" (there were no listings under Home Remodeling or Housing Rehabilitation). An initial list of 35 firms from this source was reduced to 20 by eliminating firms already contained on the first list and firms that were too specialized (e.g. just siding or roofing) to qualify as housing rehab firms.

A third and final technique was utilized for gaining additional contractors' names for an interview list. Two local organizations

dealing in housing construction and housing rehabilitation were asked to make referrals of contractors they knew of who were active in housing rehabilitation activities in the Central Knoxville area. The Greater Knoxville Home Builders Association recommended six contractors, none of whom were among the previous list of contractors already obtained. The Housing Rehabilitation office of the city's Community Development Department recommended nine contractors, all of whom were already on the previous contractor list. Utilizing the three techniques described above, then, a total list of 57 contractors or firms was obtained. Later investigations uncovered five duplicate listings, making the final interview list for contractors total 52 names.

It is difficult to determine what portion of the total contractors within the local urban housing rehabilitation industry is actually represented on this list of 52 persons or firms. It seems unlikely that many contractors operating close to full-time in central-city rehab would have neither filed a building permit within one of three active rehab neighborhoods nor advertised his services through the Yellow Pages. It is estimated, therefore, that a minimum of two-thirds of all rehab contractors active in Central Knoxville were contained on this list.

A list of "other professionals" related to housing rehab was also compiled. Included in this list were realtors, banking officials, and government officials, referred by contractors and encountered directly while investigating the survey. Three persons from each group, who were known to have had some contact with urban rehab-related activities were selected to be contacted to attempt to arrange an interview. This

produced an interview list of nine persons. Though it was not known before the interviews to what extent these persons were involved in the local rehab industry, it was felt to be important to interview a number of noncontractors such as these persons in order to be able to accurately describe the entire urban rehab industry in Knoxville.

Interview Process

The final contractor interview list of 52 persons or firms was first investigated in order to produce phone numbers for each listing. Intensive efforts to contact each person or firm were then made. Many listings had a changed or disconnected phone number, had no answer at their listed number, or had no regular time at which the person was able to be reached. Of the 52 persons on the list, 25 were never able to be contacted, despite a total of 15 or more calls being made to the same number at many different times of the day and over a four month period of time. This process proved to be an appropriate introduction to the problems of finding out about the housing rehabilitation industry.

Of the 27 names remaining on the contractor interview list, ten were contacted but were unable to arrange a suitable time and/or place for an interview. A total of 17 complete interviews were conducted. Of these, two interviews were, at the request of the respondent, completed over the phone, with full and comparable responses received. The other 15 interviews were conducted in person, at a place of the contractor's choosing. Though usually located in the interviewee's home or office, interview sites also included various job sites and restaurants.

Based on the above-mentioned estimates of the total number of contractors within the local rehab industry, the interview response from 17 contractors represents between 20 percent and 25 percent of the total. Though final interviewees were selected more on the basis of their availability for interviewing than for scientific sampling purposes, it was felt that the body of respondents was quite representative of local industry contractors as a whole.

Contact with the nine persons on the interview list of other professionals was carried out following the contractor interviews and during a shorter period of time. Of the nine, four were either unable to be contacted or were found to have had little direct involvement in housing rehab activities. Five complete interviews were carried out, with respondents including a realtor, two bankers, and two local government officials (an inspector and C.D. rehab official). These persons' direct experience in rehab work varied greatly, ranging from the everyday involvement of a government rehab official and inspector, to frequent rehab loan reviews by both banking officials, and including a realtor who had contracted out the rehab of several small homes as a sideline activity. All interviews were carried out at the interviewee's place of employment.

The interview form utilized in all interviews (though modified somewhat for the related professionals) was initially developed with the aid of several texts about interviewing formats and techniques (Gorden, pp. 251-308, and Burton & Cherry, pp. 55-65). Specific question content came from various literature on the urban housing rehabilitation industry

and from a C.D. rehab procedures manual (City of Knoxville, index). The interview form was completely revised several times, the final revisions occurring following three pretest interviews conducted with two contractors and a banking official on August 31, 1979. A copy of the interview form and of the names of all those interviewed is contained in Appendix B and C of this study.

Actual interviews were conducted throughout the Knoxville area between September 19, 1979 and January 9, 1980. All interviews were conducted by the author of the study.

B. Analysis of Results

Introduction

The interview form is divided into three parts, each of which is analyzed separately here. Part I deals with the professional rehab experience, background, and work situation of the person interviewed. Part II looks at the specific process used by the person in carrying out rehab activity. Part III examines the respondent's overall and specific answers to questions about working in the rehab business. Responses from both contractors and other rehab-related professionals (referred to throughout this summary as "Other Professionals") for each question are summarized separately but displayed together for comparative purposes. The responses of the Other Professionals serves more to compare contractors to other parts of the industry than it does to accurately describe the individual responses of members of this varied group. Relevant cross-tabulations of results are also included within the summary

for each question. Also, related comments not directly answering a specific question asked are included in these question summaries.

Part 1. Professional Experience, Background, and Work Situation

A. Opening observations

A list of the names and firms of all interviewees is contained in the Appendix. All 22 persons interviewed were males between the ages of 20 and 70 years old. Three of these persons were black, the others white.

B. Types of work done

Contractors: When describing the type of work they do, ten respondents used the term remodeling, three used the term renovations, and only one person used the term rehabilitation. Others used the terms general contracting or construction to describe their work. The term rehabilitation seemed to be widely interpreted as meaning a large improvement job funded by the C.D. loan/grant program. This occurred despite the fact that the interviewer presented a brief definition of rehab different from the above meaning at the start of each interview. Overall, contractors seemed reluctant to identify their work as being rehab work.

Other Professionals: Three respondents used the term rehabilitation in describing their work. Other respondents used the terms remodeling and renovation more often.

C. Portion of total work that is housing rehabilitation

Contractors: The average amount of rehab work carried out by contractors interviewed was 70 percent of their total work (See Table 2).

Table 2
Range of Responses on Selected "Quantative" Questions
Housing Rehabilitation Industry Interviews
Knoxville, Tennessee

Question	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	median response	Noncontractor Responses					median response
																			1	2	3	4	5	
1. Portion of total work that is housing rehab (%)	100	100	100	100	100	100	90	80	80	80	70	60	50	40	15	10	10	80	100	98	25	5	2	25
2. Average cost of rehab job in Central Knoxville area (in \$1,000's)	13.5	13	12	11	10	10	8	8	7	7	6	6	5	4	2	2	2	7	12	12	4	25	2.5	4
3. Number of years in the rehab industry	35	34	25	24	22	20	18	15	12	11	10	10	10	8	7	7	2	12	15	15	7	2	2	7
4. Number of employees in rehab firm	40	14	15	12	12	10	7	6	6	5	5	4	4	3	3	3	3	6	300	18	13	7	4	13
5. Average rehab job completion time (in weeks)	8	6	4	4	4	3	3	3	3	3	2.5	2.5	2	1.5	1	1	NA	3	3	NA	NA	NA	NA	NA

Only four contractors interviewed did less than 50 percent of their total work in rehab. Most of these persons felt that they should be even less involved in rehab work than they were at present. There seemed to be pressure to either get all the way in or all the way out of the business among those interviewed.

Other Professionals: As a whole, these professionals had a smaller portion of their total work in rehab, averaging just under 50 percent. A wide range in degrees of involvement in rehab work existed among these persons (See Table 2).

D. Portion of total rehab work that is within the Central
Knoxville Area (See Map, Appendix A)

Contractors: The average amount of rehab work carried out by contractors within the Central Knoxville area was 55 percent of their total rehab work. Among those contractors who also lived in the Central Knoxville area, the average amount was 89 percent. Much of the rehab work here was related to the C.D. rehab program.

Other Professionals: The average involvement of these persons was 90 percent of total rehab work within the Central Knoxville area. This was significantly higher than for contractors.

E. Average cost of rehab jobs in Central Knoxville

Contractors: The overall cost of an average rehab job among interviewees was \$7,500 (See Table 2). The average cost for contractors doing primarily C.D. work was \$11,000. Many respondents had difficulty defining the average cost of their rehab jobs.

Other Professionals: The two banking institutions did not handle any financing of rehab jobs costing a total of between \$10,000 and

\$18,000 (i.e. they financed only loans that were either below \$10,000 or above \$18,000). The average rehab loan made by the C.D. program was \$12,000, considerably higher than any FHA-insured home improvement loan.

F. Number of years in rehab business

Contractors: The average amount of time spent in the rehab business by respondents was 16 years, with several persons having more than 30 years of rehab experience (See Table 2). Contractors doing mostly C.D. work averaged 10 years in the business.

Other Professionals: The average amount of time in the business was eight years. Bankers had the most years of experience among these persons. On the whole, these persons had far less direct rehab experience than did the contractors.

G. Business worked in before rehab business

Contractors: Ten respondents had been in a construction-related business previous to housing rehab business. The others had been mostly in a variety of retail businesses.

Other Professionals: Only one respondent had had any previous construction-related experience. Others had experience in other professional fields not related to rehab work.

H. Location of residence

Contractors and Other Professionals: Respondents were evenly divided between living in Central Knoxville, other parts of Knoxville, and other parts of Knox County. No respondent lived outside of Knox County.

I. Licenses and bonds held

Contractors: Almost all respondents held city and/or county general contractors license and most also held state licenses; one person had no licenses at all. In addition, seven respondents had full, ongoing performance and liability bonds, while four claimed to have no bonding at all. Many mentioned that there was little effort made to keep unqualified persons out of the business, through either licensing or bonding procedures. Little or no industry quality control seemed to be enforced by either of these licensing or bonding mechanisms.

Other Professionals: Only one person had received any sort of special certification as being qualified for doing the rehab-related work he does. Individual bonding is not necessary for these persons, who receive coverage from their firms.

J. Union or professional memberships

Contractors: Only eight respondents belonged to any type of group or organization, with four belonging to the Greater Knoxville Home Builders Association, and three belonging to some type of union. The Better Business Bureau and Associated General Contractors each had two members who were interviewed. None of the groups were rehab-oriented or served a direct, functional purpose to their rehab work, although many of the groups appeared to be quite socially-oriented. One respondent briefly mentioned the possibility of forming a local rehab/remodeling organization.

Other Professionals: Two respondents belonged to some type of rehab-related professional organization, both of them being national in scope and not locally-oriented.

K. Type of training for rehab work

Contractors: At least seven respondents had received rehab-related construction training through their own family. Six others had received some type of formal classroom training related to construction. The other four respondents had received training strictly on an on-the-job basis. No respondent had had direct rehab training per se. All had to adapt other skills to rehab work.

Other Professionals: One respondent had received some construction training through his family. None had any formal training in any rehab-related activity.

L. Amount of formal education received

Contractors: The average contractor was a high school graduate with half a year of college. There were no college graduates among those interviewed, yet all but three respondents were high school graduates.

Other Professionals: The average respondent was a college graduate with half a year of graduate work. All but one were college graduates, and all had had training in a particular professional field.

M. Office organization

Contractors: Nine respondents had an office with a business phone, though many of these were connected to or within their homes. Almost half the respondents maintained no formal office. Many of their business procedures appeared to be correspondingly informal and erratic.

Other Professionals: All respondents maintained a formal office with formal business procedures and correspondence carried out.

N. Number of employees in firm (not including subcontractors)

Contractors: The median-sized firm had a total of six employees, including one office staff person (See Table 2). Contractors that carried out a large amount of C.D. work averaged five employees and no office staff. These rehab contracting firms remained very small, particularly in relation to the firms of the other professionals.

Other Professionals: All respondents belonged to firms with more employees than any of the individual contracting firms. (See Table 2).

O. Value of firm's total assets (four categories)

Contractors: The median firm maintained an estimated \$40,000 in assets (See Table 3). Several firms with many employees had almost no assets. Several contractors mentioned that moderate-to-large-sized contracting firms with large assets cannot afford to bid on most small to moderate-sized rehab jobs.

Other Professionals: This question was not applicable for these respondents.

Table 3

Assets of Rehabilitation Contracting Firms

	Less than \$25,000	\$25,000 - \$50,000	\$ 50,000 - \$100,000	More than \$100,000	Estimated amount of assets for median firm*
Number of firms in each category	5	6	3	3	\$40,000

*Based on an assumed even distribution of firms throughout the \$25,000 to \$50,000 assets category.

Part II. Specific Housing Rehabilitation Process Utilized

A number of the questions in Part II are not applicable to most of the other rehab professionals.

A. Method of client contact

Contractors: Most used a limited amount of some form of advertising, in addition to word-of-mouth referrals. They maintained very little advertising overall, especially the smaller rehab firms. Participation in C.D. programs lessens the need for advertising, due to the public bid process used.

Other Professionals: Only one respondent advertised its services. None of the others saw the advertising of their rehab services as important or relevant.

B. Process used in carrying out work writeups and cost estimates

Contractors: They almost always do their own cost estimates and work writeups. The exception is C.D. jobs, where rehab specialists do the initial work writeup. All contractors thought that this was a very important part of the rehab process.

Other Professionals: Financial institutions are the only respondents that do not get involved in either reviewing or doing work writeups or cost estimates. They also seem to rely on the judgment of the contractor (and/or rehab specialist).

C. Jobs with formal bids submitted

Contractors: Formal bids are submitted on approximately two-thirds of all jobs. One of the respondents always makes formal bids. Most of them consider bidding a good business practice in general, and do not

particularly like other pricing mechanisms (e.g. cost-plus pricing or negotiations). These other mechanisms were mentioned as having been used in the past, and they were seen as often creating unfair competition and less professionalism among contractors. Contractors say that they are now more willing to put up with many of the delays of the formal bidding system than they were before. Formal bidding procedures represent to many a more "professional" approach to rehab activities.

Other Professionals: Bidding is always used with C.D. rehab jobs; the other professionals were uninvolved in any pricing of rehab work.

D. Type of working agreement

Contractors: About one third of all respondents still use a verbal agreement on at least 25 percent of their rehab jobs. They maintain that these agreements are based on trust. Almost half, however, now regularly use a formal, typed agreement, including much specification on work and materials. The size and complexity of the jobs and the frequent unfamiliarity of clients encourage this trend.

Other Professionals: C.D. work agreement forms are very detailed; the others are not involved in any such agreements.

E. Type of payment arrangements

Contractors: Most respondents still use traditional 100 percent Payment on Completion (P.O.C.) arrangements most of the time. About half the respondents now also use a formal "draw" arrangement (e.g. several partial payments on large rehab jobs) to an increasing degree. This is particularly true on C.D. rehab jobs. More paperwork and bookkeeping is required under a draw payment system. This system is also seen as more professional in its approach to rehab work.

Other Professionals: C.D. jobs utilize a specific draw system, while the banks interviewed still use 100 percent payment on almost all small rehab jobs. Banks used a draw system on large rehab jobs.

F. Involvement of rehab financing sources for clients

Contractors: About half (48 percent) of the respondents frequently give advice or active assistance to customers in arranging financing for jobs, especially for FHA loans. For many of the contractors, this type of involvement in client financing is decreasing, though the Title I-type loan was still seen as being readily available from banks. This sort of involvement is not possible within the C.D. rehab program.

Other Professionals: The secondary mortgage market for private rehab financing was seen by two respondents as being difficult for rehab consumers. C.D. programs usually provide all funding directly, in conjunction with doing work writeups and monitoring the rehab work.

G. Portion of total jobs with building permits

Contractors: All respondents except one said that they always obtain all permits required on a job. The one respondent who did not get all required permits said that many of the others in fact often do not get them either. He said that the reason for this was that he/they were just too lazy.

Other Professionals: One respondent said that there is less and less cheating on permits and that the system is improving. All C.D. jobs verify the receipt of all permits required. This appears to be the first time that real checks on permits are being made within the Knoxville housing rehab business. Others are uninvolved.

H. Frequency of use of appraisals on rehab jobs

Contractors: Almost half the respondents said they had heard of current-value appraisals being done, though few had experienced them directly on their rehab jobs. Many appeared to not really know what an appraisal was or for what it was used.

Other Professionals: C.D. often uses current-value appraisals on large Section 312 rehab loan cases. Both banking institutions interviewed had used appraisals in rehab cases several times each.

I. The most common repairs made on rehab jobs

Contractors: Almost half the respondents said that bathroom and roofing jobs were the most common repairs; one third of the respondents said electrical and kitchen repairs were the most common. Others listed a variety of repair types.

Other Professionals: Two respondents said bathroom repairs were the number one repair problem with roofing and electrical repairs being the second most common problem.

J. Types and amount of subcontractors used

Contractors: Most respondents subcontract all electrical and plumbing activities, 35 percent subcontract masonry work, and 29 percent subcontract sheetrock and roofing work. Carpentry-related work seemed to be subcontracted the least.

Other Professionals: Not applicable.

K. Source of materials

Contractors: Seven respondents try to always use the same materials source, six "shop around" for the cheapest materials, while four go to

the closest supplier to their job site. One respondent mentioned the increasing need to shop around due to high inflation driving material prices unevenly at different suppliers. Only one person claimed to pay cash for all materials, while all others utilized accounts with each supplier.

Other Professionals: Not applicable.

L. Frequency of progress inspections

Contractors: Seven respondents have mandatory progress inspections made on all their rehab work, while four others have few, if any, inspections carried out on their jobs. Other respondents had infrequent inspections on their jobs. The jobs with the fewest inspections were usually smaller, Title I-type rehab jobs. Increased inspections are seen as a more professional approach to quality control on rehab work.

Other Professionals: Banking institutions interviewed never inspect rehab work, while the C.D. office made daily inspections on their jobs.

M. Formal final inspections

Contractors: Thirteen respondents always have a thorough final inspection at the end of a job, usually involving both the client and the contractor. Other respondents have formal final inspections less often.

Other Professionals: Final inspections are required in all cases by the C.D. rehab, the housing inspector and the realtor respondents. The two banking institutions have no inspection requirements.

N. Jobs with additional work required

Contractors: Three of the respondents reported unexpected additional work being required by the client on 30 percent or more of

their rehab jobs. Many of the respondents had additional work required on only a few jobs. Contractors do not see additional work being required as at all unusual or serious, unless it becomes a major, unforeseen financial burden.

Other Professionals: These respondents also expressed little concern over additional work, to the extent that it related to them.

O. Rehab jobs with legal action involved

Contractors: Eleven respondents had experienced some legal action related to rehab work, though they always reported such action as being taken against someone else. Few details were given on these cases by respondents. The other respondents reported no legal action involved at all with their rehab work.

Other Professionals: No legal involvement on any rehab activities was reported by any respondent.

P. Jobs with late payments

Contractors: More than half the respondents encounter late payments on a small portion (5-20 percent) of rehab jobs. The extent and amount of late payments involved are important considerations in the impact of such occurrences. Some C.D. rehab jobs (especially Section 312 loan cases) are notoriously slow.

Other Professionals: Not applicable.

Q. Average time of completion on a rehab job

Contractors: The average amount of time required is 3.2 weeks (16-18 work days), with a range of between one and eight weeks being the average for different contractors.

Other Professionals: The approximate same amount of required time was reported by these respondents, except for rehab jobs with Section 312 loans, the slow processing which can often significantly delay work on a job.

R. Jobs with cost overruns

Contractors: An average of 10 percent of all rehab jobs involved cost overruns of some sort. Most respondents saw these overruns as a minor problem. They seemed to be a normal part of doing business for most contractors.

Other Professionals: Approximately 25 percent of C.D. rehab jobs encounter some overruns in costs. C.D. jobs appear to deal with cost overruns through change orders on a daily basis.

S. Use of profit margin in cost estimating

Contractors: A standard profit margin was used by twelve respondents. The average profit margin was 22.5 percent. The profit margin fluctuates for other respondents, according to job size and size of the contracting firm. The large overhead costs of large firms were mentioned as requiring prohibitively high profit margins in order to bid on small rehab jobs.

Other Professionals: The C.D. maximum profit margin is 25 percent, which is considered normal. This question is not applicable to the other respondents.

T. Work records and audits

Contractors: Almost all respondents report keeping full work records, and six have been audited at some time. A number of them are

beginning to turn all their records over to an independent accountant for bookkeeping purposes.

Other Professionals: All respondents reported keeping full and complete records.

U. Work guarantees

Contractors: Five respondents voluntarily mentioned that they back up their work for one year and that they make periodic checkups and callbacks on past jobs. This effort appears to be increasing in use by contractors.

Other Professionals: C.D. jobs demand six and eleven month callbacks by the contractor involved. This question is not applicable for other respondents.

Part III. Overall Reactions to Being in the Housing Rehab Business

A. Ongoing problems encountered in rehab business

Contractors: Responses to a list of 13 possible problem areas (including "other problems") were extremely varied (See Table 4), with contractors listing an average of two and a half problems each. Most of them were having difficulty defining specific problem areas. Three main problem areas were mentioned most commonly by the contractors.

Inflation was the problem mentioned most often (by thirteen respondents), though many viewed it as not a particularly serious problem. One person saw it as an aid to the rehab business by increasing new construction costs. It appears that inflation has a definite and varying impact on different parts of the rehab industry.

Table 4

Ongoing Problems Encountered in the Rehabilitation Business

Problem Area	Number of Times Mentioned
CONTRACTORS —	
Inflation of rehab costs	13
Availability of dependable labor	11
Lack of business and increasing competition	8
Client relations	4
Availability of materials	3
Scheduling of work	2
Capitalization of firm	1
Cash flow of firm	1
Construction risk*	1
Availability of financing	0
Cooperation within the industry	0
OTHER PROFESSIONALS —	
Client relations	2
Availability of financing	2
Capitalization of firm	1
Availability of skilled labor	1
Competition among firms	1
Inflation of rehab costs	1
Poor enforcement of permit system*	1
Too much bank regulation*	1
Poor image of rehab*	1

*Brought up by individual respondent under "Other Problems."

The final main problem (mentioned by eight respondents) was the lack of business for some firms and the increasing competition among rehab firms.

On the other hand, several problem areas listed in the survey were not mentioned at all as being a problem for the contractors. Financial issues such as capitalization of the firm, cash flow situation, and overall availability of rehab financing were hardly ever mentioned (one respondent) as being a problem. Financial issues in general appeared to be rather touchy discussion topics with many contractors. The lack of cooperation among firms in the rehab industry was another problem area not seen at all as being a problem. Most of the other problems were mentioned several times by respondents.

Other Professionals: Both client relations and financing availability were mentioned as problems by two of the respondents (see Table 4). Among other problems mentioned by single respondents from this group, the inspections system and overregulation of banks by government were stressed the most.

B. Changes suggested to aid these problems

Contractors: There was very little agreement on specific actions to be taken to deal with the problems mentioned. Because many contractors said that such problems were "part of the system," they felt that they could not be changed. Six of the contractors had no suggested changes at all. Actions agreed upon by at least two contractors included improving the availability of different materials, confronting large economic problems (e.g. inflation and interest rates), and educating the public, subcontractors, and inspectors about rehab contractor problems.

Other Professionals: Among this group, the need for additional education of inspectors, contractors, and consumers on problems of the rehab industry and appropriate training needs was mentioned at least twice. Many of these respondents also saw few solutions to the problems mentioned.

C. Government rehab programs participated in by respondents

Contractors: Overall, a large portion of respondents had participated in government rehab programs. Eleven respondents had done some work under the city's C.D. Housing Rehab program in recent years, with a number of them doing it nearly full-time. A total of thirteen had at some time participated in the FHA Title I Home Improvement Loan program, though several thought of this as an insurance program and not a government rehab program per se. Three respondents had also participated in urban renewal rehab work through the Section 312 loan program. Only two respondents claimed to have had no experience at all in any governmental rehab program. Five respondents noted that they had previously but no longer participated in any government rehab programs. The personalities of different contractors seemed to have much to do with their tolerance for different aspects of these programs. Impatient contractors, for instance, found participation in the C.D. rehab programs impossible for them, due to the many delays and procedures involved.

Other Professionals: Four of the respondents had been involved in FHA home improvement loans before, two respondents had had C.D. rehab involvement, and one person had had no involvement with any such programs. In addition, three respondents had used other government

programs in rehab that no contractors interviewed had been exposed to (e.g. Federal National Mortgage Association, etc.).

D. Problems with government rehab programs and agencies

Contractors: A wide variety of answers were received, with six respondents giving no response at all. Five mentioned incompetent inspectors and rehab specialists as a problem. Three respondents mentioned problem areas in both delayed payments and excessive regulation. Many respondents had difficulty separating general rehab problems with government rehab program problems.

Other Professionals: Three respondents had no response, while two mentioned problems with the inspections process. They also had difficulty identifying problems of government rehab programs in particular.

E. Government actions that might aid the rehab business

Contractors: The largest response (eight respondents) was a variety of suggestions to change regulations or administration of regulations on rehab programs—better coordination, less paper work, more of a watchdog role, change in licensing procedures, and less delays. Four respondents had no response. Other multiple response areas included: more training of inspectors, rehab specialists, and contractors (three respondents); and more assistance (loans and bonding) to rehab firms (two respondents). Many of these problems seem directly linked to adjusting to the changed procedures and processes set up by C.D. . rehab programs.

Other Professionals: Three respondents were concerned over a shortage of rehab financing, two respondents wanted more training, and one respondent sought less regulation.

F. Plans to change person's own rehab business

Contractors: Twelve respondents do not plan to change their business soon, although five of these respondents wish that they could. Five respondents claimed that they were planning to change their business in the near future. Of the ten respondents either changing or wishing to change their rehab activities, five of them sought to decrease their rehab work, two sought to increase it, and three planned to shift in the business (e.g. moving, retiring). As a whole, the response of the contractors was rather pessimistic about their future in the rehab business.

Other Professionals: Four of the respondents are planning to change their rehab business; the two banking institutions and the inspector are planning to increase and the realtor to decrease their involvement with rehab work. The C.D. rehab respondent does not plan to change, although he would like to increase rehab work if it were possible. Most of these respondents seem to share an optimistic view on the future and their involvement in rehab work.

C. Summary and Conclusions

This survey, as mentioned in Chapter I, sought to answer four basic questions about the urban housing rehabilitation industry in Knoxville, Tennessee. This concluding section seeks to summarize survey results

in order to answer these questions directly and to draw conclusions about the local rehab industry.

Summary—Part I asks the question of what type of persons and firms carry out urban housing rehab work in Knoxville and what type of rehab work do they do. The average local contractor is a white male who has worked in the business sixteen years, has eight other employees and one office worker at a small office adjoining the back of his home. He is a high school graduate with little formal construction training whose father had done construction work for a living. He holds several general contracting licenses and has bonds covering most of the work he does. His firm's total assets equal about \$6,000 per employee. Three-fourths of his total work is in what he calls housing remodeling or renovation work, with more than half being within the Central Knoxville area. His average rehab job in this area costs \$7,500. He belongs to one professional organization which he doesn't feel really assists him in his rehab work.

Due to the diverse nature of the other rehab professionals interviewed, generalizing about their common traits is harder to do. All the same, the average noncontractor rehab professional has been involved in rehab work for eight years, spends less than half of his time working with rehab-related projects, and has had no training for rehab or construction work except for on-the-job experience. The firm he works for has at least 20 employees and has a large, fully-staffed office. He is a college graduate with some post-graduate study and belongs to no professional organizations related to housing rehab work.

Part II asks the question of how particular persons in the rehab industry in Knoxville carry out their work. The average contractor does a little rehab advertising beyond the work referrals that he receives. He increasingly submits a formal bid on a job he is considering and usually signs a written agreement on the work to be carried out. He used to receive full payment for a job upon completion of the work, but now frequently receives payment "draws" when he completes half or three quarters of the work on a job. He almost always obtains the permits required on his work, occasionally has an appraisal done on one of his jobs, and has been known to help arrange financing for his client when needed. His most common rehab jobs include repairs to kitchens and bathrooms, and he almost always subcontracts out the electrical and plumbing work on his jobs. He has a favorite materials supplier for his rehab jobs, and he receives at least two formal inspections on each of his jobs. Minor, ongoing problems in his work include additional required work, legal action, and late payments on some jobs. The average job takes him a little over three weeks to complete, and he frequently has minor cost overruns on jobs. He utilizes a profit margin of almost 25 percent when estimating the cost of a job. He keeps adequate work records in his office and considers it quite likely that he could be audited by the government sometime soon.

The average noncontractor rehab professional is, again, difficult to generalize about. He does little advertising of his rehab services and generally uses very formal bidding and rehab work agreements. He is already using a well-defined "draw" system of contractor payments, and

he increasingly deals only with the customer directly on rehab jobs. The secondary mortgage market for rehab is generally seen as almost nonexistent and appraisals are still quite unusual for rehab jobs. Bathroom and roof repairs are seen by this person as the most common urban housing rehab repair needs. This professional is usually increasingly concerned with carrying out a full series of inspections on rehab jobs and maintains complete records and files related to all aspects of a rehab job.

Part III seeks information on problems of being in the housing rehab business, and the person's general satisfaction with being in that business, and on involvement with public rehab programs. The average contractor sees either inflation or a shortage of skilled labor as his biggest problem, and he has few suggestions on how to change these things. He has done more jobs with FHA-insured rehab loans than with the C.D. rehab program. The major problems encountered with these programs include incompetent rehab specialists and inspectors and certain government regulations. Changes in such regulations, additional training for these rehab personnel and special assistance for small rehab firms are most often mentioned as possible aids to these problems. Although he does not actively plan to change his contracting firm, he sometimes wishes that he could do more of some other types of construction work.

The noncontractor professional generally sees his work with rehab clients and the unavailability of rehab financing as the major problems of the business. He mentions additional professional training and

consumer education as the best ways to directly aid rehab problems. Like the contractor, he usually has had much involvement in FHA-insured rehab loan jobs and more limited involvement with C.D. rehab jobs. He also has had involvement with at least one other government rehab program of some type. The lack of professionalism among program staff and the unnecessary existence of certain rehab regulations were also seen as the major problems of these programs. He sees additional assistance in rehab financing, training, and regulation coordination as the most important government actions that could aid problems in the rehab business. Finally, he sees the future of the rehab business as expanding, and he is actively planning more rehab involvement in the future.

A fourth question which this survey has attempted to answer is to what extent an urban rehab industry does in fact exist in Knoxville. At first, there seemed to be little evidence to support a claim that it exists at all. In addition to the difficulties of attempting to identify and contact contractors for any type of communication, the noncontractor rehab professionals interviewed generally spent small portions of their total time on rehab work.

Furthermore, survey results showed that very few contractors or professionals identified with the term rehabilitation at all, with more traditional terms (e.g. remodeling) still predominating when referring to their business. Rehabilitation was widely interpreted as meaning a major home improvement effort on a home that had fallen into much disrepair. Since many of these jobs have been financed recently

through the city's C.D. rehab program (either C.D. loan/grants or Section 312 loans), the term rehabilitation was also generally accepted as meaning "publicly-financed."

Further into the survey, however, strong evidence on the existence of a local housing rehab industry began to surface. There appeared to be a definite trend among contractors to utilize increasingly formal business procedures during the housing rehabilitation process. Proper licensing, bonding, and bidding procedures were being utilized by almost all contractors, while verbal agreements, contractor-arranged financing, and informal inspections were becoming less and less frequently used. More important, however, was the fact that a growing number of contractors and other professionals do a clear majority of their work in rehab, utilize most of the same professional work procedures, and seem well-satisfied with their involvement with C.D. rehab work (despite the many complicated procedures not previously used by housing rehab contractors and other professionals). It is the growing agreement of the nature of professional relationships and work activities that is beginning to define a distinct rehab industry in Knoxville, one that is completely separate from any other set of economic activities.

It is important to note, however, that just as some rehab persons seem to be increasingly joining a more formal and professional urban rehab industry, other persons continue to resist any change in their less formal rehabilitation procedures and activities. In particular, many of the contractors who had rehabbed homes under the FHA Title I Home Improvement loan program seemed to be totally unwilling or unable

to adjust to the different procedures required under the Community Development and Section 312 rehab loan programs.

In fact, it might be said that not one but two separate rehab industries exist in Knoxville. The first and most established one is oriented to the independent home improvement loan contractor, who carried out both urban and suburban type rehab through a series of simple and informal work procedures. His regular material supplier, loan institution, and word-of-mouth consumer contacts constitute the remaining part of this industry.

The second type of rehab industry existing in Knoxville is oriented to the structured relationship between contractor and financing/regulating sources, aimed more at substantial rehab jobs of older urban homes that require well-defined procedures and responsibilities. A wide variety of financial institutions, public agencies, realtors, material suppliers, and consumers are all closely tied into this industry.

Whether you define it as one or two separate groups, then, it would appear that a distinct urban rehab industry does in fact exist in Knoxville, even though the self-perception of this industry is still just developing. The relatively new phenomenon of C.D.B.G. and Section 312 rehab programs in particular can be expected to support the future development of this industry. Continued expansion of the overall private and public movement for urban neighborhood revitalization will also further strengthen the industry.

Conclusions—A growing professionalism within the local rehab industry appears to be helping to draw together different groups within

the industry. All the same, the basic differences in background and outlook of some of these groups seems to reinforce some of the ongoing problems of overall industry communication.

Results of Part I of the survey indicated great differences between contractors and other professionals in the industry, both in the amount of their rehab backgrounds and in the overall professional approach taken to their work. Rehab contractors were seen as maintaining small, experienced, and loosely-organized firms with little contact with any organized rehab industry activities. Other rehab professionals, on the whole, had far less background and experience in rehab work than did the contractors, yet utilized more formal organizations and professional approaches in most of their rehab activities.

According to Part II of the survey, many of the work procedures being utilized by small rehab firms are changing and are becoming more like procedures being used by the other rehab professionals. The flexibility of the small firm in carrying out rehab appears to be very important, and many of these firms are now changing work procedures, particularly due to the requirements of C.D. rehab programs. Many of the other professionals are taking note of these changes and seem to recognize the potential for closer cooperation with contractors.

The final part of the survey, however, showed that the growing degree of professionalism in the rehab industry still presents many problems and is viewed differently by contractors and other professionals. No real improvements are expected by rehab contractors in the basic rehab problems confronted by contractors. More and better communication

and training for both consumers and the industry are seen as particularly important aids for many contractors in making the "transition" to the more complex and professional C.D. rehab procedures. On the other hand, the increasing degree of professionalism within the industry is generally seen by other rehab professionals as bringing real improvements to the rehab business in encouraging the growth of both rehab quality and quantity in the future.

On the whole, there seemed to be good consistency of response from respondents to the survey, particularly from the contractors, most of whom saw the issue of increasing professionalism as central to their involvement in the rehab business. Even the extremely diverse group of other rehab professionals were quite consistent in their views on the effect of increased professionalism on the rehab industry. While other issues about the industry were raised by small numbers of respondents during the survey, most seemed to be tied, to some extent, with this larger issue of professionalism.

CHAPTER IV

CONCLUSIONS AND IMPLICATIONS

A. Conclusions

We shall draw our final conclusions in this study by answering the research questions mentioned earlier in the study. In particular, this section attempts to directly relate some of the results and conclusions reached in Chapters II and III. A better understanding of the urban housing rehabilitation industry in Knoxville, Tennessee, is the overall goal of the study.

1. Who is carrying out urban housing rehabilitation in Knoxville, Tennessee, and what is their background and experience in the industry?

Results of the study repeatedly stress the importance of the small rehab contracting firm within the rehab industry. The inherent unpredictability and small-scale of most rehab work lends strong support to the great flexibility and close supervision found within small firms. Survey results indicated that the median size of contracting firms of respondents was only six employees and that many contractors were consciously limiting the size of their firms through much subcontracting and minimizing of overhead and office staff. Furthermore, those firms heavily involved in C.D. rehab work (with complex work procedures) maintained slightly fewer employees than those firms which operated under simpler rehab procedures.

Survey results also indicated a recognition of the importance of small rehab firms by some of the other professionals in the Knoxville rehab industry. For example, the banking institutions' relative noninvolvement and trust of the contractor in the technical parts of rehab jobs (e.g. cost estimating and site supervision) indicate their respect for the small-scale and experience required in rehab work.

Most of the literature reviewed for this study also strongly supported the key role that the small firm plays within the rehab industry. Both the Project Rehab Report and Mandelker and Montgomery's writings point to the proven need for small firms in effectively carrying out rehab work. Though Brune's study does not address directly the need for small rehab firms, the emphasis placed by the study upon work type and business management problems among contractors indicates an awareness of the importance of small-scale firms in dealing with the innumerable problems that arise on each rehab job. The median contractor firm interviewed in Brune's study did have a slightly larger size (8 or 9 employees) and much less experience in the business (8 years) than did the median contractor firm in the Knoxville survey (6 employees and 16 years, respectively).

2. What processes, procedures, and activities does a member of the rehab industry in Knoxville follow in carrying out a rehab job?

The rehab work procedures used by contractors in Knoxville have traditionally been quite informal and different from procedures used by the more professional parts of the local industry. However, many of the contractor's procedures have been changing substantially in recent years

and becoming closer to the manner in which these other rehab professionals carry out their work. Survey results show many contractors utilizing the more professional procedures required by C.D. rehab programs, particularly in the use of certain forms, specific payment arrangements, required job inspections, work or processing delays, and working with other rehab specialists. These are procedures familiar to the other rehab professionals, who are generally parts of large, formal organizations. The contractor still maintains strict control over all estimating, constructing, and follow-up aspects of a job.

This trend toward increased professionalism among rehab contractors is supported by the literature review part of this study. Both the series of NAHRO operational guides relating to C.D. rehab programs and HUD's technical assistance programs about rehab contractors working in C.D. programs demonstrate the widespread nature of this trend. Also, efforts by the Building Research Advisory Board to better define a formal rehab process are aiding the adoption of more standardized and formal procedures by different rehab programs and rehab contractors. Finally, Brune's study pointed out the need for improved contractor accountability and consumer protection through use of more standardized rehab procedures.

3. How does the rehab industry member in Knoxville view his business, what problems does he encounter from both public and private rehab work, what remedies can he suggest, and what plans does he have for rehab involvement in the future?

An increasing professionalism among rehab contractors and other professionals provides a means for a general improvement in the status of the rehab industry and thus to aid many of the ongoing problems of

the industry. Survey results show that most rehab contractors seem to maintain a very down-to-earth approach to their work that shapes attitudes and plans for their business. Despite the different satisfactions that might be derived from rehab work, local contractors usually see their work as being low in status—as being dirty, unexciting, moderate to poorly paid, and full of unpredictable problems. Since many of the contractors accept this situation as part of the work that they have been carrying out for many years, they express little need and few possibilities for changing many of the problems associated with rehab work. Several contractors involved in C.D. rehab work, however, seemed to express a considerably more positive image about rehab work within more formal, established guidelines. They expressed a sense of pride, stability, and enjoyment in their work which was not stated by any contractors working within the more traditional and informal rehab environment.

A number of authors in the review of literature have pointed out the importance of creating a better image for the rehab industry. Rogg's report on urban housing rehab in the U.S. had this issue as his central theme—until one can begin to really build and communicate a positive image of the rehab business, based on traits such as high quality, good value, and real responsibility, the industry would not be able to overcome the many smaller problems that surround it. Rogg's visits to cities throughout the country convinced him that urban rehab was strong and growing, but that the image of the industry, for both the public and the industry itself, was a weak and disjointed one. Likewise, HUD's

Community Rehabilitation Training Center provides a very positive image and concrete model of how contractors can interact effectively with C.D. rehab programs. Lastly, NAHRO's series of operational guides related to C.D. rehab describes in detail a complete set of rehab procedures and relationships encouraging both high quality and high quantity of rehab.

Some of the rehab problems that could be improved as the result of the development of a more positive image for the rehab industry by all groups involved include a lack of rehab demand by consumers and government, lack of sufficient trained workers attracted to the industry, control over irresponsible contractors in the industry through regulatory mechanisms, and lack of rehab education for rehab consumers, industry members, and public agencies involved.

4. To what extent does an active urban housing rehabilitation industry exist in Knoxville, and what form does it take?

There is a small active rehab industry in Knoxville, though it maintains little formal organization or communication. Survey results show that the industry maintains several smaller groups within the whole that display different characteristics. Among rehab contractors, some persons utilize older informal work procedures in carrying out many Title I rehab loan jobs, while others have adopted newer more professional procedures in working with C.D. rehab jobs that tend to formalize the rehab process used. Among noncontractor professionals in the industry, rehab activity has been limited, but interest appears to be rapidly increasing. These differentiations within the industry are not particularly noted in the other literature reviewed.

Results of the survey also show that there is little coordination of local rehab efforts and activities among different groups involved in the industry. Despite the increasing similarity of procedures being used by both C.D. rehab contractors and many of the other rehab professionals, there are still no local organizations or regular communications channels for the exchange of information on problems and ideas about the industry. This situation seems to lessen the impact of industry research and communications efforts being made at the national level, as noted in the literature review. For instance, Brune's call for better interagency governmental coordination in regards to the rehab industry has not yet been seen as an issue in the local industry. The further development of the local industry, in ways now occurring at the national level, could well be expected to continue in similar fashion in years to come.

B. Implications

The planning profession as a whole and housing planners in particular need to continue to advance their understanding of the urban housing rehabilitation industry. As public and private rehab activities are increasingly relied upon as the major component of many urban revitalization efforts, the actions and problems of the urban rehab industry will increasingly become the concerns of housing planners and administrators charged with developing and carrying out housing rehab programs. Furthermore, the increased emphasis on public/private partnerships in these and other efforts demand that housing and other

types of planners gain a more sensitive awareness and understanding of the functioning of private industry in many different fields. Along these lines, we shall complete this study by mentioning the implications of several key issues of industry functioning that have been raised by the study.

1. It is important to support and promote opportunities for the small rehab firm within the industry as much as possible. Further study and demonstration programs should explore the effectiveness of training in small-scale rehab construction and business management techniques, the provision of additional working capital through small business loans, and special assistance to small firms in the obtaining of proper licenses and bonding.

2. The rehab industry should further encourage the establishment and adoption of a full set of formal working procedures for most major work contracted out in cities throughout the country. This effort would encourage an increased and uniform professionalism in the carrying out of rehab work. Further research is required into the effects of different procedures upon the resulting quality and cost of rehab activities.

3. An aggressive and comprehensive publicity campaign is needed by the rehab industry in order to create a more positive image about the nature and benefits of urban rehab activity in this country. Many of the ongoing problems of the industry need to be attacked through efforts such as training in consumer education, governmental relations, industry member recruitment, and enforcement of rehab industry standards. Though

specific techniques to use in this effort should be explored further, the content of the campaign should focus on showing a skilled, dedicated, effective, and responsible industry.

4. The rehab industry should further pursue and discover its common problems and goals as a single united industry. Both existing and new industry groups should actively attempt to explore the appropriate limits and ensuing benefits to the industry and public as the result of increased industry organization. Increased research efforts, lobbying for needed changes, greater membership in organizations, and expansion of industry literature and communication would all be important issues for future investigation in this area.

These issues are seen as the key implications resulting from this study's efforts to better understand the urban housing rehabilitation industry. Though some of the actions recommended here are not necessarily the easiest or most immediate actions that could be implemented to aid the industry, it is felt that the four areas mentioned are crucial to creating and maintaining a better long-term environment within which the rehab industry can function. Just as this study has shown the effects of past actions and changes upon the functioning of the rehab industry, so can we look to actions such as these to assist the rehab industry in the years ahead.

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APPENDICES

APPENDIX A

CENTRAL KNOXVILLE

KNOXVILLE, TENNESSEE
with selected
1970 census tracts

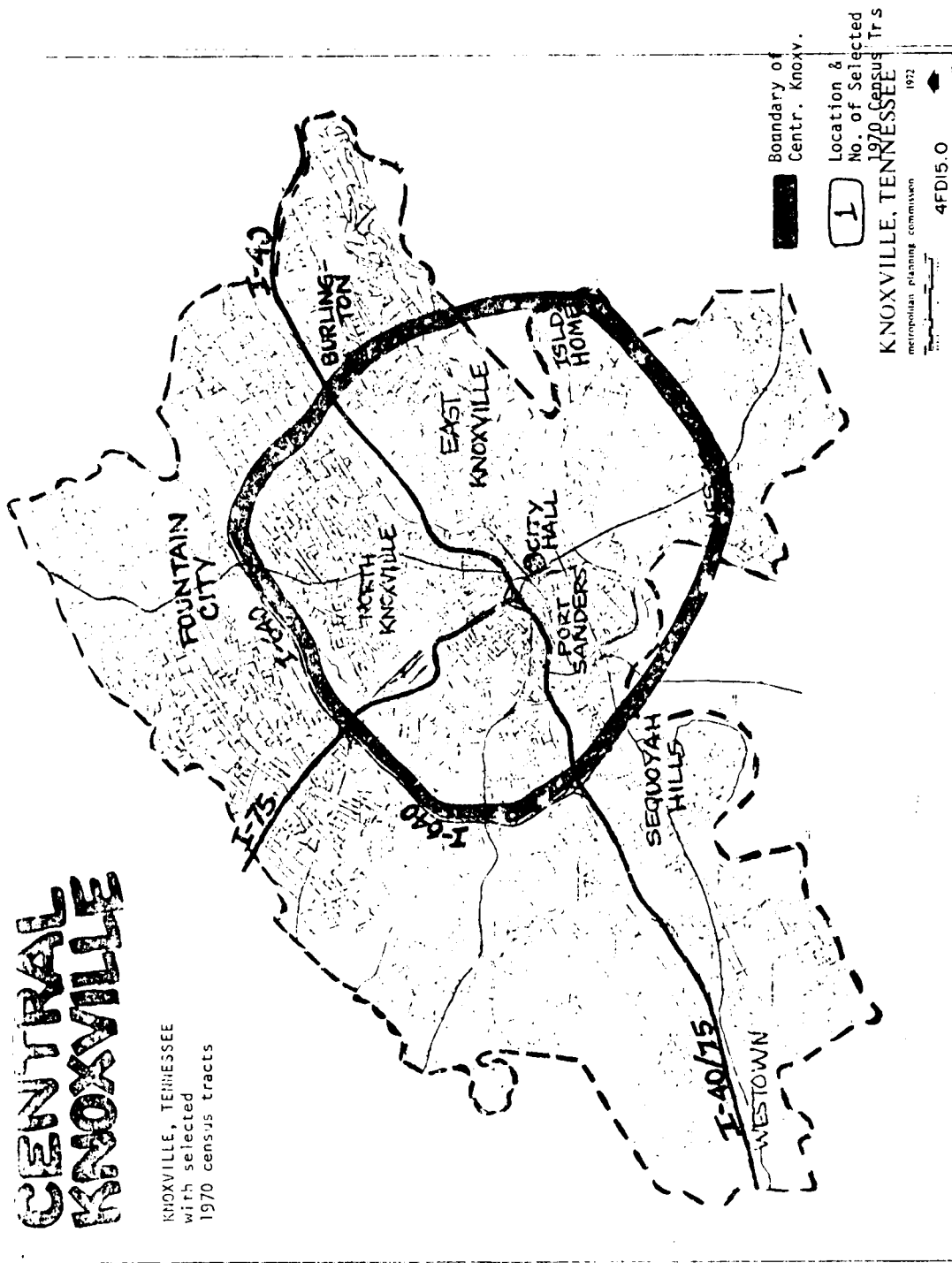


Figure A-1. Map of Central Knoxville Area, Knoxville, Tennessee.

APPENDIX B

THESIS INTERVIEW

INTERVIEW # _____

DATE _____

PLACE _____

INTERVIEWER _____

INTERVIEWEE _____

R.W.H.
9/11/79

INTRODUCTION

My name is Dick Hails and I am a graduate student at U.T. I am carrying out a study of professionals involved in housing rehabilitation and repair of older homes in central Knoxville. The term housing rehabilitation is used here to refer to repairs and improvements to homes that add to its useful life.

From building permit records, phone listings, and various referrals you have been identified as someone involved in such rehabilitation of some older homes within central Knoxville. We are seeking information on your professional background, particular activities involved in your work, and your general views of the profession.

All information received from these interviews will be kept strictly confidential, with the information only used in summary with other interview responses. We appreciate your agreeing to be interviewed for our study.

WE WOULD FIRST LIKE TO GET SOME INFORMATION ON YOUR PROFESSIONAL EXPERIENCE, BACKGROUND, AND WORK SITUATION.

1. What is your professional title and for whom (what firm) do you work? _____
2. What types of work does your firm do? (New constr., H.R., etc.)

3. What portion of your (indv. & firm's) work is in housing rehab?

4. What portion of your H.R. work has been within the inner-city area of Knoxville (as shown on this map) in recent years? _____
5. What was the approximate average total cost for each of these inner-city jobs? _____
6. For how many years have you worked in H.R.? _____
7. What other businesses had you worked in before beginning in H.R.? _____
8. On the average, how far do you travel to work each day (in miles)? _____
9. What types of licesnes and/or bonds (if any) do you now hold?

10. Do you hold any union or professional organization memberships?

11. What kind of training did you receive for this work?
(OJT, Tech. schl.) _____
12. What formal education have you received? _____

13. Where is your firm's main office located?

14. How many employees are in your firm? (office, field, p-t, etc.)

15. In which of these categories would you estimate the value of your firm's total assets? (offc., equipment, tools, etc.)

less than \$25,000 _____ \$25-50,000 _____

\$50-100,000 _____ \$100,000 & up _____

WE ARE NOW SEEKING SPECIFIC INFORMATION ON THE H.R. PROCESS USED BY YOU ON SOME OF YOUR JOBS. WE ARE PARTICULARLY INTERESTED IN INFORMATION ON JOBS CARRIED OUT IN THE BROADWAY AND MAGNOLIA AVE. PARTS OF TOWN. YOU MIGHT USE DETAILS FROM WORK ON SOME OF THESE OLDER HOMES TO ANSWER THE FOLLOWING QUESTIONS. FOR CONVENIENCE, WE ARE BREAKING THIS H.R. WORK PROCESS INTO THREE PARTS: BEFORE CONSTRUCTION, DURING CONSTRUCTION, AND AFTER CONSTRUCTION ACTIVITIES.

16. Please describe the activities carried out on such H.R. jobs before the start of construction:

_____ initial client/owner contact

_____ initial work writeup/descr.

_____ cost estimating (by whom, prof. mrg.)

_____ subm. of bids, comptn. fr. firms

_____ type of agreement reached

_____ paymt. arrangements

_____ financing source(s)

_____ permits, apprsls. obtained

_____ other (specify)

17. Please describe the activities carried out on such H.R. jobs during the construction:

1. _____ the three most common repairs
2. _____ carried out on such homes
3. _____
- _____ how often and what type of
- _____ subcontractors do you use
- _____ source & paymt. for materials
- _____ progress insp.'s & changes req'd.
- _____ other (specify)

18. Please describe activities carried out on such H.R. jobs following completion of the construction:

- _____ final inspections
- _____ additional work required
- _____ legal or other action taken
- _____ final payments (on time?)
- _____ total time of job (delays?)
- _____ cost overruns (final profit %)
- _____ work records kept (ever audited?)
- _____ other (specify)

WE'D NOW LIKE TO TALK MORE GENERALLY ABOUT THE WORK YOU DO AND YOUR OVERALL IMPRESSIONS OF BEING IN THE H.R. BUSINESS.

19. Which aspects of your work do you consider to be a serious problem, and how do you feel it affects your H.R. work?

	quantity	quality	costs	frustrtn	other (specify)
client relations _____					
captlzatn. of firm _____					
cash flow situation _____					
enough business _____					
avlblty. of sk. labor _____					
depndblty. of labor _____					
coordnatn. of labor _____					
avlblty. of mat.'s _____					
avlblty. of financg. _____					
comptn. among firms _____					
coopratn. in industry _____					
inflation _____					
other(specify) _____					

20. What changes do you think could be made to aid these problems?

21. What specific government programs or agencies have you been involved with in your H.R. work?

_____ financial (loans/grants)

_____ regulatory (permits, codes)

_____ taxation (sales, payroll)

_____ prof. asstnc. (acctg., eng., plng.)

_____ employer

_____ other (specify)

22. What problems have you encountered with these programs/agencies?

23. What actions by government (fed. or local) do you think might aid professionals like yourself in the H.R. business? _____

24. Do you have any plans to change, expand, move, or close your H.R. business? _____

APPENDIX C

Pretest Interviewees

1. Bennett W. Adams
2. David Burnett
3. Kathleen Tanver

Interviewees—as of 12/20/79

Contractors: Name

1. Bob Nash
2. Gary Lowe
3. J. B. Farley
4. Charles McWilliams
5. Jack Cunningham
6. Carl Qualls
7. Frank Rothermel
8. Jackie Boley
9. Tom Emmett
10. Aaron Allen
11. Curtis Anderson
12. Arthur Hensley
13. Felix Gaiter
14. Manuel Taras
15. L. F. Webb
16. J. H. Davis
17. Doug Hutchison

Other Professionals:

1. Don Gilson
2. John Harshaw
3. Allie Harmon
4. David Giles
5. David Prisock

VITA

Richard Willard Hails was born in Fairfax County, Virginia, on February 10, 1952. His family moved to Manchester, Connecticut, later that year and then on to his father's hometown of Glendale, California, in 1961. After graduating from Glendale High School in 1970, he attended Stanford University, where he received a Bachelor of Arts degree in urban studies in 1974. While an undergraduate, he participated in the Glee Club, the Stanford-in-Germany program, the crew team, intramural sports, the urban studies student program, a tutoring program, and Theta Delta Chi fraternity.

In July 1974, he began two years of service as a VISTA Volunteer at the East Tennessee Community Design Center in Knoxville, Tennessee. He developed a strong interest in the field of housing that led him, after leaving VISTA, to work for a private planning and housing consultant in Knoxville for three years. During that time, he also entered the Master of Science in Planning program at the Graduate School of Planning, The University of Tennessee (Knoxville) in January 1978.

During this time he was active in a number of community organizations and served as Men's Coach of The University of Tennessee Crew Team for four years. After completion of course work in December 1979, he accepted a housing planner position with the City of Durham, North Carolina, and moved to that city to begin work in January 1980. He continued work on his thesis while working in Durham and completed his Master of Science in Planning degree in December 1980.

He married the former Mary Linda Tucker at the Fountain City United Methodist Church in Knoxville in July 1978. They have no children.