

Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:

Sandra Braunstein and Risa Lavizzo-Mourey
How The Health And Community Development Sectors Are Combining Forces To
Improve Health And Well-Being
Health Affairs, 30, no.11 (2011):2042-2051

doi: 10.1377/hlthaff.2011.0838

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DOI: 10.1377/hlthaff.2011.0838
 HEALTH AFFAIRS 30,
 NO. 11 (2011): 2042–2051
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 Foundation, Inc.

ANALYSIS & COMMENTARY

How The Health And Community Development Sectors Are Combining Forces To Improve Health And Well-Being

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ABSTRACT The root causes of poor health experienced by many who live in low-income neighborhoods—such as the lack of access to health care, limited food choices, and exposure to environmental hazards—are well documented, but often go beyond the scope of the health care delivery system. But that is beginning to change. The health sector has begun to collaborate with the community development sector, which for decades has been working in low-income neighborhoods. Encouraging local and national examples of these new partnerships abound. They include an effort in Seattle, Washington, to reduce exposure to allergens and irritants among low-income asthmatic children, and a \$500 million federal program to finance the operation of grocery stores in what have previously been urban “food deserts.” To nurture such efforts, the Robert Wood Johnson Foundation, the Federal Reserve System, and others have sponsored a series of “healthy community” forums in US cities. In this article we explore the growing partnerships between the health and community development sectors as well as the challenges they face, and we offer policy recommendations that might help them succeed.

There is growing realization that where people live, work, learn, worship, and play has more impact on how well and long they live than what happens in the doctor's office.^{1–3} It is also evident that over the past forty years, the fields of community development and health have typically operated on separate tracks. The health sector has traditionally focused on people and their medical needs, and not necessarily on their surroundings or the fundamental social and economic determinants of their health. In community development, the focus has been on strengthening the capacity of people to live better, and this involves improving their physical environment.

Increasingly, both sectors are focusing on

neighborhoods: the health sector because of higher morbidity and mortality rates in poorer neighborhoods, and the community development sector because of its efforts to alleviate poverty. From the health sector, there is increased realization that social factors such as income, education, and location are strong determinants of health. The percentage of people who report being in poor or fair health, for example, increases as levels of income and education decrease.^{4,5}

For this reason, the Robert Wood Johnson Foundation convened the Commission to Build a Healthier America in 2008 and charged it with identifying factors beyond the health care system that could improve the health of all Americans. The distinguished group of commissioners, led

by Alice Rivlin and Mark McClellan, responded with ten recommendations (Exhibit 1).⁶

Many of the commission's recommendations centered on the aspects of communities that make them vibrant and are often missing from most low-income neighborhoods—for example, safe and accessible walking and bike paths and public transportation; well-equipped parks and organized community recreation; well-stocked grocery stores offering nutritious food; and well-kept homes and tree-lined streets. In particular, the commissioners provided a blueprint for addressing the characteristics of communities that enable residents to make, and follow through on, healthy choices. Although each person ultimately must bear some responsibility for his or her own health, the commissioners understood that many Americans live in neighborhoods where the obstacles to embracing healthy choices are too high, even when personal motivation is great. Taking this broader perspective is critical as society strives to ensure that everyone has the opportunity to live a long and healthy life.

The necessity of looking beyond the health care system to improve health also becomes apparent when one looks at the relative contribu-

tions of factors associated with premature death (Exhibit 2).⁷ Health care plays a surprisingly small role (10 percent). In contrast, social circumstances, environmental exposure, and behavior are estimated to account for 60 percent of the risk of premature death. For example, life expectancy increases as income rises: upper-middle-class adults can expect to live more than six years longer than poor adults.⁸ Similarly, American college graduates can expect to live at least five years longer than those who have not finished high school.⁸

Closing the gaps in life expectancy and overall health will require changes in policies, practices, and personal behavior as well as investments in infrastructure—high-quality affordable housing, child care centers and schools, community health centers, and playgrounds.

Nancy Adler, a professor at the University of California, San Francisco, has observed that once a person is ill, “health care matters a lot, but if you can prevent the illness, you are far better off than even having the best health care.”⁹ Determinants of health that fall outside the health care system can be influenced greatly by the work of community development. Establishing a well-functioning community with eco-

EXHIBIT 1

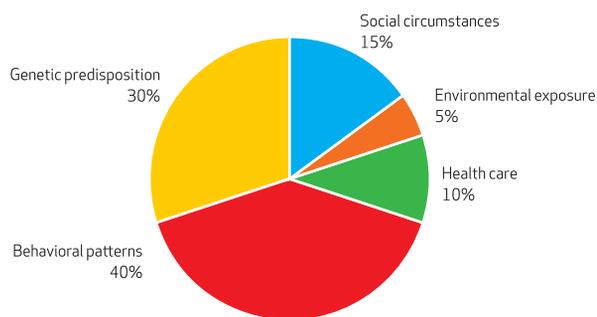
The Commission To Build A Healthier America's Ten Recommendations To Improve The Health Of All Americans

Recommendation number	Recommendation
TO PROMOTE EARLY CHILDHOOD DEVELOPMENT AND HEALTH	
1	Ensure that all children have high-quality early developmental support, especially in child care and education
2	Provide only healthy food for children in schools
3	Require all schools from kindergarten through grade 12 to include daily physical activities for students
TO PROMOTE GOOD NUTRITION FOR AMERICANS OF ALL AGES	
4	Create public-private partnerships to open and manage full-service grocery stores in communities without access to healthful food
5	Meet hungry families' need for nutritious food through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutritional Assistance Program (SNAP, formerly known as food stamps)
TO PROMOTE HEALTHY COMMUNITIES	
6	Integrate safety and wellness into every aspect of community life, including schools, workplaces, religious institutions, and neighborhoods
7	Create “healthy community” demonstration projects to evaluate the effects of a range of policies and programs
8	Develop a “health impact” rating system for housing and infrastructure projects that provides incentives for projects to increase community health
9	Eliminate smoking
OVERARCHING RECOMMENDATION	
10	Obtain reliable data, perform evaluations, and conduct research in order to promote accountability for outcomes and to identify the most successful methods of achieving goals stated in recommendations 1–9

SOURCES Note 6 in text. Williams DR, McClellan MB, Rivlin AM. Beyond the Affordable Care Act: achieving real improvements in Americans' health. *Health Aff (Millwood)*. 2010;29(8):1481–8.

EXHIBIT 2

Proportional Contributions Of Contributing Factors To Premature Death



SOURCE Note 7 in text.

nomic opportunity; a sense of community; and high-quality housing that is built using green, healthy building techniques can facilitate healthy choices. For example, access to fresh food encourages healthy eating, while the presence of safe recreational facilities encourages physical activity.

If preventing or slowing the progression of illness requires better-functioning communities, it makes sense that the health sector should team up with those most skilled in improving communities. This realization led the Robert Wood Johnson Foundation to partner with the community development group of the Federal Reserve System.

By law, the Federal Reserve has a dual mandate: to keep the economy strong with the least amount of inflation, and to do so while maintaining the maximum level of employment. Helping low-income communities become more viable economically is important to this overall mission. To this end, the community development departments of the Federal Reserve work to foster the field of community development, highlight best practices, and forge connections among multiple stakeholders—nonprofits, private corporations, and philanthropy—with the aim of promoting community revitalization.

Through these mechanisms, the Federal Reserve helps low-income communities expand access to credit for small businesses, assists homeowners in avoiding foreclosure, and finds ways to connect low-income residents to effective social services and jobs. The Federal Reserve also has responsibility for overseeing the Community Reinvestment Act of 1977, which places the federal agency in partnership with banks in promoting community-strengthening investments. The Federal Reserve's community development group has also been an ideal partner for the Robert Wood Johnson Foundation because of

the group's extensive connections in the community development industry.

The Community Development Industry

Community development is an enterprise in which public, private, and not-for-profit organizations work to strengthen the economic, physical, and social environments of low-income areas. The community development network builds affordable housing that often includes social services on site; fosters small-business development; and finances buildings that address specific community needs such as child care centers, health clinics, and charter schools.

Although the emphasis is on developing physical capital—primarily real estate—community development efforts also strengthen the social bonds within communities. They do so by involving residents in the conceptualizing, designing, building, and operating stages of development. In other words, building brick-and-mortar structures also helps build the community in a larger sense.

Community development efforts currently address a relatively small proportion of the immense need to revitalize America's low-income neighborhoods. Nevertheless, community development's accomplishments as an enterprise are impressive. Using one of the main federal funding streams for affordable housing—the Low Income Housing Tax Credit—the community development sector has built more than 2.5 million homes for low-income US families since 1987.¹⁰ Nonprofit lending institutions, known as community development financial institutions, which first emerged in 1994, now number more than 1,000 and claim more than \$25 billion in assets.¹¹

The aforementioned Community Reinvestment Act created the foundation of the community development finance system by requiring banks to meet the credit needs of the low- and moderate-income communities where they do business. Although the exact amount of capital motivated by this law is hard to measure, estimates are in the range of many billions of dollars per year.¹²⁻¹⁴

Other accomplishments of the community development sector include having financed more than 126 million square feet of commercial space for small businesses, as well as many hundreds of charter schools, child care facilities, and clinics, all in low-income neighborhoods.¹⁵

At its core, community development is an industry that integrates the views of the community into improvement efforts. At the same time, it taps the expertise of bankers, policy makers,

and entrepreneurs to get the job done. The community development field harmonizes multiple funding sources from philanthropy, government, Community Reinvestment Act-motivated banks, socially motivated investors, and market capital—all to address the needs of low-income people and their communities.

In recent years a growing number of community developers have recognized that their work also needs to finance more investments in human capital, such as in health, early child care, education, and job training. Finding ways to do this is more challenging than it may at first appear, because the current focus on real estate has two advantages: It can serve as collateral for bank loans, and most government subsidy programs (such as the Low Income Housing Tax Credit) exist for investing in physical capital.

As a result, as all parties concerned with improving the lives of low-income people work to find new and more effective strategies, community development must expand its business model to include partners on the human capital side of the equation. Strengthening alliances with the health and health care sectors is therefore of primary importance.

Pursuing Mutual Aims To Realize Mutual Benefits

Both the public health and health care sectors and the community developers are interested in fostering viable and healthy communities. Low-income neighborhoods, however, struggle with disinvestment and a number of other problems that disproportionately affect them, such as poor access to healthy food. As members of each sector learn more about the social determinants of health, they are struck by the overlap in their targets and goals, and they wonder why they did not form alliances with each other sooner.

To catalyze formation of these alliances, the Federal Reserve—both its Reserve Banks across the country and its Board of Governors in Washington, D.C.—and the Robert Wood Johnson Foundation, in conjunction with local partners, are holding a series of conferences in major US cities through 2011 and beyond. The Healthy Communities: Exploring the Intersection of Community Development and Health gatherings typically start with an overview of the health situation in a local community, followed by a discussion of community development needs.

The most striking moment of these meetings often comes when members of the health and community development sectors, whose members are largely unknown to each other, look at maps highlighting geographical areas in greatest need of their help. One map shows areas with

health concerns such as asthma or obesity. The other map shows areas with community development concerns such as overcrowding in housing or unemployment (Exhibits 3 and 4).

Meeting participants quickly realize that whether they are in the health sector or the community development sector, they are working in precisely the same neighborhoods. They conclude that they have been working together side by side to serve the same people, but without coordination, or even communication—and that they must establish mechanisms to work together.

University of California Professor S. Leonard Syme said at the first cosponsored event—the Board of Governors meeting in Washington, D.C., July 13, 2010: “Those who plan, design, and build our cities and neighborhoods have a dramatic impact on the fundamental forces that affect our health and well-being. Part of this impact shapes the way in which people can have control over the forces that impinge on our lives. And that has an important influence on our susceptibility and vulnerability to noxious disease agents. By empowering people, those who design our living environments are some of the most important public health workers of our time.”¹⁶

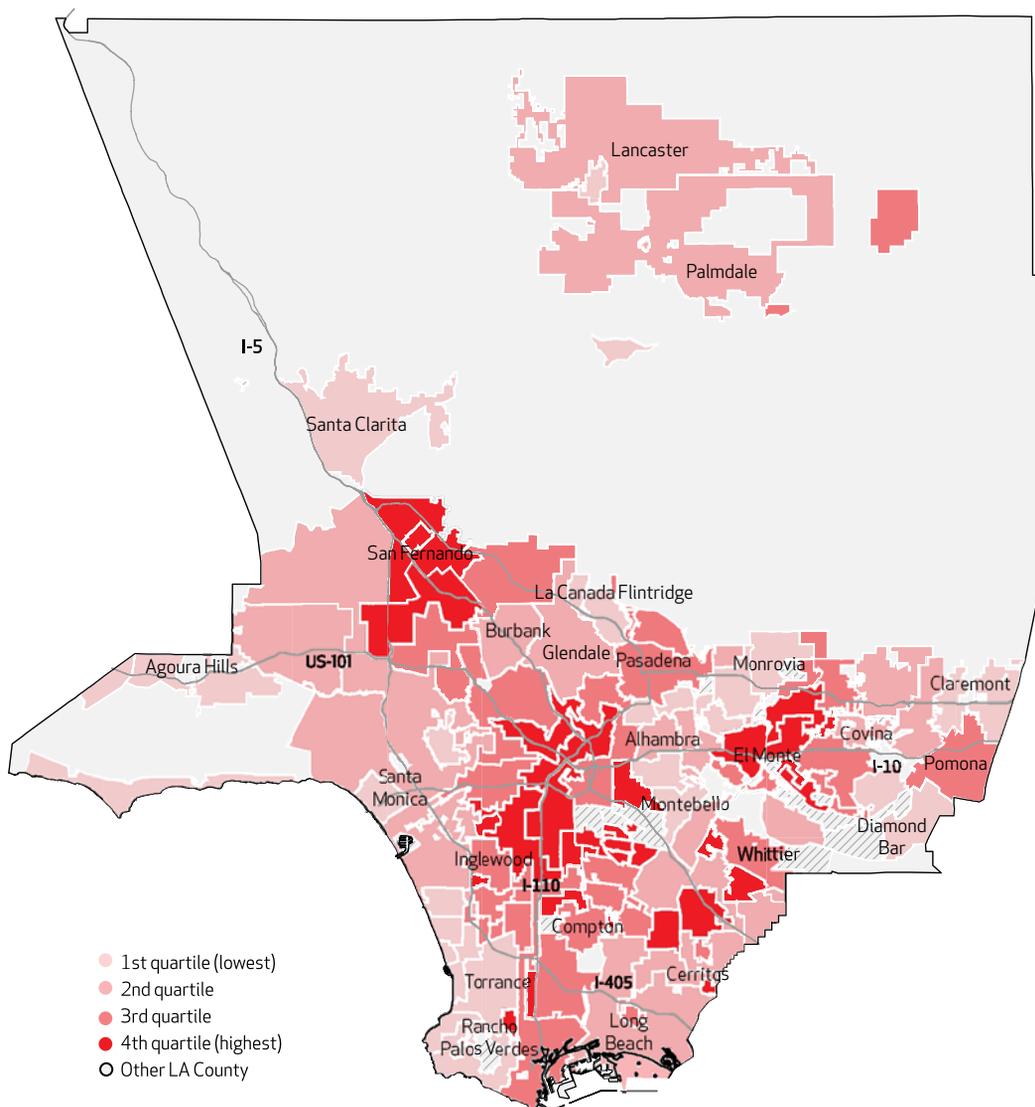
This insight captures the connection between health and community development, and it asks all those concerned to rethink their evolving roles. In an earlier era, community developers thought of themselves as agents of investment for rural areas and inner-city neighborhoods that had experienced a tremendous drain of people, capital, and other resources as more affluent residents moved to the suburbs. Community development represented one of the few attempts to reverse that process. As a result, communities that were once famously broken—such as the South Bronx in New York, Chicago’s South Side, and other struggling communities coast to coast—were revitalized.

Perspectives on how to improve health have evolved as well. Programs such as the Special Supplemental Nutrition Program for Women, Infants and Children, and the Supplemental Nutrition Assistance Program, formerly known as food stamps, have given people the means to feed their families. However, a lack of access to fresh food in many communities where enrollees live has limited the programs’ health benefits. What’s more, even if people are motivated to make healthy choices, they cannot seek screening for health conditions if there is no accessible health clinic, nor can they send their children outside to engage in more physical activity if there is no safe place to play.

Our communities’ problems, our population’s

EXHIBIT 3

Prevalence Of Childhood Obesity By City/Community, Los Angeles County, 2005



SOURCES California Department of Education, Physical Fitness Testing Program. Map prepared by and reprinted with permission of the Los Angeles County Department of Public Health. **NOTES** Includes fifth, seventh, and ninth grade students attending public schools in Los Angeles County. Areas with hatched gray shading indicate that data were not available.

circumstances, and community development’s understanding of how to create improvements have evolved since the 1970s and 1980s, when the community development sector got its start. Given the dire needs of the low-income communities that both the health and community development sectors serve today, it is clear that many problems—failing school systems, crime, low employment, higher prevalence of chronic disease—are factors that affect both health and economic prospects.

At the same time, attacking all of the root

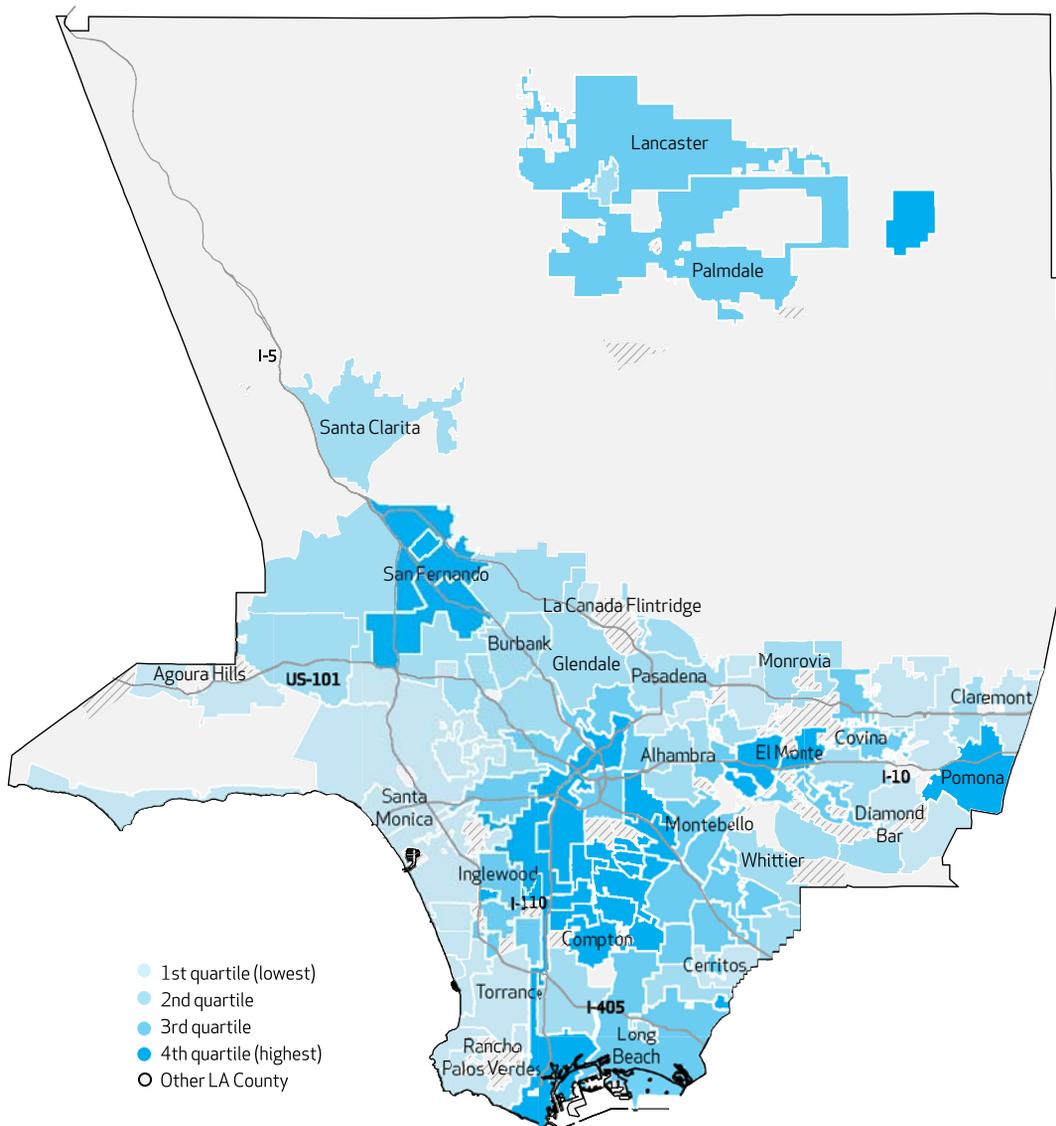
causes of these problems goes well beyond the narrower mandates of the health and community development fields. Yet together the two sectors can address these problems and mitigate their effects on health and well-being.

A New Guiding Vision

We argue that the nation would be better served by adopting a new model combining community development and community health. The model would encompass both the physical and the hu-

EXHIBIT 4

Economic Hardship Index By City/Community, Los Angeles County, 2000



SOURCES US Census 2000. Map prepared by and reprinted with permission of the Los Angeles County Department of Public Health. The hardship indicator is from Nathan RP, Adams CF, Jr. Four perspectives on urban hardship. *Political Science Quarterly*. 1989;104:482-508. **NOTE** Areas with hatched gray shading indicate that data were not available.

man capital needs of neighborhoods.

The health sector is currently showing the way by looking at root causes, or “upstream factors.” Health is shaped by many such factors—some that cannot readily be influenced, such as age, sex, or genetics, and some that have been a traditional focus of the health sector, such as behavior and health care. Living conditions, such as whether housing contains environmental contaminants, tend to be shaped in turn by economic and social forces.

The broad array of social and economic determinants of health—especially education, in-

come, opportunities, and the physical environment—are central to community development as well as health. Focusing on social determinants can provide the health and community development fields with a common foundation. It is at the intersection of social determinants and community development that important thinking begins about how to meld the strengths of each sector, overcome the deficits, and become a stronger whole.

Melding Goals And Assets

How exactly can the health and community development fields communicate, collaborate, and cooperate more effectively to act on this vision? Each sector must start with a deeper understanding of what each brings to the table in terms of capacity, financial strength, and technical skill. The complexities of changing traditional ways of thinking and working also must be addressed. Case studies of success can help demonstrate the value of collaboration, but tools and technical assistance—such as new ways to structure financial transactions drawing from both health and community development sources—will also be required. Collaboration on research and evaluation will also be essential to identifying financial benefits, including improvements to family finances and reductions in health care costs.

Both the health and community development sectors have struggled with making the “business case” for the benefits of investing in health-improving policies, such as improving low-income communities. To do so will require better data on how improving “upstream” factors—such as high-quality, affordable housing; an engaged neighborhood that provides ample opportunities to meet neighbors and get exercise; strong schools; and a healthy economy where jobs are available—makes measurable improvements in health.

The community development sector has an excellent track record of finding ways to attract all types of capital, including government subsidies and either below-market or market-rate loans to projects with good business fundamentals. It would be powerful to marry this business acumen with the health sector’s ability to measure health outcomes. The combination could make a stronger financial case for community building as a way to both improve people’s lives and save on health expenditures down the road.

Although there is much to be learned, excellent examples of how these sectors have worked together already exist, as detailed below.

Examples Of Local Collaborations

In Seattle, a partnership of public and private agencies worked from 1997 to 2005 to reduce exposure to allergens and irritants in low-income households of families with asthmatic children. Funded by the National Institute of Environmental Health Sciences, the Seattle-King County Healthy Homes Project is one of several projects conducted by the Seattle Partners for Healthy Communities, which develops strategies to address social determinants of health. This innovative program incorporated remediation of structural lead and injury haz-

ards into a broader attempt to address exposures to multiple household hazards.¹⁷

In California, meanwhile, Mercy Housing and researchers from the University of California at Berkeley and at San Francisco are creating a “learning community,” whereby local partners combine strengths to answer important questions about health and community development.¹⁸ One of these questions is, What aspects of community development interventions have the biggest influences on health outcomes? The local learning partnerships also will help identify and quantify the health improvements that come from community development interventions.

In this way, health researchers can bring a more sophisticated measurement approach to community development’s antipoverty work. Armed with that knowledge, the community development field can refine its approach and strategy, better coordinate with the health sector and health care service providers, and propel community development activities to change lives even more for the better.

The Health Impact Project, a collaboration between the Robert Wood Johnson Foundation and the Pew Charitable Trusts, is demonstrating the use of health impact assessments as a way to join forces. These assessments are tools that can be used to take health into account when making decisions in a broad range of sectors, including community planning, education, energy, and budgeting—thereby maximizing the health-promoting potential of those decisions. Health impact assessments can be employed in any location—rural, suburban, or urban—at the local, state, or regional level. Their use has grown rapidly, from only about two dozen between 1999 and 2007 to more than 100 completed or under way in 2011.¹⁹

Examples Of National Collaborations

Congress established the Healthy Homes Initiative in 1999 to improve the health of children by addressing housing-related problems: excess moisture, dust, poor ventilation, and toxic substances. Tenant health education efforts were also included in high-risk housing areas. The initiative strives both to identify multiple housing deficiencies that affect health, safety, and quality of life and to take actions to reduce or eliminate the health risks related to poor-quality housing. The Department of Housing and Urban Development has spent approximately \$81 million as of 2009 for this initiative.²⁰

Dramatically increasing access to fresh and nutritious food in low-income neighborhoods is the first line of defense against the obesity epidemic. Thus, another example of a commu-

nity development and health sector collaboration is the Healthy Food Financing Initiative. This program has \$500 million annually set aside for the financing of grocery stores in low-income neighborhoods lacking local access to fresh food. The subsidy helps cover the cost of construction and more expensive refrigeration equipment that make it possible to stock fresh food.

The effort, a joint program of the Community Development Financial Institutions Fund (part of the Treasury Department) and the Departments of Agriculture and of Health and Human Services, is largely executed through the community development finance network and institutions. The financing helps create or sustain operations of stores that will do more than simply increase access to fresh food, however. The stores will also provide jobs in their local communities, and many of them will be outfitted with meeting spaces that can be used for cooking classes, job training, or other community-building gatherings.²¹

Federally qualified health centers provide another national example of arenas in which community development and the health care sector overlap. To augment additional federal funding for the clinics that was authorized by the Affordable Care Act of 2010, people in community development finance are working on ways to finance the expansion of clinics to meet the increased demand as more low-income citizens gain health coverage under the law.

What's more, as in other community development projects involving construction, building the clinics will do more than creating physical spaces such as exam rooms.²² The hope is that these clinics will see the entire neighborhood—not just the person who walks through the door for medical attention—as their “patient.” Having the health centers serve in this expanded role as caregivers for the community will create a natural opportunity for a close relationship with community development partners.

These examples highlight a growing number of efforts on the part of the health and community development fields to tackle joint enterprises with shared outcomes. The challenge is to move to more-integrated systems that can support broad-scale accomplishments and that will be energized by shared learning and strengthened by connections across people, projects, and evaluation and research activities.

Conclusion

A vision of community development for good health is emerging, but like all visions, it comes

with challenges. In this era sometimes described as one of “doing more with less,” it is difficult to take on new challenges. However, now is precisely the time to push this agenda forward because, in the long term, it is likely to be a cost-saving initiative. These investments are a vital part of the strategy to “bend the cost curve” for health expenditures that are spiraling out of control.

For example, direct health care costs for chronic disease, which account for 75 percent of health care spending,²³ are correlated to social factors, with diabetes and heart disease twice as prevalent among poor adults as among upper-middle-class Americans.⁸

Poor health also has broader economic consequences. An unhealthy workforce is less productive, which can lower economic growth rates and over the long term can reduce the standard of living.²⁴ Estimating the economic value of life and health can also help illustrate the link between health and social factors. Using a widely employed estimate of the value of one life-year (\$100,000), researchers estimate potential gains of more than \$1 trillion if adults who have not finished college had the lower death rates and better health status of college graduates.⁸

The level of change required to achieve more active and effective collaborations may seem daunting for both the health and community development sectors. Nevertheless, it is necessary, it is possible, and it is happening.

For example, it is not acceptable that two people living just one community apart—one in the District of Columbia and the other in adjacent Montgomery County, Maryland—have a gap of nine years in life expectancy.²⁵ It is necessary to close the gap.

Collaboration is possible. Recent efforts such as the Healthy Food Financing Initiative illustrate how community development and public health can come together as partners to drive change.

Finally, these joint efforts are in fact occurring. There are pockets of activity in neighborhoods around the country. These local efforts can demonstrate to others why they should work together, how they can come together, and how to make joint action more effective than what either sector can accomplish on its own.

If leaders in the community development and health sectors can seize this moment in time to capture the imagination of their visionaries and can bring their expertise and considerable resources to bear in order to align their efforts, both sectors can move closer to the common goal of an America where every individual has the opportunity to live a long and fulfilling life. ■

The opinions set forth in the article are those of the authors and do not necessarily reflect the views of the Board of Governors of the Federal Reserve System or other members of their staff.

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In this month's *Health Affairs*, Sandra Braunstein and Risa Lavizzo-Mourey explore the growing partnerships between the fields of health and health care and community development to improve health outcomes in disadvantaged communities. The authors discuss the challenges such partnerships face and recommend ways to help them succeed.

Braunstein, who has been with the Board of Governors of the Federal Reserve Board's Division of Consumer and Community Affairs since 1987, has served as its director since 2004. She administers outreach efforts to the financial services industry,

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Braunstein holds a bachelor of science degree in psychology from American University.



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Lavizzo-Mourey has been president and chief executive officer of the Robert Wood Johnson Foundation since January 2003. In that capacity, she was instrumental in convening the Commission to

Build a Healthier America in 2008 and has led the foundation's efforts to halt the rise in childhood obesity by 2015.

A leader in academic medicine and government service for decades, she was the Sylvan Eisman Professor of Medicine at the University of Pennsylvania, as well as director of the university's Institute on Aging (1994–2002). She has also been a member of the Institute of Medicine since 1997, and she was deputy administrator of the Agency for Health Care Policy and Research (1992–94), now known as the Agency for Healthcare Research and Quality.

Named one of *Modern Healthcare's* 100 Most Powerful People in Healthcare in 2007, 2008, and 2009, Lavizzo-Mourey received her medical degree from Harvard Medical School and her master of business administration degree from the Wharton School of Business at the University of Pennsylvania.