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Federal Reserve Bank of San Francisco

Health and Community Development

Plus:

Banking Conditions in the 12th District

Addressing the Financial Needs of Small Businesses

The Nevada Bankers Collaborative



CI Notebook

by Laura Choi, Editor

On its surface, health may appear to be an individualized product of genetics, personal lifestyle choices, and proper medical care. But it's becoming increasingly clear that the broader social, economic, and physical context in which we live has a profound impact on health outcomes, particularly among low- and moderate-income populations. While community developers have long understood the importance of promoting affordable housing, employment opportunities, and financial security for community well-being, the field is just beginning to understand how these "traditional" community development activities relate to health outcomes such as life expectancy, infant mortality, and rates of chronic disease.

Earlier this year, the Federal Reserve Board of Governors, the Federal Reserve Bank of San Francisco, and the Robert Wood Johnson Foundation co-hosted the Healthy Communities Conference in Washington DC to explore how the health and community development sectors can collaborate to promote better health outcomes for low-income people and communities by addressing issues concerning the social determinants of health (visit www.frbsf.org/cdinvestments/conferences/hc/ for more information). This issue of *Community Investments* follows up on the ideas introduced at the conference and examines the rich opportunities for cross sectoral partnerships between the community development and health fields.

The issue begins with an examination of the relationship between health and communities, uncovering the striking health disparities that exist across populations of different socioeconomic and demographic backgrounds. The articles also delve deeper into specific examples of community-based approaches to improving health outcomes, such as the unique Equity and Social Justice Initiative introduced by Public Health—Seattle & King County and the Fresh Food Financing Initiative in Philadelphia. In addition, the issue examines the role of community-based organizations in promoting health.

Our "Eye on Community Development" section brings you the latest information on banking conditions in the 12th District and key themes from a national series of meetings on the financing needs of small businesses. We're also pleased to introduce "Community Perspectives," a new feature that provides an opportunity for community members to share the experiences and lessons learned from their own community development initiatives.

We hope this issue of *Community Investments* encourages you to think in new ways about the links that exist between your own community development work and the health of the communities that you serve. Your feedback and comments are always welcomed, and we hope you have a wonderful new year!



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Building Communities and Improving Health

Finding New Solutions to an Old Problem

By Carolina Reid



“It would occupy a long time to give an account of the progress of cholera over different parts of the world . . . and unless this account could be accompanied with a description of the physical condition of the places, and the habits of the people, which I am unable to give, it would be of little use.”

—On the Mode of Communication of Cholera, John Snow, M.D.

In 1854, a cholera epidemic swept through Broad Street, in London, England. Within two weeks, more than 500 people had died, and the death rate of the St. Anne’s, Berwick Street and Golden Square subdivisions of the parish had risen to 12.8 percent—more than double that for the rest of London. That it did not rise even higher was thanks only to Dr. John Snow, who through interviews with the families of the victims traced the outbreak not to a “miasma in the atmosphere,” but to a water pump on the corner of Broad Street and Cambridge Street. Removing the water pump handle did more to temper the epidemic than the leeches, bleeding, or prayers common to medical interventions of the day, leading Snow to conclude that human behavior and the environment, the intersection between people and the places where they live, are inextricably linked to health outcomes.

Today, we have a much more sophisticated understanding of disease. We can trace the origin of pathogens across the globe down to individual tomatoes or meat processing plants, and we can map not only the neighborhoods where diseases occur but the structure of the human genome itself, down to the atomic scale where diseases first take hold. Smallpox and polio—once deadly diseases that exacted a huge human toll—are largely confined to pages in the history books. Every year, more than 3,000 people receive a heart transplant. Cancer mortality rates are down, despite an aging population. Yet, despite these advancements in the field of medicine, the intersection between people and place remains fundamental to human health. In fact, where someone lives—and the social and environmental conditions in their neighborhood—has a much greater influence on their health than whether or not they have health insurance. The recent cholera outbreak in Haiti provides stark evidence of the continuing inter-relationship between poverty, social dislocation, and disease.

It is not only in poor countries that socioeconomic inequalities—both at the individual and neighborhood level—result in dramatic differences in health outcomes. A study conducted by researchers at Harvard University poignantly illustrates the degree to which inequalities in the United States translate into disparate health outcomes. In the study, the researchers classified counties in the United States into “Eight Americas,” distinguishing between urban and rural counties, their income levels, and the race and ethnicity of residents. They found striking differences in life expectancy among the different areas: Native American males in South Dakota had a life expectancy of 58 years, while Asian females in Bergen County, New Jersey had an average life expectancy of 91 years, a gap of 33 years.¹ For young African American men living in poor urban areas, average life expectancies were more similar to those in sub-Saharan Africa than to whites living just a few metro stops away.

This link between socioeconomic factors and health suggests that if we truly want to improve health outcomes in this country, increasing access to quality health care is only a first step, albeit an important one.

Equally important is reducing socioeconomic inequalities and tackling the neighborhood level factors that contribute to ill-health, including poverty, inadequate schools and housing, and crime. This is where community development comes in. Changing neighborhood conditions for the better—including empowering neighborhood residents—can have dramatic positive impacts on human health. As David Erickson of the Federal Reserve Bank of San Francisco argues, “The most important contribution of community development finance may be something we don’t focus on or measure: the billions of dollars of social savings from fewer visits to the emergency room, fewer chronic diseases, and a population more capable of making a contribution as healthy productive citizens.”² However, the community development and health fields have traditionally operated in silos, and have failed to work together towards the shared goal of healthier communities.

The intent of this issue of *Community Investments* is to help break down some of these silos by providing a detailed look at how health and community development intersect. This article provides an overview of what we know about health in lower-income communities, and seeks to describe how socioeconomic inequalities interplay with health outcomes. First, the article describes how socioeconomic inequalities shape access to health care and health insurance, and provides data on gaps in health care access across the 12th District. In the second section, the article explores the social and environmental determinants of health, and reviews the research that documents how

neighborhood socioeconomic conditions shape exposure and susceptibility to health risks. Finally, the article looks at how community development interventions—such as high quality housing, grocery stores and parks, and community organizing—can help to reduce persistent health inequalities and create healthier communities for all.

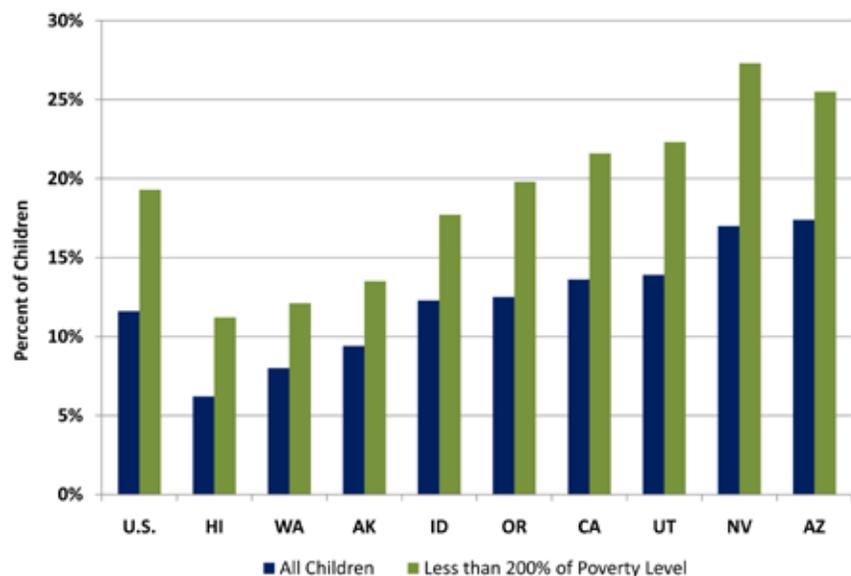
Trends in Health Care Costs and Coverage

On March 23, 2010, after a highly partisan debate both in Congress and in the public sphere, President Obama signed the Patient Protection and Affordable Care Act into law. While the impact of the law, and its costs and benefits, are likely to be debated for some time to come, the push for health care reform was driven by concerns over the growing number of uninsured in the United States. In 2006, 46.5 million Americans—18 percent of the population under 65—did not have health insurance. Between 2000 and 2006, at a time when the economy was doing quite well, the number of uninsured grew by nearly 9.4 million.³ Particularly troubling are the declines in health coverage for lower-income workers and children. Approximately one in five children living under 200 percent of the federal poverty line do not have health insurance coverage; in Nevada and Arizona, the ratio is one in four (see Figure 1).

In part, the growing lack of coverage is due to fewer employers offering health insurance coverage to their workers. Between 2001 and 2005, the share of working adults with incomes below the federal poverty level covered by employer provided health insurance dropped

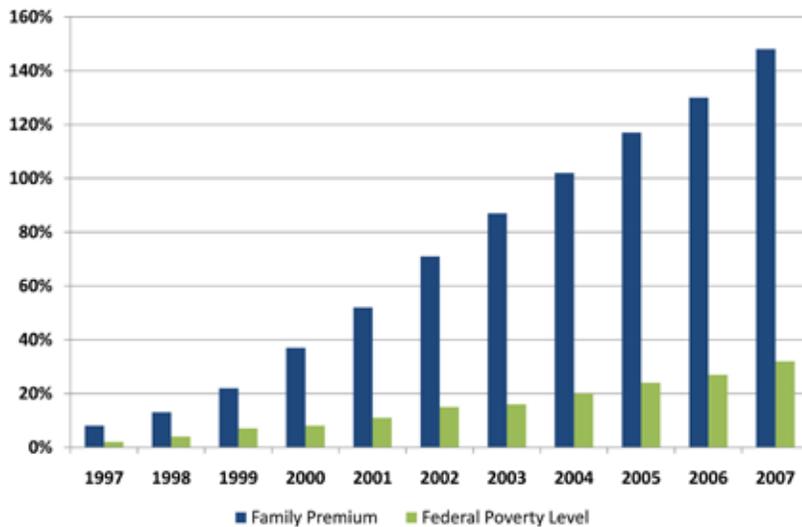
“Approximately one in five children living under 200 percent of the federal poverty line do not have health insurance coverage.”

Figure 1 Percent of Uninsured Children



Source: “The Uninsured: A Primer.” Hoffman, C., Karyn Schwartz, Jennifer Tolbert, Allison Cook, and Aimee Williams. Kaiser Commission on Medicaid and the Uninsured. October 2006.

Figure 2 Cumulative Change in Family Health Insurance Premiums and the Federal Poverty Level since 1996



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1996-2007.

“For families living near or just above the poverty line, health insurance premiums have increasingly soared out of reach.”

from 37 percent to 30 percent, while the share with no coverage rose from 47 percent to 54 percent. Health insurance costs have also been growing more rapidly than either wages or inflation. Between 2000 and 2006, family premiums grew by a cumulative 87 percent, on average, compared with a cumulative 20 percent for worker earnings and 18 percent for overall inflation. For families living near or just above the poverty line, health insurance premiums have increasingly soared out of reach (see Figure 2).⁴ The economic consequences of inadequate health insurance coverage are often dire: unexpected health care expenses are one of the leading causes of bankruptcy in the United States⁵, and one in five households reports financial distress related to medical bills, including using up their savings to pay for medical expenses, being unable to pay for basic necessities like food, heat or housing, or taking out a loan or another mortgage.⁶

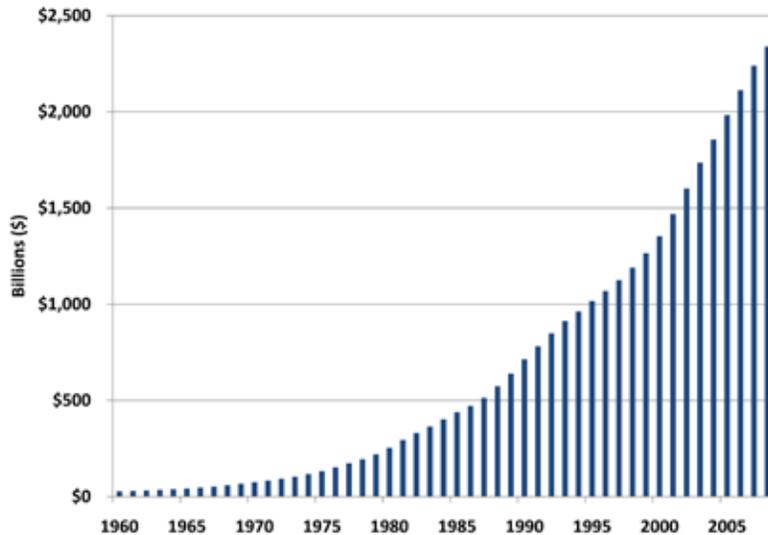
The Patient Protection and Affordable Care Act of 2010 seeks to redress these gaps in health insurance coverage. Estimates suggest that by 2018, an additional thirty-two million Americans will acquire health insurance coverage, reducing the proportion of uninsured to about six percent of the U.S. population.⁷ The Act will significantly benefit low- and moderate-income families. For example, Medicaid will be expanded to up to 133 percent of the poverty line, meaning that those families working for just a bit more than the minimum wage will now have health insurance coverage. In addition, individuals and families who have incomes that are too high to qualify for Medicaid, but below 400 percent of the poverty line, will

receive “premium credits” to lower their health insurance costs.⁸ Within the 12th District, the Act will help to offset health care costs for a large number of low- and moderate-income households, the exception being undocumented immigrants, who are not eligible for federal benefits. For legal immigrants, the law maintains the current five-year-or-more waiting period for Medicaid benefits, though they will not face a waiting period for enrolling in state insurance exchanges or premium tax credits.⁹

In addition to expanding health insurance coverage, a second goal of health care reform was to stabilize health care costs, which have been growing exponentially over the past 50 years (see Figure 3). In 1960, health care expenditures represented 5.2 percent of gross domestic product (GDP); in 2008, that share had risen to 16.2 percent, and if current trends continue, medical care costs will reach 20 percent of GDP by 2015.¹⁰ Economists warn that if this trajectory continues, health care costs will comprise an increasingly large proportion of the U.S. economy, which is unlikely to be sustainable over the long-term. Indeed, the United States spends more on average per person on health care than any other nation, including high-income nations, and by a wide margin. Yet, despite these high expenditures, the United States ranks below average on a variety of measures of health status, even below some much lower-income countries (see Figure 4). Among the 192 nations for which data are available, the United States ranks 46th in average life expectancy from birth and 42nd in infant mortality.

This discrepancy between health care spending and health care outcomes has led researchers and policymakers

Figure 3 Growth in National Health Expenditures, 1960 – 2008



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, compiled by the Kaiser Family Foundation.

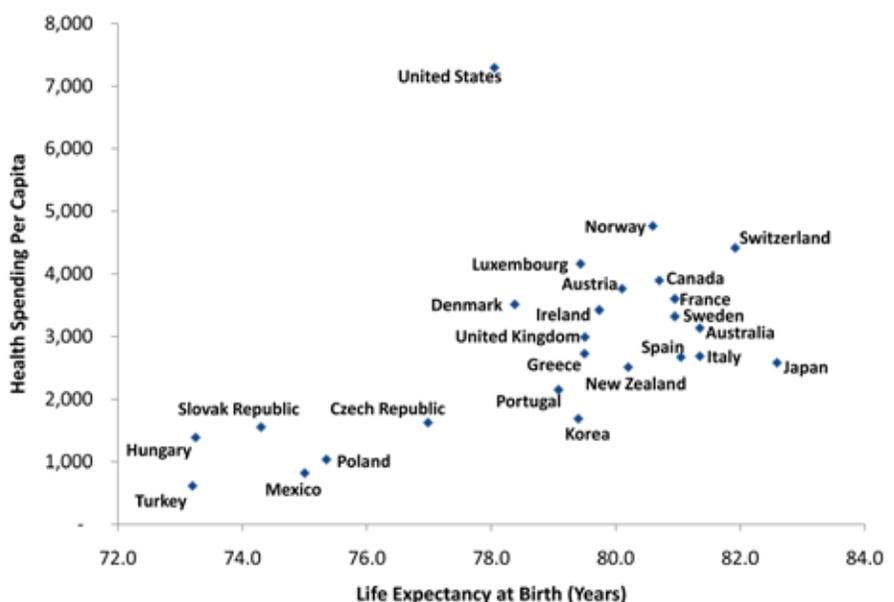
“... a second goal of health care reform was to stabilize health care costs, which have been growing exponentially over the past 50 years.”

ers alike to think more critically about what matters for good health. Certainly, access to high quality and affordable medical care is essential, especially when someone is already sick. However, researchers now estimate that medical care prevents only about 10-15 percent of premature deaths.¹¹ Equally important are social factors such as education, income, and neighborhood quality, particularly when it comes to not getting sick in the first place.¹² The costs of failing to pay attention to these other deter-

minants of health are extremely high. An analysis commissioned by the Robert Wood Johnson Foundation estimates that if the health of all Americans was equal to that of college graduates, the annual average savings to the U.S. economy would be in the order of \$1 trillion through higher worker productivity, reduced spending on social programs, and increases in tax revenues. Certainly, education on its own won't guarantee good health, but the analysis does suggest that socioeconomic disparities in

Figure 4 U.S. Spends More, but Life Expectancy Below Other Countries

“... despite these high expenditures, the United States ranks below average on a variety of measures of health status, even below some much lower-income countries.”



Source: OECD Health Data, 2008

health have major economic impacts.¹³ In addition, analyses such as these are leading to a growing recognition that in order to reduce health disparities, there is a need to tackle the underlying causes of ill-health, such as poverty and socioeconomic disadvantage at both the individual and neighborhood level.

Community Matters: The Social Determinants of Health

As John Snow identified in his early maps of the cholera epidemic, disease is as much a function of neighborhood and behaviors as it is a function of germs and cells. This has become even more apparent as the leading causes of mortality in this country have shifted from infectious diseases such as cholera and malaria to chronic health issues such as heart disease and cancer. Nevertheless, it is very hard to disentangle the effects of social factors on health, and even harder to disentangle whether or not it is individual or neighborhood level factors that matter most when looking at health outcomes. Income, educational attainment, race, and neighborhood quality are all intertwined in complicated ways. Yet despite the fact that it is hard to come up with a precise estimate of the proportion of morbidity or mortality that can be attributed to each of these various elements, there is no doubt that socioeconomic disadvantage leads to poorer health outcomes. This relationship holds whether the measures of disadvantage are calculated using income, wealth, occupation, prestige, education, where one lives, or whether the measures are objective (e.g. income below the poverty line) or self-reported (e.g. “I earn less than those around me”).¹⁴ Some

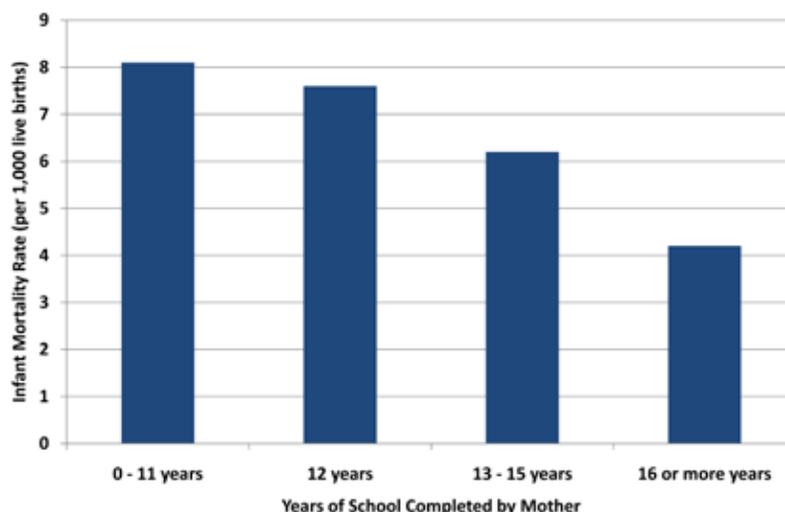
research also suggests that it’s not just the absolute level of disadvantage that matters, but rather the relative level of disadvantage among different population groups.¹⁵

Importantly, socioeconomic disadvantage has been linked to a number of poor health outcomes, from overall mortality to the higher incidence and prevalence of chronic conditions such as diabetes, heart disease, and cancer. To provide just one example, babies whose mothers have less than 12 years of schooling (and are unlikely to have completed high school) are nearly twice as likely to die before their first birthdays as babies born to mothers with 16 or more years of schooling (most of whom are college graduates) (see Figure 5).¹⁶ The links among socioeconomic status, disease, and mortality are especially strong among communities of color. Figure 6 presents infant mortality rates by race for states within the 12th District. In California, Arizona, Nevada and Hawaii, the infant mortality rate for non-Hispanic blacks is more than twice that of whites.¹⁷

As more and more of these health disparities have come to light, researchers are working to understand how socioeconomic disadvantage intersects with health outcomes. First, while behavioral factors account for approximately 40 percent of preventable deaths¹⁸, behaviors are shaped as much by social context as they are by individual risk factors. Socioeconomic conditions, peer influences, marketing tactics, and policies and practices can all affect individual choices. For example, it is hard to eat healthy when the only place to buy groceries in the neighborhood is the corner liquor store; and it is hard to ensure that children are getting enough exercise if there is

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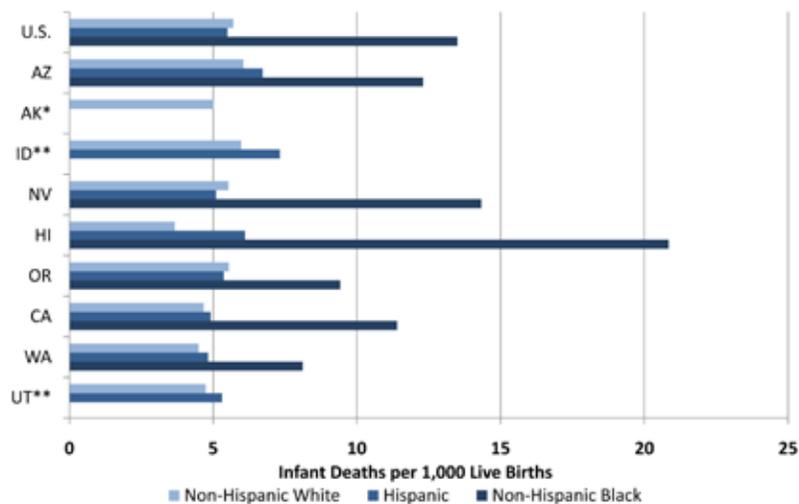
Figure 5 Infant Mortality Rates are Closely Linked to their Mother's Educational Attainment



Source: Robert Wood Johnson Foundation (2008). *Overcoming Obstacles to Health. Report From the Robert Wood Johnson Foundation to the Commission to Build a Healthier America.*

“In California, Arizona, Nevada and Hawaii, the infant mortality rate for non-Hispanic blacks is more than twice that of whites.”

Figure 6 Infant Mortality Rates by Race/Ethnicity In 12th District States



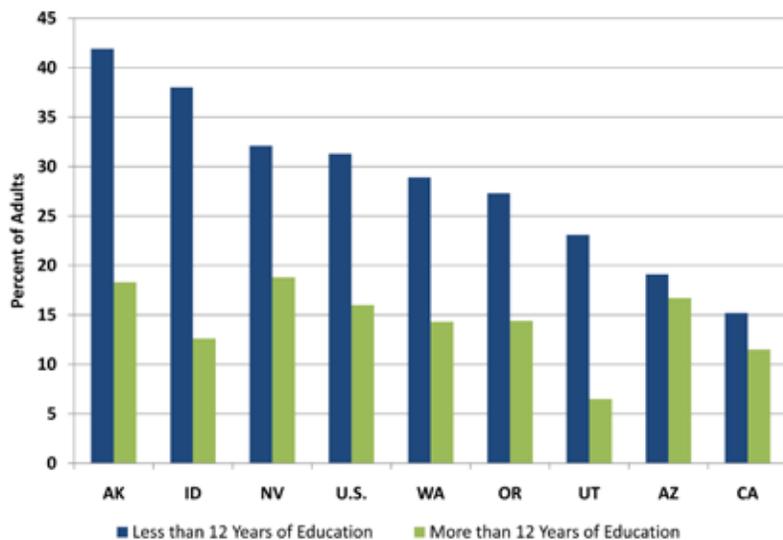
* Insufficient data for Hispanic and Non-Hispanic Black
 ** Insufficient data for Non-Hispanic Black

Source: Matthews, TJ, M.S., et. al. *Infant Mortality Statistics from the 2006 Period Linked Birth/Infant Death Data Set*. Division of Vital Statistics. National Vital Statistics Report, Vol 58, No. 17, July 30, 2010.

no safe playground nearby. As a result, many of the behavioral changes that have led to health benefits over the past couple of decades have accrued more to higher-income households.¹⁹ For example, cigarette smoking continues to be the leading cause of preventable morbidity and mortality in the United States. While overall smoking levels have decreased over the past three decades, adults in poor families or with lower levels of education saw the smallest reductions, and continue to be more likely to smoke than other adults. Figure 7 shows the percent of adults in the 12th District who smoke, comparing those who do not have a high school degree with those who have a high school degree and additional years of schooling. Across all the states, smoking is much more prevalent among those with less education. While some of this is due to individual choice, social context is critical in understanding this trend as well. Tobacco companies have increased their marketing campaigns in low-income neighborhoods and in communities of color, which in turn have the least information about the health risks of smoking, the fewest social supports, and the least access to cessation services. Policies also matter: smoke-free policies tend to cover white-collar workers more than blue-collar workers.²⁰ Education and income can also shape other factors that can influence behaviors and health, such as the knowledge and/or capability to access health resources, the effects of stress, and/or a different orientation towards the future.

Second, living in poverty can also expose someone to direct health hazards, such as violence or environmen-

tal contaminants such as mold or air pollution. Many of these health hazards are directly related to neighborhood and housing quality.²¹ For example, in the 1970s, the federal government implemented numerous policies to reduce exposure to lead, especially among children. Research had shown that even very low levels of lead exposure could increase children’s risk of adverse effects, including mental impairment, reading problems, attention deficit-hyperactivity disorder, school failure, and juvenile delinquency. While these federal policies significantly decreased exposure to lead, housing built before 1978, especially when not well-maintained, can still have lead based paint on the walls. Lower-income and minority households—those who are most likely to live in older, substandard housing—are thus at a much greater risk of lead exposure. In a recent study, an estimated 12.3 percent of African American children had elevated blood lead concentrations, compared with 2.3 percent of white children.²² Evidence also shows that communities with the largest percentage of minority residents also have most of the toxic waste facilities, landfills, and superfund hazardous waste sites located nearby.²³ Certain lower-skilled occupations can also lead to differential exposures to health risks. For example, agricultural work is associated with a high fatality rate, with 21.3 deaths per 100,000 workers per year, compared with an overall rate of 3.9. In addition, agricultural workers have increased rates of nonfatal injuries, chronic pain, heart disease, many cancers, and chronic symptoms associated with pesticide exposure.²⁴

Figure 7 Smoking Prevalence among Adults in 12th District States, 2004

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2004. Data are not available for Hawaii.

“While overall smoking levels have decreased over the past three decades, adults in poor families or with lower levels of education saw the smallest reductions, and continue to be more likely to smoke than other adults.”

Third, an emerging literature argues that it is the social aspects of the neighborhood—the social networks, political forces, organizations, and community values—that have perhaps one of the greatest influences on human health and well-being. Evidence has shown that individuals with weak social ties have higher rates of many types of diseases, even after controlling for other factors that might contribute to ill-health.²⁵ In addition, perceptions of control may also greatly influence health. Researchers are increasingly demonstrating that a low social status, coupled with a lack of control, may actually have a direct impact on the biological processes that make us more vulnerable to a wide range of different diseases.²⁶ For example, Len Syme, a distinguished researcher at UC Berkeley, has been examining the question of how social control and empowerment influences health. In a study of San Francisco bus drivers, he found that the bus drivers’ health problems, including hypertension, back pain, gastrointestinal and respiratory difficulties, and high rates of alcohol use, were not easily solved through medical interventions. Instead, it was the job itself that was leading to these poor health outcomes—the computer timed bus schedule was unrealistic, leading to significant stress resulting from angry passengers, penalties for arriving late, and lack of control over traffic jams and terrible shift arrangements. Studies such as these have led Professor Syme to conclude that in order to improve health, there is a need to focus on interventions that help to empower people and give them more control over decisions that affect their lives.²⁷ He writes, “The evi-

dence now shows that no matter how elegantly wrought a physical solution, no matter how efficiently designed a park, no matter how safe and sanitary a building, unless the people living in those neighborhoods can in some way participate in the creation and management of these facilities, the results will not be as beneficial as we might hope. It turns out that, for maximum benefit, physical improvements must be accompanied by improvements in the social fabric of the community.”²⁸

Linkages between Community Development and Health

For community development professionals, Professor Syme’s observations resonate with something the field also learned the hard way: resident participation is vital to the success of any redevelopment effort. Early urban renewal efforts in the 1950s and 1960s did not include any affected residents or businesses in the planning process, and by all accounts failed to achieve either sustainable or equitable neighborhood revitalization. Today’s community development efforts are much more likely to involve residents in the planning and design of their community, encompass a wide range of community groups and partners, and build on local economic priorities and assets. In addition, community development already focuses on many of the community pathways that influence health, including land use planning, housing, crime prevention, access to healthy foods, charter schools and childcare facilities, and entrepreneurship and small business develop-

ment. As a result, there is an incredible opportunity for the health and community development fields to work across conventional policy silos to engage in cross-sector partnerships and solutions, and to build on the two fields' complementary skills and resources.²⁹

“For community development, the jump to thinking about health outcomes should be a small one. Already, the field has been responsible for making investments in communities that can have positive effects on community health.”

There is already movement in that direction, at both the federal and the local level. For example, the Department of Housing and Urban Development, the Department of Transportation, and the Environmental Protection Agency have launched the Sustainable Communities initiative to coordinate federal investments in transportation, environmental protection, and housing to make neighborhoods safer, healthier, and more vibrant. The U.S. Departments of the Treasury, Agriculture, and Health and Human Services also announced the Healthy Food Financing Initiative, which allocates \$400 million to help finance grocery stores in underserved communities. The initiative will help to expand community residents' choices of healthy food, as well as support community development goals by bringing new jobs to the neighborhood (see the “Healthy Food Financing Initiatives” article in this issue of *Community Investments*). Interagency collaboration has also started to happen at a more local level. In Washington State, for example, there have been explicit efforts to build collaboration across government agencies so that health concerns and a consideration of health equity are integrated into all aspects of city planning (for more information, see the next article, “Making Up for Lost Time: Forging New Connections between Health and Community Development”). Other collaborations are even more localized. In Arizona, for example, the Phoenix Neighborhood Services Department and the Phoenix Children's

Hospital worked together to combine housing structural repairs with asthma education and the provision of asthma inhalers. Combining the housing rehab work with more traditional interventions focused on asthma reduction resulted in significant improvements to the families' health and safety. In Alameda County, California, the local public health department is employing community-based strategies, such as a neighborhood initiative for outreach and empowerment, to improve both health outcomes as well as educational, economic, and social outcomes (see “Community-based Strategies for Improving Health and Well-being” in this issue).

For community development, the jump to thinking about health outcomes should be a small one. Already, the field has been responsible for making investments in communities that can have positive effects on community health. The Corporation for Supportive Housing, for example, has found that providing housing for the homeless coupled with employment services and other social services on-site not only increases employment and earned income, but can also reduce emergency room visits and decrease emergency detoxification services.³⁰ Investments in early childhood education can also support long-term positive health outcomes.³¹ Investments in green building, in addition to reducing utility costs for lower-income households, can also reduce household exposure to environmental toxins. Transit-oriented development can also yield improved health outcomes, especially when residents trade in their cars for walking and biking. Indeed, by many respects, CDFIs and other community development organizations have long been working to leverage public and private dollars to create social conditions for health, even if this goal has not always been explicit. As Lisa Richter from GPS Capital Partners has pointed out, the goals of community reinvestment and improving health outcomes are mutually reinforcing, as both sets of outcomes are enhanced by investments that increase access to quality child care, education, jobs, affordable housing, and other local services in a sustainable environment.³² The challenge is to step out of established silos, and actively consider how all of these projects could be enhanced by developing new partnerships with organizations focused on health, and by explicitly choosing metrics that consider health as part of the outcomes we hope to achieve. Doing so would bring new resources to the table, and make both fields even more effective going forward. **CI**



Making Up for Lost Time: *Forging New Connections between Health and Community Development*

By David Fleming, Hilary Karasz, and Kirsten Wysen,
Public Health—Seattle & King County

“The best time to plant a tree was 20 years ago. The second best time is today.”

—Chinese proverb

In 1915, on the lower east side of New York, dilapidated tenements were packed with the nation’s poorest people and our newest immigrants. Poor air, water, and food were the rule rather than the exception. Tuberculosis, pneumonia and diarrhea were rampant, and early death was common. That year, under the headline of “Poverty Kills 300,000 Babies Yearly,” *The New York Times* reported: “Babies whose fathers earned less than \$10 a week died at the appalling rate of 256 per 1,000. On the

other hand, those whose fathers earned \$25 a week or more—who had what might be called an ample income—died at the extremely low rate of 84 per 1,000.”¹ A century ago, the link between poverty and poor health was both recognized and operating in full force.

Today, health and economic status remain as intimately intertwined as they were 100 years ago. Across the globe, countries with the lowest GDP also have the highest mortality rates. Here in the United States, the infant death rate

in Mississippi, where the typical household earns less than \$36,000 per year, is twice that of New Jersey, where the average income exceeds \$64,000. And in King County, Washington, home to 1.9 million residents, life expectancy in the poorest communities averages seven years less than in the wealthier Seattle neighborhoods and suburbs.

Wealthier people on the whole are healthier, and healthier people are more economically productive. Common sense suggests it should be fairly easy to create mutually re-enforcing strategies and programs that lead to both economic improvement and better health, but it has proven to be much more difficult than expected. Despite shared goals, public health and community development professionals have been curiously slow to partner and benefit from each other's wisdom and expertise. However, three evolving realities in today's public health world are making an obvious and important case for bringing public health and community development efforts together. These include:

- The changing nature of 21st century preventable disease;
- The increasing link between health disparities and place; and
- The early positive evidence from early adopters of combined health and development strategies.

Below, we describe each trend in more detail and explain why we think they are creating new incentives for public health to partner with community development. We also provide examples of efforts from our community—King County, Washington—that are capitalizing on these changes and simultaneously advancing both health and community development.

The Changing Nature of 21st Century Preventable Disease: Chronic Disease Prevention Requires a Community Approach

In 1900, pneumonia, tuberculosis and diarrhea were the leading causes of death in the United States. Public health regulations and programs were enacted to improve sanitation and protect people from unsafe food and drinking water. Vaccines were developed to prevent many communicable diseases altogether. Public health nurses went house to house to help prevent mother and infant deaths in families. These interventions worked; better yet, they were effective regardless of an individual's economic status. The life expectancy of people living in the United States rose from 49 years in 1900 to 78 years in 2000 due in large part to the effectiveness of these traditional public health practices.²

Today, the leading causes of death are heart disease, cancer, and stroke. The underlying preventable causes

of these conditions are smoking, poor diet, and lack of physical activity. Public health's historical approaches—providing medical and technological services or programs and regulations as protection from external threats—are now mismatched with the job at hand. There is no obesity vaccine or pill that will prevent children from smoking their first cigarette. The key to better health now lies in the prevention of chronic diseases, largely through the adoption of healthy behaviors. While behavior is ultimately an individual choice, the ability to make healthy choices is increasingly dependent on the community in which one lives. Eating nutritious food is difficult if fresh produce is not stocked by your corner grocery store. Keeping physically active is hard if you don't have access to bikes or walking trails and your streets are unsafe to walk on.

Improving health today requires interventions that create communities in which the healthy choice is the easy choice. The assets of well-designed and developed communities—like safe streets, a mix of retail stores, local jobs, good local schools, adequate housing, transportation choices, and opportunities to get adequate physical activity—are increasingly recognized as major determinants of the rates of chronic disease. The shift in the nature of preventable disease in this country from infectious to chronic diseases is pushing public health to develop new approaches and to prioritize goals, strategies and interventions that now, more than ever, align with those of community development.

Integrating Health into Community Planning Processes

In King County, as in many other communities around the country, neighborhood planning typically falls to departments of planning and development, transportation, parks, and other experts in land use planning and design. Recognizing that the environment in which people live, work, learn and play is linked to their health, Public Health—Seattle & King County (Public Health SKC) staff have worked for several years to integrate health into these land use and transportation planning processes. To support cities in advancing this approach, the King County Board of Health developed and adopted Planning for Healthy Communities Guidelines in 2010 (see Table 1). These guidelines are designed to inform and provide standards for local land use and transportation planning and development practices that promote health and ensure that all people and communities have the opportunity to make healthy choices regardless of their income, education or ethnic background.

While having guidelines is a necessary first step, it is often challenging for individual cities with limited staff resources to incorporate policies based on guidelines into their city comprehensive plans. Using federal stimulus funds from an American Recovery and Reinvestment Act

Table 1 King County Board of Health Guidelines: Planning for Healthy Communities

Topic	Guideline	Rationale	Community Planning Element
Physical Activity	Residents in all communities in King County have access to safe and convenient opportunities for physical activity and exercise.	Planning and design that encourages and enables access to walking, bicycling, transit, and other means of exercise in safe and inviting environments provides residents with ways to obtain needed levels of daily physical activity.	<ul style="list-style-type: none"> Housing, schools, jobs, parks, and commercial and public services within walkable proximity of neighborhoods; Number, size, and accessibility of parks and open space; Presence of sidewalks, walking and bicycle paths; Transit safely reached by walking or bicycling; Presence of affordable community centers and other recreational facilities.
Nutrition	Residents in all communities in King County have access to healthy, affordable foods.	Land use planning incorporates all aspects of the food system, especially access to healthy, affordable, and nutritious foods.	<ul style="list-style-type: none"> A robust local farm to table chain, including community gardens and other food growing opportunities in urban areas; Long-term preservation of farm land; Number and location of healthy food retail outlets including farmers' markets and grocery stores; Safe and reliable transportation options to healthy food retail outlets.
Harmful Environmental Exposures	Residents in all communities in King County are protected from exposure to harmful environmental agents and infectious diseases.	Community design and land use, building, and housing standards can reduce exposure to harmful environmental agents in our air, water, food and soil.	<ul style="list-style-type: none"> Building and design standards that create safe, healthy, and accessible indoor environments; Planning policies and practices to reduce generation of and exposure to air pollutants; Water resource management that provides safe water for drinking, recreation, and fisheries; Management of standing water to prevent transmission of infectious disease; Safe management and disposal of solid and hazardous waste and overall reduction of solid and hazardous waste.
Injury, walking and biking	Residents in all communities in King County use transportation systems designed to prevent driver, bicyclist and pedestrian injuries.	Land use patterns, roadway design, and availability of and access to safe non-motorized transportation can reduce risk of motor vehicle collisions and bicycle and pedestrian injuries.	<ul style="list-style-type: none"> Safe roadways and roadway design that prevent motor vehicle collisions; Safe pedestrian paths, sidewalks, and street crossings; Well designed and safe bicycle paths and lanes.
Injury, violence	Residents in all communities in King County live in safe communities free from violence and fear of violence.	Land use patterns and community design can create environments that reduce violence by fostering a sense of community and security in which residents are safe accessing services, recreation, schools, and jobs.	<ul style="list-style-type: none"> Commercial districts and community spaces designed for interaction and community cohesiveness, safety, and convenient access; Presence of well lit and maintained parks, streetscapes, and other public spaces; Site and building design enables open and unobstructed views of public areas and prevents isolated and hidden spaces.
Tobacco Use	Residents in all communities in King County are protected from involuntary exposure to second hand tobacco smoke and children cannot access tobacco products.	Land use patterns, ordinances, and zoning affect access to and use of tobacco products and exposure to secondhand smoke.	<ul style="list-style-type: none"> Policies limiting tobacco use and exposure to second hand smoke; Planning practices limiting tobacco retail outlets near public open spaces and youth-centered facilities, especially schools.
Alcohol Use	Residents in all communities in King County are protected from negative impacts of alcohol.	Land use patterns, ordinances, and zoning can affect access to and use of alcohol products and alcohol-related violence and injury.	<ul style="list-style-type: none"> Land use and zoning patterns inform community decisions about access to alcohol; Planning practices managing the location and impact of bars, taverns, and retail outlets that sell alcohol near public open spaces and youth-centered facilities.
Mental Health and Well-being	Residents in all communities in King County benefit from community design that maximizes opportunities for social connectivity and stress reduction.	Community design can reduce individual isolation, promote social interaction and community cohesiveness, and alleviate environmental determinants of stress.	<ul style="list-style-type: none"> Safe, inviting, accessible venues and community places that encourage beneficial social interaction and community cohesiveness; Parks and green spaces that provide stress relief, rest, and relaxation; Noise levels managed and mitigated, especially near residential neighborhoods, schools, and hospitals.
Access to Health Care	Residents in all communities in King County have local access to health care services.	Accessibility of health care services in a community is an important determinant of community health and well-being.	<ul style="list-style-type: none"> Number and accessibility of health clinics providing routine and preventive medical care; Availability of urgent and emergency care services; Location and response time for emergency response

of 2009 grant, we have provided funding to allow seven King County cities with high rates of poverty and poor health indicators to translate guidelines into city policy.

Increasing Access to Healthy Food as a Combined Health and Economic Development Strategy

Access to healthy foods is a critical element of obesity prevention, yet many low-income communities lack access to healthy food, with few full-service grocery stores.³ Residents often rely on corner grocery or convenience stores with limited inventory, consisting mostly of high calorie, low nutrition processed foods and beverages. As an early step to help solve this problem, Public Health SKC, in partnership with the City of Seattle's Office of Economic Development, recently launched a "Healthy Foods Here" (HFH) Initiative to make healthy food more available in low-income communities in King County. Funding from a Centers for Disease Control "Communities Putting Prevention to Work" grant and capital leveraged from the private sector are available in specific neighborhoods for low interest loans, grants, technical assistance and marketing resources to help local corner stores carry more healthy foods and to make healthy foods highly visible and accessible.

Specifically, the HFH Initiative aims to increase access to healthy foods through a variety of approaches, including conducting outreach to engage convenience store owners, recruiting them to participate in the program, and developing marketing strategies to drive customers to participating businesses. The initiative is also working to develop the business case that demonstrates profitable methods of increasing healthy food options in convenience stores. HFH provides a package of specific incentives that food-related businesses can use to improve access to healthy foods, including: 1) technical assistance in topics such as merchandising, inventory management, and marketing; 2) assistance with finding suppliers; and 3) financial incentives such as grants, rebates, or access to low-cost financing for working capital, purchasing equipment or completing store improvements. In addition, HFH has created a lending referral network to connect food related businesses needing financing to community development financial institutions, and is working with the lenders to develop specific financial products that provide financial incentives to participating food related businesses such as interest rate buy downs.

Similar efforts to make healthy food more accessible and affordable to people living in low-income communities are gaining traction around the country. For example, Philadelphia's Food Trust has operated for more than a decade. And earlier this year, President Obama pledged over \$400 million to the Healthy Food Financing Initiative, a key goal of which is to bring grocery stores to underserved communities in urban and rural communities

across the United States (see the article "Healthy Food Financing Initiatives" in this issue of CI).⁴

The Link between Health Disparities and Place: Your ZIP Code Is Making You Sick

Race and class are strong predictors of health. In most places, including King County, infant mortality, diabetes, smoking, and cancer rates are higher among low-income and minority populations. And because neighborhoods tend to segregate by race and class, geographic clustering of people with poor health outcomes is inevitable. Recently, however, it has become clearer that clustering of health disparities in poor communities arises from more than just the aggregation of the individual characteristics of the people who live there. We are now recognizing that a neighborhood's characteristics directly affect the opportunities residents have to be healthy.⁵

For example, lower-income neighborhoods tend to have convenience stores rather than grocery stores, fewer parks, walking or biking paths, fewer transportation options, and a higher density of tobacco outlets and liquor stores—all factors that contribute to poorer health. While community developers have been focusing on improving low-income communities for years, public health has only recently begun to fully understand how much place matters⁶, and therefore how much the goals of community development and public health overlap.

Promoting Equity and Social Justice

Health disparities in communities occur in specific neighborhoods and the solutions to these inequities require long term, multi-sector interventions. But mobilizing and coordinating assets over the long term to enable sustainable, comprehensive change requires sustained efforts by the private and public sectors. Public Health SKC is taking a new approach to enable sustainable, comprehensive change by spearheading King County's Equity and Social Justice Initiative. This new initiative requires all departments within King County government—from transportation and natural resources to public health and permitting services—to address inequities across the communities they serve. The Initiative's goal is for "all King County residents to live in communities of opportunity... [where] all people thrive... and have access to a livable wage, affordable housing, quality education, quality health care, and safe and vibrant neighborhoods."⁷ In October 2010, the Initiative was adopted into county statute, making it law that all branches of county government will explicitly tackle equity and social justice in an ongoing, integrated fashion.

The Equity and Social Justice Initiative works across 13 social, economic and physical environment factors which collectively provide multiple opportunities for a lifetime of good health and well-being (see Table 2).

Table 2 King County Equity and Social Justice Initiative
Factors creating health and community well-being:

Family wage jobs/job training
Community economic development
Affordable, quality, healthy housing
Quality early childhood development
Quality education
Healthy physical environment
Community and public safety
A law and justice system that provides equitable access and fair treatment
Neighborhood social cohesion
Access to all modes of safe and efficient transportation
Access to affordable food systems and affordable and healthy foods
Access to parks and nature
Access to affordable and culturally appropriate health and human services
Equity in County practices

“The Equity and Social Justice Initiative works across 13 social, economic and physical environment factors which collectively provide multiple opportunities for a lifetime of good health and well-being.”

The Initiative has been operationalized through attention to policy development and decision-making, delivery of county services, and internal education and communication for the 18,500 county employees. In policy development, for example, an “equity lens” tool has been developed to help policy makers in all departments assess how new policies impact inequities. Each year, every county department must develop and commit to specific actions related to their core services, like bus, parks and public health services. Internal education and communication activities have been organized through an intensive training program. Hundreds of employees, starting with managers and supervisors, participated in facilitated discussions about inequity following screenings of the PBS series “Unnatural Causes: Is Inequality Making Us Sick?”⁸

An “equity in all policies” initiative has been compelling to a wide array of county departments. This mantle of equity may prove to be more effective in making changes to the underlying causes of ill health and injustice in communities than a “health in all policies” approach, which risks creating turf battles with departments that don’t see themselves as working in “health.”

Using Global Health Practices to Improve Local Health in Poor Communities

The link between economic and physical health has long been understood by some of the poorest countries in the world. Although much of the U.S.’ health investment

goes into treating people after they’ve gotten sick, many low-resourced countries have recognized that lower-cost prevention activities are often more effective in the long run. Working with less, these countries have been innovative in finding community-based strategies that improve health, often by linking it with economic development.⁹ It is time to profitably adapt these global health strategies to low-resourced local communities.

Seattle is fortunate to have one of the highest concentrations of global health expertise in the world. Leveraging this expertise, we have launched a “Global to Local” (G2L) project to determine if effective community-based health strategies from under-resourced areas of the world can effectively improve the well-being of local residents. SeaTac and Tukwila, two cities in King County with low socioeconomic indicators and poor health outcomes, are pilot communities for G2L and the project has received \$1 million in seed financing from Swedish Health Services, a large, local health care delivery organization. Other partners include the Washington Global Health Alliance, Public Health SKC and HealthPoint (a community health center system).

G2L is implementing a toolbox of strategies (see Table 3) to improve individual and community health outcomes, lower health care costs, and contribute to economic development. Adopting these approaches as a whole is intended to improve both the economy and the health of the community.

Table 3 Global to Local Pilot Project

Global strategy	Local example and potential partner
Training and deploying community health workers	Community House Calls Harborview Medical Center has a network of “Interpreter Cultural Mediators” to guide new arrivals through the health care and related systems.
Using technology to leapfrog barriers and transform community health practices	Grameen Technology Center Seattle-based organization using mobile phones to improve access to health-related information and to track patient care.
Generating targeted campaigns around priority health issues	Public Health - Seattle & King County Partnered with community organizations and media that serve and reach the most vulnerable to carbon monoxide poisoning hazards to warn people of the risks of operating charcoal grills inside, using pictograms and key messages translated into a wide range of languages.
Linking health with economic development	Healthy Food Here and Jump Start Loans The Refugee Resettlement Office in Seattle offers a non-profit microenterprise development program to refugees and asylees in the Puget Sound area and has provided over \$560,000 in micro-loans to 130 recipients.
Mobilizing and empowering community-based organizations	Welcome Back Program Highline Community College has recertified over 150 new arrivals that had been certified as health care professionals in their home country, but were ineligible to work in Washington State.
Linking the delivery of clinical, primary health care and public health services	HealthPoint Bothell site A collaboration of Public Health - Seattle & King County and HealthPoint to provide primary care and public health services at the same location.

The Early Evidence from Early Adopters of Combined Strategies: Evidence and Data To Support Community-Based Approaches

Governments and investors are fundamentally cautious and unlikely to invest in expensive interventions without knowing if they are effective. There is good evidence that traditional public health interventions work: vaccines prevent diseases, clean water prevents the spread of water-borne disease, and nurse home visiting improves pregnancy outcomes. However, there are fewer examples of the success of combined public health and community development interventions, since the two fields have only rarely worked together.

Even within the field of public health, the evidence base for how to make communities healthier is only beginning to be collected. As recently as 2003, the Institute of Medicine’s (IOM) report on how to improve the public’s health provided only vague guidance about the role of policy, system and environment changes, and IOM called for more research to determine what is effective practice. Currently, a growing, but still relatively new, body of evidence on community-based public health interventions is available through the CDC’s

“Guide to Community Preventive Services,” an online resource that assesses the strength of the evidence for programs and policies in areas such as adolescent health, alcohol, asthma, cancer, diabetes, nutrition and social environment, to improve health and prevent disease in the community.¹⁰

While we are beginning to gather evidence on the effectiveness of community-based preventive measures, specific indicators that measure the health of the community, beyond summary measures of the health of individuals, are not well developed. There are few standard definitions and little routine data collection of measures of community well-being. However, we need these kinds of data to diagnose problems across communities, direct interventions in the neediest places, and monitor the effectiveness of our interventions. Such evidence is crucial for developing convincing arguments for policy makers about the value of cross-sector collaboration between public health professionals and community development experts. Collaboration will become more common as we build the evidence base that demonstrates that working together, public health and community development can create stronger, healthier communities.

Integrating Housing Development and Asthma Prevention

In King County, as elsewhere, children from low-income neighborhoods are several times more likely to be admitted to the hospital for asthma than children from higher-income communities. Conditions due to mold from dampness, dirt in carpets and fur and dander from pets in substandard housing can trigger respiratory reactions.

In the late 1990s, the Seattle Healthy Homes project trained community health workers to go house-to-house to educate community members about taking asthma medications and home cleaning methods that are proven to reduce asthmatic episodes. When needed, the health workers provided allergy-control bedding, low-emission vacuum cleaners with microfiltration bags, cleaning kits, roach bait, and rodent traps. The intervention worked. Children from the families who received frequent visits, intense education and cleaning materials spent fewer days with symptoms and had half as many trips to the doctor and hospital. The health care savings more than covered the cost of the program.¹¹

The Seattle Housing Authority used lessons learned from this project while renovating the High Point development in West Seattle from 2004 to 2008. Before renovation, residents of these older post-World War II era buildings had asthma at rates as high as 10 to 12 percent. The new development is now a mixed-income community of over 34 city blocks with sidewalks, walking paths, open space, and porches. Of the more than 700 rental units, 60 are “Breathe Easy” units built specially for low-income people with asthma. The units cost about \$5,000 more to build, due to filtered ventilation systems, insulated foundations, moisture-removing fans, cabinets free of asthma-triggering glues, low-outgassing paints, hard floors, and landscaping with low-allergenic plants.¹² Initial evaluation showed that asthma triggers declined 97 percent, and emergency room visits and asthma attacks were reduced by about 66 percent compared to previous rates from the old units.

Gathering Data to Respond to the Needs of the Community

King County’s “Communities Count” initiative is one of the few data projects that has engaged community members to articulate what aspects of their community are important to them and then tracked these measures over time. Communities Count is a collaboration of public and private organizations to measure a vision of a healthy community and track progress toward that vision over time. The project used an iterative community-based approach to select indicators compelling to community members and policymakers. Over 1,500 King County residents participated in the process through surveys, focus

groups and forums. Thirty-eight indicators were chosen related to: 1) basic needs and social well-being; 2) positive development through life stages; 3) safety and health; 4) community strength; 5) natural and built environment; and 6) arts and culture. It has identified and reported on broad indicators of community life over time, tracking social, economic, health, environmental and cultural conditions since 2000. The next report will be released in 2011 and will report 10 year trends across all indicators.

Communities Count reports have been used to shape policy discussions, inform program development, and identify funding priorities. Examples of how the reports have influenced local planning and action include:

- The City of Burien committed \$50,000 to support community-based early childhood development programs after seeing community-specific data on school readiness.
- A new partnership with Sustainable Seattle formed in 2007 to push forward an action agenda around sustainable communities.
- The City of Renton responded to indicators of perceived discrimination by identifying ways that the City could address discrimination in their jurisdiction. The City is exploring staff training and community dialogues about social, economic and racial inequities.
- The Moving Data to Action Initiative solicited proposals from community organizations to address childhood poverty, an indicator of concern for the region. Two community action projects were funded, including a strategic plan to impact childhood poverty in Washington State and the development of an ordinance establishing paid sick and safe days as a labor standard in Seattle to promote women’s full and equitable participation in the workplace.

Moving Forward

As the leading causes of death and disease have shifted from communicable to chronic conditions, public health remedies have changed, requiring collaboration with new partners. These broader interventions are often best implemented in specific places. Rather than working to improve individuals’ health one-by-one, neighborhood characteristics need to be changed to reduce inequitable burdens of ill health and improve the economic productivity of communities. Measuring the community features that need to change and building an evidence base of community-centered interventions will help move this critical work forward. There is a wealth of opportunity to bring public health and community development together to build stronger, healthier communities, but what are the next steps?

“... the relationships that community development organizations and individuals have built with the business and private sector would be a valuable contribution to collaborative projects with the public health sector.”

While public health's experience in economic and community development work is in its early stages, public health professionals can contribute three important resources to the field of community development. First, health is highly valued by the public, and development projects that result in better health outcomes for residents and communities at large may stimulate interest and support, and broaden opportunities for multiple public and private funding sources. Second, the public health field has developed practical evaluation methods that can effectively measure the impact of interventions in communities, such as conducting long-term surveys of population health characteristics that can reveal changes over time. Lastly, the public health field has worked in high poverty neighborhoods since its inception and has developed several approaches to working respectfully and collaboratively with community partners.

On the other hand, public health is lacking specific expertise and relationships that community development professionals can bring to the table. Among many assets, community development professionals can offer an understanding of finance and lending mechanisms for community projects. For example, initial work to make healthy food available has made it clear that public health needs to work with specialized partners to understand how to structure a loan fund. An inventory of various public and private funding streams and guidance on how to match these with specific health projects would be valuable. Lastly, the relationships that community development organizations and individuals have built with the business and private sector would be a valuable contribution to collaborative projects with the public health sector.

In these difficult economic times, resources to do our work are even more difficult to come by than usual. Even so, public health can bring some financing to the table, and community developers may be able to do the same. In the immediate future, one funding stream both health

and community development could benefit from is the Affordable Care Act of 2009. Health care reform offers at least two vehicles for health investments that could overlap with community development. The Prevention and Public Health Trust offers funding for policy, system and environment changes; and the federal community health center investments through the Health Resources and Services Administration (HRSA) offer possibilities of expanding social and health services at community health centers in high-need locations. In short, the skill sets and resources of public health and community development professionals seem to be complementary and working together may get us farther toward our goals than respective individual efforts of the past.

To get started, we need joint ventures. We can work together to propose pilot projects that use community development methods to improve health in specific locations. New community development projects can include chronic disease health indicators as measures of success.¹³ Public health interventions can include lending features to improve the physical and economic health of communities. Both fields can work strategically in high poverty locations to improve underlying conditions and evaluate these efforts. We can work together to build on evaluation findings to leverage resources to scale up promising approaches. We can continue to educate each other about the strengths and weaknesses of our respective fields. We can introduce each other to the best thinkers in our own fields.

The need to accelerate the accumulation of shared knowledge and apply what we've learned is clear. Using rapid change methods like continuous quality improvement, we must identify problems, rapidly develop and test solutions, and reassess and build on success. Given our shared goals of improving the health and well-being of high need communities, public health and community development professionals could have created beneficial partnerships decades ago. Even though we are discovering our shared agenda belatedly, to make up for lost time, the next best time to get started is today.

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Healthy Food Financing Initiatives: *Increasing Access to Fresh Foods in Underserved Markets*

By Matthew Soursourian

The limited availability of full-service supermarkets in lower-income neighborhoods makes it a challenge to find affordable healthy food, exacerbating health disparities related to obesity and diet-related diseases that already disproportionately impact low-income and minority communities.¹ Given the time and cost constraints of traveling outside their neighborhoods to find less expensive healthy food, many residents end up shopping at small corner stores whose shelves are predominantly stocked with high-fat and sugary processed foods.

Recognizing the important health implications of food access, quality, and cost in low-income neighborhoods, the community development field has begun to address these interrelated issues. Pennsylvania has led the way with its innovative Fresh Food Financing Initiative (FFFI), now a model for national replication. The FFFI serves the

financing needs of supermarket operators that plan to operate in underserved communities where infrastructure costs and credit needs cannot be filled solely by conventional financial institutions.²

History of the Fresh Food Financing Initiative

The Food Trust, a nonprofit organization in Philadelphia, was established in 1992 and began its work by providing nutritional education classes for children at a local farmers' market. After expanding their scope to include establishing farmers' markets in underserved areas, the Food Trust recognized the lack of affordable healthy food in low-income neighborhoods. In 1999, the Food Trust partnered with the Philadelphia Department of Public Health and researchers at University of Pennsylvania to conduct a study on the interrelated issues of food access, income,



and diet-related health problems. The report concluded that low-income residents are less likely to live near a full-service supermarket and more likely to suffer from diet-related diseases.³

The findings galvanized support for the cause and caught the attention of various public and private actors, including the Philadelphia City Council. The City Council requested that the Food Trust form a working group to address the issues raised in the reports. In 2004, the working group released another report, which generated more attention throughout the state. After several hearings at the Pennsylvania General Assembly, the State allocated \$30 million over three years to create the FFFI, designed to help lower the costs associated with opening and operating grocery stores in urban areas. The Reinvestment Fund (TRF), a Philadelphia-based community development financial institution, leveraged the State's investment with private funds and tax credits to build a \$120 million fund.

Success through Partnerships

FFFI is a collaboration between TRF, the Food Trust, and the Greater Philadelphia Urban Affairs Coalition, with each organization playing a critical role tailored to its own strengths. TRF manages the financing and grant program, distributing funds that can be used for pre-development costs, land assembly and other capital expenses, preopening and soft costs, and construction expenditures. Applicants are eligible if their project demonstrates a benefit for an underserved area (defined as a low or moderate income census tract), an area with supermarket density that is below average, or an area with a supermarket customer base with more than 50 percent living in a low-income census tract.

The Food Trust coordinates with supermarket developers to match community needs with FFFI resources and promotes the fund through a statewide marketing campaign. The Greater Philadelphia Urban Affairs Coalition works with supermarket developers to enhance contracting opportunities for minority and women-owned businesses and to ensure that women, minorities, and local residents have access to employment in the new supermarkets.

As of June 2010, FFFI has approved 93 applications for funding, totaling \$73.2 million in loans and \$12.1 million in grants since its inception in 2004.⁴ In addition to increasing access to healthy and fresh foods at affordable prices, the new and expanded stores have a substantial economic impact on their neighborhoods. The funded projects will create or retain over 5,000 jobs and develop 1.67 million square feet of commercial space. Jeremy Nowak, President and CEO of TRF, explains, "These markets provide economic anchors for communities across Pennsylvania, attracting jobs to the community. These investments can drive the health and economic vitality of these communities, particularly during difficult economic times."⁵

Taking the Model to Scale

The FFFI has generated national policy interest, particularly as the costs of obesity are becoming increasingly apparent. California-based PolicyLink, along with TRF and the Food Trust, is leading a campaign for a national-scale Healthy Food Financing Initiative (HFFI). The campaign found its first major success when President Obama included over \$400 million in his 2011 budget proposal for a national HFFI and in October 2010, the Treasury Department announced a Notice of Funds Availability (NOFA) for part of HFFI. While additional steps are necessary to ensure that HFFI is funded, including Congressional appropriations, the NOFA from Treasury signals that support for a national program is strengthening.

At the same time that Washington is turning its attention to food scarcity, researchers continue to explore the ways that policy and capital can be harnessed to address the challenge of supermarket access. Most recently, TRF and the Brookings Institution released an online mapping tool that displays demographic and economic information for areas that are underserved by full-service supermarkets. The maps focus on ten metro areas and are available online at www.trfund.com through TRF's PolicyMap platform.

While the FFFI financing model is gaining traction across the country, it should be noted that grocery stores are not a panacea for poor health outcomes in low-income communities. Demand-side issues also play into the market for fresh healthy food. A recent study by the USDA recognized the merits of a financing initiative like FFFI but pointed out that "if consumer demand factors, such as inadequate knowledge of the nutritional benefits of specific foods, contribute to differences in access by reducing demand, then a public health campaign may be a preferred strategy."⁶ As such, a comprehensive strategy that addresses demand- as well as supply-side concerns may have the most impact on the public health and community development issues that first drew attention to fresh food scarcity in low-income neighborhoods. **CI**



Photo Credit: Elev8 NM

Middle School Students participating in Elev8's integrated services and education model.

Community-based Strategies for Improving Health and Well-being

By Naomi Cytron

Introduction

Notions of health most often center around individual cases of disease, diagnosis, and, hopefully, recovery. But, as the other articles in this issue of *Community Investments* discuss, health outcomes are mediated by much more than just exposure to germs or interactions between patients and doctors. Rather, community and societal-level factors play a significant role in determining health risks and outcomes for individuals. Indeed, numerous public health studies have demonstrated that the social and economic characteristics of a given neighborhood are linked to the incidence of disease as well as mortality rates, with low-income areas seeing a disproportionate occurrence of conditions like heart disease, high blood pressure, and asthma.

In part, this link can be understood through the issues that the community development field addresses daily. The conditions that often characterize low-income, minority neighborhoods—such as poor housing quality, deteriorating public infrastructure, high levels of crime and violence, and elevated exposure to pollutants—concentrate potentially pathogenic factors. The interaction between health risks and issues traditionally tackled by community development entities suggests that there may be benefit to interweaving health promotion and community development efforts.

This article looks at two initiatives that are taking this approach at the local level—utilizing community-based strategies to improve health outcomes as well as edu-

cational, economic, and/or social outcomes. These initiatives aim to recognize and address the give and take between individual and community health, and to impact the political and institutional factors that can affect the conditions leading to poor health outcomes for residents of low-income neighborhoods.

Elev8: School-based Integration of Services

“We’re using health centers in schools as a point of entry to get involved in the community and get kids engaged in their futures,” said Frank Mirabal, President of Contigo Research, Policy & Strategy in New Mexico. Mirabal was speaking about the aims of the local Elev8 program—part of a national initiative spearheaded by the Atlantic Philanthropies to enhance children’s learning and success by integrating a range of health and social services into middle-school sites. These include extended learning opportunities, family and community engagement and support services, and comprehensive school-based health care services, which provide a range of preventive, primary, behavioral and oral health care for students.

Elev8 draws on the results of numerous studies that have shown that these kinds of school-based services offer a range of benefits, particularly for low-income and minority students. Beyond just improving access to basic health services, which can alleviate health conditions that otherwise might interfere with learning, integrated services can enhance youths’ sense of attachment to school, improve attendance, decrease risk behaviors and increase parental involvement.¹ Atlantic Philanthropies chose middle-school sites because children in their middle-school years often struggle with significant emotional, physical and social challenges as they transition to adulthood. These challenges can lead to behaviors and choices that can derail academic achievement and ultimately, economic opportunity. Elev8 is designed to provide multiple supports to middle-school aged students and their families in order to lower barriers to success.

Chris Brown, LISC/Chicago’s Director of Education Programs and the head of Chicago’s Elev8 program, noted that since the time the five school-based health clinics were established between 2008 and 2009, they’ve seen over 5,000 visits to date. “The health centers are a good way to connect with students—to identify a range of challenges and help them get connected to other services and programs,” he said. For instance, under Elev8 a child might enter a school-based health clinic struggling with asthma. The clinician can help treat the child’s illness and, upon discovering that the child’s housing conditions might be playing a role in aggravating her asthma, can refer her family to the Elev8 family resource center, where they can get help in finding healthier living conditions.

Through the resource center families can also gain access to other supports and benefits, and can learn financial literacy skills that might help stabilize the household. Additionally, Elev8 offers children the chance to participate in after-school, weekend, or summer enrichment programs, like art, music, sports, or gardening programs. Each of these program aspects aims to build on the other to help stabilize families and keep middle-school students from risky trajectories, including dropping out of school, joining gangs, abusing drugs or alcohol, or otherwise being left untreated for physical or mental health issues that might compromise achievement.

School-based health clinics operate in many schools nation-wide, but this integration of services—rather than just co-location of a clinic and a school—is what makes Elev8 unique. Mirabal, who has been involved in implementing Elev8’s program in New Mexico, noted that children and families often face something akin to a bumper car lot when seeking assistance, bouncing from one program to the next without seeing solutions to the underlying—and interwoven—challenges they face. “Through integrated services,” he said, “we are seeking to shed the silo effect that’s been endemic to the social services world for decades.”

Elev8 is currently operating in a number of middle-school sites in underserved and challenged areas of New Mexico, Chicago, Baltimore and Oakland. These sites were selected based on health profiles, socioeconomic needs, academic performance, as well as community capacity to commit to improving outcomes for neighborhood youth. In each site, the program involves a unique configuration of public and private partners, including local foundations, intermediaries, nonprofits, and public sector agencies. But all sites operate on the principle that a child’s health and success cannot be disentangled from the context of family and community.

Elev8 has not, of course, been without implementation challenges. Mirabal noted that gaining buy-in from school staff and leadership around the importance of weaving Elev8 into school programming has been difficult. It has required careful articulation of how comprehensive services can connect to school goals, like meeting targets for academic proficiency and parental involvement. Additionally, the school and the health clinic needed to clearly define the fundamentals of their working relationship—from issues as basic as which entity would be responsible for supplying paper towel rolls, to more complicated questions of how to maintain student safety and guard patient privacy.

Gaining buy-in from participants has also taken work. One of Elev8’s primary goals is to engage community members and parents in their children’s school activities, but in New Mexico, the first year of operation saw low par-

ticipation rates among eligible families. Program staff realized that they needed to take a more grassroots approach to building connections with community members, and ultimately created a position for a community organizer, who conducted door-to-door outreach and intensive intake services for community members.

While the program is still young and evolving, Mirabal noted that they'd already learned important lessons. First, working across sectors is challenging. Conflicts can arise due to differences in organizational culture, values, or expectations, but determining how to find the processes that generate positive outcomes—whether cost savings or other efficiencies—for all involved entities is critical. Brown additionally noted that success is “all about relationship building—creating real roles for all partners and sharing power in decision-making.” However, he said that it is also important to have a lead agency involved that is capable of convening all partners and holding all the pieces together.

Elev8 also includes a policy advocacy component that seeks to expand and strengthen supports for middle-school aged children and their families at the local, state, and federal level. Though the current budget environment makes policy work challenging, Mirabal said, “We’re starting to make headway! State-level players understand the need to align resources.”

Alameda County Public Health Department: Community Approaches to Improving Health

The 2008 report, *Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County*, examined the multiple ways that place is linked to health

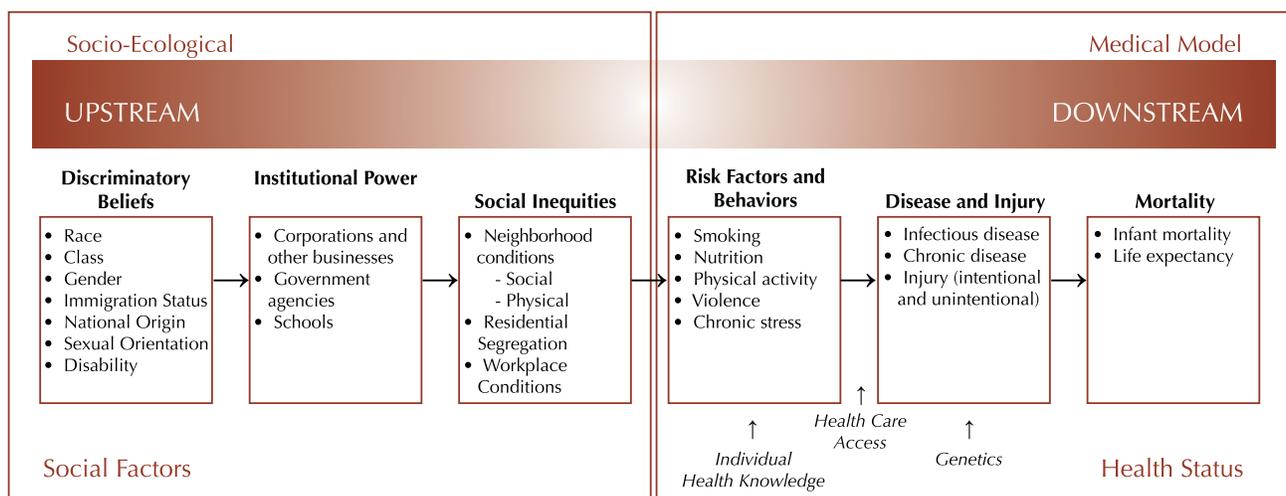
outcomes. “Illness concentrates among low-income people and people of color residing in certain geographical places,” reads the report, further noting that an African American born in a low-income neighborhood in West Oakland has a life expectancy that is 15 years shorter than a White person born in the more affluent suburbs of the Oakland Hills.²

Anthony Iton, previously the Director of the Alameda County Public Health Department (ACPHD), was quoted as asking, “Are health disparities due to something wrong within low-income minority neighborhoods? Or are they due to something wrong with American society that concentrates health disparities in certain neighborhoods?”³

The department’s answer—some of both—underlies the strategy that ACPHD has taken to addressing health inequities in low-income neighborhoods in the county. ACPHD’s health equity framework considers not just traditional medical model issues, like individual health knowledge, behavior and risk exposure, but also “upstream” issues including neighborhood-level conditions, social and economic inequalities, institutional power, and policies that affect the regional distribution of resources (see Figure 1).

This framework translates into several initiatives that tackle issues that health departments typically do not have purview over, noted Sandra Witt, Deputy Director of Planning, Assessment & Health Equity at ACPHD. One of these programs, the City-County Neighborhood Initiative (CCNI), is a partnership between ACPHD, the City of Oakland, and residents and community based organizations in two small predominantly minority neighborhoods found to be “hot spots” of high poverty, disease, and mortality. But, in line with the department’s

Figure 1 A Framework for Health Equity



Source: Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008

“Mini-grants have been awarded to resident action groups for neighborhood improvement and civic engagement programs, including block parties and activities to promote healthy eating and exercise.”

fundamental belief that community residents must have “a voice in identifying policies that will make a difference as well as in holding government accountable for implementing these policies,”⁴ the focus of CCNI is not on health education or access, but rather on community organizing and empowerment.

Through the CCNI, community organizers conduct outreach to neighborhood residents and engage them in community forums where they can identify priorities for action. Mini-grants have been awarded to resident action groups for neighborhood improvement and civic engagement programs, including block parties and activities to promote healthy eating and exercise. ACPHD also supports a Time Bank program, through which residents exchange services with other members, like pet sitting, child care, car repair, handiwork, or gardening. All of these elements are aimed at building community capacity and community cohesion, and toward empowering communities to advocate on their own behalf.

Mia Luluquisen, ACPHD’s Deputy Director of Community Assessment Planning, Education and Evaluation, noted that they are learning lessons that might sound familiar to those working in the community development field. “You have to start the community organizing process from what the residents want to work on,” she said. “But part of the challenge is to reach beyond the ‘natural helpers’ in a community—our aim is to engage wider networks and add their voice to the conversation.”

ACPHD recognizes, though, that community capacity building alone can’t solve the upstream institutional and political factors that influence health outcomes in specific geographies. As such, ACPHD is pairing community capacity building with efforts to enhance its own institutional capacity to address health inequities. Departmental staff receive training covering issues like cultural competency, institutional racism, and social determinants

of health. ACPHD’s strategic plan includes goals to align its daily work to achieve health equity and to cultivate and expand community-driven partnerships. Additionally, through their “Place Matters” Initiative, ACPHD staff are working on a policy agenda that focuses on a range of issues that impact health, including criminal justice, education, housing, land use and transportation. “We are highlighting the policies across agencies that can help decrease health inequities, and adding a health lens to the conversation,” said Witt. “So much of this is about power and how decisions get made—and the ‘values’ that are held about different people that dictate those decisions.”

ACPHD struggles, though, with many of the same challenges that community developers face in implementing place-based initiatives.⁵ “We’re really trying to force the focus on place, and cross-sector alignment is key—which is difficult since in practice we’re set up to be siloed,” said Witt. Additionally, they face resource shortfalls and the resulting inability to bring their efforts to scale. Given budget constraints, they find themselves wrestling with questions like where to invest for the highest return. “Our programs are small scale, but we’re looking to have a multiplier effect,” said Luluquisen.

Conclusion

Questions still remain about how to make both Elev8 and ACPHD’s programs sustainable over the long term, and how to expand or replicate the programs in other neighborhoods. Many of the challenges faced by these initiatives fit into a conversation about how to better align similarly-intentioned public and private investments that have not traditionally been delivered to communities in a coordinated way. Efficiencies that can be generated through coordinated investments—and the cross-sector partnerships that enable coordination—are critically important to find, particularly in light of continued public and private budget shortfalls and the resulting reductions in social service provision and nonprofit support. The close ties between community development goals and health outcomes make for a natural partnership between the two sectors. As Elev8 and ACPHD are demonstrating, small scale interventions at the local level can have significant impacts on community health and well-being. The early work of resident engagement and the creation of cross-organizational partnerships, even in just a few neighborhoods, can lay the foundation for far-reaching efforts and policy change in the future. 



Banking Conditions in the 12th District: *Has the Recovery Taken Hold?*

By Wally Young, Federal Reserve Bank of San Francisco, Division of Banking Supervision and Regulation

On September 20, 2010 the National Bureau of Economic Research announced that the longest and deepest recession since the Great Depression officially ended in June 2009. Yet, here we are more than a year later and many banks throughout the nation are still struggling mightily to recover from this downturn. This is even more pronounced in the 12th Federal Reserve District (comprised of Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah, and Washington) where 42 banks and thrifts failed in 2008 and 2009, and another 31 banks have failed so far in 2010. Why has this recession had such a profound impact on banking conditions in the 12th District? In this article, we'll address some of the issues that contributed to the still-prevalent banking crisis, discuss some emerging signs of improving banking conditions, and consider the

headwinds that the banking industry will continue to face as it mounts its recovery.

12th District Profile

Currently, roughly 520 banks are headquartered within the 12th District. A vast majority of these banks (83 percent) are small, community banks with total assets of less than \$1 billion. Over the last two decades, the loan portfolios of these community banks in particular have become less diversified as they focused on certain niches that enabled them to effectively compete against credit unions and large banking organizations. Community banks found their competitive advantage in commercial real estate (CRE) financing, which includes funding the acquisition of income producing properties such as office buildings, retail centers, and apartment buildings, as well as

funding the acquisition of land for future development and the construction of residential and commercial buildings.

With appropriate risk management practices in place, CRE lending itself is not a concern, especially when market conditions are benign. However, ever increasing concentrations of CRE loans do pose a risk to financial institutions when market conditions turn. Historically, commercial property values are more sensitive to adverse economic and real estate market conditions because the value of these properties are in large part driven by rents, vacancy rates, and the investor's rate of return expectations. In an economic downturn, it is inevitable that rents decline, vacancy rates increase, and rate of return expectations rise. Combined, these factors place significant downward pressure on property values and borrower repayment capacity. More importantly, land values (which typically generate no income until development and construction is complete) also often fall dramatically when economic conditions weaken, as demand for future development quickly stalls.

The increase in CRE lending in the 12th District is also the direct result of the strong growth that many parts of the District have experienced in recent years. Areas like Las Vegas, Phoenix, the Inland Empire of Southern California, and many others, were experiencing strong growth that was largely financed by community banks. Both residential and commercial property values in these markets were far more exposed when the downturn hit, as the pipeline of new and pending construction quickly outpaced waning demand. Over a very short timeframe, property

values plummeted, as did the financial strength of the real estate developers and investors.

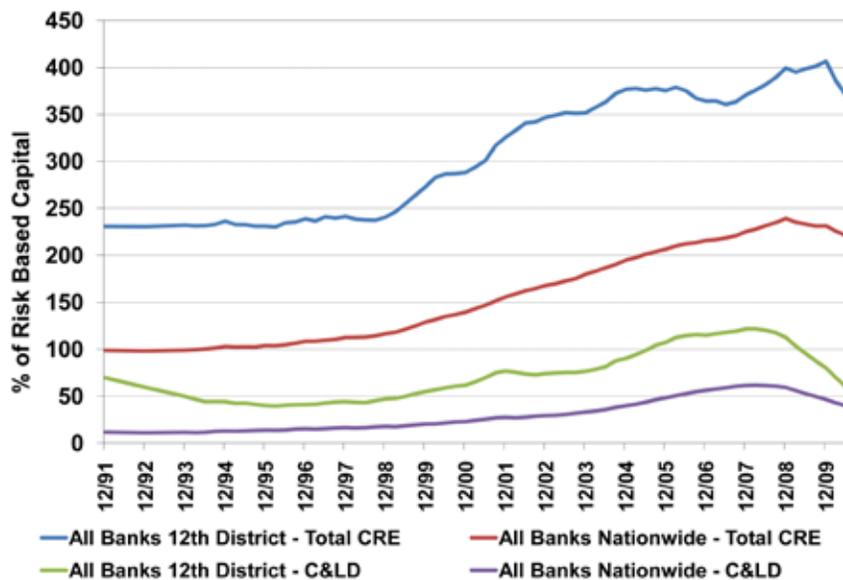
Rising CRE Concentrations

Figure 1 illustrates the extent to which CRE concentrations have increased since 1991 for all banks nationwide and those within the 12th District. Note that in the 12th District, before abating somewhat in 2010, total CRE peaked at over 400 percent of Risk Based Capital in 2009.¹ This was close to double the nationwide concentration, which was around 225 percent at the same time. Meanwhile, the overall levels of CRE lending are notably higher than they were in 1991.

We observe a similar trend in loans to finance Construction & Land Development (C&LD). Beginning in the mid-1990s, the concentration of C&LD loans in the 12th District increased from less than 50 percent of Risk Based Capital, to approximately 120 percent in late 2007. However, as the real estate market crashed and the recession began in late 2007, the concentration of C&LD loans dropped quickly; in the 12th District, the C&LD concentration has fallen back to a level last seen in 2000. Even more dramatic, the concentration of residential C&LD in the 12th District declined from just under 40 percent of risk based capital, to approximately 15 percent since late 2007.

The declining CRE concentrations, and in particular the declining C&LD concentrations, are not the result of these loans being repaid. Instead, the declining concentrations are largely the result of banks charging-off and restructuring more of these loans. At the end of 2007, the

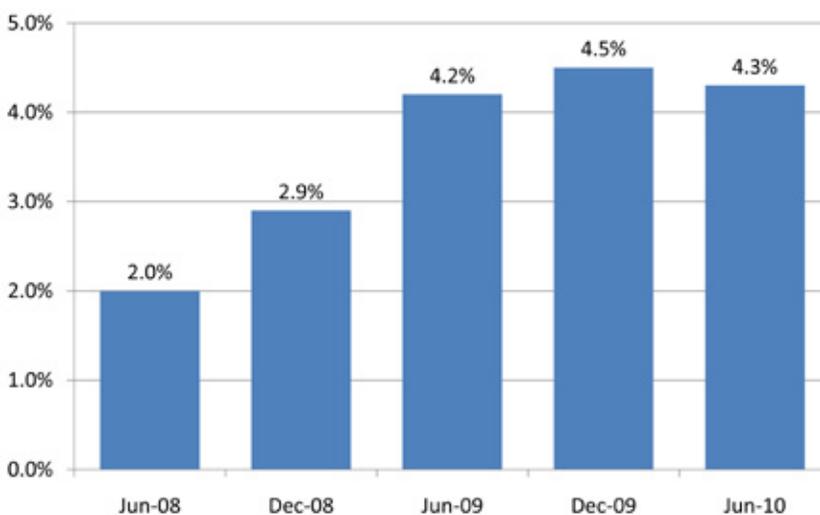
Figure 1 Loan Concentration History



“... total CRE peaked at over 400 percent of Risk Based Capital in 2009.”

“In the last quarter of 2009, 54 percent of 12th District banks lost money. In the first quarter of 2010, this percentage fell to 38 percent; it then fell again to 37 percent in the second quarter.”

Figure 2 District Noncurrent Loan Ratio Edging Downward
12th District Bank Noncurrent Loan Ratio (Aggregate*)



* Aggregate data for all District commercial banks with <\$50B in loans
Source: Federal Reserve Bank of San Francisco 12th District Banking Profile, September 2010

net charge off rate for C&LD loans in the 12th District was 0.26 percent. This net charge off rate ballooned to 3.75 percent by the end of 2008—the highest loss rate since 1991. Then, in 2009 it swelled to 8.55 percent, and for the first six months of 2010, the net charge off rate remained high at an annualized 6.05 percent. The numbers are even more striking if we focus specifically on residential construction loans.

These hefty losses on large volumes of CRE loans have directly led to declining profits for the banking industry, particularly for the banks located in the 12th District. The second quarter of 2010 marked the seventh consecutive quarter of negative Return on Average Assets (ROAA) for the 12th District. The average quarterly ROAA in the 12th District on June 30, 2010 was -0.11 percent. Further illustrating the disparate impact on smaller banks, the ROAA for community banks was -0.28 percent; for banks with total assets of \$1 billion to \$10 billion it was 0.08 percent, and for banks larger than \$10 billion it was a relatively strong 0.99 percent.

Some Signs of Stabilization

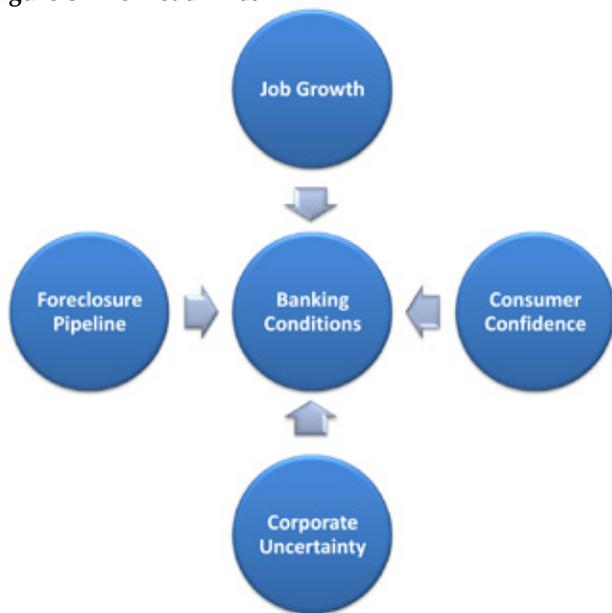
Despite the sizeable losses that many banks in the 12th District incurred as a result of their significant concentrations of loans secured by CRE and more specifically, C&LD, there are some signs that banking conditions have stabilized and may improve. For example, the volume of problem loans is beginning to recede, an increasing number of banks have returned to profitability, there are some signs of emerging loan growth, and an increasing

number of banks have successfully raised capital in recent quarters. Consider the following trends:

- The total noncurrent loan rate (loans past due 90 days or on nonaccrual status) has been relatively flat over the last three quarters and has actually inched down in the latest quarter (see Figure 2). At June 30, 2010 the percentage of total noncurrent loans was 4.3 percent.
- The noncurrent rate for C&LD loans dropped from 15.7 percent in the first quarter of 2010 to 14.6 percent in the second quarter of 2010. This is still at a very high level, but it appears to have peaked.
- In the last quarter of 2009, 54 percent of 12th District banks lost money. In the first quarter of 2010, this percentage fell to 38 percent; it then fell again to 37 percent in the second quarter.
- Although the annual loan growth in the District is still negative, some loan segments are now showing positive loan growth. Of note, loans secured by apartment buildings are increasing at an eight percent annual rate. Credit card loans are increasing at a five percent annual rate.
- At June 30, 2010, almost 10 percent of 12th District banks successfully raised capital over the prior 12 month period. This is up from 7.7 percent at mid-year 2009 and 6.6 percent at mid-year 2008. Meanwhile, capital ratios are improving in the District.

These are just a few of many positive developments noted in the June 30, 2010 data. However, improving trends need to be kept in perspective. Although we see signs of improving profitability, it is still negative on

Figure 3 *The Headwinds*



average for the District. Although noncurrent loans are starting to decrease, the level still remains extremely high and although capital ratios have improved, they still need to improve further. Moreover, as addressed in the next section, there are headwinds facing the industry that could reverse some of these positive trends, or more likely, make the recovery in banking conditions a long and slow one.

The Headwinds

Although we may have technically exited the recession in mid-2009, the economy has clearly not yet fully recovered. Until the economy gains strength, it will be difficult for the banking industry to fully recover. Many of the factors that are now impeding the economic recovery also contribute to the uncertain banking environment. These so-called headwinds make it difficult for us to conclude that banking conditions have definitely turned the corner. At the very least, these headwinds strongly suggest that it will be some time before the banking industry is back at full strength.

The first headwind is low job growth and high unemployment. Without a substantial uptick in hiring, consumers and businesses will continue to hold back on spending. Consumers do not spend money if they are out of work or fear that they may soon be. Also, in the face of unemployment and reduced income, borrowers are less able to repay any loans that they may already have.

A second challenge is that consumer confidence remains weak. Consumer confidence will improve as unemployment falls, but consumers continue to worry about their housing situations and their own balance sheets.

Even with improving job prospects, consumers may still be slow to spend until they feel they have appropriately replenished their own net worth.

Third, there is still a great amount of corporate uncertainty. Corporations are slow to expand operations in periods of uncertainty. Political issues, tax issues, consumer confidence, and the changing regulatory environment together create a cloud of uncertainty. Even when this cloud clears, it may be some time before businesses actually need credit because corporate balance sheets are now flush with cash.

A fourth headwind is the significant volume of residential mortgage loans that is still working its way through the foreclosure pipeline. Even as housing conditions improve (albeit gradually), home prices will continue to face downward pressure as an ever increasing number of distressed properties are put on the market. It will be some time before the market fully absorbs this inventory and home prices begin to show any notable improvement. The current moratorium on foreclosures by some banks—prompted by concerns over their foreclosure processing systems—may also affect the housing recovery.

The Outlook

Given these headwinds, the outlook for banking conditions remains uncertain. There is strong evidence to suggest that the industry has turned the corner and that the worst is behind us. Nevertheless, the industry is still facing significant challenges. Community banks in particular are still struggling to recover from losses in their CRE portfolios, and although capital is improving throughout the District, banks will need to continue to strengthen their capital positions as problem loans remain high and significant uncertainties remain.

In the coming quarters, we will likely see incremental improvement in banking conditions at the community bank level and continued profitability at the larger institutions. However, until there is more clarity around the headwinds noted above and other uncertainties affecting the industry, it is more than likely that it will be well into 2011 before the banking industry is back on sound footing.

If you're interested in learning more about banking conditions in the 12th District, you can find additional reports by the Division of Banking Supervision and Regulation on their website at <http://www.frbsf.org/publications/banking/index.html>.

*Wally Young is Senior Manager in the Risk, Monitoring & Analysis Department of the Banking Supervision and Regulation Division of the Federal Reserve Bank of San Francisco. **CI***



Addressing the Financing Needs of Small Businesses

Summary of Key Themes from the Federal Reserve System's Small Business Meeting Series

Introduction

Since the start of the recession, bank lending to small businesses has contracted significantly: the number of loans to small businesses has dropped from 5.2 million loans in 2007 to 1.6 million in 2009.¹ To address this emerging credit gap, the Federal Reserve System's Community Affairs Offices hosted more than 40 meetings in 2010 as part of an initiative entitled "Addressing the Financing Needs of Small Businesses." The meetings brought together small business owners, small business trade groups, financial institutions and other private lenders, bank supervision officials, community development finan-

cial institutions (CDFIs), and other small business support service providers to discuss ways to improve credit flow to viable small businesses. The meetings highlighted numerous challenges related to both the supply of and demand for small business credit, but participants also highlighted possible solutions. This excerpt from the meeting proceedings document provides an overview of the key issues and recommendations that emerged from the convenings. For the full report, visit *Addressing the Financing Needs of Small Businesses*, available online at <http://www.federalreserve.gov/events/conferences/2010/sbc/default.htm>.²

At a meeting in Cincinnati, *small business owners said they were required to make cash payments when reassessments of LTV ratios resulted in insufficient collateral. If the payment was not made, the loan could be subject to default.*

Factors Impacting the Supply of Small Business Credit

One of the key themes that emerged in the stakeholder meetings was the contraction in the supply of small business credit since the start of the recession. The meetings identified several reasons why credit supply has shrunk. First, both small businesses and banks reported that underwriting standards had tightened considerably, leading to higher collateral requirements. For example, small businesses reported that routine re-evaluations of assets that directly or indirectly secure existing loans—including personal residences, commercial property, and equipment—have resulted in additional collateral requirements because of a significant drop in asset values. In addition, in some markets, banks noted they were no longer readily taking real estate as collateral, especially if there was another outstanding lien against the property. Many banks have also reduced their loan-to-value (LTV) thresholds. Banks and small businesses also concurred that strong cash flow is now one of the chief underwriting criteria. Another recent trend has been to require more personal resources and guarantees, such as higher personal credit scores. All of these factors have made it more challenging for small businesses to access credit.

Second, banks also indicated that their own resources have become more constrained during the recession, making it more difficult to process small business loans. For example, banks reported that higher-than-average delinquency and loss rates have taxed their workout units, forcing them to shift seasoned staff to assist with the increased number of problem loans. Some banks, particularly smaller banks, described a temporary suspension of all lending activities while they assess portfolios, manage workouts and distressed loans, and reevaluate collateral. Lack of capacity to process applications has led some banks to limit the types of applications that they will consider. Banks frequently said that they do not have enough time to handle applications with insufficient documentation, such as sparse tax returns or inadequate income statements. Some banks have significantly reduced or eliminated loans below a certain threshold, typically \$200,000, as a way to limit time-consuming applications from smaller businesses. Banks also cited the imbalance between time commitment and returns as a reason for not

participating in certain SBA loan products, such as the America's Recovery Capital or 7(a) loan programs.

Third, banks cited the regulatory environment and examination-related concerns as important factors in credit availability for small businesses. Banks noted that because of the declining asset values of their balance sheets, they have been required to raise capital to cover potential losses. Some banks also expressed frustration about their perception of conflicting messages from different government stakeholders. On the one hand, the banks feel pressure to lend, but at the same time they are encouraged to apply stricter credit standards and raise their capital requirements. The result is a more cautious approach to lending overall.

As a result of the contraction of small business credit from banks, many small businesses represented at the meetings said that they were turning to alternative, often higher cost, sources of financing. Small businesses described turning to credit cards in lieu of a bank loan, at the same time that their credit limits were being reduced. Businesses described, and several banks confirmed, that in some cases banks are recommending the use of credit cards in response to requests for smaller loans. Some small businesses also said they relied on home equity lines on their personal residence or on retirement savings. Family and friends are another source often mentioned for small business financing, particularly for start-ups.

The contraction in bank lending has also led to an increased demand for loans from other financial institutions, and many CDFIs and credit union participants noted an increase in small business loan demand over the last two years. However, meeting that demand is a challenge. CDFIs and credit unions have more limited access to capital and underwriting capacity. Credit unions also noted the statutory limitation on the percentage of small business loans they may make (12.25 percent of total assets). At several meetings, CDFI participants described the challenges in becoming authorized to provide loans under the SBA's 7(a) program.

At the Baltimore meeting, *several bankers said that they understand the frustration of small businesses that may be experiencing reduced cash flow during the recession but that had a solid track record before the downturn. They noted, however, that generally they cannot extend credit if there is no recent history of positive cash flow. According to one banker, even if a business has strong collateral, banks do not want to be in the business of taking collateral to recoup loan principal.*

In meetings in Nashville and Tampa, *several participants expressed the view that uncertainty about the duration, availability, and conditions of SBA program enhancements has made banks reluctant to invest the time to adapt to new program requirements.*

Factors Impacting the Demand for Small Business Credit

In addition to highlighting the many constraints to the supply of credit, the stakeholder meetings across the country also identified several ways in which the economic downturn has influenced demand for small business credit. On the one hand, the recession is leading consumers to spend less, which has depressed demand for goods and services. As sales drop, many small businesses are seeing weakened balance sheets and asset values, and a number of small businesses reported that declining sales made them more cautious about seeking credit. Uncertainty about business prospects in the near future further affected their credit and business decisions.

On the other hand, the high-unemployment environment may actually be generating demand as more individuals who are jobless seek to start their own business. Demand for technical assistance and help for new entrepreneurs is particularly high. Several bankers indicated that small businesses need help locating suitable lenders and technical assistance to prepare business plans and loan applications. Participants also noted heightened demand for technical assistance among minority-owned businesses, which may lack strong networks, limiting their access to financial resources, technical assistance, or mentoring.

Existing Credit Gaps

The combination of disruptions on both the supply and demand sides of the small business credit market has resulted in notable credit gaps. Participants pointed to a number of credit gaps, including reduced lines of credit and working capital and the inability to refinance loans (especially related to commercial real estate). Several small business participants cited the need for smaller dollar loans, particularly in amounts under \$200,000. In addition, both banks and small businesses cited the need for sources of patient capital to assist small businesses in financing equipment and other large purchases. Start-up capital is particularly difficult to access. Start-up businesses have always had difficulty obtaining financing, but participants agreed that it is now almost impossible to secure bank credit, despite an increased demand for start-up financing as unemployed workers are looking to start businesses.

Identified Recommendations

At each of the meetings, stakeholders also identified policy and regulatory recommendations that could help to increase the flow of small business credit. Participants expressed the need for continued and consistent dialogue between financial institutions and examination staff and greater clarity of supervisory expectations from regulators. Another suggestion focused on establishing a means through which institutions can report concerns about or appeal an examiner's decision to the regulatory agency through a neutral intermediary such as an ombudsman. Some participants emphasized the need for greater Community Reinvestment Act (CRA) consideration for community development loans and investments such as Equity Equivalent Investments (EQ2s) or program-related investments. They also noted that banks should receive greater consideration for investments and grants that increase access to lending capital, loan-loss reserves, loan packaging, and technical assistance.

In Los Angeles, *meeting participants indicated that Asian Pacific Islander (API) small businesses rely heavily on personal real estate for their financing, and the significant decline in residential property values has led to a reduction in credit and rising delinquencies for API small business loans.*

Participants, particularly banks, expressed strong support for the SBA enhancements that extend fee waivers and increase the guarantee limits for the 504 and 7(a) programs, which were extended this fall. They also emphasized the need for certainty and clear expectations regarding the duration and terms of the enhancements, noting the challenges of adapting to periodic and temporary changes in the programs. There was also general support for more simplification and consistency in SBA regulations, guidelines, and processes to reduce confusion for both lenders and borrowers. Participants recommended improving access for CDFI loan funds to participate as guaranteed lenders in the SBA 7(a) program in order to increase the availability of credit to the underserved markets that CDFIs serve.

Overall, the meetings highlighted many ways in which CDFIs could be strengthened to meet some of the credit gaps, especially for small businesses that may not qualify under conventional bank standards. For example, there was support for more low-cost, longer-term capital for CDFIs. Participants also recommended that banks and CDFIs set up more effective and consistent processes for banks to refer small business applicants whose credit needs they cannot meet to CDFIs.

In St. Louis, a participant stated that demand for technical assistance is up 150 percent at Small Business Development Centers (SBDCs). Some of this demand stems from increased interest in entrepreneurship among recently unemployed or underemployed individuals.

Participants also recommended broader use of lender “second look” or similar programs to help ensure that viable applicants are not overlooked and that decisions such as credit-line reductions are warranted. Both pre- and post-financing technical assistance were identified as critical tools for risk-mitigation, helping to reduce the number of business failures, as well as a way to support business expansion. Additional suggestions focused on increased use of the SBA Service Corps of Retired Executives (SCORE) and other similar business counseling programs as well as initiatives that connect small businesses with each other to facilitate peer mentoring.

Participants noted the need for advisory services to

provide guidance to small businesses on the different types of capital—from equity to debt—that would best match their financial state and funding needs. Some participants noted that the current dialogue about small business finance tends to emphasize debt even in cases where other forms of capital are more appropriate. Participants also noted that the multitude of government, non-profit, and private sector efforts around small business finance should include consideration of the entire capital structure.

Finally, participants expressed the need for timely, meaningful, and accurate data related to small business lending.

Conclusion

Through the small business stakeholder meetings, the Federal Reserve sought to deepen its understanding of the dynamics of the supply of and demand for small business credit, to identify specific credit gaps, and to learn of promising practices and suggestions for improvement. Within the 12th District, the Federal Reserve Bank of San Francisco will continue to convene local meetings to identify ways to overcome barriers to access to credit for small businesses. **CI**

New Community Development Working Paper

The Community Reinvestment Act and Small Business Lending in Low- and Moderate-Income Neighborhoods during the Financial Crisis

By Elizabeth Laderman and Carolina Reid, Federal Reserve Bank of San Francisco



This paper examines trends in small business lending in low- and moderate-income (LMI) neighborhoods by large banks regulated under the Community Reinvestment Act (CRA). Since 2007, small business lending has contracted significantly, particularly in areas that have also seen contractions in the housing sector. The results show significant spillover effects of the mortgage crisis into small business lending—for the economy as a whole as well as for LMI areas in particular. Available online at

<http://www.frbsf.org/publications/community/wpapers/>



Community Perspective: *The Nevada Bankers Collaborative*

By Joselyn Cousins, Bank of Nevada

Nevada bankers know a thing or two about collaboration. Since 2002, bankers in Nevada have been working together to pool resources with the goal of increasing the impact of our community development dollars. It hasn't all been easy: with collaboration comes compromise. You need to be willing to change course and to challenge your long-held beliefs. And it requires patience, lots of patience. But looking back over the past eight years, the things we've been able to accomplish have been worth the challenges, and show what can happen when bankers set aside competition to improve the well-being of lower-income households and communities in their region.

How did it all start? In 2002, a group of bankers came together as the Nevada Individual Development Account (IDA) Collaborative Fund, pooling resources to establish a statewide asset building program and jointly fund an IDA

matched savings program. This was our first success—bringing together 17 diverse financial institutions, all committed to the idea of financial education, savings, and asset building, and all willing to contribute real dollars to the program.

But our success didn't necessarily translate to success on the ground. The IDA program did not have the impact we expected, helping less than a dozen clients. If you have funding for a program, how can it not succeed? We learned the hard way that money isn't everything. Two vital pieces were missing. First, our nonprofit partners were already stretched thin, without the resources or the capacity to manage or develop another program. And second, we did not have enough clients who were in a position to invest the resources necessary to meet their determined goal of homeownership, especially when housing prices in Nevada were skyrocketing out of reach of most lower-income households.

This experience, however, helped to shape what has now become the Nevada Bankers Collaborative, or the “Collaborative,” which consists of Community Development Officers from several small to large sized financial institutions. In partnership with the Community Development Staff of the Federal Reserve Bank of San Francisco and the Office of the Comptroller of the Currency, we worked to reframe our mission and develop initiatives driven by the needs in our community. In other words, we listened to what our partners wanted, and have continued to respond and change course as Nevada’s housing boom turned into a severe foreclosure crisis, and as the communities we work in struggle with the effects of the recession.

So what kind of things have we done? One focus of the Collaborative has been on building the capacity of Nevada’s nonprofit organizations. Our nonprofits did not just need funding, they needed the training and technical assistance to sustain themselves in these trying times. To fill this gap, we hosted intensive training sessions in Southern and Northern Nevada geared to help nonprofits with their strategic planning processes. Earlier this year, we also sponsored a “One Page Business Plan” training for nonprofits in Northern Nevada, which provides nonprofits with a quick and easy tool to develop a business plan that they can use for fundraising. Our plan is to offer a similar training in early 2011 targeting struggling small business owners, and we continue to explore other capacity building and training opportunities.

The second key focus of the Collaborative has been to develop partnerships with other entities—to “practice what we preach” and collaborate across a greater range of stakeholders. Working with HUD’s regional office, we reached out to local jurisdictions to identify ways the Collaborative could help to promote the economic advancement and sustainability of our communities through involvement in neighborhood revitalization.

One of the partnerships to emerge from this initiative has been the Collaborative’s work with the City of North Las Vegas. Together, we identified a target neighborhood for investment and concentrated services. Formerly known as the 40-Block area, the target neighborhood struggled with blight, crime, and limited educational and employment opportunities. Over a two year period, we identified goals for the community—including resident leadership training, summer reading programs for kids, and crime prevention—and engaged additional partners who could help us to achieve these goals. Residents renamed the neighborhood North Valley, reflecting their desire to change their community for the better, and to move away from its identification with gangs and crime.

These meetings laid the groundwork for other activities. With an array of partners, including a large number of city agencies and departments, nonprofits, and the neigh-

borhood residents themselves, we organized financial education and foreclosure prevention workshops, held neighborhood clean-up days, and implemented code enforcement and safety initiatives, all to build a stronger sense of community for the residents. The Nevada Banker’s Collaborative also helped to make some of these projects happen through its collaborative funding. For example, we provided a match grant in partnership with the City of North Las Vegas for a neighborhood physical improvement program to bring 500 older homes up to code by painting the home address on the curb in reflective paint. While this may seem a small fix, the curb painting assists public safety responders to identify home addresses for service calls. The work in the North Valley neighborhood continues and the Collaborative plans to carry on the partnership established with the City of North Las Vegas.

The Collaborative’s work also continues to evolve as we identify new needs and opportunities in Nevada. A lot of our attention over the past two years has been on foreclosure prevention, and we have co-sponsored and participated in borrower outreach fairs where struggling homeowners can meet in person with a bank representative or housing counselor. Neighborhood stabilization is also an important part of this work, and we’ve provided funding in Sparks and Reno for neighborhood improvement and rehabilitation projects. Recognizing that a stabilized community involves more than just building rehab, we also recently provided funding for school and community based health centers that provide services in at-risk neighborhoods. This gave us the opportunity to work with a new range of community partners, including the City of Las Vegas Neighborhood Services Department, University of Nevada School of Medicine – Pediatrics Department, Clark County School District Community Partnership Office, and Nevada Youth Alliance, just to name a few.

Through all these projects, and through the countless hours spent learning about the neighborhoods we work in, thinking about the challenges confronting low-income families, and brainstorming with partners about potential solutions, the Collaborative has become a new model for how banks can work together. We’re proud of our achievements, although we recognize that there’s much more work to be done. Nevada’s community and economic environment continues to change, and as we embark on our own strategic planning process for 2011, we’re not sure yet what comes next. But we know that we will continue our community development efforts through collaboration, since in the end, it’s what allows us to do our best work in the community.

Joselyn Cousins is Senior Vice President and Community Development Manager at Bank of Nevada, headquartered in Las Vegas, NV. 

DOCTOR CRA

by John Olson



Dear Dr. CRA:

As an avid reader of the Federal Register, I noticed that there were some changes to the CRA regulations in the October 4, 2010 issue (Vol. 75, No. 191). Can you help me make sense of these new changes and give me the bottom line?

Sincerely,
Need Exciting Reading Docket

Dear NERD,

Of course! The good doctor is also an avid reader of the Federal Register, particularly on nights when he can't fall asleep. The October 4, 2010 changes you're referring to dealt with two separate legislative changes that impacted the CRA rules. These changes were originally proposed in a June 30, 2009 notice of proposed rulemaking, and the regulatory agencies took public comment on the proposal. The October 4th document is a final rule, so it is officially part of the CRA regulations going forward. These changes added two new paragraphs to the section of the regulation that describes the performance standards used by the agencies in conducting CRA examinations.

The first change deals with student loans. The new rule states that the agencies will consider certain student loans in their evaluation of a bank's performance in

meeting community credit needs. As usual, the devil is in the details. The agencies will consider low-cost education loans, particularly in the bank's assessment area, to borrowers who have an income that is less than 50 percent of the area median income. In this context, "low-cost education loan" means a loan to a student at an institution of higher learning with interest rates and fees no greater than those of comparable education loans offered directly by the U.S. Department of Education.

The second change addresses collaboration with minority-owned financial institutions, women-owned financial institutions, and low-income credit unions. The new rule states that the agencies will consider capital investment, loan participation, and "other ventures" undertaken by the bank in partnership with any institution in one of these categories. These activities must help meet the credit needs of the local community in which the minority- or women-owned institution or low-income credit union is chartered. The activity need not be located in the investing bank's assessment area or even in the broader region that contains the bank's assessment area.

There's your bottom line! If you want to dig into the details, you can find the Federal Register Notice online by searching the 2010 volume for "Page 61035" (in quotes) at www.gpoaccess.gov/fr/. And as always, be sure to check in with your own regulator if you have questions about how any particular transaction will be evaluated.



RESEARCH BRIEFS

Negative Equity and Residential Mobility

The housing bust that began in 2006 reversed much of the price appreciation that occurred during the earlier part of the decade. Rising interest rates and falling house prices often raise concerns about negative equity and the possibility of “strategic defaults,” where homeowners choose to foreclose on their homes because of a loss in equity. But to what extent do rising interest rates and negative equity impact residential mobility?

Using two decades of American Housing Survey data from 1985 to 2007, Fernando Ferreira, Joseph Gyourko, and Joseph Tracy find that that negative equity and rising interest rates serve to ‘lock-in’ owners to their homes—reducing, not raising mobility. The authors control for characteristics such as family size, educational attainment, marital status and family income. They find that having negative equity reduces the two-year mobility rate by four percentage points, a one-third reduction from the baseline mobility rate. Observing the effects of different levels of negative equity, the results suggest that mobility declines are larger when negative equity is higher. Additionally, higher monthly interest costs also reduce mobility; a \$1,000 higher real annual mortgage interest cost is estimated to reduce mobility by 1.4 percentage points, or by about 12 percent of the baseline rate. Lower residential mobility has important implications for the labor market as households may not be able to move to access jobs, a particular concern given present employment conditions.

The authors warn that the results cannot simply be extrapolated into the future, but the findings do have implications for the recent concerns around the housing bust and the potential impact of negative equity on household well-being.

Ferreira, Fernando, Joseph Gyourko, and Joseph Tracy. (2010). Housing busts and household mobility. *Journal of Urban Economics*. July 2010. 68(1): 34–45.

The Education of Children Living in Public Housing

Most public housing developments in the U.S. are located in socially and economically disadvantaged neighborhoods, often with high concentrations of poverty and large shares of minority residents. Previous research has demonstrated that children growing up in these developments tend to have worse social and economic outcomes later in life, including poorer health and lower educational attainment. However, relatively little is known about the characteristics of the schools serving these children.

Amy Ellen Schwartz, Brian J. McCabe, Ingrid Gould Ellen, and Colin C. Chellman use data from the New York City Department of Education and the New York City Housing Authority to examine the characteristics of elementary and middle schools attended by students living in public housing developments in New York City. They find no large differences between the resources and teacher characteristics at the schools attended by students living in public housing and the schools attended by their peers living elsewhere in the city. Per-pupil expenditures at the typical school attended by students living in public housing are approximately 12 percent greater than expenditures at other schools. However, students living in public housing perform substantially worse on standardized math and reading exams than their peers living in other neighborhoods. In fact, students living in public housing earn lower scores on standardized tests, on average, than their schoolmates who attend the very same school but live outside of public housing.

This research suggests that the causes of the educational achievement gap that exists for students living in public housing go well beyond matters of school funding. The authors suggest that researchers and policy makers should continue to examine the community environments experienced by children and families living in public housing to identify factors outside of local schools that help to shape the observed performance gap.

Schwartz, Amy Ellen, Brian J. McCabe, Ingrid Gould Ellen and Colin C. Chellman. (2010). Public Schools, Public Housing: The Education of Children Living in Public Housing. *Urban Affairs Review*. September 2010. 46(1): 68-89.

Can Financial Education Change Savings, Investment, and Consumer Behavior?

Financial education for youth takes many different forms, and it's still not clear which delivery mechanisms and approaches work best. For example, some proponents favor better base education at an early age while others stress "just in time" education around specific financial decisions. But can financial education change financial behaviors?

Using a quasi-experimental approach, Bruce Ian Carlin and David T. Robinson studied the impact of Junior Achievement's Finance Park (FP) program on youth financial decision making. The FP program typically begins with classroom based personal financial management training, followed by active participation in a simulation in which students are assigned fictitious life situations and asked to create household budgets for these roles. Carlin and Robinson compared FP simulation performance among students that received classroom training versus those that did not receive classroom training. They found that students who received financial literacy training were 35 percent more likely than their untrained peers to successfully complete the budget balancing exercise. Students that received financial education were also more likely to make choices that are consistent with delaying immediate gratification in favor of investing in longer-term outcomes. Another finding was the impact of financial education on the utilization of financial advice; students who had attended financial training were significantly more likely to act on "just in time" decision support that was offered during the simulation. The authors suggest that this finding indicates that decision support and financial literacy training are complements, not substitutes.

While we still don't know which programs and delivery strategies are most effective, these findings suggest that financial education can lay a foundation for supporting consumers in financial decision making. Further research is required to better understand the interaction between financial education and timely decision support.

Carlin, Bruce Ian and David T. Robinson. What Does Financial Literacy Training Teach Us? *NBER Working Paper Series*. Working Paper 16271. <http://www.nber.org/papers/w16271>.

Childhood Neighborhood Conditions and Adult Health Outcomes

Research has demonstrated that the neighborhood in which you live can have a profound impact on your health. Residents of neighborhoods with high concentrations of poverty tend to have significantly worse health outcomes than residents of more affluent neighborhoods, signaling the importance of "place." However, research has tended to focus on the effect of neighborhood factors on adolescents; the timing of these effects across the life-span is less well understood. What are the long term impacts of childhood neighborhood conditions on health outcomes in later life?

Using 38 years of longitudinal data from the Panel Study of Income Dynamics (PSID), Thomas Vartanian and Linda Houser examined how neighborhood conditions experienced in childhood, as well as adulthood, affect self-reported indicators of adult health. Not surprisingly, they find positive long-term health effects for growing up in affluent neighborhoods. However, they also find that those who grow up with low incomes relative to their neighbors report better overall health as adults, suggesting that growing up surrounded by comparative advantage may allow children to utilize neighborhood resources to their benefit. However, once they reach adulthood, the effects of being "relatively deprived" are reversed; relative inequality appears to have negative health impacts. Additionally, Vartanian and Houser find some evidence that the relationships between childhood neighborhood conditions and adult health are stronger for nonwhites than for whites.

This research offers evidence that growing up in a disadvantaged neighborhood hurts the long-term health outcomes of children, particularly nonwhite children. The authors suggest that further research should be done to better understand how neighborhood factors affect long-run health outcomes in order to direct policies and resources to critical issues of health and well-being.

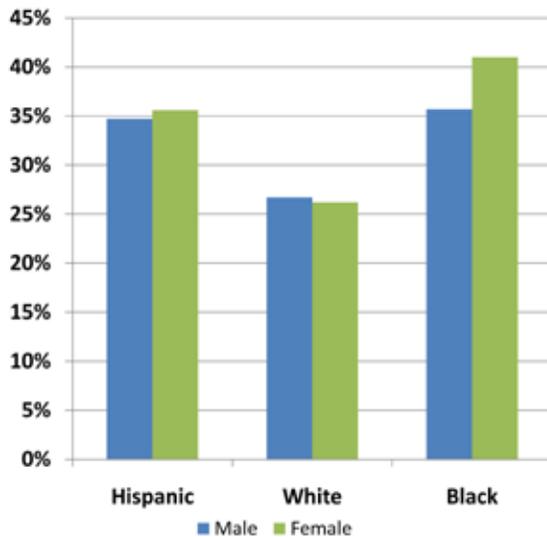
Vartanian, Thomas P. and Linda Houser. (2010). The Effects of Childhood Neighborhood Conditions on Self-reports of Adult Health. *Journal of Health and Social Behavior*. September 2010. 51(3): 291-306.

DATA SNAPSHOT

Health and Community Development

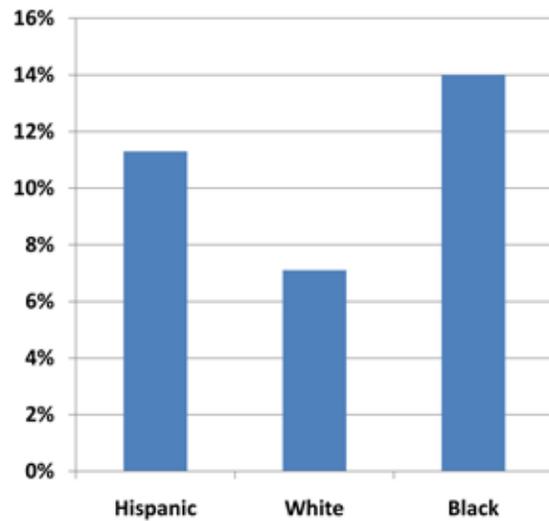
Socioeconomic and demographic factors, such as income and race, play an important role in determining health outcomes and access to care.

**Obesity among Adults by Sex and Race
United States, January – March 2010**



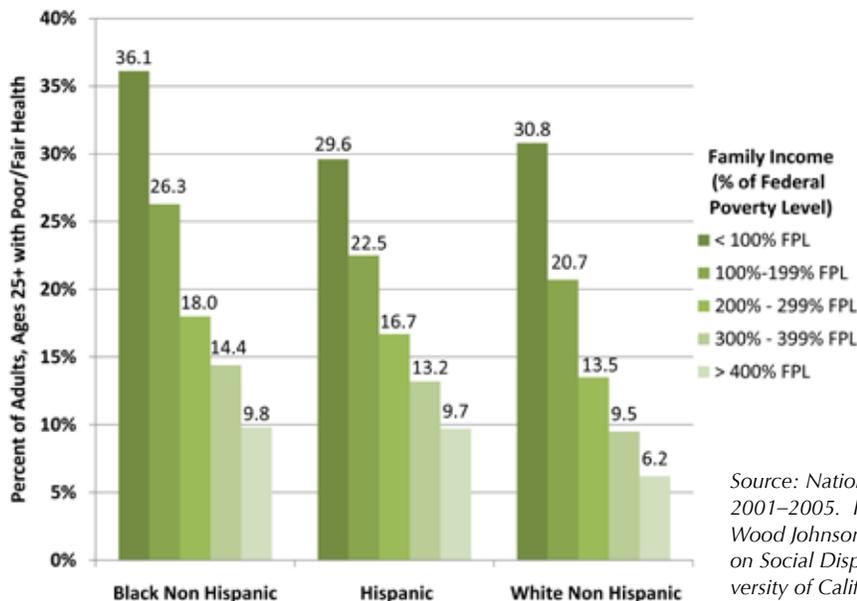
Source: CDC/NCHS, National Health Interview Survey, January-March 2010.

**Diagnosed Diabetes among Adults by Race
United States, January – March, 2010**



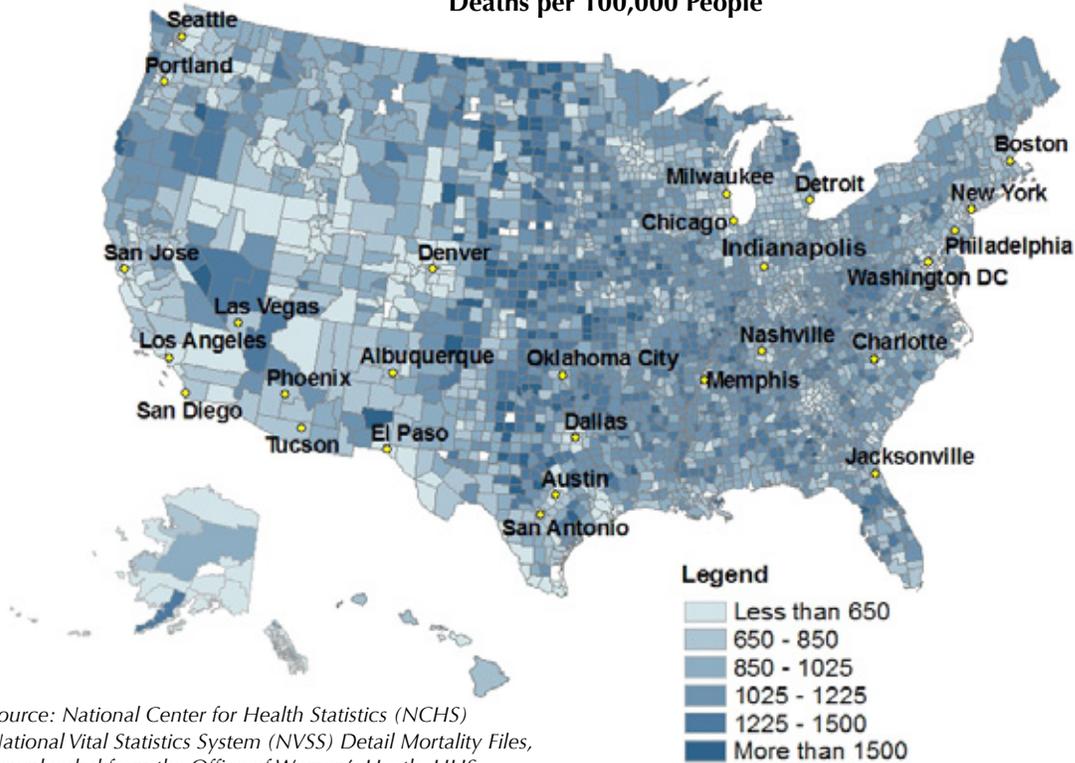
Source: CDC/NCHS, National Health Interview Survey, January-March 2010.

Income Is Linked With Health Regardless of Racial or Ethnic Group



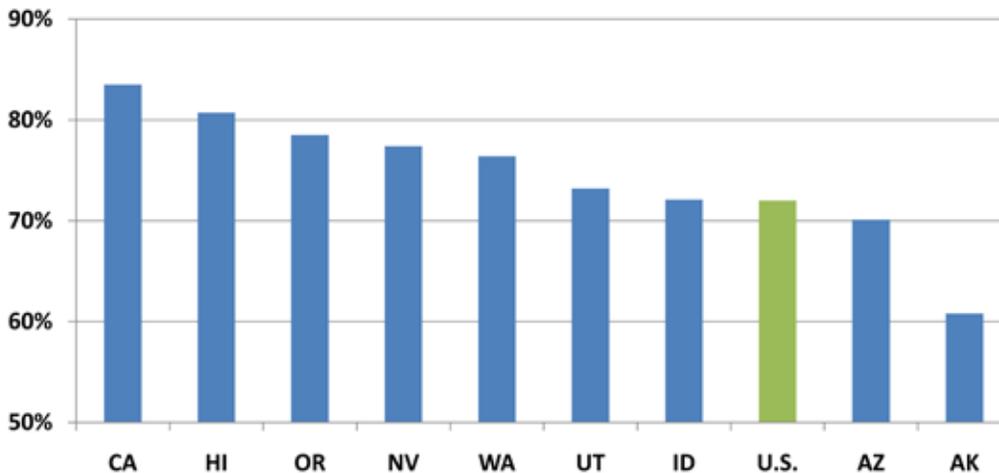
Source: National Health Interview Survey, 2001–2005. Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.

**Total Death Rate by County (2006)
Deaths per 100,000 People**



Source: National Center for Health Statistics (NCHS) National Vital Statistics System (NVSS) Detail Mortality Files, downloaded from the Office of Women's Health, HHS.

**Percent of Census Tracts with Healthy Food Retailers within
1/2 mile – 12th District States**



Source: Centers for Disease Control and Prevention, State Indicator Report on Fruits and Vegetables, 2009.

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Banking Conditions in the 12th District: Has the Recovery Taken Hold?

1. For regulatory purposes, capital is divided into two segments, Tier 1 (core capital) and Tier 2 (supplemental capital). Tier 1 (or core capital) includes: common equity, surplus, and undivided profits (retained earnings); qualifying non perpetual preferred stock; and minority interest in the equity accounts of consolidated subsidiaries; less any amounts of goodwill, other intangible assets, interest only strip receivables and non financial equity investments that are required to be deducted, and unrealized losses on Available for Sale investment equity portfolio, as well as any investments in subsidiaries that the Federal Reserve determines should be deducted from Tier 1 capital. Tier 2 capital consists of a limited amount of the allowance for loan and lease losses; perpetual preferred stock that does not qualify for inclusion in Tier 1 capital; certain other hybrid capital instruments; mandatory convertible securities; long-term preferred stock with an original term of 20 years or more; and limited amounts of term subordinated debt, intermediate term preferred stock, including related surplus, and unrealized holding gains on qualifying equity securities.

Addressing the Financing Needs of Small Businesses

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2. Chairman Bernanke addressed the challenges facing small businesses, and the Federal Reserve's response, in his Semiannual Monetary Policy Report to the Congress on July 21, 2010, available at <http://www.federalreserve.gov/newsevents/testimony/bernanke20100721a.htm>



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