

# Community Development INVESTMENT REVIEW

[www.frbsf.org/cdinvestments](http://www.frbsf.org/cdinvestments)

FEDERAL RESERVE BANK OF SAN FRANCISCO

## Articles

The Importance of Community Development for Health and Well-Being

*S. Leonard Syme and Miranda L. Ritterman*

*School of Public Health, University of California, Berkeley*

Prescription for Healthy Communities: Community Development Finance

*Lisa Richter, GPS Capital Partners, LLC*

Coming Out as a Human Capitalist:

Community Development at the Nexus of People and Place

*Nancy O. Andrews with Christopher Kramer, Low Income Investment Fund*

Community Health Centers: A Vital Strategy for Community Development

*Scott Spote and Annie Donovan, NCB Capital Impact*

Building Healthy Communities Through Equitable Food Access

*Judith Bell, PolicyLink and Marion Standish, The California Endowment*

The Disability Housing Market: Opportunity for Community Development Finance as the Americans with Disabilities Act Turns 20

*Charles D. Hammerman, The Disability Opportunity Fund*

*and Samantha Bennett, Center for Wealth Preservation*

The Small Business Perspective on Health-Care Reform

*Allison Kelly and Kirsten Snow Spalding, Pacific Community Ventures*

The Cash Market in Health Care: A Community-Based Approach

*Joy Anderson and Andrew Greenblatt, Criterion Ventures*

## Commentary

Financial Stress and Its Physical Effects on Individuals and Communities

*Laura Choi, Federal Reserve Bank of San Francisco*

The Relevance of Health Reform to Community Health and Development

*Peter Long, Henry J. Kaiser Family Foundation,*

*and Neal Halfon, University of California, Los Angeles*



## Community Development INVESTMENT REVIEW

The Community Affairs Department of the Federal Reserve Bank of San Francisco created the Center for Community Development Investments to research and disseminate best practices in providing capital to low- and moderate-income communities. Part of this mission is accomplished by publishing the *Community Development Investment Review*. The *Review* brings together experts to write about various community development investment topics including:

**Finance**—new tools, techniques, or approaches that increase the volume, lower the cost, lower the risk, or in any way make investments in low-income communities more attractive;

**Collaborations**—ways in which different groups can pool resources and expertise to address the capital needs of low-income communities;

**Public Policy**—analysis of how government and public policy influence community development finance options;

**Best Practices**—showcase innovative projects, people, or institutions that are improving the investment opportunities in low-income areas.

The goal of the *Review* is to bridge the gap between theory and practice and to enlist as many viewpoints as possible—government, nonprofits, financial institutions, and beneficiaries. As a leading economist in the community development field describes it, the *Review* provides “ideas for people who get things done.” For submission guidelines and themes of upcoming issues, visit our website: [www.frbsf.org/cdinvestments](http://www.frbsf.org/cdinvestments). You may also contact David Erickson, Federal Reserve Bank of San Francisco, 101 Market Street, Mailstop 215, San Francisco, California, 94105-1530. (415) 974-3467, [David.Erickson@sf.frb.org](mailto:David.Erickson@sf.frb.org).

Center for Community Development Investments  
Federal Reserve Bank of San Francisco  
[www.frbsf.org/cdinvestments](http://www.frbsf.org/cdinvestments)

### Center Staff

**Joy Hoffmann**, FRBSF Group Vice President

**Scott Turner**, Vice President

**John Olson**, Senior Advisor

**David Erickson**, Center Manager

**Ian Galloway**, Investment Associate

### Advisory Committee

**Frank Altman**, Community Reinvestment Fund

**Jim Carr**, National Community Reinvestment Coalition

**Prabal Chakrabarti**, Federal Reserve Bank of Boston

**Catherine Dolan**, Wells Fargo Bank

**Andrew Kelman**, Bank of America Securities

**Judd Levy**, New York State Housing Finance Agency

**John Moon**, Federal Reserve Board of Governors

**Kirsten Moy**, Aspen Institute

**Mark Pinsky**, Opportunity Finance Network

**John Quigley**, University of California, Berkeley

**Benson Roberts**, LISC

**Clifford Rosenthal**, National Federation of Community Development Credit Unions

**Ruth Salzman**, Russell Berrie Foundation

**Ellen Seidman**, ShoreBank Corporation and  
New America Foundation

**Bob Taylor**, Wells Fargo CDC

**Kerwin Tesdell**, Community Development Venture  
Capital Alliance



# Table of Contents

## Articles

The Importance of Community Development for Health and Well-Being .....	1
<i>S. Leonard Syme and Miranda L. Ritterman</i> <i>School of Public Health, University of California, Berkeley</i>	
Prescription for Healthy Communities: Community Development Finance .....	14
<i>Lisa Richter, GPS Capital Partners, LLC</i>	
Coming Out as a Human Capitalist: Community Development at the Nexus of People and Place .....	47
<i>Nancy O. Andrews with Christopher Kramer, Low Income Investment Fund</i>	
Community Health Centers: A Vital Strategy for Community Development.....	66
<i>Scott Sparte and Annie Donovan, NCB Capital Impact</i>	
Building Healthy Communities Through Equitable Food Access .....	75
<i>Judith Bell, PolicyLink and Marion Standish, The California Endowment</i>	
The Disability Housing Market: Opportunity for Community Development Finance as the Americans with Disabilities Act Turns 20.....	88
<i>Charles D. Hammerman, The Disability Opportunity Fund</i> <i>and Samantha Bennett, Center for Wealth Preservation</i>	
The Small Business Perspective on Health-Care Reform .....	97
<i>Allison Kelly and Kirsten Snow Spalding, Pacific Community Ventures</i>	
The Cash Market in Health Care: A Community-Based Approach .....	104
<i>Joy Anderson and Andrew Greenblatt, Criterion Ventures</i>	

## Commentary

Financial Stress and Its Physical Effects on Individuals and Communities .....	120
<i>Laura Choi, Federal Reserve Bank of San Francisco</i>	
The Relevance of Health Reform to Community Health and Development .....	123
<i>Peter Long, Henry J. Kaiser Family Foundation,</i> <i>and Neal Halfon, University of California, Los Angeles</i>	

# Foreword

David J. Erickson  
*Federal Reserve Bank of San Francisco*

*December 2009*

**C**an community development finance help “bend the cost curve” for health care? That is one of the questions motivating this issue of the Review. In light of the insights and research from the authors in this volume, the answer is a resounding yes. The reality is that people who live in supportive, connected, and economically-thriving communities tend to be healthier. Therefore, perhaps the most important contribution that community development finance provides – more than the affordable apartments, more than the startup capital for small businesses, more than the funding for a grocery store, charter school, or day care center – is the larger contribution of a more vibrant and healthier community. In the end, 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.

Cost savings, of course, are welcome but it is also interesting to note the increasing interest in the health community on issues that are referred to as the “social determinants of health.” In this area, community development can play an important role. In fact, S. Leonard Syme, considered by many to be the modern father of social epidemiology, and his co-author Miranda Ritterman (both from UC Berkeley) put the issue to us bluntly in the first line of their article: “Few topics are more important to health than community development.” Syme and Ritterman’s article on the social environment’s role in “getting under our skin” explains how our surroundings and circumstances can have a positive or negative effect on our health at the cellular level. Their article, and others in this volume of the *Review*, point to new directions on how community development finance can help promote health by minimizing the negative social and economic circumstances that contribute to poor health.

Syme and Ritterman’s essay is followed by two big-picture articles, one by Lisa Richter and the other by Nancy Andrews and Christopher Kramer. Richter (GPS Capital Partners) provides a sweeping overview of the connections and potential synergies that are possible thanks to recent innovations in the worlds of both community development and health. Andrews and Kramer (Low Income Investment Fund) explore how their CDFI has incorporated some of the new research in health into its finance strategies in order to be a more effective player in community revitalization and a more successful agent for reducing poverty.

Scott Sporte and Annie Donovan (NCB Capital Impact) write about state-of-the-art financing strategies for community health centers. These centers have the double benefit of increasing access to health care in a low-income community while also serving as anchor institutions that can revitalize the area and provide well paying jobs. Judith Bell

(PolicyLink) and Marion Standish (California Endowment) write about the problem of “food deserts” where there is little or no access to fresh high-quality food because there are no stores or markets to serve the community. They offer a number of ideas and innovative new strategies to finance fresh food options in low-income communities.

Writing about the VidaCard, Allison Kelly and Kirsten Snow Spalding (Pacific Community Ventures) explain the problems small businesses face in providing health care to their workers and describe an innovative product that offers a new way to do that inexpensively and effectively. In a similar vein, Joy Anderson and Andrew Greenblatt (Criterion Ventures) tackle the larger problem of the cash market for health care – a market they argue is ripe for reorganization and rationalization that would ultimately help low-income individuals disproportionately affected by a medical market that favors large institutional players (usually insurance companies) over individuals paying cash.

Finally, we have two commentary articles: one by Laura Choi (Federal Reserve Bank of San Francisco) that argues that good financial health can lead to good physical health. And an article by Peter Long (Henry J. Kaiser Family Foundation) and Neal Halfon (UCLA) that covers elements of the health reform bill moving through Congress and opines on the effects it will have on community development.

A handwritten signature in black ink, reading "David Eickman". The signature is written in a cursive style with a large, stylized initial "D".



# The Importance of Community Development For Health and Well-Being

*S. Leonard Syme and Miranda L. Ritterman*

*School of Public Health*

*University of California, Berkeley*

## **A New Perspective On Health Promotion And Disease Prevention**

Few topics are more important to health than community development. At first, this assertion seems a wild exaggeration when considered in relation to other important contributors to health, such as high-quality medical care, healthy behavior, and good genetic stock. However, substantial evidence reveals that environmental and community forces also are important determinants of health. This observation is critical for those involved in the development of affordable housing and enhanced community facilities for people living in low-income neighborhoods. The evidence 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.

The French sociologist Emile Durkheim in 1897 conducted one of the earliest, and now classic, studies on the importance of the role that community social forces play in the health of the individual (Durkheim, 1951). In his work on suicide, Durkheim noted that, in conventional thinking, the causes of suicide must be found within the individual: a person's personal demons, failures, aspirations, and dashed hopes. Yet Durkheim noted that suicide rates were dramatically higher among certain groups and communities and that these differences persisted over time even as individuals entered and left those communities. To explain this difference among group rates, Durkheim argued that convention falters and one must refer to community factors. He reasoned that if different groups have different suicide rates, something about the social organization of the groups may play a role in encouraging or deterring individuals from committing suicide. This social force would not explain why particular individuals committed suicide, but it would explain why suicide rates were higher or lower in certain groups. Durkheim's research led him to conclude that the major factor affecting suicide rates was the degree of social integration of groups. Today we use terms such as "social capital" to refer to this concept that Durkheim introduced over a hundred years ago.

Many years later, another classic study led to the same conclusion. In that study, Haan, Kaplan, and Camacho showed that people living in a federally designated poverty area in

Alameda County, California, experienced higher age-, race-, and sex-adjusted mortality rates over a nine-year follow-up period compared to people living in a nonpoverty area (Haan, Kaplan, & Camacho, 1987). That finding in itself was not surprising. What was surprising is that these differences in mortality rates persisted even after considering a wide range of demographic, behavioral, social, psychological, medical insurance, and other health characteristics. Haan and colleagues concluded that qualities of the social environment contributed to higher or lower mortality rates independently of individual factors. These findings, generated in 1987, have held fast nationally since then (Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Kennedy, Kawachi, & Prothrow-Stith, 1996; Lynch, Smith, Kaplan, & House, 2000).

The issue of medical care deserves to be considered in more detail in light of current debates concerning community development and health. Many people feel that the major inequities we observe in health among different groups in our society could be substantially reduced if everyone had equal access to good-quality, affordable medical care. It is difficult to challenge this seemingly obvious contention. Nevertheless, the distinguished scholar Thomas McKeown did just that. He wrote an influential book in 1976 showing that the dramatic decline since 1900 in overall mortality in both Britain and the United States could not be explained by the introduction and use of medical interventions (McKeown, 1976). Indeed, he said, many medical measures against disease (both chemotherapeutic and prophylactic) were introduced several decades after a marked decline in mortality from those diseases had already occurred. In the following year, McKinlay and McKinlay wrote a paper citing five diseases that indeed did benefit from medical intervention: influenza, pneumonia, diphtheria, whooping cough, and poliomyelitis (McKinlay & McKinlay, 1977). They noted, however, that even if the entire decline in these diseases was attributable to medical measures, at best they accounted for only 3.5 percent of the total decline in mortality. In assessing these statistics, McKeown argued that most of the decline in mortality since the second half of the nineteenth century was due to improvements in hygiene and to rising standards of living, especially improved nutrition (McKeown, 1979). Since many of the diseases were primarily infectious in origin, he argued that altering environmental conditions could have an important impact on the occurrence of these diseases.

With the decline of many infectious diseases today, noninfectious diseases such as heart disease, cancer, and diabetes have become the major source of morbidity and mortality in our society. It is easy to think of environmental conditions as being more important than medical care in the production of many infectious diseases, but it is not as easy to think of noninfectious diseases in the same way. We tend to think of noninfectious diseases as caused by personal behavior choices and therefore think that good-quality individual medical care is more important than some generalized environmental intervention in the prevention and treatment of these diseases.

This individual medical-care approach to disease prevention shaped the health policies of the British government at the end of World War II. At the time, there was widespread acknowledgment that major health inequalities existed in Great Britain and the govern-



ment made a commitment to reduce these differences by providing first-rate medical care to everyone regardless of ability to pay. The National Health Service (NHS) was an ambitious and expensive program designed specifically to reduce these inequalities in health. In 1980, 32 years after the NHS was organized, an expert committee chaired by Sir Douglas Black found that providing good medical care to everyone, free of cost, had improved the overall health of the country in terms of improved mortality rates. But it also found that providing such care had no effect at all on widespread health inequalities. The committee concluded instead that the main cause of these inequalities was poverty, and that to tackle these inequalities the gap between persons in the upper class and lower class would need to be narrowed. In 1998, 50 years after the establishment of the NHS, another committee, this one chaired by Sir Donald Acheson, concurred with this finding (Acheson, 1998). Canada had reached the same conclusion (Evans, Barer, & Marmor, 1994). Medical care is obviously important for all of us, but it will not solve inequalities in health.

This point was emphasized in the Report of the World Health Organization Commission on Social Determinants of Health, which was published in 2008 (World Health Organization, 2008). In 2009, Secretary General Ban-Ki Moon summarized one of the major findings from this report in his address to the UN Economic and Social Council:

Deep inequities in health outcomes—the unfair and avoidable differences in health status seen within and between countries—persist. For example, differences in life expectancy between the richest and poorest countries exceed 40 years. The lifetime risk of maternal death in Ireland is 1 in 47,600; in Afghanistan it is 1 in 8. Even within a given country, inequities can be great. Maternal mortality is three to four times higher among the poor compared to the rich in Indonesia. Although some of the inequities in health outcomes are due to differences in access to health services, the majority is attributable to the conditions in which people are born, grow, live, work, and age. In turn, poor and unequal living conditions are largely the result of poor social policies and programs, unfair economic arrangements, and politics driven by narrow interests.

Secretary General Moon's emphasis on governmental policies, economic, structural, and institutional arrangements, and narrow political interests highlights one of the main deficiencies in the current public health model. The model that dominates most public health work today first identifies the risk factors of a disease and then develops interventions to reduce them. There are three problems with this model. First, we have not done a good job in identifying disease risk factors and it is doubtful that more and better-designed research will improve this situation. An entirely new approach is needed. Heart disease provides a clear case of the problem we face. Coronary heart disease is the number-one cause of death in the United States and rigorous research has been done for over 50 years to identify the risk

factors involved (Kaplan & Keil, 1993; Nieto, 1999; Syme, 1996). Many of the risk factors have now been identified, including cigarette smoking (Samet, 1990), high lipid levels (Gordon et al., 1989), hypertension (MacMahon et al., 1990), obesity (Hubert, Feinleib, McNamara, & Castelli, 1983), physical inactivity (Jennings et al., 1986), and diabetes (Stamler, Vaccaro, Neaton, & Wentworth, 1993). Taken together, all the risk factors that have been identified account for less than half of the heart disease that occurs in the United States (Chang, Hahn, Teutsch, & Hutwagner, 2001).

While the risk factors that have been identified obviously are important, it is disappointing, and surprising, that they do not explain 50 percent of disease that does occur. It is unlikely that important risk factors have been missed because they would have to be very powerful indeed to account for this other 50 percent. The problem we see for coronary heart disease is similar to the problems we have for many other diseases as well.

The second problem with the model is that even when disease risk factors are identified, it is often difficult to get people to change their behaviors to lower their risk. Many excellent intervention studies have been done with high-risk individuals to help them lower their risk and these studies, almost without exception, have failed to accomplish their goal (Minkler, 1999). A few years ago, one of us chaired a committee at the Institute of Medicine of the U.S. National Academy of Science to examine the success of our intervention programs. The 500-page report concluded that while some people do follow our advice, overwhelmingly most do not. This is especially disappointing because while some individuals do not do well in our intervention programs, many make these changes on their own without our help.

One reason for our failure is that public health workers are determined to focus on problems that interest them as researchers and not on the problems of concern to individuals. An illustration of this difficulty is provided by a smoking cessation project we directed in the city of Richmond, California, a few miles north of Berkeley. The project was intended to change the way smoking was perceived in Richmond. It was designed as a community project in which every neighborhood would have a block captain. We would also involve the business community, the schools, and community groups. Our intent was to change the climate in Richmond with regard to smoking and to challenge public attitudes toward the acceptance and attractiveness of smoking.

We obtained a substantial grant for this project from the National Cancer Institute after it did a lengthy and detailed project site visit. The conclusion of the review committee was that the proposed design and research team met the most rigorous and demanding standards of excellence. The project that was subsequently implemented was executed in an exemplary manner for five years. At the end of the five years, we compared the results we achieved in smoking cessation in Richmond to the results observed in our two comparison communities: Oakland and San Francisco. To our dismay, we observed no differences in smoking cessation rates.

This failure is not unique. Most intervention projects of this kind have failed to achieve intended results. Naively, we thought we had done a better job than others. On reflection,

we came to the following conclusions: Richmond is a poor city with high rates of unemployment, crime, and drug use. It also has heavy levels of air pollution from nearby oil refineries. At the time, there were few health facilities. And our research team descended on this troubled community with a brilliant plan to do a smoking cessation project! It is doubtful that smoking was high on the priority list of people in this community, but our team paid little attention to that. Even if we had asked the citizens of Richmond about their priorities, it is unlikely that we would have taken them seriously because, after all, we at the university were the experts.

The general problem we face is that specialists in such fields as health, city planning, and finance have a solid level of expertise to share with people regarding their life situation. We have well-researched messages to convey. But people have lives to lead and have concerns that may or may not be in accord with those imagined by the experts. A wide gap often exists between our expertise and the concerns of the communities or groups that we target.

The third problem with the current model is the most challenging. Even if many individuals were successful in changing their behavior to lower their disease risk, new people would continue to enter the at-risk population at an unaffected rate because we have not dealt with the fundamental social forces in the community that caused the problem in the first place. Our current model is firmly focused on individuals. We continue to study individuals and their diseases and their risk factors even though it is clear that their problems are for the most part a consequence of these larger environmental, community, and social forces.

Even in the face of these fundamental and overriding social forces, it remains difficult to convince researchers about their importance. We emphasize this point in an introductory class we give in the Graduate School of Public Health at Berkeley. We tell students a fictitious story about a curvy road in the mountains where, at one point, cars fall off a cliff at a high rate. The cars crashing at the bottom of the mountain cause severe physical injuries. The head and spinal-cord injuries that occur are serious and require skilled medical attention. Unfortunately, the medical care at the bottom of the mountain is rudimentary and not appropriate for the degree of care that is needed. Thus, the injured must be transported long distances by helicopter or ambulance to get help.

We then propose that a state-of-the-art health promotion and injury prevention program be developed for this road. First, a hazard assessment and barrier program will be developed that will prohibit certain groups from driving on this road. Certain elderly or people with vision and physical problems will be directed to an alternative road. Those drivers who are permitted to proceed will have to submit to a behavioral intervention: a safe-driving course. In addition, an environmental intervention will be developed: car manufacturers will be required to reinforce and strengthen cars before they can use the road. Finally, a state-of-the-art medical facility will be built at the bottom of the cliff. This new facility will have a top-notch medical staff of neurosurgeons, orthopedists, and other specialists. In our model, all economic barriers for care will be removed so that everyone has universal access and everyone will receive culturally appropriate medical treatment with language translation

help when necessary. In short, everything will be done that is now being recommended in first-rate health promotion and disease prevention programs.

One student in the class will eventually raise his or her hand and quietly ask, “How about fixing the road?” That student is then attacked by the professor, who responds by asking how they can permit the diversion of funds from critically injured and bleeding people to do a highway construction project. Eventually, another student will tentatively suggest that if we do not accomplish the highway work, people will continue to fall off the road. Everyone in the class eventually agrees that a truly effective health promotion program must take account of the fundamental forces that caused the problem in the first place: fix the road. This hard-won resolution is difficult to achieve because our attention is inevitably drawn to the injured individuals and it is difficult to talk about some vague prevention programs that will be of potential value in the future.

Prevention is a difficult concept to deal with when we are confronted with sick and dying people. Focusing on the environment is challenging when the presumptive causes of illness seem immediately apparent (cigarette smoking, obesity, physical inactivity), while environmental causes may lie below our threshold of perception and may seem remote and less urgent. It may be difficult to think seriously about environmental forces, but we really have no choice if our goal is to improve the health of communities and the nation.

It is all well and good to suggest that researchers pay attention to prevention in the context of environmental, community, and social forces, but it is not as easy to specify what precisely it is about these forces that can be intervened upon to make a difference for health. To this point, we have not even attempted to define these terms. In using these terms, we have attempted to emphasize a perspective that contrasts with the dominant approach now used in the health field, an approach focused almost exclusively on the individual. Our use of these terms is intended to describe many different conditions and influences under which any person or living thing grows and develops. These terms have been used to describe many phenomena, including the air we breathe, the water we drink, the geographic regions and buildings in which we live, the groups to which we belong, and the climatic conditions that we experience. While one can distinguish between the human-made environment, the natural environment, and the social and cultural environment, none of these aspects exists independently of the others. The environment is the result of the continuing interaction between natural and human-made spatial forms, social processes, and the relationships between individuals and groups. In spite of the fact that we are dealing with a complex and interconnected set of influences, it nevertheless would be useful to provide at least one example of what could be accomplished by focusing on the environment.

## **Developing A Model Focused On Environments**

Research on the link between social class and health provides a convenient example for a new model. Since the beginning of recorded history, individuals in a low social-class position have higher rates of virtually every health condition that we know about (Antonovsky, 1967;

Haan, Kaplan, & Syme, 1989; Marmot, Shipley, & Rose, 1984; Marmot et al., 1991). This observation holds whether one classifies individuals in terms of income, wealth, occupation, prestige, residence, or education (Adler et al., 1994). This observation is also seen whether or not one relies on objective or self-reports of social-class position (Singh-Manoux, Adler, & Marmot, 2003; Singh-Manoux, Marmot, & Adler, 2005). More relevant for the purposes of this paper, there is a patterned regularity to these rates: these differences in health by social class persist over the years even as individuals come and go from the population (Kaplan, 1996). The social circumstance of being in a lower social position generates a higher rate of many diseases and conditions over and above individual characteristics.

What is it about a lower social-class position that results in worse health? Is it money, or lower levels of education, or inadequate nutrition, or inaccessible medical care, or unhealthy or unsafe jobs, or contaminated or crowded housing? It is of course impossible to separate these influences since they are inextricably interrelated. One consequence of this complexity is that health researchers have not seen social class as a sensible target for intervention efforts. Since one cannot with confidence target one or another facet of social class for intervention, it is too complicated a phenomenon and not one worth fussing about. The predominant view has been that, short of revolution, social classes will always be with us because nothing can be done to eliminate them; thus, it is more useful to work on topics that are amenable to intervention, such as diet, smoking, and physical activity. As noted earlier, these personal-level targets of intervention have not yielded good results and, even if they did, these interventions would have little effect in stemming the flow of new individuals into the at-risk population. The result of all this research is that until recently a major social determinant of disease has been ignored as a focus for intervention.

The breakthrough in this difficult dilemma came about through the work of Marmot in his study of 17,530 civil servants in the Whitehall section of London (Marmot, Rose, Shipley, & Hamilton, 1978). Marmot observed a fourfold difference in rates of coronary heart disease between those at the top and those at the bottom of the occupational hierarchy. When he adjusted these findings by accounting for such important coronary heart disease risk factors as smoking, hypertension, and high serum cholesterol values, the difference in rates between those at the top and those at the bottom fell to 2.6. Of course this is still a major and important difference. This finding was what would have been expected. What was not expected was that he observed a gradient of disease from the top to the bottom of the civil-service occupational hierarchy. Thus, he found that workers at step 2 of the hierarchy, one step from the top, professionals and executives, doctors and lawyers, had rates of disease twice as high as those above them, the directors of the civil service agencies. And the rates of coronary heart disease progressively increased as one went down the hierarchy.

These findings are important because they force us to think about determinants of disease beyond simply looking at poverty, since civil servants at higher levels are not poor, nor do they have poor education, poor nutrition, poor housing, or unsafe jobs. Marmot argued that something else must be influencing health even near the top of the social-class

hierarchy. Subsequent research has revealed that the gradient exists not only for coronary heart disease but also for every disease studied in this British civil-service cohort (Marmot et al., 1991; Singh-Manoux et al., 2005). Later it was also found that this gradient exists beyond the British civil service. It has now been observed for virtually every disease in every industrialized country in the world (Wilkinson & Marmot, 2003; Adler, Boyce, Chesney, Cohen, Folkman, Kahn, and Syme, 1994).

One major hypothesis that has been suggested to explain this phenomenon involves the concepts of participation and control. The lower an individual is in the hierarchy, the less opportunity there is to control one's destiny, to influence the events that impinge on one's life (Syme, 1989). Importantly, we now have evidence that having less control over one's destiny actually influences biological processes that make us more vulnerable to a wide range of different diseases (Bosma, Marmot, Hemingway, Nicholson, Brunner, & Stansfeld, 1997; Karasek, Baker, Marxer, Ahlbom, & Theorell, 1981; Karasek & Theorell, 1990; Stansfeld, Fuhrer, Shipley, & Marmot, 1999). This is a revolutionary idea in the health field. Almost all the research and training that is done in the health field is oriented toward one or another disease. The National Institutes of Health sponsors the overwhelming majority of research and training in the United States and it is organized primarily around a variety of clinical diseases. Its emphasis reinforces a narrow focus on issues of concern to individuals. This way of dividing things up is helpful in the study and treatment of individual diseases, but it is not at all useful in understanding population health. Infectious disease epidemiologists have established a more useful way of studying disease by categorizing diseases as being waterborne, food-borne, airborne, and vector-borne. These categories were not useful in the treatment of individual patients, but they were exactly what was needed for the prevention of disease. They told us where the disease was coming from and where prevention efforts should be directed. We have no similar classification scheme for the noninfectious diseases of concern today.

Such research leads us to entertain the idea that when people are not able to participate in influencing the life events they care about, they are more susceptible to a wide range of disease risk factors. However, we must determine why disease-specific risk factors only sometimes result in disease. These risk factors take a toll on people only when they are vulnerable to them, only when their immune systems are compromised by stress due to a lack of empowerment. These notions are only hypothetical at this point, but the empirical evidence we have to date suggests they are reasonable ideas.

## Summary and Conclusions

The question, then, is how to design an environment that accounts for all of this information. In the mid-nineteenth century, city planning and development policies were primarily intended to mitigate the most unpleasant effects of industrialization and urbanization: the dirt, dilapidation, overcrowding, and unsanitary conditions in industrial cities. Although this approach still makes some sense, it seems inappropriate to continue uncritically and extend

these policies as priorities for the twenty-first century because they do not take into account at least three new circumstances. First, sanitary programs in the nineteenth century were primarily directed toward, and had a major impact on, the infectious diseases that decimated populations at the time. These diseases are no longer the main causes of morbidity and mortality in industrialized nations. The main causes of disease today include conditions not directly related to sanitation, such as coronary heart disease, stroke, cancer, mental illness, accidents, and suicide. Second, the development of modern industrialized communities has generated a range of new disease-producing agents that also are not related directly to sanitation, such as toxic chemicals and waste, increased levels of ionizing radiation, vehicle exhaust, and other new synthetic products that pollute air, water, and food. Third, we have new evidence that was not available earlier indicating that disease occurs more frequently among those with fewer meaningful social relationships and among those in lower social-class positions (Berkman, 1984; Berkman & Kawachi, 2000; Cohen & Syme, 1985).

The significance of supportive social relationships in maintaining health was another major contribution Durkheim made in his study of suicide (Durkheim, 1951). Seventy years later, John Cassel noted that the lack of “meaningful social contacts” resulted in higher rates of tuberculosis, schizophrenia, alcoholism, accidents, and suicide (Cassel, 1974). Since those early studies, overwhelming evidence from around the world has accumulated showing that individuals with weak social ties have higher rates of virtually every disease that has been studied, independently of other disease risk factors (Berkman & Kawachi, 2000).

What does this finding have to do with the way in which we design our cities and neighborhoods? It turns out that some of the major causes of the breakdown of social relations include technological change, population mobility, explosive population growth, the fact that work is now done far from home, and the destruction of existing communities. These changes have combined to make it more difficult for individuals to maintain bonds that tie them to family, community, kinship networks, and geographic locations. These developments often lead to interrupted social ties, which are clearly associated with increased rates of disease and ill-health (Berkman, Glass, Brissette, & Seeman, 2000). The importance of interventions that mitigate the fraying of meaningful social relationships is clear.

The issues of participation and control are also affected by the way we design our living environment. Turner, for example, has argued that when “people control major decisions and are free to make their own contributions to the design, construction, and management of their housing, both the process and the environment produced stimulate individual and social well-being. When people have no control over this process, when they have no responsibility for key decisions in the housing process, their housing may instead become a barrier to personal fulfillment” (Turner, 1976). Turner cites the well-known examples of housing projects in Saint Louis in which the conditions of several projects were approaching an irreparable state. When management was taken over by the tenants, occupancy increased, elevators worked, grounds were well kept, and crime and vandalism decreased. Not everyone agrees that tenant management always leads to such improvements in environmental

quality, but clearly there are cases in the United States and in other countries in which tenant control has resulted not only in better living conditions but also in raising self-esteem and morale and improving health.

The participation and control of individuals in the significant events that shape their lives may be even more important than the objective circumstances in which they find themselves. The impact of the most demanding situation may be softened if one has chosen to be in that situation and if one has options for dealing with the demands. Those lower down in the social hierarchy often have less opportunity to participate in the planning and execution of activities that affect them. They are asked for their opinion less frequently, they have less chance to decide on important matters, and they are less often able either to prevent undesirable events from occurring or to cause good things to take place.

To summarize: Our efforts to promote health and prevent disease must be directed not only to individuals but also to the environments within which people live. If we fail to consider the environment, we will not be able to stem the continuing flow of new individuals into the at-risk and diseased population. To develop appropriate environmental programs, we must therefore focus on those fundamental environmental forces that have an impact on health. Social class is one such fundamental force. Research on the social-class gradient suggests the importance for health of individuals being able to control their destinies and of being able to participate in the social factors that influence their lives (Syme, 2004). Community development programs that fail to take into account the issues of control and participation will not be as effective as they should be.

We really have little choice but to confront these difficult and challenging problems. The baby-boomer generation will begin entering the over-65 year old population in 2011. Shortly after that, the number of older people in our population will double. Our medical care system is strained; the impact on medical care of this doubling of the older population is almost beyond belief. We must dramatically improve our programs to prevent disease and promote health earlier in life so that those individuals entering the over-65 population are healthier than they are now. The best and most reasonable way to accomplish this objective is through the development of healthier environments.

## REFERENCES

1980. Inequalities in health: Report of a research working group. *Health Visit*, 53(11): 458.
- Acheson, D. 1998. Inequalities in health: Report on inequalities in health did give priority for steps to be tackled. *BMJ*, 317(7173): 1659.
- Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., & Syme, S. L. 1994. Socioeconomic status and health: The challenge of the gradient. *Am Psychol*, 49(1): 15–24.
- Antonovsky, A. 1967. Social class, life expectancy, and overall mortality. *Milbank Mem Fund Q Health Soc*, 45(2): 31–73.
- Berkman, L. F. 1984. Assessing the physical health effects of social networks and social support. *Ann Rev Public Health*, 5: 413–32.



- Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. 2000. From social integration to health: Durkheim in the new millennium. *Soc Sci Med*, 51(6): 843–57.
- Berkman, L. F., & Kawachi, I. o. 2000. *Social Epidemiology*. New York: Oxford University Press.
- Bosma, H., Marmot, M. G., Hemingway, H., Nicholson, A. C., Brunner, E., & Stansfeld, S. A. 1997. Low job control and risk of coronary heart disease in Whitehall II (prospective cohort) study. *BMJ*, 314(7080): 558–65.
- Cassel, J. 1974. An epidemiological perspective of psychosocial factors in disease etiology. *Am J Public Health*, 64(11): 1040–43.
- Chang, M., Hahn, R. A., Teutsch, S. M., & Hutwagner, L. C. 2001. Multiple risk factors and population attributable risk for ischemic heart disease mortality in the United States, 1971–1992. *J Clin Epidemiol*, 54(6): 634–44.
- Cohen, S., & Syme, S. L. 1985. *Social Support and Health*. Orlando, Fla.: Academic Press.
- Durkheim, E. 1951. *Suicide: A Study in Sociology*. Glencoe, Ill.: Free Press.
- Evans, R. G., Barer, M. L., & Marmor, T. R. 1994. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*. New York: A. de Gruyter.
- Gordon, D. J., Probstfield, J. L., Garrison, R. J., Neaton, J. D., Castelli, W. P., Knoke, J. D., Jacobs, D. R., Jr., Bangdiwala, S., & Tyroler, H. A. 1989. High-density lipoprotein cholesterol and cardiovascular disease: Four prospective American studies. *Circulation*, 79(1): 8–15.
- Haan, M., Kaplan, G. A., & Camacho, T. 1987. Poverty and health: Prospective evidence from the Alameda County Study. *Am J Epidemiol*, 125(6): 989–98.
- Haan, M., Kaplan, G. A., & Syme, S. L. 1989. Socioeconomic status and health: Old observations and new thoughts. In J. P. Bunker, D. S. Gombay, & B. H. Kehrer (eds.), *Pathways to Health*, 76–135. Menlo Park, Calif.: The Henry J. Kaiser Family Foundation.
- Hubert, H. B., Feinleib, M., McNamara, P. M., & Castelli, W. P. 1983. Obesity as an independent risk factor for cardiovascular disease: A 26-year follow-up of participants in the Framingham Heart Study. *Circulation*, 67(5): 968–77.
- Jennings, G., Nelson, L., Nestel, P., Esler, M., Korner, P., Burton, D., & Bazelmans, J. 1986. The effects of changes in physical activity on major cardiovascular risk factors, hemodynamics, sympathetic function, and glucose utilization in man: A controlled study of four levels of activity. *Circulation*, 73(1): 30–40.
- Kaplan, G. A., & Keil, J. E. 1993. Socioeconomic factors and cardiovascular disease: A review of the literature. *Circulation*, 88(4 pt. 1): 1973–98.
- Kaplan, G. A. 1996. People and places: Contrasting perspectives on the association between social class and health. *Int J Health Serv*, 26(3): 507–19.
- Kaplan, G. A., Pamuk, E. R., Lynch, J. W., Cohen, R. D., & Balfour, J. L. 1996. Inequality in income and mortality in the United States: Analysis of mortality and potential pathways. *BMJ*, 312(7037): 999–1003.
- Karasek, R., Baker, D., Marxer, F., Ahlbom, A., & Theorell, T. 1981. Job decision latitude, job demands, and cardiovascular disease: A prospective study of Swedish men. *Am J Public Health*, 71(7): 694–705.
- Karasek, R., & Theorell, T. 1990. *Health Work: Stress, Productivity and the Reconstruction of Working Life*. New York: Basic Books.

- Kennedy, B. P., Kawachi, I., & Prothrow-Stith, D. 1996. Income distribution and mortality: Cross sectional ecological study of the Robin Hood index in the United States. *BMJ*, 312(7037): 1004–7.
- Lynch, J. W., Smith, G. D., Kaplan, G. A., & House, J. S. 2000. Income inequality and mortality: Importance to health of individual income, psychosocial environment, or material conditions. *BMJ*, 320(7243): 1200–1204.
- MacMahon, S., Peto, R., Cutler, J., Collins, R., Sorlie, P., Neaton, J., Abbott, R., Godwin, J., Dyer, A., & Stamler, J. 1990. Blood pressure, stroke, and coronary heart disease. Part 1, Prolonged differences in blood pressure: prospective observational studies corrected for the regression dilution bias. *Lancet*, 335(8692): 765–74.
- Marmot, M., & Winkelstein, W., Jr. 1975. Epidemiologic observations on intervention trials for prevention of coronary heart disease. *Am J Epidemiol*, 101(3): 177–81.
- Marmot, M. G., Rose, G., Shipley, M., & Hamilton, P. J. 1978. Employment grade and coronary heart disease in British civil servants. *J Epidemiol Community Health*, 32(4): 244–49.
- Marmot, M. G., Shipley, M. J., & Rose, G. 1984. Inequalities in death: Specific explanations of a general pattern? *Lancet*, 1(8384): 1003–6.
- Marmot, M. G., Smith, G. D., Stansfeld, S., Patel, C., North, F., Head, J., White, I., Brunner, E., & Feeney, A. 1991. Health inequalities among British civil servants: The Whitehall II study. *Lancet*, 337(8754): 1387–93.
- McKeown, T. 1976. *The Modern Rise of Population*. London: Edward Arnold.
- McKeown, T. 1979. *The Role of Medicine: Dream, Mirage, or Nemesis?* (2d ed.). Princeton: Princeton University Press.
- McKinlay, J. B., & McKinlay, S. M. 1977. The questionable contribution of medical measures to the decline of mortality in the United States in the twentieth century. *Milbank Mem Fund Q Health Soc*, 55(3): 405–28.
- Minkler, M. 1999. Personal responsibility for health? A review of the arguments and the evidence at century's end. *Health Educ Behav*, 26(1): 121–40.
- Nieto, F. J. 1999. Cardiovascular disease and risk factor epidemiology: A look back at the epidemic of the 20th century. *Am J Public Health*, 89(3): 292–94.
- North, F. M., Syme, S. L., Feeney, A., Shipley, M., & Marmot, M. 1996. Psychosocial work environment and sickness absence among British civil servants: The Whitehall II study. *Am J Public Health*, 86(3): 332–40.
- Samet, J. M. 1990. The 1990 Report of the Surgeon General: The health benefits of smoking cessation. *Am Rev Respir Dis*, 142(5): 993–94.
- Singh-Manoux, A., Adler, N. E., & Marmot, M. G. 2003. Subjective social status: Its determinants and its association with measures of ill-health in the Whitehall II study. *Soc Sci Med*, 56(6): 1321–33.
- Singh-Manoux, A., Marmot, M. G., & Adler, N. E. 2005. Does subjective social status predict health and change in health status better than objective status? *Psychosom Med*, 67(6): 855–61.
- Stamler, J., Vaccaro, O., Neaton, J. D., & Wentworth, D. 1993. Diabetes, other risk factors, and 12-yr cardiovascular mortality for men screened in the Multiple Risk Factor Intervention Trial. *Diabetes Care*, 16(2): 434–44.
- Stansfeld, S. A., Fuhrer, R., Shipley, M. J., & Marmot, M. G. 1999. Work characteristics predict psychiatric disorder: Prospective results from the Whitehall II Study. *Occup Environ Med*, 56(5): 302–7.

Syme, S. L. 1989. Control and health: A personal perspective. In A. Steptoe & A. Appels (eds.), *Stress, Personal Control, and Health*. New York: Wiley.

Syme, S. L. 1996. Rethinking disease: Where do we go from here? *Ann Epidemiol*, 6(5): 463–68.

Syme, S. L. 2004. Social determinants of health: The community as an empowered partner. *Prev Chronic Dis*, 1(1): A02.

Turner, J. F. C. 1976. *Housing by People: Towards Autonomy in building Environments*. London: Marion Boyars.

Wilkinson, R., & Marmot, M. 2003. *Social Determinants of Health: The Solid Facts* (2d ed.). Geneva: World Health Organization.

World Health Organization. 2008. *CSDH final report: Closing the gap in a generation: Health equity through action on the social determinants of health*. In WHO (ed.), *Commission on Social Determinants of Health*. Geneva: World Health Organization.

# Prescription for Healthy Communities: Community Development Finance

*Lisa Richter*

*GPS Capital Partners, LLC*

*Building a healthier nation will require substantial collaboration among leaders across all sectors, including some—for example, leaders in child care, education, housing, urban planning and transportation—who may not fully comprehend the importance of their roles in improving health.*

*—Beyond Health Care: New Directions to a Healthier America, Recommendations from the Robert Wood Johnson Foundation Commission to Build a Healthier America*

We are at a crossroads in the fields of both community development finance and public health. Persistent poverty in many of our nation's communities, along with increasing economic challenges faced by the working poor, are forcing a realization that traditional approaches to community development finance focused on affordable housing and business development are not sufficient to move and keep families out of poverty. Since the 1990s, Community Development Financial Institutions (CDFIs) and their partners have augmented traditional community development approaches with investments in human development (child care, education, and workforce development), family economic security (savings, insurance, and asset building), and "green" initiatives aimed at better positioning low-income residents to achieve health and financial security. Although the current economic crisis has interrupted and in some cases drastically reversed progress, innovation within the field continues to advance these trends.

Declining health status in the current generation of Americans, escalating health-care costs, and stark, persistent disparities in health outcomes among income and ethnic groups similarly call into question the traditional approach to health care in the United States, which has primarily focused on the treatment of disease. As stated in the 2009 report of the Robert Wood Johnson Foundation Commission, "Building a Healthier America" (RWJF Commission Report): "Although medical care is essential for relieving suffering and curing illness, only an estimated 10 to 15 percent of preventable mortality has been attributed to medical care. A person's health and likelihood of becoming sick and dying prematurely are greatly influenced by powerful social factors such as education and income and the quality of neighborhood environments."<sup>1</sup> Faced with this evidence, health practitioners and advocates are increasing their focus on preventing disease through physical and social environments that promote better health outcomes and community-based initiatives that promote healthy behavior.

---

1 <http://www.commissiononhealth.org/Report.aspx?Publication=64498>.

Developments in both fields set the stage for a coordinated approach. By articulating a vision for healthy communities and more directly fostering the human development, physical well-being, and economic prospects of community residents, both community development finance and public health are poised to improve outcomes. The shift is particularly important for services targeted to children, who have the greatest vulnerability to unhealthy conditions. If we cannot better position our children for health and financial security, we face continuing, rampant increases in chronic disease and medical expenses, lost productivity, and lost income.

Coordinated effort requires adjusting both community development finance and public health practices to leverage the respective resources of each effectively. The RWJF Commission calls for society to adapt a “culture of health” to inform not only community development but also school, workplace, and public-policy priorities. As described in the sections that follow, we suggest that the field of public health adapt a “culture of community development finance” as an essential component of scaling successful models of community, school, and workplace health promotion.

The RWJF Commission Report identified a range of ways to improve health at local, state, and federal levels—“practical, feasible and effective solutions often hiding in plain sight”—but noted that these programs generally are not funded to achieve scale: “Too often, while start-up funds are provided to establish programs, funders move on to other issues once programs are under way. The value of collaboration to create a broader base of support is a key theme of this report and a necessity if successful programs are to expand across sectors and across the nation.”<sup>2</sup>

The prevailing funding model for community-based public health has relied on public and private grants.<sup>3</sup> We suggest that community development finance is an essential, if perhaps unrecognized partner in taking scaling efforts to the next level. Combining mission focus and investment discipline, community development finance brings highly developed skills in identifying and financing organizations that are both committed to improving conditions for vulnerable populations and capable of repaying investments. In general, such organizations are unable to obtain the financing needed for scaling from commercial sources. This may be because these organizations focus in markets that are small and perceived as too risky; lack assets or credit history; have early-stage needs (such as the predevelopment phase of a real estate project); and depend on innovative approaches to problem solving (which carry the risk of untested, new business lines).

Community development finance aggregates subsidies and flexible capital from public and private sources to directly finance such initiatives or to structure credit enhancement that attracts additional, larger volumes of commercial capital. While much more capital is needed to finance the range of qualifying initiatives, community development finance has

---

2 RWJF Commission Report.

3 Major institutions, such as hospitals and large clinics, are generally able to also raise bond and other debt financing.

invested billions of dollars in projects that effectively enhance health. Examples include mixed-income transit-oriented development; quality early child care, high-performing public charter schools and other educational programs that offer nutritious food and physical exercise programs along with academic support; social services enriched housing; and community health centers. Increasingly these strategies are executed with green approaches that conserve resources, avoid harmful building materials, and are landscaped to promote safe physical activity. In addition, such projects bring both services and jobs to urban and rural low- to moderate-income communities.

The field of community development finance in turn can benefit from the medical framework for defining healthy community that is offered by the field of public health. Often this framework takes the form of a needs assessment developed in the context of a city, state, or region (which corresponds to a bank's assessment area or CDFI's market area). Public health also brings infrastructure to gather and analyze longitudinal data on both health status and health-care costs of populations by income, ethnic group, and geography, providing important social and economic impact data to reinforce output measures traditionally tracked by community development finance practitioners. Finally, health interests bring significant public and private financial resources that community development finance needs but has seldom tapped, including potential grants and investments from health-focused philanthropy, health-focused public funding (including the federal stimulus), and a share of the nation's significant, ongoing health-care expenditures. Health-care expenditures were estimated as 15.3 percent of GDP in 2006, and amount that is \$2 trillion per year and projected to grow.<sup>4</sup>

Plans for coordination between community development finance and public health need not be complex. Indeed, public health interventions are often astonishingly basic, historically depending largely upon clean water and proper sanitation. As Len Syme's article in this journal points out, lack of proper sanitation is no longer the main cause of morbidity and mortality in industrialized nations. Our communities have generated new disease-producing agents, such as pollutants of air, water, and food. We have also learned, he notes, that disease occurs more frequently among those with fewer meaningful social relationships and those in a lower social class. These are risk factors that community development finance and public health can work together to minimize.

The benefits of collaboration between the fields will be greatest if focused on those of lower social class—those known to health policy advocates and philanthropy as “vulnerable populations” and known to community development finance practitioners as low- to moderate-income and minority communities and persons. Extensive evidence documents this popu-

---

4 World Health Statistics 2009 (Geneva: World Health Organization, 2009), 114. Available at: [http://www.who.int/whosis/whostat/EN\\_WHS09\\_Full.pdf](http://www.who.int/whosis/whostat/EN_WHS09_Full.pdf).

lation's greater health risks that also potentially bring catastrophic financial consequences.<sup>5</sup>

One example of a cost-effective prevention that could be implemented in partnership with community development finance practitioners was highlighted in a 2008 study prepared by the Trust for America's Health. The study found that an investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could significantly reduce chronic disease and save California households, insurance companies, and public coffers more than \$1.7 billion in annual health-care costs within five years—a return of nearly \$5 for every \$1 of expense. Evidence suggests that implementing these programs could reduce rates of Type II diabetes and high blood pressure by five percent within two years; reduce heart disease, kidney disease, and stroke by five percent within five years; and reduce some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years.<sup>6</sup> Community-based programs such as those cited in the study are frequently offered by organizations that CDFIs finance, including but not limited to schools open after hours for children to play with adult supervision, farmers markets and other venues providing access to nutritious foods in low-income communities, and child care, youth, and health organizations providing guidance on how to make good choices about nutrition and tobacco use.<sup>7</sup>

If collaboration between community development finance and public health offers the prospect of creating a virtuous circle in which strategic investments help residents of low-income communities to make healthy choices and generate health-care savings, the risks of failing to join forces appear likely to perpetuate the existing vicious circle in which these residents fall further behind in health and income. The RWJF Commission Report cautions:

---

5 As an example of the high risks and costs of chronic disease among vulnerable populations, overweight is by far the most common public health nutrition problem facing women and children participants of the federal Women, Infants and Children Program (WIC). . . . Taken together, well over one-third of California WIC children are overweight or at risk for obesity, with the highest rates among Hispanic, African American, and Native American children. The reported consequences are staggering: increased rates of Type II diabetes, heart disease, respiratory difficulties, psychosocial problems, and adult obesity cost California an estimated \$25 billion annually and will kill more people than AIDS, violence, car crashes, and drugs combined. [http://www.calwic.org/docs/federal/harnessing\\_WIC\\_obesity.pdf](http://www.calwic.org/docs/federal/harnessing_WIC_obesity.pdf).

6 "Prevention for a Healthier California: Investments in Disease Prevention Yield Significant Savings, Stronger Communities," 2008: <http://healthyamericans.org>.

7 Health care uses primary, secondary, and tertiary types of prevention, offering different opportunities for disease prevention and medical savings: (1) Primary prevention involves taking action before a problem arises to avoid it entirely, rather than treating or alleviating its consequences. (2) Secondary prevention is a set of measures used for early detection and prompt intervention to control a problem or disease and minimize the consequences. (3) Tertiary prevention focuses on the reduction of further complications of an existing disease or problem, through treatment and rehabilitation. Many factors influence whether specific prevention efforts result in cost savings. Tertiary efforts involving direct medical treatment or pharmaceuticals often have higher costs. Secondary efforts, including early detection and intervention to control a problem or disease and minimize the consequences, are more cost effective if targeted to at-risk populations. Community-based primary and secondary prevention efforts may be low-cost and have demonstrated results in lowering disease rates or improving health choices without involving direct medical care, including promoting increased levels of physical activity, improved nutrition and reduced tobacco use. <http://healthyamericans.org>.

The economic implications of our nation's health shortfalls are sobering. . . . The costs of medical care and insurance are now out of reach for many American households, pushing some families into bankruptcy, draining businesses, reducing employment and severely straining the budgets of federal, state and local governments. . . . The current path of rising costs and rising rates of chronic disease is simply not sustainable. Greater access to effective, efficient medical care is important for our nation's well-being, but medical care cannot deliver wellness, nor can health care system reforms alone bring costs under control. Instead, we need a new vision of health that rests on changing the lives of Americans in ways that lead to healthier, longer lives.<sup>8</sup>

To frame the possibilities for collaborating on that new vision, the following sections discuss a definition of healthy community, identify tested models for replication, profile investors, and assess a way forward.

### **Defining and Building Healthy Communities: Two Fields, One Objective**

In formulating a definition of healthy community that aligns community development finance and public health interests, a logical first step is to refer to the meaning of community development in the Community Reinvestment Act (CRA), which has provided the regulatory framework for bank and other community development finance for decades.<sup>9</sup> While the CRA does not tell us what constitutes a healthy community, it states that community development includes:

1. Affordable housing (including multifamily rental housing) for low- or moderate-income individuals
2. Community services targeted to low- or moderate-income individuals
3. Activities that promote economic development by financing businesses or farms that have gross annual revenues of \$1 million or less
4. Activities that revitalize or stabilize low- or moderate-income geographies, designated disaster areas, or distressed or underserved nonmetropolitan middle-income geographies<sup>10</sup>

As of 2007, National Community Reinvestment Coalition reported more than \$407 billion in 375,000 CRA loans and investments that advance community development across urban and rural assessment areas nationwide.<sup>11</sup> Often these investments have had a transforma-

---

8 RWJF Commission Report.

9 [www.ffiec.gov/CRA](http://www.ffiec.gov/CRA); see also "Revisiting CRA" at <http://www.frbsf.org/publications/community/cra/index.html>.

10 <http://www.occ.treas.gov/fr/cfrparts/12cfr25.htm>.

11 John Taylor and Josh Silver, "The Community Reinvestment Act: 30 Years of Wealth Building and What We Must Do to Finish the Job," <http://www.frbsf.org/publications/community/cra/index.html>, 2009.

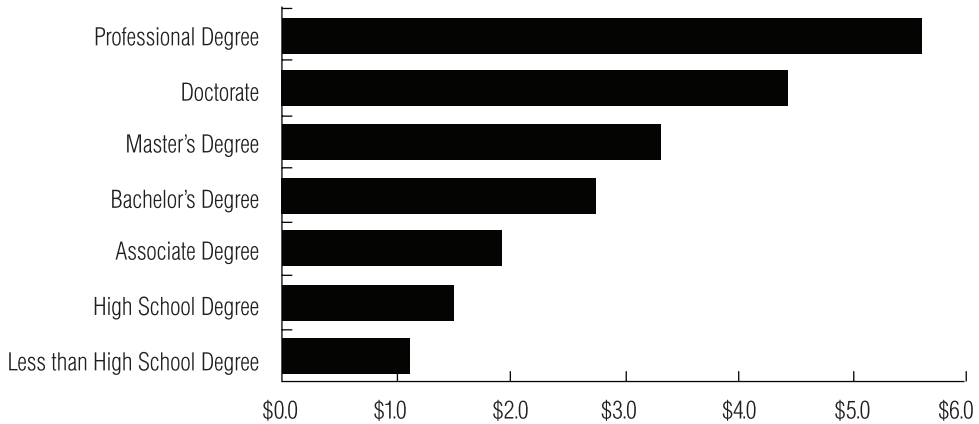


tional effect on neighborhoods, jump-starting both housing and commercial development in areas of persistent blight. Their impact has been more limited, however, on the health, education, earnings power, and poverty status of neighborhood residents. The evidence suggests that absent a more deliberate focus on human development, low- to moderate-income communities continue to face dim prospects of graduating their youth from high school, much less preparing them for college or secure financial futures.

We are learning that these poor educational outcomes also affect health, with consequences that are far graver than we previously understood.<sup>12</sup> We have long known that lifetime earnings are correlated with educational level (Figure 1). Recent research documents a strong correlation between health outcomes and both education and income. “When socioeconomic factors were added into the Framingham Risk Scoring risk assessment . . . the proportion of low-income and low-education patients at risk for death or disease during the next 10 years was nearly double that of people with higher socioeconomic status.”<sup>13</sup> The effects of good education are of a magnitude that, if high school graduation were a prescription drug, it would be a “blockbuster.”<sup>14</sup>

- 
- 12 Nationwide, only about 70 percent of students earn their high school diplomas. Among minority students, only 57.8 percent of Hispanics, 53.4 percent of African Americans, and 49.3 percent of American Indians and Alaska Native students graduate with a regular diploma, compared to 76.2 percent of white students and 80.2 percent of Asian Americans. High school dropouts face long odds of landing a good-paying job in the ultra-competitive job market of the twenty-first century. In addition, they generally die earlier, are less healthy, more likely to become parents when very young, more at risk of tangling with the criminal justice system, and more likely to need social welfare assistance. [http://www.all4ed.org/about\\_the\\_crisis](http://www.all4ed.org/about_the_crisis).
- 13 A University of Rochester Medical Center study published in the June 2009 *American Heart Journal* noted that doctors who ignore the socioeconomic status of patients when evaluating their risk for heart disease are missing a crucial element. The study found that the accepted risk assessment model, known as Framingham Risk Scoring (FRS), does not accurately predict whether a person of low income and/or less than a high school education will develop heart disease or die in the next 10 years. When socioeconomic factors were added into the FRS risk assessment, the proportion of low-income and low-education patients at risk for death or disease during the next 10 years was nearly double that of people with higher socioeconomic status. <http://www.sciencedaily.com/releases/2009/06/090616133936.htm>.
- 14 In the pharmaceutical industry, a blockbuster drug is one that achieves acceptance by prescribing physicians as a therapeutic standard, most commonly for a highly prevalent chronic (rather than acute) condition. From a financial perspective, a blockbuster drug is typically defined as achieving annual worldwide sales exceeding \$1 billion, <http://www.ftpress.com/articles/article.aspx?p=1163084>. While the medical savings from a nearly 50 percent reduction in heart disease risk factors associated with improved high school graduation rates have not been estimated to GPS' knowledge, economic savings well in excess of \$1 billion per year from improved graduation rates have been. Assuming based upon Figure 1 that every high school graduate realizes \$400,000 in lifetime income that he or she would not otherwise receive, it takes only 2,500 additional high school graduates per year to generate a \$1 billion differential. Per the U.S. Committee on Education and Labor, there are almost three times this number of high school dropouts per day: “Nationwide, 7,000 students drop out every day. . . . Research shows that poor and minority children attend . . . so-called “dropout factories”—the 2,000 schools that produce more than 50 percent of our nation’s dropouts—at significantly higher rates. . . . A recent report by the McKinsey Corporation showed that if black and Latino student performance had reached the level of white students by 1998, the GDP in 2009 would have been between \$310 billion and \$525 billion higher—or approximately 2 to 4 percent of GDP. The report also notes that achievement gaps in this country are the same as having “a permanent national recession.” May 12, 2009, <http://edlabor.house.gov/newsroom/2009/05/high-school-dropout-crisis-thr.shtml>. The full McKinsey Report, “The Economic Impact of the Achievement Gap in America’s Schools,” is available at [http://www.mckinsey.com/App\\_Media/Images/Page\\_Images/Offices/SocialSector/PDF/achievement\\_gap\\_report.pdf](http://www.mckinsey.com/App_Media/Images/Page_Images/Offices/SocialSector/PDF/achievement_gap_report.pdf).

*Figure 1. Worklife\* Earnings for Full-time Year-round Workers by Educational Attainment<sup>15</sup>  
(in Millions of 2005 Dollars)*



The pronounced health and financial risks among many whom CRA sets out to serve suggest that traditional investing to comply with the regulation may be necessary for healthy communities, but it is not sufficient. Applying a public health lens broadens the perspective and points the way to promising new avenues. A healthy community is described by the “Healthy People 2010” report of the U.S. Department of Health and Human Services as

One that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential. Healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders—where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options.<sup>16</sup>

Incorporating these dimensions into community development finance practice offers potential to reinvigorate the sector’s efforts to alleviate poverty while engaging the expertise of public health to drive better results. Public health and health-focused philanthropy organizations have developed useful templates to clarify further what constitutes a healthy community and what actions the range of stakeholders must take to create such communities nationwide (Figure 2 and Appendices A and B).

For example, given the observation that health outcomes are closely correlated to neighborhood conditions and a mandate to “identify interventions beyond the health care system

15 Mark Kantrowitz, “The Financial Value of Higher Education,” *NASFAA Journal of Student Financial Aid* 37, no. 1 (2007); U.S. Census Bureau, “The Big Payoff: Educational Attainment and Synthetic Estimates of Work-Life Earnings,” July 2002. <http://www.census.gov/prod/2002pubs/p23-210.pdf>.

16 <http://www.cdc.gov/healthypaces>.

that can produce substantial health effects,” the RWJF Commission Report articulated ten recommendations for building a healthier America (see Figure 3 and Appendix B). While some of these depend largely on public-sector programs, many, including promoting access to high-quality child care, education, nutritious food, physical activity, and health care, are promoted through CDFI investment strategies, often with capital invested by CRA-motivated banks (See examples in Figure 4).

*Figure 2. Healthy Communities<sup>17</sup>*

<b>Unhealthy Community</b>	<b>Healthy Community</b>
Unsafe even in daylight	Safe neighborhoods, safe schools, safe walking routes
Exposure to toxic air, hazardous waste	Clean air and environment
No parks/areas for physical exercise	Well-equipped parks and open spaces/ organized community recreation
Limited affordable housing is run-down; linked to crime-ridden neighborhoods	High-quality mixed-income housing, both owned and rental
Convenience/liquor stores, cigarette and liquor billboards, no grocery store	Well-stocked grocery stores offering nutritious foods
Streets and sidewalks in disrepair	Clean streets that are easy to navigate
Burned-out homes, littered streets	Well-kept homes and tree-lined streets
No culturally-sensitive community centers, social services, or opportunities to engage with neighbors in community life	Organized multicultural community programs, social services, neighborhood councils, or other opportunities for participation in community life
No local health-care services	Primary care through physicians' offices or health center; school-based health programs
Lack of public transportation, walking or biking paths	Accessible, safe public transportation, walking and bike paths

17 RWJF Commission Report.

*Figure 3 - Recommendations From the Robert Wood Johnson Foundation Commission*<sup>18</sup>

1. Ensure that all children have high-quality early developmental support (child care, education and other services). This will require committing substantial additional resources to meet the early developmental needs particularly of children in low-income families.	6. Become a smoke-free nation. Eliminating smoking remains one of the most important contributions to longer, healthier lives.
2. Fund and design WIC and SNAP (Food Stamps) programs to meet the needs of hungry families for nutritious food.	7. Create “healthy community” demonstrations to evaluate the effects of a full complement of health-promoting policies and programs.
3. Create public-private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.	8. Develop a “health impact” rating for housing and infrastructure projects that reflects the projected effects on community health and provides incentives for projects that earn the rating.
4. Feed children only healthy foods in schools.	9. Integrate safety and wellness into every aspect of community life.
5. Require all schools (K-12) to include time for all children to be physically active every day.	10. Ensure that decision-makers in all sectors have the evidence they need to build health into public and private policies and practices.

The RWJF Commission’s criteria for what constitutes a healthy community seem basic (Figure 2 and Appendix A), yet it is precisely the inadequacy of such basic conditions in most low- to moderate-income and minority communities that constitute many of the so-called adverse social determinants of health, driving disparity, increased chronic disease, and rising cost burdens.<sup>19</sup>

For example, while achieving good health requires choosing healthy behaviors such as eating a nutritious diet, exercising, and not smoking, health professionals agree that it is much harder to make these healthy choices in either urban or rural low- to moderate-income communities. As the RWJF Commission observes: “Many people live and work in circumstances and places that make healthy living nearly impossible. Many children do not get the quality of care and support they need and grow up to be less healthy as a result; many Americans do not have access to grocery stores that sell nutritious food; still others live in communities that are unsafe or in disrepair, making it difficult or risky to exercise. While individuals must make a commitment to their own health, our society must improve the opportunities to choose healthful behaviors, especially for those who face the greatest obstacles.”<sup>20</sup>

Although the field of community development finance has to date generally placed less emphasis on strategies that directly affect the physical health and human development of

<sup>18</sup> RWJF Commission Report.

<sup>19</sup> See discussions in RWJF Commission Report; Place Matters, <http://www.policylink.org/site/c.lkIXLbMNJrE/b.5137443/apps/s/content.asp?ct=6997411>; and [www.unnaturalcauses.org](http://www.unnaturalcauses.org).

<sup>20</sup> RWJF Commission Report.

low- to moderate-income persons, practitioners who have applied such focus represent the cusp of innovation and demonstrate the potential. As profiled in Figure 4 and the following articles in this journal, CDFI-financed health-enhancing projects include:

- NCB Capital Impact’s (NCBCI) loans for nonprofit health-center facilities described by Scott Sporte and Annie Donovan, which in partnership with bank, insurance, foundation, and public-sector lenders, finance entities that meet the primary-care needs of many of the nation’s Medicaid recipients and uninsured in underserved areas. NCBCI has expanded on this successful model in three ways: (1) by incorporating New Markets Tax Credit incentives in selected transactions, (2) by adding working capital loans to help borrowers expand or manage delays in state reimbursements, and (3) by partnering with Capital Link, a national technical assistance provider that assists health centers in deal structuring, financial planning and management.
- Pacific Community Ventures’ equity investments in small businesses that provide quality benefits for workers described by Allison Kelly and Kirsten Snow Spalding, including health coverage and the VidaCard Prepaid MasterCard®, which offers employers a means to help both insured and uninsured employees pay for uncovered expenses, including preventive care, insurance premiums, or co-payments.
- The Reinvestment Fund’s lead financing role in fresh food supermarkets of varying sizes and descriptions in urban and rural communities throughout Pennsylvania, a model described by Marion Standish of The California Endowment and Judith Bell of PolicyLink that is being adapted in other states through collaborations between The Reinvestment Fund, other CDFIs, foundations, and banks.
- The Low Income Investment Fund (LIIF) and other CDFIs’ increasing investments in human capital development described by Nancy Andrews, which for LIIF alone include direct financings of \$60 million in early child care, \$200 million in high performing charter schools, \$500 million in services enriched affordable housing and \$40 million in other facilities, such as for health care, domestic violence shelters and youth recreation. Generally, these investments utilize public and philanthropic sector credit enhancement or tax credits to attract much larger sums of senior debt from banks, insurance companies, and pension funds.
- The Disability Opportunity Fund’s housing solutions for disabled persons and their families described by Charles Hammerman. The fund’s financing leverages public-sector subsidies to structure financing for affordable, accessible, and supportive housing for the disabled, including the developmentally disabled and increasing numbers of families of military and the elderly.

These investments spur development that is consistent with the “Healthy People 2010” healthy communities definition, catalyzing resident wellness while creating significant numbers of local jobs, particularly in child care, health care, and retail or other healthy food

delivery systems.<sup>21</sup> The potential benefits, ranging from decreased childhood obesity to dramatically improved high school graduation and college matriculation rates, to increased employment, income, and health coverage, are correlated with significantly improved long-term health outcomes and, therefore, reduced health-care costs. As tested models, these investments offer the potential to be replicated in communities across the country. Doing so requires commitments of capital by a broad range of investors.

*Figure 4. Scaling Success in Healthy Community Investments*

The field of community development finance is increasing its focus on projects that improve health and reduce health-care costs in low-income neighborhoods. Successes and plans from CDFI-financed initiatives include:

**For health-care delivery:**

- NCB Capital Impact has extended over \$429 million in loans to community-based health-care providers for over 20 years to create more than 2.9 million square feet of community health center space where providers meet the health-care needs of more than 350,000 low-income, underinsured, and uninsured patients annually. In addition, NCBCI has provided innovative financing to substance abuse rehabilitation/behavioral care facilities, adult day health care facilities and assisted living/continuing care facilities.
- Nonprofit Finance Fund provided \$500,000 in financing to the District of Columbia Primary Care Association to cover start-up costs of Medical Homes DC, which will leverage some \$145 million for facilities, quality improvements, and administrative services to rebuild and increase access to DC's primary-care system for 210,000 low-income residents. Goals include to provide better health outcomes, reduced disparities and decreased expensive emergency room visits; anchors for economic development in the health centers' neighborhoods; quality entry-level jobs and hiring from the community; and to increase traffic from patients and those who accompany them for potential businesses nearby (research by Capital Link based on 2006 data demonstrated that 11 DC health centers generated a \$210 million impact on the District's economy and approximately 2,100 jobs).<sup>22</sup>

21 Job growth in these sectors is expected to be among the most robust nationwide. The Department of Labor identifies Education and Health services as a supersector that is projected to grow by 18.8 percent, and add more jobs, nearly 5.5 million, than any other industry supersector. More than 3 out of every 10 new jobs created in the U.S. economy will be in either the healthcare and social assistance or public and private educational services sectors. Combined food preparation and service workers are fourth in occupations with the largest projected increase in number of jobs from 2006 – 2016. See Appendix E and <http://www.bls.gov/oco/oco2003.htm>. May 13, 2009.

22 <http://www.regionalprimarycare.org/primary-care-medical-homes/medical-homes-dc.aspx>

**For supportive and safe housing:**

- The Corporation for Supportive Housing reports decreases of more than 50 percent in tenants' emergency room visits and hospital inpatient days and more than 80 percent in use of emergency detoxification services, a \$1,448 decrease in dependence on entitlements per tenant each year, increases of 50 percent in earned income and 40 percent in the rate of participant employment when employment services are provided in supportive housing, more than 80 percent of homeless people with mental illness remaining housed a year later (at least a third of those people living on the streets and in shelters have a persistent mental illness) and 90 percent of tenants with substance abuse problems remaining sober for one year, versus approximately 55 percent who live independently or in halfway houses.
- CDFIs such as Rural Community Assistance Fund and CASA of Oregon have provided thousands of units of safe migrant housing, reducing risks for this vulnerable population (see Appendix D)

**For quality education, a linchpin for children to achieve financial security and good health:**

- In California, where in 2008 approximately one in three high school graduates completed the courses required to gain admission to a four-year college (with lower college-readiness rates for minority students), the College-Ready Promise is a newly formed coalition of five charter school management organizations (CMOs) that have earned a reputation for excellence in serving low-income and minority students, with more than 75 percent of their graduates over the past two years attending four-year colleges. Alliance College-Ready Public Schools, Aspire Public Schools, Green Dot Public Schools, ICEF Public Schools, and Partnerships to Uplift Communities operate 85 public schools with more than 28,000 students, primarily in Los Angeles County (Aspire also runs schools in East Palo Alto, Modesto, Oakland, Sacramento, and Stockton).
- Collectively, these CMOs have received hundreds of millions in facilities financing from a range of CDFIs, including the Low Income Investment Fund, NCB Capital Impact, Local Initiatives Support Corporation, and Raza Development Fund. Many of the schools provide Revolution Foods' nutritious lunches and several use Playworks' active recess program. The Bill & Melinda Gates Foundation recently awarded the Coalition \$60 million to increase teaching effectiveness so that more students graduate college-ready.
- In rural Arkansas, the CDFI, Southern Bancorp, recruited and financed the charter management organization, KIPP Houston, to a town of 15,000. KIPP Delta

charter school opened in Helena-West Helena's abandoned train station, soon expanding into previously abandoned buildings on the town's main street. KIPP achieved 100 percent college matriculation in its first graduating class, in an almost 100 percent African American student body where the academic scores for this population were typically in the 15th percentile. KIPP Delta plans to open 12 charter schools in the region. In addition to financing charter schools, CDFIs finance a range of supplemental educational services that support both academic achievement and health-promoting behaviors such as safe physical activity and not smoking. These include Boys and Girls clubs and similar organizations around the country.

**For child care, where quality experiences set the stage for childrens' later success:**

- Self-Help Credit Union began child care lending in 1987, has lent over \$42 million to quality child care providers and is part of The National Child Care Facilities Network, a group of CDFIs emphasizing child care lending that has provided over \$230 million in child care finance, leveraging \$877 million to create or improve 3,680 centers serving over 211,000 children across the country.
- Acelero Learning is one example of a quality Head Start manager that has equity investment from CDFIs, Boston Community Capital and New Jersey Community Capital, as well as the W.K. Kellogg Foundation. Results by combining federal Heat Start funding with state child-care funding include:
  - In Camden, N.J.: Increased enrollment from 18 to 90 children and improved staff qualifications by 100 percent so that all teachers have at least an Associate degree.
  - In Monmouth, N.J.: Increased enrollment from 330 to 506 children using the same amount of federal funds, expanded annual days of service from 190 to 220 days per year, increased average teacher salary by 75 percent, increased number of family advocates from 8 to 14, and built partnerships to provide previously untapped, much needed dental services.

**For safe, nutritious food and physical activity:**

- ShoreBank began sponsoring a Farmers Market in the 1970s and in 1990 brought one of Chicago's leading full-service grocery stores to its low- to moderate-income African American neighborhood. In 1999, Local Initiatives Support Corporation working with Abyssinian Development Corporation and the Community Association of East Harlem Triangle brought a Pathmark super-market to East Harlem.



- The Reinvestment Fund (TRF) is spearheading an effort to establish supermarkets in urban and rural communities in Pennsylvania in partnership with the Fresh Food Financing Initiative. As of June 2009, FFFI had committed \$57.9 million in grants and loans to 74 supermarket projects in 27 Pennsylvania counties, ranging in size from 900 to 69,000 square feet, which were expected to create or retain 4,854 jobs and more than 1.5 million square feet of food retail. TRF is working with a range of other CDFIs and partners to expand the initiative to other states.
- With equity and debt from bank and foundation social investors, including the W.K. Kellogg Foundation, DBL investors, and RSF Social Finance, Revolution Foods provides nutritious school breakfasts, lunches and snacks, serving more than 5 million healthy meals to more than 50,000 school children, 80 percent of whom qualify for free or reduced-price lunches.
- With working capital financing from the CDFI, OneCalifornia Bank, and a loan guarantee and grants from the Robert Wood Johnson Foundation, Playworks is expanding its services to improve the health and well-being of children by increasing opportunities for physical activity from its on-site programs that serve more than 70,000 students at 170 low-income schools in 10 cities to more than 650 low-income schools in 28 cities, along with training for adults to bring safe, healthy, and inclusive play to more than 1 million students by 2012.

**For sustainable development, CDFIs have been in the lead of financing and tracking innovations that safeguard community health and the environment in urban and rural areas:**

- Enterprise Green Communities has invested \$700 million to build and preserve nearly 16,000 green affordable homes and partnered with the U.S. Department of Energy and BuildingGreen to create the High Performance Buildings Database.
- SJF Ventures, a CDFI venture capital firm with \$26 million in cumulative investments, reported holdings in 28 companies that added 5,900 jobs in renewable energy and efficiency, organic and healthy consumer products and other companies offering significant employee benefits. Approximately 85 percent of the total 5,900 people employed are low- to moderate-income.
- The Triple Bottom Line Collaborative (TBLC) is an alliance of CDFIs pursuing the integration economic development and poverty alleviation with environmental issues through equity and debt investments as well as impact tracking. Collectively, members and their affiliates have made well in excess of \$1 billion of TBL investments (see Appendix D).

## **Scaling Investment in Healthy Communities: An Overview of Promising CDFI Strategies**

The field of community development finance engages in continuous efforts to attract the capital needed to scale proven initiatives, and it can benefit from potential new sources of capital from public and private investors in the health sector. Despite a general tightening of credit in the economic downturn, model investment structures and partnerships have continued to evolve between banks, CDFIs, and other community development finance intermediaries, public-sector agencies (some of which are managing one-time additional federal stimulus dollars), and philanthropic investors interested in leveraging their grant making with financial investments that reinforce their health-focused charitable missions.

Structuring investments that promote healthy communities requires due diligence from any investor, whether bank, CDFI, foundation, or government agency. Characteristics of community development financial transactions that potentially add risk and cost include but are not limited to: (1) low margin revenues (characteristic of all nonprofit service providers in low- to moderate-income communities), (2) unstable cash flows (particularly where government is the payer and budgets may be slashed or delayed), (3) low property valuations (corresponding to limited available collateral or high loan-to-value ratios), (4) multiple transaction objectives and/or sites (such as services-enriched affordable housing using “green,” nontoxic building materials near a new public transportation hub, which will include a supermarket selling fresh food), and (5) complicated documentation associated with the use of tax credits or subsidized programs. Particularly when conventional credit markets are tight, these cost and risk factors create the need for more flexible capital, such as a foundation program-related investments (PRI, see below) or public-sector credit enhancements.

A flexible and relatively common deal structure is to have a CDFI create an off balance sheet fund or project financing that includes a layer of public-sector funding as a first loss fund, a larger layer of foundation PRI or CDFI subordinated debt as a second loss fund, and a much larger layer of commercial investor senior debt from a bank, insurance company, or other institutional investor. The New York City Acquisition Fund combines an \$8 million, zero percent city loan as a first loss fund with \$32 million in foundation-subordinated debt as a second loss fund. This \$40 million in credit enhancement leverages over \$200 million in bank senior debt authority to finance affordable housing site acquisition.

This model has been replicated for affordable housing in the Gulf Coast, Los Angeles, and the State of Oregon. Similar structures use grants from the Department of Education as first loss funds for charter schools facilities finance and are being planned to finance community health centers using American Recovery and Reinvestment Act of 2009 funds.

CDFIs and similar intermediaries also attract public subsidy by using tax incentives in the form of Low Income Housing Tax Credits, New Markets Tax Credits (NMTC), and Historic Tax Credits. Transactions using these programs are more difficult to close in the current environment due to fewer corporations with profits to shelter and fewer lenders willing to extend the so-called leveraged loans used in combination with equity from tax credits.

In the current environment, a particularly promising trend is the increasing number of foundations that are participating in community development finance through mission investing strategies. Defined broadly as financial investments made with the intention of advancing a foundation's charitable mission while earning a financial return, foundation mission investments can carry below-market-rate or market-rate returns on a risk-adjusted basis.

Program-Related Investments (PRIs) were created by the Ford Foundation in 1968 and defined for private foundations in the Tax Code of 1969 as meeting three criteria: (1) a primary purpose that is charitable, (2) no significant purpose of income generation or capital appreciation, and (3) no purpose of political activity that is prohibited for nonprofit organizations generally. Structured mostly as long-term debt with below market rates of interest on a risk-adjusted basis, private foundations are permitted to count qualifying PRIs against their annual five percent charitable distribution requirement.<sup>23</sup> Although community foundations do not have a charitable distribution requirement, most give away five percent or more of their average assets per year, and an increasing number are using PRIs in a similar fashion as private foundations.<sup>24</sup> Health-focused foundations, which can be private or community foundations, are also increasingly using PRI strategies, often to scale successful, health-promoting business models, such as Playworks' supervised recess services for low-income public schools (see Figure 4 and Appendix C).

In order to leverage larger portions of their endowments to advance mission (the so-called "other 95 percent"), more foundations of all types are also making mission investments that carry market rates of expected return on a risk-adjusted basis. Sometimes called Mission-Related Investments or MRIs (a term of art, since MRI is not a regulatory term), these investments meet the same financial hurdles as any conventional foundation investment while also offering social and/or environmental expected returns (Double and/or Triple Bottom Lines, or DBL and TBL, respectively). DBL and TBL investments have tended to be in market-rate, insured deposits with CDFI banks, geographically targeted fixed-income securities, and selected private equity funds, many of which support healthy community goals. For example, CDFI banks may provide SBA-guaranteed loans to minority and other health professionals who set up offices in low- to moderate-income communities. Fixed-income managers may purchase pools of the SBA-guaranteed portion of these loans to create fixed-income securities and provide liquidity to the banks for additional lending. Private equity funds may invest in health-focused businesses, such as Revolution Foods (Figure 4). Other private equity funds such as Pacific Community Ventures support the growth of businesses

---

23 Private foundations can count qualifying PRIs toward their annual charitable distribution requirement of 5 percent of average assets. While they are obligated to redistribute any repaid PRI principal as new PRIs or grants, this recycles charitable dollars, and foundations may use this feature to set up revolving PRI pools.

24 <http://www.communityphilanthropy.org/downloads/Equity%20Advancing%20Equity%20Full%20Report.pdf>. A few banks also use the term "PRI," generally to refer to long-term, fixed-rate concessionary debt to CDFIs or other community development organizations.

that provide good benefits to low-income workers, and some equity funds support real estate development in low- to moderate-income communities, including both transit-oriented, mixed-income workforce housing, and foreclosure mitigation.

Although direct mission investing in the health sector has been limited to date, there is a 40-year track record of well over \$2 billion in PRI investing in community development sectors that counter the adverse social determinants of health (see Figure 5).<sup>25</sup> The investments have generally performed, demonstrating the creditworthiness of a range of sectors that reinforce health in low- to moderate-income communities, from affordable housing and minority small-business lending, to charter school, child care, human service organization, sustainable development, and, most recently, fresh food supermarket finance.

Excluding outliers in the initial years of PRI practice, foundations report repayment rates of 96 percent on mission investing debt over a 40-year period.<sup>26</sup> Loss rates have improved with the evolution of due diligence and portfolio monitoring practices by foundations, and particularly as an increasing number of organizations such as CRA-motivated banks and other social investors have chosen to partner with CDFIs and similar specialized entities to execute their mission investing strategies. An industry-wide survey of CDFI intermediaries reported loss rates of under one percent for each year between 2000 and 2006.<sup>27</sup> While the current environment presents challenges for all investors, CDFIs have proactively managed the heightened risk. In addition, there are now sophisticated due diligence tools, such as the CDFI Assessment and Rating Service (CARST<sup>TM</sup>), and investment partners (including CRA-motivated banks and niche-specialized CDFIs) and services that can assist foundation investors with identification of high performing CDFIs, due diligence, deal structuring, and portfolio monitoring processes.

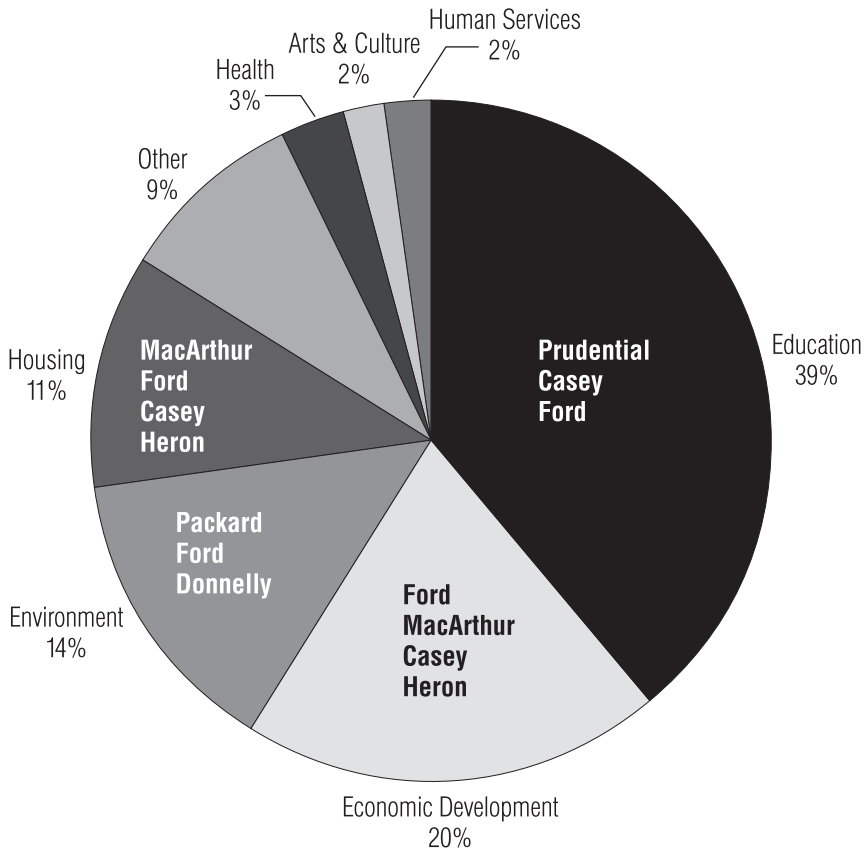
---

25 FSG Social Impact Advisors' 2007 retrospective on 40 years of mission investing tracked \$2.3 billion in cumulative investments through 2006, based upon a survey of 92 foundations. Since that time, GPS estimates that foundations originated \$200 million in PRIs per year on average, so that cumulative mission investments now likely exceed \$3 billion. Note that the Education volume in Figure 5 is skewed by one anonymous foundation that anecdotally provided major support for higher education versus K-12 education in low- to moderate-income (LMI) communities. However, an increasing number of foundations are providing PRI financing to intermediaries that finance high-performing charter schools that serve primarily low-income students.

26 FSG Social impact Advisors, 2007.

27 CDFI Data Project, 2007 [http://opportunityfinance.net/store/downloads/cdp\\_fy2007.pdf](http://opportunityfinance.net/store/downloads/cdp_fy2007.pdf). Although loss rates were higher in 2007, the CDFI industry has taken extensive measures to manage risk and contain losses. As of June 2009, a survey of CDFIs reported lower charge-offs than at year-end 2008 (1.1 percent at June 30, 2009, versus 1.7 percent at December 31, 2008) and a slowing in the pace of increased delinquencies. CDFI Market Conditions Reports, [www.opportunityfinance.org](http://www.opportunityfinance.org). Despite this generally strong performance, some of the largest foundation and bank investors in CDFIs have extended forbearance on interest and principal for a period of time as they more closely evaluate the challenges that individual CDFIs in their portfolios may be facing due to the adverse economy and tightened credit environment.

Figure 5. Mission Investing Segmentation by Program (2001–2005)<sup>28</sup>



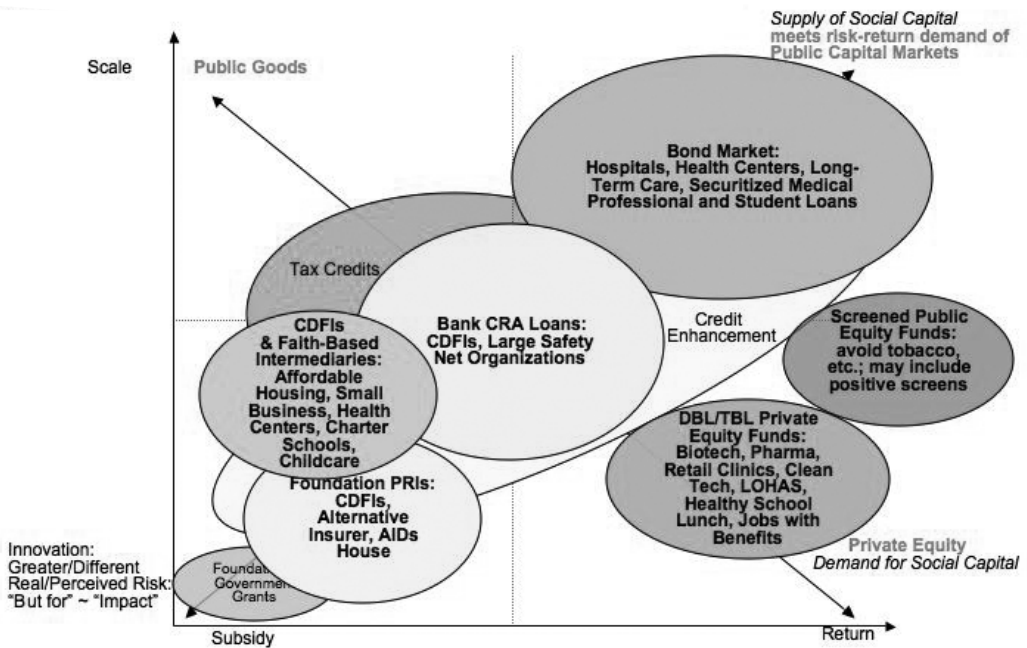
Consistent with their grant making, health-focused foundations currently considering mission investment strategies within the United States focus primarily on health care (financing for community health centers and the supply of health-care professionals in underserved communities), health coverage (alternative insurance, medical savings, and medical debt programs), and healthy community (access to quality child care, education, physical activity, healthy food, and jobs in a sustainable environment).

Given the need to attract large volumes of capital to scale successful initiatives, foundations as well as CDFIs often use PRIs as credit enhancement to leverage investment from the commercial capital markets. Structured as guarantees, subordinated debt, or, in some cases, tax credits that reduce transaction risk for bank or bond lenders, foundations and CDFIs aim

28 FSG Social Impact Advisors, *Compounding Impact*, 2007. <http://www.fsg-impact.org/ideas/item/485>.

to attract a portion of the estimated \$200 trillion in global capital markets (Figure 6).<sup>29</sup> In the current environment, when new grant or PRI resources may be limited due to reduced endowments, foundations are increasingly interested in guarantees as a means to leverage their balance sheets for the purpose of mobilizing capital from third-party investors.

Figure 6. Mapping US Health Care Financing Supply & Demand For Health Care, Health Coverage, Healthy Communities<sup>30</sup>



Key: CDFI – Community Development Financial Institution; LOHAS – Lifestyles of Health and Sustainability; DBL/TBL – Double and/or Triple Bottom Lines of Financial, Social and/or Environmental Return

29 Guarantees are a special form of PRI that can be counted against a private foundation’s charitable distribution requirement only if disbursed. Under normal circumstances, a disbursement would imply that the guarantee was called and the underlying loan was in default. However, some foundations disburse funds into reserve accounts for guarantees, counting these disbursed amounts against their charitable distribution requirements.

30 Figure 6 suggests that the supply of grant and below market-rate funds for innovative and early stage projects is very limited and historically has come from the public sector, faith-based investors, philanthropy and CDFIs (who typically raise their capital from these other investors, as well as from CRA motivated banks). As borrowing organizations become more experienced and manage larger projects, they need larger volumes of financing, which they may be able to access from larger, commercial debt markets, particularly if financing structures include credit enhancement. Such financing structures are often sponsored by CDFIs on behalf of their borrowers. The equity markets expect a high level of risk as a matter of course, and increasingly are financing companies with Double Bottom Line and Triple Bottom Line, health-enhancing products. GPS Capital Partners, LLC, 2009.

## The Way Forward

Effective collaboration between community development finance and public health requires concerted strategy development, followed by investment from a range of institutional investors representing community development and health interests, including CDFIs and similar intermediaries, government, foundations, banks, and other commercial capital markets investors. Collaboration efforts can benefit from considering the following Strengths, Weaknesses, Opportunities, and Threats (preliminary SWOT analysis):

### *Strengths:*

- A high level of mission commitment within both the community development finance and public health fields, with a focus on vulnerable populations and particularly children in low- to moderate-income and minority communities.
- A growing awareness of shared mission objectives and interest in collaborating, which set the stage for community development finance to develop a “culture of health” and public health to develop a “culture of community development finance.”
- Complementary skills and resources: for community development, this includes skills in identifying and financing high-performing and innovative community organizations, including by aggregating a range of public and private subsidies to credit enhance significant volumes of commercial financing; for public health, this includes a medical framework for defining healthy community, outcome measures that track longitudinal changes in health status and health-care costs among income, ethnic, and geographic groups and access to sector-focused financing sources.

### *Weaknesses:*

- No broad vision for healthy community that specifies the importance of private-sector financial investment has yet been articulated in policy or private initiatives.<sup>31</sup>
- While certain tested healthy community finance models exist, no systematic assessments of demand have been conducted, so there are no estimates of qualified demand. (Demand estimates have been prepared for specific sectors, such as affordable housing, community health centers, and charter schools.)
- Investing in healthy communities requires large investments up front for results that may be difficult to measure in the short term.
- Proposed collaboration between community development finance and public health presents learning curves for each on the other’s delivery systems, business models, agencies, financing sources, and language.

### *Opportunities:*

- Untapped investment potential from a range of mission-driven private investors, including health-focused foundations.

---

31 Isolated examples exist, such as among the Codman Square Health Center and its partners in Boston.

- One-time federal stimulus funds, a range of which can be leveraged in investments that jump-start health-enhancing projects in low- to moderate-income communities.
- Significant job creation outcomes as a by-product of investment in health-enhancing community services and projects, which allow low- to moderate-income communities to command an increasing share of the nation's more than \$2 trillion in annual medical expense as income to local health centers, related businesses, and health-care workers.
- The health-care-reform debate has raised awareness of the physical and economic effects of the deteriorating health status of Americans, increasing interest in finding community-based and cost-effective ways to prevent disease.

***Threats:***

- The economy may experience a protracted recovery, limiting the amounts of government and private-sector capital available for investment in healthy communities.
- Ongoing consumer advertising by the range of industries offering products and services that are harmful to health—particularly the high volume of ads that are targeted to children—will continue to jeopardize investments designed to motivate healthier choices. In this regard, community development brings useful lessons about the need for strong regulation and education as parallel strategies with market-driven solutions to social problems.<sup>32</sup>
- A new influx of any product, service, or disease that causes widespread health threats (including new strains of illicit drugs or natural pathogens) could create distraction.
- Unclear federal policy goals or weak local policy leadership could prevent the focus needed for the proposed collaborations to be a success.
- Regulations affecting community development financing are in flux, including but not limited to the CRA. This may reduce the willingness of banks and other institutional investors to extend financing for community development projects. A reduction in the number of banks and CRA programs, along with generally tighter credit, also threatens to reduce the supply of capital.

---

32 The community development finance field was launched in response to redlining, the deliberate withholding of credit by lenders in low- to moderate-income and minority communities. Community development finance offered nonpredatory, asset-building loans and financial services. Predatory providers, however, soon glutted the same markets with products that undermine household financial security. The current lack of nutritious food supplies in low-income communities—leading to their designation as “food deserts”—bears some similarity to financially redlined areas. The concentration of unhealthy food and other products (tobacco, liquor) in these communities, while perhaps not designed as predatory per se, bears parallels to the glut of predatory financial services and threatens residents' human capital as predatory financial services threaten their financial capital. As communities increase access to healthy food through investments in supermarkets, farmers markets, school lunches, and other initiatives, it will be important to maintain efforts to both educate residents about the risks of unhealthy products and curb the availability and advertising of these products.



- Effective community development strategies usually require direct input from and ownership by community members, which often requires a lengthy and potentially costly process.

Perhaps the greatest threat is taking no action to better coordinate community development finance and health-care strategies, given trends of deteriorating health status, which undermine the benefits of traditional community development investments and generate debilitating health-care costs. The good news is that action is already under way. Models of community development finance that promote human development and health have been tested and continue to evolve. Indeed, they and the community development finance organizations that sponsor them may be some of the most valuable assets that are “hiding in plain sight.” An important next step is to ensure that the models and partnerships become better known and more widely applied to scale both the health and economic benefits.

## Conclusion

The fields of community development finance and public health can improve poverty alleviation and health outcomes through collaboration focused on financial investments that improve the quality of life for all people who live, work, worship, learn, and play in low- to moderate-income and minority communities.<sup>33</sup> The goals of reducing poverty and improving health outcomes are mutually reinforcing, as both sets of outcomes are enhanced by investments that increase access to quality child care, education, affordable housing, and other local services in a sustainable environment, while producing jobs for local residents.

*Lisa Richter is principal and co-founder of GPS Capital Partners, LLC, a consultancy that assists foundations, banks and institutional investors in the design and execution of profitable investment strategy that enhances public-purpose goals. Her work spans asset classes and issue areas, incorporating place-based and investment focus to increase equitable access to opportunities, particularly in community development, education, and health. She is currently writing a guide to mission investing with Grantmakers In Health. This article was prepared with support from the W.K. Kellogg Foundation, which supports children, families, and communities as they strengthen and create conditions that propel vulnerable children to achieve success as individuals and as contributors to the larger community and society.*

---

33 <http://www.cdc.gov/healthypaces>.

*Appendix A: Healthy and Unhealthy Communities<sup>34</sup>*

<b>Unhealthy Community</b>	<b>Healthy Community</b>	<b>Example Community Development Finance Intervention</b>
Unsafe even in daylight	Safe neighborhoods, safe schools, safe walking routes	Foreclosure mitigation strategies are critical at this time to minimize abandoned property, which attracts crime. In addition, mixed-use affordable housing, commercial and facilities developments, including health care centers, bring needed foot traffic to low- to moderate-income communities, and charter schools and child care centers, often as “green” infill development that may offer safe, extended day activities, promote a sense of community and restore derelict sites.
Exposure to toxic air, hazardous waste	Clean air and environment	Use of brownfields, restoration, and green building techniques to retrofit hazardous environments and increased attention to siting of housing, schools, and other projects in areas that are remote from hazardous conditions.
No parks/areas for physical exercise	Well-equipped parks and open spaces/ organized community recreation	Situating of charter school and child care facilities adjacent to parks where possible, with use of parks for recess and other supervised physical activity.
Limited affordable housing is rundown; linked to crime-ridden neighborhoods	High-quality mixed-income housing, both owned and rental	The community development finance field has produced hundreds of thousands of units of affordable housing, including rental and ownership opportunities. It is increasingly using green building techniques that both improve air quality and lower operating costs. As noted, efforts to preserve these developments are critical in the wake of the foreclosure crisis.
Convenience/liquor stores, cigarette and liquor billboards, no grocery store	Well-stocked grocery stores offering nutritious foods	Public-private partnerships such as Pennsylvania’s Fresh Food Financing Initiative and use of creative financing tools such as New Markets Tax Credit are leading to new fresh-food outlets in urban and rural communities.
Streets and sidewalks in disrepair	Clean streets that are easy to navigate	Mixed-income housing developments may replace concentrations of public housing, restoring original street grids to promote pedestrian access to local goods and services.
Burned-out homes, littered streets	Well-kept homes and tree-lined streets	While these factors are typically supported by public dollars, residents tend to maintain and/or invest in the appearance of properties where a range of public and private investors, including community development organizations, are actively involved.

34 “Unhealthy and Health Community Profiles,” RWJF Commission Report; Community Development Finance Activity, GPS Capital Partners, LLC.

No culturally-sensitive community centers, social services, or opportunities to engage with neighbors in community life	Organized multicultural community programs, social services, neighborhood councils, or other opportunities for participation in community life	Many CDFIs have become facilities and cash-flow lenders to nonprofit organizations in order to ensure that quality human services and opportunities for community life are available at the neighborhood level. This includes programs that serve youth, such as YWCAs and Boys & Girls clubs. It also includes faith-based organizations that often anchor community life. Supportive housing is a model in which health and social services are offered on-site for disabled residents, particularly those at risk of repeat visits to emergency rooms. In San Francisco, a network of such housing has reduced costly emergency room visits by residents some 58 percent in the first year. [This result is from San Francisco Department of Public Health's Direct Access to Housing program that provides permanent housing with on-site supportive services for approximately 600 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. <a href="http://www.csh.org/index.cfm?fuseaction=Page.viewPage&amp;pageId=501">http://www.csh.org/index.cfm?fuseaction=Page.viewPage&amp;pageId=501</a> .]
No local health-care services	Primary care through physicians' offices or health center; school-based health programs.	A small number of community development lenders have become expert in the structuring and financing of community health center facilities and cash-flow needs. Some specialist developers of and lenders to charter schools facilities have indicated interest in incorporating school-based clinics in their facilities designs.
Lack of public transportation, walking or biking paths	Accessible, safe public transportation, walking and bike paths	The "smart growth" segment of community development has led the field in transit-oriented developments. While these are typically public-private partnerships with long planning horizons, they often include mixed-income housing and retail development that brings additional benefits to the community.

*Appendix B - Recommendations from the Robert Wood Johnson Foundation Commission<sup>35</sup>*

<b>Recommendation</b>	<b>Commission Rationale and Commentary</b>	<b>Example of CDFI Financing Intervention</b>
<p>1. Ensure that all children have high-quality early developmental support (child care, education, and other services). This will require committing substantial additional resources to meet the early developmental needs particularly of children in low-income families.</p>	<p>Children who do not receive high-quality care, services, and education begin life with a distinct disadvantage and a higher risk of becoming less healthy adults, and evidence is overwhelming that too many children are facing a lifetime of poorer health as a result. Helping every child reach full health potential requires strong support from parents and communities, and must be a top priority for the nation. New resources must be directed to this goal, even at the expense of other national priorities, and must be tied to greater measurement and accountability for impact of new and existing early childhood programs.</p>	<p>CDFIs are leading providers of child-care facilities finance, often incorporating technical assistance on best practices for the design and siting as well as financing of sites. Lack of conveniently located, appropriately designed child-care facilities is a major barrier to meeting the need for additional quality child-care slots, particularly in low- to moderate-income communities.</p>
<p>2. Fund and design WIC and SNAP (Food Stamps) programs to meet the needs of hungry families for nutritious food.</p>	<p>These federal programs must have adequate support to meet the nutritional requirements of all American families in need. More than one in every 10 American households do not have reliable access to enough food, and the foods many families can afford may not add up to a nutritious diet. Nutritious food is a basic need to start and support an active, healthy, and productive life.</p>	<p>CDFIs are increasingly financing supermarkets (see Figure 4 and following) and some CDFIs help to sponsor Farmers Markets that provide fresh food in low- to moderate-income communities. Both venues increasingly accept Food Stamps. CDFIs and similar intermediaries also provide financing to local farmers and sustainable value-added food producers.</p>
<p>3. Create public-private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.</p>	<p>Many inner city and rural families have no access to healthful foods: for example, Detroit, a city of 139 square miles, has just five grocery stores. Maintaining a nutritious diet is impossible if healthy foods are not available, and it is not realistic to expect food retailers to address the problem without community support and investment. Communities should act now to assess needs to improve access to healthy foods and develop action plans to address deficiencies identified in their assessments.</p>	<p>Pennsylvania's Fresh Food Financing Initiative (FFFI), which partners with the Philadelphia-based CDFI, The Reinvestment Fund, is the model for several supermarket initiatives that increase access to fresh food, provide jobs, and improve the attractiveness of low- to moderate-income urban and rural areas. NCB Community Impact has long financed sustainable food cooperatives.</p>
<p>4. Feed children only healthy foods in schools.</p>	<p>Federal funds should be used exclusively for healthy meals. Schools should eliminate the sale of "junk food," and federal school breakfast and lunch funds should be linked to demonstrated improvements in children's school diets.</p>	<p>New social enterprises such as Revolution Foods provide nutritious breakfasts, lunches and snacks in public schools with financing from double bottom-line equity and debt funds capitalized by bank and foundation investors.</p>

35 Sources: Recommendations and Commentary, RWJF Commission Report; Community Development Finance Examples, GPS Capital Partners, LLC.

Recommendation	Commission Rationale and Commentary	Example of CDFI Financing Intervention
5. Require all schools (K-12) to include time for all children to be physically active every day.	One in five children will be obese by 2010. Children should be active at least one hour each day; only one-third of high-school students currently meet this goal. Schools can help meet this physical activity goal through physical education programs, active recess, after-school and other recreational activities. Education funding should be linked to all children achieving at least half of their daily recommended physical activity at school, and over time should be linked to reductions in childhood obesity rates.	The CDFI, OneCalifornia Bank, provides working capital financing to Playworks with a guarantee from the Robert Wood Johnson Foundation. Playworks provides supervised recess in public schools serving low-income students in several cities, with expansion to additional cities under way.
6. Become a smoke-free nation. Eliminating smoking remains one of the most important contributions to longer, healthier lives.	Progress on many fronts—smoke-free workplaces, clean indoor air ordinances, tobacco tax increases, and effective, affordable quit assistance—demonstrates that this goal is achievable with broad public and private-sector support.	The RWFJ Commission Report suggests that early intervention that provides children with nurturing, stimulating environments and models for healthy behaviors “may be the most effective strategy for improving the health and well-being of our nation.” Boys & Girls Clubs and similar organizations offer still needed tobacco guidance (per the Centers for Disease Control some 20 percent of high school students smoke). CDFIs are a main source of facilities finance for quality child care and youth development facilities nationwide.
7. Create “healthy community” demonstrations to evaluate the effects of a full complement of health-promoting policies and programs.	Demonstrations should integrate and develop successful models that can be widely implemented and that include multiple program approaches and sources of financial support. Each “healthy community” demonstration must bring together leaders and stakeholders from business, government, health care, and nonprofit sectors to work together to plan, implement, and show the impact of the project on the health of the community.	Codman Square Health Center is one example of a health-focused neighborhood revitalization strategy in a low- to moderate-income, minority community, incorporating affordable housing development, financial counseling, and a charter school that prepares students for health careers. CDFIs have provided financing for affordable rental and limited-equity housing projects by the Codman Square Neighborhood Development Center. [ <a href="http://www.codman.org/">http://www.codman.org/</a> ; <a href="http://www.csndc.com/about.php#fp">http://www.csndc.com/about.php#fp.</a> ]

<b>Recommendation</b>	<b>Commission Rationale and Commentary</b>	<b>Example of CDFI Financing Intervention</b>
<p>8. Develop a “health impact” rating for housing and infrastructure projects that reflects the projected effects on community health and provides incentives for projects that earn the rating.</p>	<p>All homes, workplaces, and neighborhoods should be safe and free from health hazards. Communities should mobilize to correct severe physical deficiencies in housing, and health should be built into all efforts to improve housing, particularly in low-income neighborhoods. New federal housing investments should be held accountable to demonstrate health impact.</p>	<p>Enterprise Community Partners’ Green Community Initiative has created a set of building criteria designed to result in high-quality, healthy living environments and reduced utility and maintenance costs associated with single- and multifamily housing, among other goals. The Triple Bottom Line Collaborative articulates broad criteria for projects that advance community equity, economic and environmental goals (see Appendix D). [<a href="http://www.greencommunitiesonline.org/about/mission.asp">http://www.greencommunitiesonline.org/about/mission.asp</a>, <a href="http://tripleblc.ning.com">http://tripleblc.ning.com</a>.]</p>
<p>9. Integrate safety and wellness into every aspect of community life.</p>	<p>While much remains to be done to create safe and health-promoting environments, many schools, workplaces, and communities have shown the way, with education and incentives for individuals, employers, and institutions and by fostering support for safety and health in schools, workplaces, and neighborhoods. Funding should go only to organizations and communities that implement successful approaches and are willing to be held accountable for achieving measurable improvements in health.</p>	<p>The CDFI’s emerging focus on human development and health and its ongoing application of sustainable development and “smart growth” practices support this goal.</p>
<p>10. Ensure that decision-makers in all sectors have the evidence they need to build health into public and private policies and practices.</p>	<p>Decision-makers at national, state, and local levels must have reliable data on health status, disparities, and the effects of social determinants of health. Approaches to monitor these data at the local level must be developed by, for example, adapting ongoing tracking systems. Funding must be available to promote research to understand these health effects and to promote the application of findings to decision-makers.</p>	<p>Many CDFIs already report outputs to the federal CDFI Fund and other investors, and a number prepare analyses to better convey their health and other social impact. CDFIs can benefit from partnering with the health sector, which has significant longitudinal and demographic health status and health-care-cost tracking systems in place. [See CDFI Data Project, 2007 <a href="http://opportunityfinance.net/store/downloads/cdp_fy2007.pdf">http://opportunityfinance.net/store/downloads/cdp_fy2007.pdf</a>.]</p>

*Appendix C - Healthy Community Investment Structure and Impact*

<b>Example of Investee and Use of Proceeds</b>	<b>Possible Structure</b>	<b>Credit Enhancement, Tax Credit, or Subsidy</b>	<b>Example of Nonbank Investors</b>
<b>Health Care</b>			
Federally Qualified Health Center or "Look-Alike" Facility  Provides community-based care and medical home for coordinated care of chronic disease	Direct loan to health center Loan to CDFI or similar intermediary that lends to health centers	Facilities: New Market Tax Credit; USDA and HRSA guarantees; foundation subordinated loans, guarantees or grants	MetLife Kresge Foundation Rhode Island Foundation California Community Foundation
Federally Qualified Health Center or "Look-Alike" Working Capital  Enables expansion or continuous service during reimbursement delays	Direct loan to health center Loan to CDFI or similar intermediary that lends to health centers	Foundation subordinated loans, guarantees or grants	New Hampshire Charitable Foundation investment in NCB Capital Impact
<b>Health Coverage</b>			
Nonprofit-Sponsored Insurance Company  Provides affordable insurance for freelance workers in New York and selected states.	Long-term, low-interest loan to nonprofit insurance company sponsor, which it invests as equity in insurance company subsidiary	Foundation grants	Ford Foundation New York State Health Foundation Prudential Social Investments New York City Investment Fund
Family Economic Security: Bank or Credit Union; typically a CDFI  Promotes household savings and use of Earned Income and Child Care Tax Credits; provides nonpredatory household, business, and nonprofit organization finance	Market- or below-market-rate certificates of deposit, which can fuel general lending by the depository, or trigger or serve as a guarantee for particular loans by the depository	Foundation guarantees of bank or credit union loan(s) to selected borrower(s), such as nonprofit organizations in a particular sector. For enhanced deposit insurance: CDARS, a bank service that extends FDIC insurance up to \$50 million per depositor National Federation of Community Development Credit Unions' nominee accounts, which extend the amount of federal deposit insurance available per credit union depositor	Annie E. Casey Foundation F.B. Heron Foundation WK Kellogg Foundation John D. and Catherine T. MacArthur Foundation

Example of Investee and Use of Proceeds	Possible Structure	Credit Enhancement, Tax Credit, or Subsidy	Example of Nonbank Investors
<p>Healthy Communities</p> <p>Obesity Prevention: For-profit healthy food vendor to schools</p> <p>Provides nutritious breakfasts, lunches and snacks in public schools where childhood obesity is a high risk</p>	<p>Equity investment via private equity fund</p> <p>Working capital line of credit via intermediary</p>	<p>Private equity fund works with portfolio companies to identify local government subsidies for hiring of workers from low- to moderate-income areas or accessing space at below market- rental rates.</p>	<p>W.K. Kellogg Foundation</p> <p>Annie E. Casey Foundation</p> <p>Bay Area Equity Fund. [Revolution Foods had initial investment from the Bay Area Equity Fund I, whose nonbank investors include the F.B. Heron Foundation, Ford Foundation, John D. and Catherine T. MacArthur Foundation, Sand Hill Foundation, Peninsula Community Foundation (now Silicon Valley Foundation) and Annie E. Casey Foundation, as well as Catholic Healthcare West, Contra Costa Employees' Retirement Association, California State Automobile Association, and several insurance companies.]</p>
<p>Education: Nonprofit provider of structured recess in low-income public schools</p> <p>Provides daily, safe physical activity emphasizing team play, which also reinforces fitness</p>	<p>Working capital line of credit from local CDFI bank, which is guaranteed by foundation deposit in the bank. [Some guarantees can be secured by unfunded pledge of assets.]</p>	<p>Foundation guarantees working capital loan, which subsidizes interest rate on bank debt to nonprofit borrower</p>	<p>Robert Wood Johnson Foundation</p>
<p>Education: Charter School or Charter Management Organization</p> <p>High performing charter schools and charter management organizations provide improved educational outcomes, and better educational outcomes are correlated with better health outcomes. Charter facilities also often incorporate green, healthy building techniques.</p>	<p>Subordinated debt or guarantee for facilities financing by CDFIs, banks or the bond market</p>	<p>Federal Department of Education Credit Enhancement for Charter Schools Facilities</p> <p>New Market Tax Credit</p> <p>USDA guarantees for rural charter schools</p> <p>Foundation subordinated loans, guarantees or grants</p>	<p>Prudential Foundation</p> <p>Walton Foundation</p> <p>Annie E. Casey Foundation</p> <p>The Broad Foundation</p> <p>Bill &amp; Melinda Gates Foundation</p>



<b>Example of Investee and Use of Proceeds</b>	<b>Possible Structure</b>	<b>Credit Enhancement, Tax Credit, or Subsidy</b>	<b>Example of Nonbank Investors</b>
<p>Housing:</p> <p>Improved health outcomes are linked with safe and services enriched housing in urban, rural and reservation communities, including for the disabled and farm workers and their families. Achieving housing stability also calls for foreclosure prevention, where possible.</p>	<p>Subordinated and senior debt for all phases of housing development: predevelopment, construction and permanent mortgage</p>	<p>Low Income Housing Tax Credit            USDA Rural Rental Housing            Indian Housing Loan Guarantee            Federal Housing Administration            HOME            National Stabilization Program</p>	<p>John D. and Catherine T. MacArthur Foundation            Annie E. Casey Foundation            F.B. Heron Foundation            Ford Foundation            Rockefeller Foundation            The California Endowment</p>

*Appendix D: Balancing Environmental, Economic and Health Concerns in Urban and Rural America*

Investing in healthy communities can take many forms—from financing toxin-free housing to financing facilities that house quality child care, education and health care, to financing businesses that operate to restore or sustain a healthy environment. Often a higher initial investment is needed to install sustainable and energy efficient design elements for buildings or agriculture. These investments maintain the safety and productivity of natural resources that support rural economies. They also lower both environment toxins and ongoing energy use and other operating expense affecting all economies. As such, they are critical investments for low-income urban and rural communities.

The health risks in rural environments can be extremely severe, yet easily overlooked given the pressing problems of larger, urban communities. For example, migrant farm workers are among the most disadvantaged, medically indigent persons and have the poorest health of any group in the United States. The infant mortality rate among migrants is 125 percent higher than the general population, and the life expectancy of migrant farm workers is 49 (compared to the national average 75 years).<sup>36</sup> Toxicity from pesticides, physical straining and equipment risks are particularly high for migrant farm workers. Weather- and equipment-related risks are high for other rural occupations, such as fishing, logging and farming and ranching, which ranked first, second and sixth among the 10 most dangerous jobs in the United States reported by the Bureau of Labor Statistics in 2009.<sup>37</sup>

CDFIs have been investing to mitigate the special risks of rural communities for decades. As examples, Sacramento-based Rural Community Assistance Corporation, founded in 1978, continues to be a leader in financing safe migrant farm worker housing, as well as rural facilities and infrastructure. Community and Shelter Assistance Corporation of Oregon (CASA), founded in 1988, continues to finance a high volume of migrant worker housing and to provide asset building financial services.<sup>38</sup>

More recently, CDFIs throughout the nation are pursuing triple bottom line (TBL) financing strategies to stimulate local economies that restore or sustain the environment while promoting community wealth building (equity) and generating a financial return. As described by the Triple Bottom Line Collaborative (TBLC), elements of the approach include a commitment to delivering capital with triple-E impacts (economy, environment and equity), willingness to work with business borrowers and commitment to measuring and quanti-

---

36 Health conditions of migrant farm workers can be improved through not only safe housing structures but also through learned behaviors that promote a healthy home environment, such as removing pesticide-ridden shoes before entering one's home. <http://www.ohsu.edu/croet/aghealth/family.html>

37 <http://www.classesandcareers.com/education/2009/09/25/2009s-10-most-dangerous-jobs/>

38 <http://www.rcac.org/>, <http://www.casaoforegon.org>

fying the mission outcomes of investments (TBL Scorecard).<sup>39</sup> TBLC members include Coastal Enterprises, Inc., Four Directions Development Corporation, Montana Community Development Corporation, Mountain Association for Community Economic Development, Natural Capital Investment Fund, Northern Initiatives, Self-Help, ShoreBank Enterprise Cascadia, and Southern Mutual Help Association, Inc.

There are tensions inherent in the TBL approach. As described by TBLC member, ShoreBank Enterprise Cascadia, “Poverty trumps the environment . . . People struggling for solvency make decisions that solve the crisis at hand. Therefore, an honest long-term commitment to a triple bottom line demands an institutional commitment to delivering economic opportunity that follows directly from environmental well-being. CDFIs—formed in response to the crisis of limited investment engines for distressed communities—are a natural responder to structural environmental issues that threaten economic security.”<sup>40</sup> In practice, and increasingly in urban as well as rural communities, CDFIs are applying the TBL approach by investing in diverse natural resources, real estate, community facilities, affordable housing and related community development enterprises with three criteria in mind:

- Economic feasibility, or financial merits of the project;
- Equity contribution of the project to individuals and families in the form of good wages, local ownership of resources (businesses or property) and asset creating opportunities;
- Benefits and effects of the project’s operations, products, services, supply chain and related policies and practices on the environment.<sup>41</sup>

TBLC members apply these principles to financing services that promote community health and well-being—child care, education, health care and social services—along with business. Considering the demonstrated, increased risks to health from a contaminated environment, the comprehensive TBL approach offers great promise as a strategy to create healthier communities and residents for the long-term.

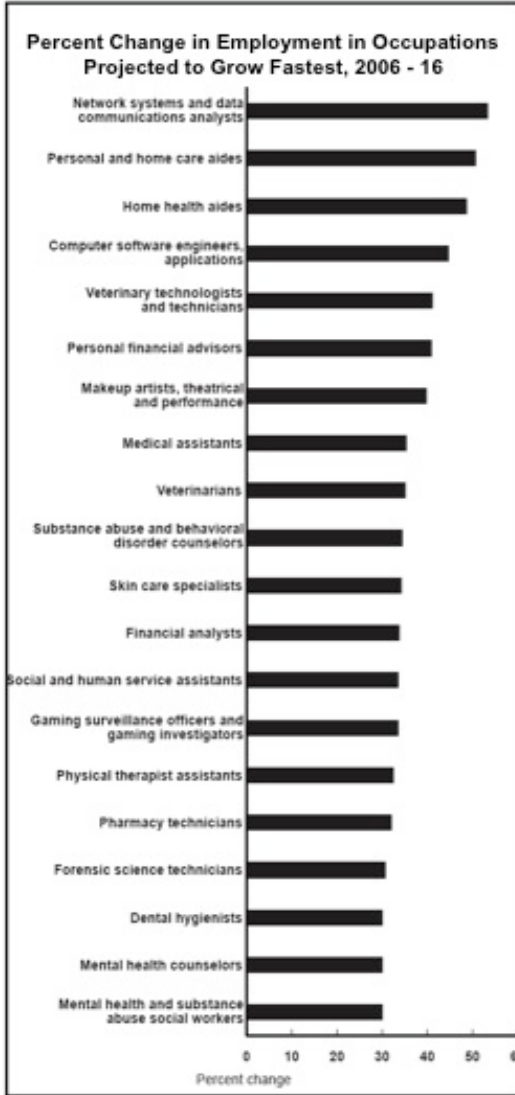
---

39 Other elements of the approach include: desire to apply the principles to the CDFI’s own operations, conviction that TBL financing is an important business opportunity for CDFIs and committed to forging related capital, policy and R&D initiatives. <http://tripleblc.ning.com/forum/topics/tblc-at-ofn-2008>.

40 ShoreBank Enterprise Cascadia. Measure What Matters: ShoreBank Enterprise Cascadia’s Commitment to Triple-Bottom-Line Metrics <http://www.sbpac.com>. ShoreBank Corporation has a broad commitment to triple bottom line investing under which it has disbursed more than \$1 billion in sustainable financing through bank and nonbank affiliates since 2000.

41 Ibid.

*Appendix E: Jobs Growth Outlook by Sector<sup>42</sup>*



42 U.S. Department of Labor, <http://www.bls.gov/oco/oco2003.htm> (last updated May 13, 2009).

# Coming Out as a Human Capitalist: Community Development at the Nexus of People and Place

*Nancy O. Andrews  
with Christopher Kramer  
Low Income Investment Fund*

*If poverty is a disease that infects an entire community in the form of unemployment and violence, failing schools and broken homes, then we can't just treat those symptoms in isolation. We have to heal that entire community. And we have to focus on what actually works.*

*President Barack Obama, "Changing the Odds for Urban America," July 18, 2008*

## **Executive Summary**

Recent research is making the case that the communities we live in can help or harm us at every level—physically, socially, emotionally. These effects can stay with us for the rest of our lives. There is a revolution in knowledge afoot that demonstrates convincingly that investing in people, especially in children, is every bit as important as investing in markets and buildings. It is important for the community development field to take this on board and, it is potentially transformative for our strategies and programs.

Knowledge emerging from multiple fields—housing, early care, education, health care and medicine—all contribute to a transformation in our understanding of poverty: what causes it and how to fight it. This evolving understanding of the physiological damage caused by poverty, of the connection between community and health, and of how early investment can reverse this damage is so new that it is rarely synthesized. Yet, taken as a whole, we see a new picture for community development. Community development in the United States arose from the War on Poverty in the 1960s. But 40 years of trial and error have taught us a great deal about what works and what does not. We must adapt by developing a more integrated vision of people and place. We must understand that our vision cannot be community development alone, but rather community and human development together. Particularly important are strategies that focus on young children, bringing support before too much harm is done.

This new vision raises the stakes for our work. A well functioning neighborhood is a place where investments are made in families and children, where they find the support they need to build the skills that secure a better future. As community developers, we must take the lessons of the current knowledge revolution to heart and apply them to our practice. Poised at the intersection of people and place, we are uniquely positioned to play an important role in bringing new strategies to bear, bringing hope to the families and communities where we work. This article is an effort to summarize the new information from the past 15 years and how it informs our work in community development.

## I. Introduction

“Poverty in early childhood poisons the brain.” This was the startling message heard by scientists, gathered for the American Association of the Advancement of Science conference in February 2008. Stunning new research suggested that children growing up in poor families experienced levels of stress so high that their brain development was actually impaired.<sup>1</sup> A year later, Cornell University quantified the impact of this: the stress caused by persistent poverty resulted in a 10 percent reduction in working memory. In effect, children in persistent poverty live more stressed lives, affecting their ability to learn. They enter school with a 10 percent penalty compared to other children.<sup>2</sup> Without help, the gap between them and other children widens and limits their life chances. Moreover, the Cornell study found that “only the duration of poverty during early childhood predicted subsequent working memory in young adulthood.”<sup>3</sup> Dr. Gary Evans, author of the Cornell study, said:

We know low-socioeconomic-status families are under a lot of stress—all kinds of stress....You may have housing problems. You may have more conflict in the family....You'll probably end up moving more often. There's a lot more demands on low-income families. We know that produces stress in families, including on the children.<sup>4</sup>

The 2009 results built on an earlier Cornell report showing that kids with persistent exposure to psychological risks (family turmoil, poverty) and physical risks (over-crowding, substandard housing) experienced higher levels of stress.<sup>5</sup> These findings are just the latest in a growing body of evidence that is shedding new light on how central child development, human capital development, and the environment are to the problem of poverty.

There are two distinct stories being told – one is about challenges and difficulties, and the second is about hope. The first story outlines the challenges we face in improving the lives of people and the communities where they live. We see with poignant clarity the corrosive effects of poverty, especially on young children. In the early years, children can be so harmed by poverty that they are ill-prepared to learn, to grow, and to thrive.

---

1 Clive Cookson, “Poverty Mars Formation of Infant Brain,” *Financial Times*, February 16, 2008.

2 Gary Evans and Michele Schamberg, “Childhood Poverty, Chronic Stress and Adult Working Memory,” *Proceedings of the National Academy of Sciences* 106, no. 16 (2009): 6545-6549.

3 *Ibid.* p. 6548.

4 Rob Stein, “Research Links Poor Kids’ Stress, Brain Impairment,” *Washington Post*, April 6, 2009, A06.

5 Gary Evans, et al., “Cumulative Risk, Maternal Responsiveness and Allostatic Load among Young Adolescents,” *Developmental Psychology* 43, no. 2 (2007): 341-351. Evans shows that young adolescents exposed to persistent psychological and physical trauma in the form of family turmoil, poverty, over-crowding, high noise levels, and poor housing experienced higher and cumulated stress levels, which result in higher wear and tear on the body. The impact of this could be mitigated by maternal responsiveness. If not, however, the stress loads built and were cumulative.

But, the second story gives us hope. A renaissance of knowledge is emerging that helps us know what works and how to organize our efforts to be most effective. The building evidence suggests that the starting point must be with children, and that providing a better environment of support for their development will pay off richly for them and for society. The earlier we intervene, the cheaper the interventions can be and the stronger the social returns. We also are learning that even in the teen years, children can make important strides in improving their skills, their educational attainment and their readiness to succeed in the broader economy.<sup>6</sup>

Over the past three decades, we have learned a great deal about what hurts and what helps.

### What Hurts

- Stress and its role in harming brain development
- Inadequate nutrition and health support
- Unsafe, unstable homes and neighborhoods
- Lack of language support, and the preponderance of negative verbal cues

### What Helps

- Human capital strategies – quality early care and education, good schools and parent support programs
- Safe, healthy communities with a strong infrastructure of services: schools, housing, transportation, health care, food access, and nutrition support
- Cost-benefit analysis showing return for social investment so we focus on what actually works

Because community development is the one field operating at the nexus of people and place, we have an important role to play, if we act on the insights emerging from this knowledge revolution. In this paper, we will discuss the interplay of various strategies within community development—housing, child care, education, health care, nutrition—and suggest that these strategies align well with the renaissance in understanding that is accumulating. We will summarize the important new information and key take-aways for community development, using the Low Income Investment Fund (LIIF) as a touchstone, particularly for its work in housing, child care and education. We also touch on the contributions of several

---

6 A number of studies have shown that the brain retains a certain amount of plasticity and has the ability to develop after childhood. David Kirp in *The Sandbox Investment: The Preschool Movement and Kids-First Politics* (Cambridge: Harvard University Press, 2007) writes: “Early learning does matter greatly, since it is the scaffolding for all the learning that follows, and so it’s sensible to focus on strengthening that scaffolding. But the life of the brain neither begins at birth nor ends at age three. The brain is more dynamic than that.” (111). See also, Jack Shonkoff and Deborah Phillips, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, DC: National Research Council and Institute of Medicine, National Academy Press, 2000). They write: “People are not like rockets whose trajectory is established at the moment they are launched. Indeed, it is the lifelong capacity for change and reorganization that renders human beings capable of dramatic recovery from early harm and incapable of being inoculated against later adversity....The real question is not which matters more—early or later experience—but how later experience is influenced by early experience.” (90).

other community capital organizations that are investing in human capital programs, including health and food access. By examining the evolution and success of these real world examples, we hope to create a pathway for the community development field that unlocks human potential while building community assets.

## II. The Knowledge Revolution: Coming Out as a Human Capitalist

Over the past several decades, community developers have become experts in providing housing and community facilities in low-income communities. The new research tells us that while housing is a key in the fight against poverty, its role may be most powerful in promoting stability for children and families. But the research also makes abundantly clear that housing alone is not enough to lift families out of poverty. Other human capital strategies – child care, education and others—must be employed to truly make a difference in the life chances of children. This paper will explore three of these in depth – child care, housing, and education.

Recent research has shown us that poverty and stress play a “killer” role for young minds, contributing to a well-documented achievement gap that persists through adulthood. Consider the following recent findings:

- Greg Duncan and Jeanne Brooks-Gunn’s analysis of the Infant Health and Development Program estimates a nine point IQ reduction for children younger than five exposed to chronic poverty.<sup>7</sup>
- Poor kids showed a 60 percent lower cognitive performance entering school, according to the Early Childhood Longitudinal Study,<sup>8</sup> and have shown in other studies to score lower on language proficiency and academic achievement measures.<sup>9</sup>
- Five times as many poor children as middle-income kids experience poor health through their lives, according to the National Household Survey,<sup>10</sup> and individual differences in adult health status are related to childhood poverty.<sup>11</sup>

---

7 Greg Duncan and Jeanne Brooks-Gunn, *Consequences of Growing Up Poor* (New York: Russell Sage Foundation, 1997), 12. This outcome is compared to children who had never lived below the poverty line, by age five; children who had lived below the poverty line some of the time showed a four point lower IQ compared to non-poor children. Cited also in Greg J. Duncan, et al., “Economic Deprivation and Early Childhood Development,” *Child Development* 65, no. 2 (1994): 296-318, 306.

8 Valerie E. Lee and David T. Burkam, *Inequality at the Starting Gate* (Washington, DC: Economic Policy Institute, 2002), 2.

9 Bradley, R.H., and Corwyn, R.F. (2002). “Socioeconomic Status and Child Development.” *Annual Review of Psychology* (53): 371-399.

10 Cited in Susan Neuman, *Changing the Odds for Children at Risk: Seven Essential Principles of Educational Programs that Break the Cycle of Poverty* (Westport, CT: Praeger Publishers, 2009), 18. See also Chen, E., Boyce, W.T., and Mathews, K.A. (2002) “Socioeconomic Differences in Children’s Health: How and Why Do These Relationships Change with Age?” *Psychological Bulletin*, 128: 298-329.

11 Rhakonen, O., Lahelma, E. and Huuhka, M. (1997). “Past or Present? Childhood Living Conditions and Current Socioeconomic Status as Determinants of Adult Health,” *Social Science and Medicine* (44): 327-336. And Smith, G.D., Hart, C., Blane, D., Gillis, C., and Hawthorne, V. “Lifetime Socioeconomic Position and Mortality: Prospective Observational Study.” *British Medical Journal* (314): 547-552.



The uneven playing field on which poor children must compete seems to start with handicaps around language and encouragement. Consider the following:

- Poor children have a deficit of more than 30 million words by the time they reach school, compared to middle income kids. Betty Hart and Todd Risley in *Meaningful Differences in the Everyday Experience of Young American Children* produced the remarkable result that the sheer number of words—not sophistication or complexity of words, but quantity—spoken to a child in the first three years of life predicted language skill much later, at ages nine and ten.<sup>12</sup>
- These researchers also confirmed that the verbal cues poor kids do receive are overwhelmingly negative—5 positive to 11 negative cues per hour for poor kids in one study, compared to 32 positive to 5 negative cues among middle class children. Hart and Risley estimate that poor children accumulate 125,000 more admonishments than encouragements by age four, compared to middle class children, who receive 560,000 more encouragements than admonishments.<sup>13</sup>

Hart and Risley also demonstrated that the differences in exposure to words predicted how well children would learn much later in life. They found that, the “Amount of parent talk accounted for all (emphasis added) the correlation between socioeconomic status (and/or race) and the verbal intellectual accomplishments...”<sup>14</sup> To their surprise, the negative effects of the 30 million word deficit turned out not only to linger, but to accurately predict child outcomes much later, even in third grade. “We were awestruck at how well our measures of accomplishments at 3 predicted measures of language skill at 9-10.”<sup>15</sup>

Perhaps the most damaging of all, however, is the growing evidence that children exposed to poverty suffer from actual impairment of brain function. Children from low-income backgrounds perform well below their higher-income peers on tests of language, memory, intelligence and concentration—all indirect measures of neuro-cognitive development.<sup>16</sup> However, new research has for the first time demonstrated disparities in direct measures of neural activity in the brain. Using electroencephalography (EEG) to examine responses to visual stimuli, children from low-income families showed electrophysiological patterns similar to patients with known brain damage to their lateral prefrontal cortex. This is an area critical for higher-level brain processing (known as executive function) such as planning, troubleshooting, decision making, abstract thinking, learning of rules, inhib-

---

12 Betty Hart and Todd R. Risley, *Meaningful Differences in the Everyday Experience of Young American Children* (Baltimore, MD: Paul H. Brookes Publishing Co., Inc., 1995), 198. Neuman and Celano produced similar findings: 126 words spoken per minute to middle-income children, but only 67 words spoken to low-income children. Susan B. Neuman, *Changing the Odds for Children at Risk* (Westport, CT: Praeger Publishers, 2009), 36-37.

13 *Ibid.*, 199.

14 *Ibid.*, xx.

15 *Ibid.*, 160.

16 Farah, M. J., Shera, D.M., Savage, J.H., Betancourt, L., Giannetta, J.M., Brodsky, N.L., et al. (2006). “Childhood Poverty: Specific Associations with Neurocognitive Development,” *Brain Research* (1110): 166-174.

iting inappropriate actions (resisting temptation), and the filtering of sensory information (concentration)—all processes important for success in school and in the workplace.<sup>17</sup>

Susan Neuman, an Assistant Secretary for Education in the Bush administration summarized the emerging knowledge as follows: “Brain development is much more vulnerable to environmental influence than previously suspected. New scientific evidence attributes negative impact on brain function, in part, to early stress. Good nutrition and nurturance support optimal early brain development.” Going further, Neuman touches on the influence of community on child development, pointing to “so many families cloistered in unsafe neighborhoods.” “Bad neighborhoods are bad for children,” she says.<sup>18</sup> These multiple factors combine to deeply influence child life outcomes.

Why is poverty so stressful and damaging to young children? The realities of poverty are hard to fully translate for a general audience, but the following common sense example brings it home: Housing costs consume 66 percent of a poor household’s budget. That leaves less than \$500 per month for everything else<sup>19</sup>—less than \$20 a day to feed the children, pay for transportation, health care, books for the kids, clothing, and recreation. This is a budget of deprivation, where families are often forced to choose between the rent and food, between heating and eating. Conditions like this can produce high levels of stress, poor nutrition and poor health. They can be crushing, especially to young children.

Nearly 40 million Americans (12.5 percent) live below the poverty line. Of these, 13.3 million are children, and 5.1 million are under six years old.<sup>20</sup> Add to this living in neighborhoods with high levels of crime and violence, and the stress on families can ripple through children’s lives for years. Is it any wonder that the Cornell University study cited above found a 10 percent reduction in learning capacity? Is it any wonder that by kindergarten, poor children already have such deep learning deficits that the gap between them and middle-income kids will persist and grow?

But as we learn, we are also honing in on what interventions make the biggest difference. For example, early care and education programs markedly reduce the gap caused by poor environment, generating social returns that are four or five times their cost. Indeed, one extensive cost-benefit analysis of a high-quality early care program documented as much as

---

17 Mark M. Kishiyama, W. Thomas Boyce, Amey M. Jimenez, Lee M. Perry, and Robert T. Knight, “Socioeconomic Disparities Affect Prefrontal Function in Children.” 2008. *Journal of Cognitive Neuroscience* (21), 6: 1106-1115.

18 Susan Neuman, “Changing the Odds for Children at Risk: Seven Essential Principles of Educational Programs that Break the Cycle of Poverty,” (Westport, CT: Praeger Publishers, 2009), 127.

19 Harvard University Joint Center for Housing Studies tabulations of data from the US Census, 2007 American Community Survey (provided at author’s request). The “State of the Nation’s Housing 2009” published by the Joint Center estimates that low-expenditure families with high housing cost burdens have \$485 per month after housing costs for all other expenditures, 26.

20 John Cook and Karen Jeng, “Child Food Insecurity: The Impact on our Nation.” C-SNAP, 6.

17-to-1 returns for each dollar invested.<sup>21</sup>

In *Changing the Odds for Children at Risk* (2009), Susan Neuman assembles a compendium of such programs. She details an array of community-based programs—early care centers, parenting support programs, and others—that are generating 5-to-1 returns or higher in societal savings compared to their costs. These programs are known to work and are known to erase some of the worst deficits of poverty.

In a different corner of social science research, other findings have been emerging that create tantalizing suggestions about the possible connections between the newly recognized importance of stress on children and the built environment—including housing support and the quality of neighborhoods. In particular, the Welfare to Work (WtW) and Moving to Opportunity (MTO) demonstrations revealed a connection between reduced housing costs and more stable lives, between neighborhood quality and psychological distress, anxiety and health outcomes. For example, the Welfare to Work program demonstrated that affordable housing results in a 50 percent reduction in over-crowding, a risk factor implicated in the 2007 Cornell University study on child stress levels. WtW also recorded a 35 percent reduction in family moves and a 40 percent increase in food expenditures, linked to the availability of lower cost housing.

Even modest interventions can make measurable differences, if support is given early enough and is focused on the children most at risk. For example, early results from a University of Oregon study demonstrate that parents attending an eight week course in how to better handle their children's disruptive behavior reported lower family stress levels than the control group. Neural scans of their children showed improvements in the formation of neural pathways, as well.<sup>22</sup> Another study showed that children stunted by poor nutrition and poverty were able to catch up after two years of weekly play sessions with mothers at home, combined with a nutritional supplement.<sup>23</sup>

Results like these are coming forth in greater numbers, often as the results of multi-year longitudinal experiments are reported. As a consequence, there are increasingly strong suggestions that a more integrated approach focused on child and human development is needed to effectively tackle poverty. They lead to a vision centered on human development within a community environment that is safe, healthy, and served by strong institutions—schools, early care and education, libraries, food access, health and recreational services.

---

21 Barnett WS. "Cost Benefit Analysis." In Schweinhart LJ, Barnes HV, Weikart DP. Significant Benefits: the High/Scope Perry Preschool Study Through Age 27. Ypsilanti, MI: High/Scope Press, 1993: 143-173. See also, Schweinhart LJ, Berruta-Clement JR, Barnett WS, Epstein AS, Weikart DD (1985). "Effects of the Perry Preschool Program on Youths through Age 19: A summary." *Topics in Early Childhood Special Education Quarterly*, 5:26-35.

22 Cookson, op cit.

23 S.M. Grantham-McGregor, et al., "Nutritional Supplementation, Psychosocial Stimulation, and Mental Development of Stunted Children: The Jamaican Study," *Lancet* 338, no. 8758 (1991): 1-5.

This convergence of knowledge suggests three broad groupings of interventions that are most beneficial in addressing poverty:

- **Early care and education**, i.e. quality child care with structured play for brain stimulation and development, in a safe and non-chaotic setting,
- **Parent education**, to teach the importance of reading and talking to a child, particularly with positive disciplinary strategies,
- **Healthy, safe communities** that provide a stable environment of supporting institutions – affordable housing, early care centers, schools, libraries, health centers, food access.

In “Schools, Skills and Synapses,” Nobel Prize-winning economist James Heckman noted: “A divide is opening up in American society. Those born into disadvantaged environments are receiving relatively less stimulation and resources to promote child development than those born into more advantaged families....[A] major determinant of child disadvantage is the quality of the nurturing environment rather than just the financial resources available.”<sup>24</sup>

Traditionally, child care programs have been seen as second sisters to investments in elementary education. But the information emerging in recent years suggests that investment in education works best along with earlier investment in child development. Study upon study confirms the rich reward we receive for investing in early care program – sometimes 10 percent and even as high as 20 percent for well-staffed, intensive programs.<sup>25</sup> James Heckman and colleagues summarized the costs and benefits of investing in early child development programs in “The Dollars and Cents of Investing Early”<sup>26</sup> and found:

- A 10-to-1 cost-benefit was shown for the Chicago Child Parent Centers (CPC), with a 22 percent internal rate of return.
- A 4-to-1 cost savings benefit was shown for the Carolina Abecedarian child care program of full-day early care, compared to a control group; this translated to a 7 percent return.
- A 17-to-1 benefit from the Perry Preschool Program with an 18 percent annual return on investment
- A 5-to-1 benefit from the Nurse Family Partnership, with a 23 percent return on investment.
- Neuman reports a 2-to-1 benefit for Bright Beginnings in Charlotte, N.C., with long-term benefits of \$13.74 for every dollar invested, although the long-term benefits must still be confirmed with longer term studies.<sup>27</sup>

24 Heckman, James J. “Schools, Skills and Synapses” National Bureau of Economic Research, Working Paper 14064, June 2008 <http://www.nber.org/papers/w14064>, 14, 16.

25 Neuman, op. cit., 44.

26 Heckman, James, Rob Grunewald and Arthur Reynolds, “The Dollars and Cents of Investing Early: Cost-Benefit Analysis in Early Care and Education,” (2006), 13, available at [www.zerotothree.org/reprints](http://www.zerotothree.org/reprints).

27 Neuman, op cit., 110.

The Abecedarian and Perry Pre-School programs (above) both show results where individuals scored higher on achievement tests, attained higher levels of education, required less special education, earned higher wages, were more likely to own a home and were less likely to go on welfare or be incarcerated than control groups. Children were followed until age 40 with the Perry Pre-School Program, and until age 21 with the Abecedarian program.

Heckman concludes that these programs produce benefits at least as good as returns from the stock market. He says, “An estimated rate of return (the return per dollar of cost) to the Perry Program is in excess of 10%. This high rate of return is higher than standard returns on stock market equity (7.2%) and suggests that society at large can benefit substantially from these kinds of interventions. These are underestimates of the rate of return because they ignore economic returns to health and mental health.”<sup>28</sup>

### **III. Human Capital and the Built Environment: An Integrated Vision of Community Development**

Traditionally, community development has centered on the “hard” skills of real estate development, finance, and capital leverage. The softer side of the equation – human services and support—has frequently been associated with dependency, rather than true, long-term advancement. Moreover, there is an interesting gender aspect within this, with human services often led by women, while the more “muscular” areas of market growth and real estate development attracted male leadership and more investment. The knowledge revolution challenges these subtle but powerful cultural biases, teaching us that soft skills and nurturing support may be fundamental to hard skills and durable development. Contrary to creating dependency, these services actually create the human scaffolding that allows other social development to take root and flourish.

Community development programs create affordable housing and finance school facilities at scale, mobilizing billions of dollars to revitalize low-income places. However, the renaissance of knowledge now suggests that without commensurate investment in the people-side of the equation, the benefits of community investments will be weaker and more short-lived. It is time for those of us in community development to more completely embrace the value and importance of human capital development and to integrate such strategies more proactively into our toolkit. We need to develop a vision that is more clearly centered on the growth of human potential, especially young human potential.

Investments in the physical infrastructure without investments in people run the risk of fleeting returns; the positive effects of investment dollars are often blunted by the root causes of poverty. Recognizing the vital importance of the human capital strategies, community developers can become a stronger voice in advocating that these kinds of resources be delivered to the communities we serve. We can prioritize our support for projects that include

---

28 Heckman, James J. “Schools, Skills and Synapses” National Bureau of Economic Research, Working Paper 14064, June 2008 <http://www.nber.org/papers/w14064>, 21.

human capital growth, and we can present opportunities for our public and philanthropic partners to help us apply the new lessons to build stronger communities.

This integrated vision was evident in a recent speech by Housing and Urban Development Secretary Shaun Donovan, when he recalled the origins of the urban development and housing movement:

Riis, Jane Adams, Lillian Wald and others in the emerging settlement house movement recognized that substandard physical structures, as terrible as they were, were only part of the problem. They believed ... that transformation required a focus on something far more ambitious: on physical health, on education, on access to economic opportunity. On meaningful outcomes that often resulted from the overall condition of the neighborhood – on which the built environment was a major influence to be sure.<sup>29</sup>

The insights of these early visionaries, like Riis and Adams, remain important to community developers today. Their original inspiration of an integrated approach to people and place is being confirmed today by emerging research, and points the way toward the future of community development.

The story of the Low Income Investment Fund (LIIF) mirrors the evolution in this thinking. Founded 25 years ago as the Low Income Housing Fund, LIIF started out to finance housing in communities red-lined by banks. Believing that capital flowing into poor places would create growth and opportunities for residents, LIIF quickly became a leader within the emerging community capital movement. LIIF specialized in finding capital solutions for neighborhood housing projects that combined an array of social services and quirky revenue streams, while simultaneously serving very low income people. However, by 1998, LIIF had begun to realize that providing housing alone was not enough to address poverty. LIIF saw that stable, affordable housing was part of a larger puzzle of improving the life chances of poor people. However, even in those early days, LIIF pioneered financing for human service projects: battered women's shelters, health clinics, community service centers.

In the late 1990s, the City of San Francisco turned to LIIF to leverage its Community Development Block Grant program to build new child care centers. San Francisco faced a deep shortage of child care facilities at a time when welfare reform was pushing parents into the workforce and extra demand-based subsidies were entering the system. Parents who wanted to work could not find places to put their children during the day, and the "vacancy rates" in child care centers serving poor communities were virtually zero. New centers needed to be created, and LIIF had the know-how to make it happen. LIIF's child care financing efforts started in San Francisco, but have since spread throughout the state of California and to New York City, as well, supporting over 125,000 spaces in safe, quality centers. With this experience under its belt, LIIF began actively to seek other ways its finan-

---

<sup>29</sup> Shaun Donovan, "From Despair to Hope: Two HUD Secretaries on Urban Revitalization and Opportunity" National Press Club, Washington, DC, July 14, 2009.

cial expertise and experience with human service organizations could be used toward the larger goals of poverty alleviation and economic advancement.

LIIF's early efforts have evolved into three new programs that provide early stage, high risk capital for the facilities and real estate needs of nonprofit, community based developers across the U.S. in the following areas of need: (1) child care, (2) housing, and (3) education. The focus on these three areas has paid off in tangible results. In total, LIIF has made \$750 million in investments in these three programs, supporting 54,000 affordable homes for families and kids, 43,000 school spaces, and 125,000 child care spaces in poor neighborhoods. LIIF estimates that these investments have yielded more than \$15 billion in family and societal benefits.

LIIF's programs followed the vision of improving the skills and human assets for the lowest income people, while promoting investments to create healthy communities. LIIF believed that sustainable development was fundamentally rooted in creating human capital and that human development occurred best in the context of strong, healthy communities. The three strategies—child care, housing, and education—are described below.

### *Child Care*

Why are early care programs so important? For two reasons: first, to allow parents to go to work and stay in work, knowing that their children are safe and well cared for while they are away; and, second, to mitigate the worst effects of stress and poverty on child brain development, by stimulating neural development and laying a foundation for future success in school. Good, quality early care helps children thrive and learn. It is a lynchpin to breaking the cycle of poverty. The knowledge revolution of the past few years has taught us that the first years in a child's life can make a significant difference. Stress robs a child of needed brain development. The lack of verbal exchange and parent engagement appear to do the same. In addition, we now know that most of the neural pathways that allow us to think are created early, between the fourth and seven month of gestation.<sup>30</sup> We've learned that neural pathways in young children flourish with verbal stimulation and parent engagement, but go on hold when under frequent or prolonged stress, i.e. threats to physical or psychological well-being.<sup>31</sup>

As important as this early stage is, only half of all low-income children are enrolled in quality care programs—programs that have a chance of providing the brain stimulation, positive reinforcement and quality care that boosts a child's life chances. Poor families' budgets

---

30 Cited in Neuman, *Changing the Odds for Children at Risk*, 3. Neuman cites Dr. Bernard Shaywitz et al, "Development of Left Occipito-Temporal Systems for Skilled Reading Following a Phonologically Based Intervention in Children," *Biological Psychiatry*, 55 (2004).

31 Neuman (above), p. 5 cites the work of Jack Shonkoff in describing the impact of stress on brain development. She also cites (p. 8-9) the work of Patricia Kuhl at the University of Washington, comparing the learning of infant children interacting with adults in language sessions, versus children listening to DVDs. No learning whatsoever occurred with the children listening to DVDs, whereas those listening and interacting with adults progressed. "The message was clear: learning is enhanced in a social setting."

are stretched to the point of breaking, with housing consuming two thirds of household income. The average cost of child care runs an additional \$10,000 per year – out of reach of the poor. They depend upon federally and locally subsidized early care programs, like Head Start or a number of the others featured above. The dearth of children receiving this essential, high return support is tragic and ultimately, damaging to the overall economic performance of the country.

There are two key barriers to closing the gap:

- **Insufficient operating support.** In 2009, \$12 billion in total federal funding was available for child care. All needy children could be served with an additional annual investment of \$17 billion.
- **Too few facilities.** Even when operating support is available, the supply side of the equation represented by the number of physical facilities, creates a bottleneck. In California, LIIF estimates that 60,000 additional children could be served without additional cost if adequate facilities were available to house them. Capital programs, in tandem with existing operating subsidies would close a measurable portion of the gap.

Community development has four important contributions to promote child care. First, our stature within national and state policy circles means that our voice could add a great deal to the debate about directing public resources. Second, our expertise in financing community facilities would add tremendous capacity to the child care sector. Third, our financial engineering expertise can optimize the use of public dollars, leveraging private capital and allow the combination of existing resources to add to the current supply. And fourth, we can help cut the red-tape of local planning rules, zoning requirements and jurisdictional issues to shorten the development process and save money in the creation of child care facilities. LIIF's Constructing Connections program does exactly this—cuts local red-tape by coordinating rules, building standards and competing oversight by multiple agencies. We estimate that these interventions have saved six months in the development cycle for each child care facility developed or renovated.

Preparing young children to learn means they will perform better in school. Better school performance leads to better jobs and a more productive workforce. All of these lead to a better, more competitive national economy. Quite literally, the nation's future is tied to its investment in children and in education. Yet there is a portion of the workforce that is not learning as well as it could, or contributing as much as it could to our collective prosperity. Child care is a lynchpin to ensure that disadvantaged children are better able to reach their potential.

### *Housing*

While early care programs can advance a child's learning capacity and allow parents to enter the workforce, affordable housing is a platform for family stability. Affordable housing is a fundamental safety net which, if frayed, allows other investments to drain through. It is a platform for family stability.



When too much of a family budget is devoted to housing, there is little room left for investment in kids. Furthermore, stressful housing conditions can create stress that negatively impacts human development. Poor families sometimes have little choice but to live in unsafe neighborhoods, where the threat of violence erupts visibly at times, but is always simmering beneath the surface. For the past 20 years, affordable housing has been linked to health, emotional well-being, and the ability of families to get by in high cost environments. For example, the recent Welfare to Work (WtW) demonstration program showed that housing support created a:

- 50 percent reduction in over-crowding
- 35 percent reduction in family moves and
- 40 percent increase in food expenditures

These positive results were compared to a control group that lacked housing subsidies.<sup>32</sup> The results are based on a five year, random assignment experiment involving 8,731 families from six major cities. Welfare to Work tested the role of housing support and found that it “offered security in the face of job loss or other financial disaster: Recipients knew that the family would always have a roof over its head and this relieved a great deal of stress.” They cited the voucher’s role in reducing stress for themselves and their children:

In some cases, the voucher enabled a parent to work less and spend more time with children; in others, worrying less about finding and keeping adequate housing enabled parents to focus better on their children’s needs.<sup>33</sup>

The reduction in moves and over-crowding are particularly notable. Fewer family moves are believed to positively affect child educational attainment; over-crowding is suspected as detracting from a child’s ability to study and learn. Interestingly, the lack of child care emerged in WtW follow up interviews as a key barrier to work. Finally, the WtW program also reported that the extra family income from lower housing costs “often went to providing for children’s needs and wants and for basic household expenditures, including food.”<sup>34</sup>

With respect to food and nutrition, Harvard University’s “State of the Nation’s Housing” report provides support to the positive WtW conclusions. In 2007, this report linked housing affordability and the subsequently freed up family income with higher food and health care expenditures – poor families with affordable housing spent 30 percent more on food and 70 percent more on health care than families with high cost burdens.<sup>35</sup>

---

32 Wood, Michelle, Jennifer Turnham, and Gregory Mills. “Housing Affordability and Family Well-Being,” *Housing Policy Debate*, Volume 19, Issue 2, 384, 390, 402. The Welfare to Work demonstration program was a random assignment, controlled experiment involving 8,371 families, observed over a five year period.

33 *Ibid.*, 401,404.

34 *Ibid.*, 401.

35 *State of the Nation’s Housing*, (2007), 27, 29.

The role of place is illuminated even more through the Moving to Opportunity (MTO) program, which combined housing subsidies with relocation to low-poverty neighborhoods.<sup>36</sup> The MTO interim evaluation finds that affordable housing paired with low-poverty neighborhoods resulted in “a substantial reduction in psychological distress among adults” and, among children, “moderately large reduction in psychological distress” for girls, though worse outcomes for boys. The report also found “a substantial decrease in the incidence of depression among girls in the Section 8 group; and very large reductions in the incidence of generalized anxiety disorder among girls in both treatment groups.” The interim U.S. Department of Housing and Urban Development (HUD) evaluation of the MTO program linked these improvements in mental health to improved safety in the neighborhoods. MTO also saw a significant decrease in obesity among adults. The interim evaluation for MTO reports: “Perhaps not surprisingly, these improvements in living environment led to significant gains in mental health among adults in the experimental group. The level of psychological distress was substantially reduced in this group.”<sup>37</sup>

These results suggest that housing assistance is an important safety net for families fortunate enough to receive it. In addition, the MTO interim findings suggest that moving to low-poverty places may have positive outcomes, particularly on psychological distress among adults and girls, as well as the physical health of adults. The findings are not definitive and additional research would need to be done to draw firm conclusions. However, they suggest that reduced housing expenditures and better neighborhoods give families the economic and psychological freedom to invest more in their children’s nutrition and health. The ethnographic reports from WtW participants suggest a tantalizing connection between housing support and the recent research about stress, poverty, and children’s outcomes. Housing support appears to be a factor, likely an important factor, in greater family stability and therefore, to the future life chances of poor children.

Questions remain, however, about how important housing affordability is to future child outcomes, and how strong the neighborhood must be to produce the benefits seen in MTO—must families move to middle-income neighborhoods to see these results, or is simply moving to lower crime, higher safety communities good enough? The answer to these questions would lay the groundwork for cost-benefit analysis that can help us understand how much social investment is required in housing and place-based strategies to achieve social goals.

---

36 In July 2009, the Pew Economic Mobility study released results underscoring the importance of place and community in shaping the life chances of children. The study found that for children whose family income is in the top three quintiles, spending childhood in a high-poverty neighborhood versus a low-poverty neighborhood (say, experiencing a poverty rate of 25 percent compared to a rate of 5 percent) raises the chances of downward mobility by 52 percent. Indeed, neighborhood poverty can explain one-quarter to one-third of the black-white gap in downward mobility. Neighborhood poverty alone accounts for a greater proportion of the black-white downward mobility gap than the effects of parental education, occupation, labor force participation and a range of other family characteristics.

37 “Moving to Opportunity: Interim Impacts Evaluation,” U.S. Department of Housing and Urban Development, x and xvi of Executive Summary.

## *Education*

*Early investment must be followed up to be effective. Capabilities produced at one stage of the life cycle raise the productivity of investment at subsequent stages.*

—James J. Heckman “Schools, Skills, and Synapses” (2008)

There is broad consensus that education is the key that unlocks a child’s future. A high school graduate will earn \$270,000 more over his/her lifetime than a high school dropout. College graduates earn nearly twice (177 percent) the amount earned by students who have received only a high school diploma.<sup>38</sup> And these benefits carry over into future generations – children from parents with higher levels of education do better than those without. Moreover, the benefits of education have been growing: in 1973, a male high school dropout’s wage would have been \$13.61 per hour, compared to \$9 per hour now; those with advanced degrees earn 20 percent more than three decades ago.<sup>39</sup> Beyond this consensus, however, the situation becomes murkier.

As President Obama also said, “there’s this sense that education is somehow a passive activity, and you tip your head over and pour education in somebody’s ear. And that’s not how it works.”<sup>40</sup> Putting kids in schools by itself is not enough to reverse the corrosion of poverty. In fact, poor children entering schools struggle to catch up, and in most cases do not. By age 24, about three-fourths of all students from families in the top income quartile had earned bachelor’s degrees, compared to only about 10 percent of students from the bottom income quartile.<sup>41</sup> But well-run, well-managed schools that demand active parental engagement can draw forth much higher achievement from students. The following examples give a sense of possibility.

- The graduation rate from Green Dot schools significantly outpaces those of local school districts—81 percent of Green Dot entering freshmen graduate from high school, compared to 47 percent from the Los Angeles Unified School District (LAUSD). More than 75 percent of graduating seniors have been admitted to four-year universities.<sup>42</sup>
- All schools within the Alliance for College Ready Schools system outscored the neighboring public school that their students would otherwise have attended by a range of 112 – 296 points on the Academic Performance Index (API). Four Alliance high schools have earned

---

38 Jennifer Cheeseman Day and Eric C. Newburger, “The Big Payoff: Educational Attainment and Synthetic Estimates of Work-Life Earnings” (Washington, DC: U.S. Census Bureau), July 2002, 10.

39 Data cited in Neumann, op cit., 11.

40 Barack Obama, quoted in the *New York Times*, “The Way We Live Now – 24/7 School Reform,” by Paul Tough, September 7, 2008.

41 “Family Income and Educational Attainment, 1970 to 2007,” Postsecondary Education Opportunity 197 (2008): 1-16, 8.

42 Green Dot Public Schools, “School Results.” Available online at <http://www.greendot.org/results>.

2008 API scores that rank them among the top 12 high schools in the Los Angeles Unified School District.<sup>43</sup>

LIIF alone has invested \$200 million in neighborhood schools like these. Several other CDFIs, notably The Reinvestment Fund, NCB Capital Impact, and the Local Initiatives Support Corporation have done the same, helping hundreds of thousands of low-income children have access to excellent school environments. Despite the political arguments that surround charter schools, the outcomes confirm that children can make huge strides when given the opportunity to do so and when investments are made in their futures. While the section above on early care and education demonstrates the importance of investing early in children's futures, the experience of these new school experiments suggest that progress is possible.<sup>44</sup>

#### IV. Demonstrating Social Impact

Community development finance will thrive to the extent that we can provide a convincing case that we leverage human potential and create a good return for the taxpayer's dollar. The cost benefit studies performed for the child care sector make a compelling case that these programs produce excellent return for the investment. The same needs to be done for other social strategies employed by community development practitioners. For example, there are striking connections between the role of affordable housing in reducing stress and anxiety, in increasing food security and in creating a platform for family stability. These ideas have yet to be fully explored, yet the potential cost-benefit payoff could be huge. Notably, the MacArthur Foundation is now funding research that hopes to address at least some of these questions.

However, as an industry, we could advance our work if we took the initiative and tried to show how we hit the impact bulls-eye. As practitioners, we are not researchers. Nevertheless, we can do our best to develop information that is useful. There are several practical things we can do: First, we can lend our voices to the call for supporting evidence-based impact analysis and we can embrace such evidence when it is made available. Second, as we have done with

---

43 Alliance College-Ready Public Schools, "Four of the Top Twelve LAUSD High Schools are Alliance Charter Schools." Available online at <http://www.laalliance.org/comparison.html> (last visited September 14, 2009).

44 Elementary, middle and high school are crucial to creating college readiness. They create the training and skills necessary to succeed in higher education environments. They also create the atmosphere that teaches children they can and should aspire to college. They open the doors to future achievement. The importance of college cannot be overstated. Recent research has also demonstrated the significant returns to higher education, showing returns 12 percent or more, similar to those calculated by Heckman in his evaluation of early care and education programs:

- "If the value of a college education is expressed on the same basis as the return on a financial investment, the net return is on the order of 12 percent per year, over and above inflation. This compares favorably with annual returns on stocks that historically have averaged 7 percent."
- "Accounting for costs of education and the time value of money, discounted lifetime net benefits from a university degree including combined individual and societal benefits—exceed \$600,000 per worker—a combined internal rate of return of about 16 percent."

Kent Hill, Dennis Hoffman, and Tom R. Rex, "The Value of Higher Education: Individual and Societal Benefits," p. 1-2. Arizona State University, Productivity and Prosperity Project, October 2005.

the CARS financial rating system, we can agree that impact analysis is at least as important as financial performance; we can hold our own feet to the fire in setting performance standards. Third, we can agree on estimation techniques that we develop and/or that rely on a growing literature of the costs and benefits of social programs, as has been done by Heckman and others. While not perfect, it is better than silence on this topic.

LIIF attempts to apply such impact-focused cost-benefit analyses to its housing, child care and education investments. By these (imperfect) measures, LIIF estimates that its investments have created \$15 billion in family and societal benefits through its investment in community projects. This is an excellent return for \$750 million in LIIF's own capital investments and \$5 billion in additional capital investments attracted by LIIF's participation.

LIIF estimates impact in three primary ways:

*Child care* – Relying on the Heckman et al. research cited above, LIIF assumes a conservative 4-to-1 benefit for the investments made in child care. LIIF determines the one year operating cost of the center and multiplies it by \$4 to achieve an estimated societal benefit. This substantially understates the true benefit, because most children stay in child care for at least three years, and LIIF's support is long term.

*Housing* – LIIF computes the difference between the affordable rents/price of the housing we finance and the market price, based on appraisals at the time of financing. We multiply this difference by the number of years affordability is certain, i.e. the term of the Low Income Housing Tax Credit (LIHTC) if an LIHTC property, or if not, by the term of LIIF's loan (generally two-to-three years). The result is the "income benefit" to the families in these residences, and thus the "impact" of the housing. This is not true impact analysis in the research sense. But, it is a useful way to consider the monetary benefit of affordable housing, which, as noted earlier in this paper, provides a stabilizing influence on families through fewer moves and reduced crowding.

*Education* – Relying on solid research, LIIF calculates the incremental high school graduation rate in the schools it finances, compared to the schools in the surrounding district. Based on this differential, LIIF multiplies the number of desks filled with students that would not otherwise have graduated from high school by \$270,000, the lifetime earning difference for a high school degree. This understates the "impact" because desks are only counted once, rather than for the full life of the school and because no college benefit is assumed.

These ways of measuring impact are suggestive, not definitive. They create a picture of the power of leverage. The CDFI industry would benefit by discussing its impact—either cost-benefit analysis or internal rate of return (IRR) for the taxpayer/philanthropic dollar.

## **V. Putting the Pieces Together—A Paradigm Shift for Community Development**

CDFIs are innovators—we invent new opportunities when we focus on challenges. The goal of this paper is to urge innovation in new directions—directions centered on human

growth and development, within the context of healthy communities. This is a bulls-eye for our industry. But it requires us to renew our vision in keeping with the renaissance of knowledge emerging over the past decade. We must adapt by developing a more integrated vision of people and place – we must understand that our vision cannot be community development alone, but rather community and human development together. Particularly important are strategies that focus on young children, bringing support before too much harm is done.

If there are three points the reader should take away from this paper, they are:

- *Human capital strategies* – especially for young children – deserve a more prominent place within community development; place based strategies alone are not enough.
- *Creating safe, healthy communities* with a strong infrastructure of proven, high-quality human services should be the future organizing principle for community investment. This can include in-place strategies as well as mobility strategies.
- *Cost-benefit analysis* of our own work is essential to future success.

CDFIs use their intellectual capital – their smarts – to attract private capital into places and services that would not receive investments otherwise. CDFIs are leverage machines, developing ingenious ways to create new investment and new assets in the sectors and communities left behind by mainstream economics. We described the history of the Low Income Investment Fund in searching for strategies beyond housing to address poverty. This search opened channels to community impact that included leadership in the area of child care.

Other community capital organizations like The Reinvestment Fund (TRF) and NCB Capital Impact are opening other chapters as well. For example, TRF is pioneering a new pathway for investing in quality food stores in poor areas, with the goal of food access and nutritional support. With LIIF, TRF and NCB Capital Impact pioneered capital investment in charter schools; collectively, these three organizations have delivered nearly \$700 million to the charter school industry. In total, CDFIs have a strong track record in human capital investments.

Boiling it down to its essence, CDFIs capitalize public support—housing subsidies, child care subsidies, health care subsidies—to create long-term assets that serve low-income populations and places for many years. But the most durable asset of all is a change in the life chances of a child.

Community developers are uniquely positioned to synthesize this new perspective with our more traditional work on the built environment. Our field operates at the nexus between people and place. Over the past 40 years, we have created scale, credibility, and perhaps most importantly, a voice that speaks for places and people left behind by the mainstream economy. By embracing a more integrated, holistic vision – and by focusing on what works, as President Obama has urged—the field of community development can become even more important to the goal of social progress and equality. To achieve this, we must aggressively

advocate for impact analysis and cost-benefit reviews of our work. We must be willing to confront results that are less than we hoped for and correct our course appropriately. At the end of the day, doing less than this short-changes the ultimate goal of our work – giving all Americans an opportunity to reach their full potential.

*Nancy O. Andrews is the president and CEO of the Low Income Investment Fund (LIIF), a \$600 million Community Development Financial Institution. LIIF has invested \$750 million in capital in low income communities, supporting 54,000 affordable homes for families and children, 100,000 spaces of child care and 44,000 spaces in school facilities. LIIF's capital has leveraged \$5.1 billion in capital for low income communities, mobilizing \$12 billion in family and societal income.*

*Christopher Kramer is a senior fellow at the Low Income Investment Fund (LIIF). Prior to joining the organization, he consulted on policy and new program development. He previously worked on various policy issues as a professional staff member for the United States Senate. Mr. Kramer holds a J.D. and an M.B.A. from Stanford University and a B.A. from the University of Michigan.*

# Community Health Centers: A Vital Strategy for Community Development

*Scott Sparte and Annie Donovan*

*NCB Capital Impact*

Community health centers contribute in significant ways to the growth and stability of low-income neighborhoods. Their impact has been long-standing, yet not widely known in the community development field. With the nation's health-care system poised for significant change, it is an appropriate time to shed light on the link between health centers and community development.

The benefits that health centers deliver to communities reach well beyond their core purpose of improving access to essential health services for low-income people. The health outcomes they achieve increase worker productivity, which can lead to poverty reduction. Further, health centers provide direct employment to local residents, including entry-level jobs with career ladders. Health centers purchase goods and services from local businesses, thus spreading indirect benefits more broadly through the multiplier effect. The facilities constructed by health centers bring capital investment to underserved communities and anchor commercial revitalization.

As community development investments, health centers have an excellent track record of responsibly using debt to finance their growth. With appropriately structured financing, health centers have been able to develop modern, efficient facilities that enhance the quality of care provided while stimulating economic development, assuring their continued role as important economic engines, as well as essential components of the nation's health care system.

## **What Are Community Health Centers?**

Community health centers (CHCs) are nonprofit organizations that meet the primary-care needs of individuals and families living in low-income communities, including many of the nation's Medicaid recipients and uninsured, in areas traditionally underserved by physicians. Health center services are provided to all, regardless of the patients' ability to pay, and services are tailored to the cultural and linguistic needs of individual constituencies. Health-care practices have evolved, as have community health centers, growing from small storefront clinics in the late 1960s to large comprehensive health-care facilities today. As health centers have evolved into organizations of greater sophistication and complexity, their impact on the surrounding communities has grown as well.

Community health centers were originally created as part of the Office of Economic Opportunity in the 1960s War on Poverty, at the same time that community development corporations (CDCs) were formed. Both CHCs and CDCs share a common focus on local empowerment and development through the concept of maximum feasible local participation. Health centers were conceived from a grassroots movement and remain deeply



embedded in their local communities. To this day, CHCs require that 51 percent of the governing board be composed of consumer users of the health center's services.

Community health centers act as the nation's health-care safety net, offering a full spectrum of care that is sensitive to each community's unique needs from more than 7,000 delivery sites in underserved urban and rural areas nationwide.<sup>1</sup> Most health center patients live at or below the federal poverty level, which is less than \$11,000 in annual income for a single person or about \$22,000 for a family of four.<sup>2</sup> To help provide services to such a low-income client base, community health centers rely on a combination of federal and state grants, Medicaid and Medicare reimbursement, patient fees, private insurance payments, and donations, underscoring the need for cost-effective delivery.

So important is the need for community health facilities that the Bush administration increased federal operating support to enable community health centers to double their capacity by opening 1,200 new or expanded service sites between 2002 and 2006, and in 2009 the Obama administration has provided more than \$1 billion in grants for facilities and technology through the American Recovery and Reinvestment Act of 2009.

Most health centers are not just small organizations working to meet the needs of low-income people. Many operate from multiple sites around the community, from small school-based clinics to large comprehensive-care facilities that provide a combination of primary care, dental care, and behavioral health services. A typical health center sees approximately 50,000 patient visits annually, has an annual operating budget of \$10 million or more, three to five clinic sites, and 60 to 80 employees, including physicians, nurses, and other health practitioners, as well as accounting staff and other administrative positions. Some of the larger organizations have budgets approaching \$100 million, twenty or more sites, and 200 or more employees.

To help improve health outcomes for their patients and strengthen operating efficiency, community health centers also make a significant investment in equipment and technology. Federal stimulus dollars are targeted toward the purchase of electronic medical records systems that allow health centers to interface across sites, with hospitals and specialty providers, and with other health-care organizations. This investment will place community health centers near the forefront of the latest improvements in managing patient care.

## Impact

As of 2007, 1,100 federally funded CHCs operating from 7,000 sites served more than 16 million patients. Nearly 40 percent of those patients were uninsured and 35 percent were enrolled in the Medicaid program.<sup>3</sup> These health centers are improving health outcomes for medically underserved populations, creating employment and other economic opportunities and stimulating investment in low-income areas.

---

1 National Association of Community Health Centers, *US Health Center Fact Sheet*, 2008.

2 US Department of Health and Human Services, <http://aspe.hhs.gov/poverty/09poverty.shtml>.

3 National Association of Community Health Centers, *US Health Center Fact Sheet*, 2008.

## Better Care, Lower Cost

People who lack primary health-care services are at greater risk for poor health outcomes and are more likely to use more expensive emergency room care. Low-income people and communities are among the most vulnerable. Access to primary health care can reduce avoidable hospitalizations, help to manage chronic conditions, and lead to less serious episodes of illness. As medical “homes” for low-income individuals, CHCs are the first line of defense. Studies show that both uninsured and insured patients without access to CHCs were twice as likely to go without the care they need, even those who were privately insured.<sup>4</sup>

Compared to Medicaid patients treated elsewhere, health center Medicaid patients are between 11 percent and 22 percent less likely to be hospitalized for avoidable conditions and are 19 percent less likely to use the emergency room for avoidable conditions. They also have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient and other care costs.<sup>5</sup>

With a heavy emphasis on prevention, health centers help patients manage the most prevalent diseases or disease factors facing low-income communities, such as diabetes, hypertension, substance abuse, and HIV/AIDS. For example, diabetes patients at health centers receive more care than other low-income diabetics,<sup>6</sup> and have lower rates of low-birth-weight babies when compared to both other low-income patients and all U.S. patients.<sup>7</sup> Of critical importance, CHCs have reduced health-care disparities based on race and income.<sup>8</sup>

A study released in August 2007 by the National Association of Community Health Centers (NACHC), in collaboration with the Robert Graham Center and Capital Link, found that medical expenses for health center patients are 41 percent lower (\$1,810 per person annually) compared to patients seen elsewhere. As a result, they save the health-care system between \$9.9 and \$17.6 billion a year.<sup>9</sup>

- 
- 4 R. Politzer et al., “Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care,” *Medical Care Research and Review* 58 (2) (2001): 234–48.
  - 5 Falik et al., “Comparative Effectiveness of Health Centers as Regular Source of Care,” *JACM* 29 (1) (2006): 24–35. Falik et al., “Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers,” *Medical Care* 39 (6) (2001): 551–56. B. C. Duggar et al., “Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers,” Center for Health Policy Studies, 1994.
  - 6 L. Shi, “A Review of Community Health Centers: Issues and Opportunities,” Washington, D.C., May 25, 2005. Based on Community Health Center User Survey, 2002, and National Health Interview Survey, 2002.
  - 7 L. Shi et al., “America’s Health Centers: Reducing Racial and Ethnic Disparities in Prenatal Care and Birth Outcomes,” *Health Services Research* 39 (6) (2004): pt. 1, 1881–1901.
  - 8 P. Shin, K. Jones, and S. Rosenbaum, “Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low Income Communities,” September 2003. Prepared for NACHC, [http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/GWU\\_Disparities\\_Report.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/GWU_Disparities_Report.pdf).
  - 9 NACHC, Robert Graham Center, and Capital Link, *Access Granted: The Primary Care Payoff*, August 2007.

## Economic Impact

Health centers are more than service providers. They are employers and local businesses that have a significant impact on the surrounding community. Using available economic modeling tools, community health centers are able to quantify the direct and indirect effect of providing jobs and income to employees and other businesses, which then ripples through the local economy.

The NACHC study found that in 2005, CHCs directly generated over \$7 billion of revenue and employed 90,000 people nationally. Using the IMPLAN model for estimating multiplier effects, the study shows total economic impact of \$12.5 billion and the creation of 143,000 jobs in some of the country's most economically deprived neighborhoods.<sup>10</sup>

*Table 1. Total Economic Activity Stimulated by CHCs, 2005<sup>11</sup>*

	<b>Total Economic Impact</b>	<b>Employment (Total FTEs)</b>
Direct	\$7,261,975,096	89,922
Indirect	\$1,124,387,922	10,233
Induced	\$4,172,328,893	42,918
Total	\$12,558,691,911	143,073

## Anchoring Revitalization

In many cases, when health centers improve their facilities, they spark community revitalization. Examples of the impact of health centers on local revitalization abound. In Brockton, Massachusetts, a New England town that has been struggling with the effects of the loss of a manufacturing and industrial base, the Brockton Neighborhood Health Center (BNHC) is an example of a facility that has grown from humble beginnings to being a large and visible economic engine in the city's downtown. BNHC is the only community health center in this city of 94,000, which is economically distressed with poverty levels significantly exceeding statewide averages. Brockton's higher level of poverty is the result of the loss of a manufacturing base in recent years since its core shoe- and boot-making industry moved out

10 IMPLAN's output, earnings, and employment figures are aggregated based on direct, indirect, and induced economic effects defined as:

Direct effects: represents the response for a given industry (in this case Total Operating Expenditures of health centers).

Indirect effects: represents the response by all local industries caused by "the iteration of industries purchasing."

Induced effects: represents the response by all local industries to the expenditures of new household income generated by the direct and indirect effects.

11 NACHC, Robert Graham Center, and Capital Link, Access Granted: The Primary Care Payoff, August 2007, [www.nachc.com/research](http://www.nachc.com/research).

of the country. An estimated 4,200 jobs have left the city during the last ten years.

Because this area faces high rates of disease, illness, and teen pregnancy in addition to low rates of prenatal care, BNHC's services are critical for Brockton's population. Despite the fact that more than half of Brockton's mothers receive publicly funded prenatal care, more than a third do not receive prenatal care in their first trimester. Most of Brockton's disease rates, especially HIV/AIDS and other STDs, particularly among adolescents, far exceed state rates. In addition, most of Brockton's residents may not have access to primary care, leaving many residents to suffer from manageable conditions such as asthma and pneumonia.

As the demographic profile of Brockton has changed, the health center has worked to focus on providing culturally competent care. Almost 40 percent of the health center's 12,000 patients require translation assistance. In response to this need, the center employs staff members fluent in Cape Verdean Creole, Portuguese, Spanish, French, and Haitian Creole. Approximately 70 percent of patients live at or below the federal poverty level. Most of the center's active patients live in Brockton, with others residing in the neighboring communities of Stoughton, about three miles northwest of Brockton, and Taunton, about ten miles south. A smaller segment lives in the smaller towns situated east of Brockton toward the coast. No other health centers are available to people living in these small towns.

The need for health care in greater Brockton is acute. BNHC began operating from a mobile van in a church parking lot in 1994, and over the years it has grown by adding leased sites throughout the city. In 2007, the center moved into a new 57,000-square-foot, five-story facility on a vacant lot in downtown Brockton, which has allowed them to consolidate leased sites and more than double patient capacity.

The health center's board and management chose to develop its new facility in the heart of downtown. This site anchors one end of the city's main street, combining the entire health center's scattered sites into one facility and generating significant additional traffic to Brockton's downtown. The center also partnered with a small local pharmacy, which moved from its location down the street to a space in the new center, thus supporting a locally owned business while also providing needed access to pharmaceuticals under the health center's roof. As evidence of the project's positive impact on Brockton's downtown, part of the funding for the health center came from the Economic Development Administration of the U.S. Department of Commerce. Additional financing came through New Markets Tax Credits, using the subsidy to reduce the health center's annual debt service expense and allocate more of its cash flow to providing services to low-income patients.

This project is expected to create more than 92 new jobs at the health center. Using the multiplier effect, the project can be expected to create more than 276 indirect jobs and bring millions of dollars of additional revenue into the Brockton area.

## **Financial Strength and Facility Needs**

In this time of economic uncertainty, community health centers face many challenges in providing high-quality primary care to low-income patients. Uninsured populations increase

with growth in unemployment, placing pressure on providers and facilities. State budget deficits force reductions in entitlement programs. Health centers find it difficult to recruit and retain staff willing to work for lower wages in what are often older facilities than their private-practice equivalents. In addition to rising costs, shifting reimbursement streams, and the strain of a constantly growing demand for their services, health centers have traditionally encountered difficulty in obtaining appropriately structured financing for working capital, building projects, and equipment needs, often due to a perception that their clientele, their funding, and their location make them a higher-than-average risk.

Fortunately, experience has shown that community health centers and other community-based health-care providers are remarkably resilient and resourceful. Even as there have been times of tight state budgets and reductions in reimbursement, community health centers have been and continue to be financially stable with diverse revenue sources. Maintaining stability requires creativity, dedication to managing costs, and improving efficiency in the face of a challenging economic environment.

Another example of a resilient, innovative CHC is Community Health Center, Inc., based in Middletown, Connecticut, serving the entire state from multiple sites. This health center took advantage of its eligibility to participate in a federal pharmaceutical purchasing program by partnering with a for-profit pharmacy that co-locates in a number of the health center's clinical sites. This partnership allows the health center to connect its patients with low-cost pharmaceuticals through the federal pricing program without having the logistical and investment burden of operating a pharmacy of its own. It also makes use of the buying power of a large pharmacy chain to provide patients with access to other medical supplies not covered by the federal pricing program—and patients don't even have to leave the health center property. This allows the health center to meet patient needs and improve health outcomes because patients don't have to make a second trip to a pharmacy in another location that might be difficult to reach.

Although they serve a predominantly low-income population, a community health center's facilities do not have to be in poor repair. Health centers suffer from the perception that they are a health-care provider of last resort, with outdated facilities to match. But with appropriately structured financing, health centers in many parts of the country have been able to improve the efficiency and capacity of their facilities while maintaining high-quality care for their patients. One health center's board and management recently undertook the construction of a new facility to be a focal point for their community that would not, in their own words, "look like a clinic for poor people."

South of Market Health Center (SMHC) in San Francisco is an excellent example of a project that was developed to act as a community focal point. For more than 30 years, SMHC has been the primary source of medical and dental care for the low-income, uninsured, homeless, and medically-needy residents of the city's South of Market (SOMA) neighborhood as well as parts of the adjacent Tenderloin district.

SOMA has always been among the more affordable neighborhoods in San Francisco and

is home to a large number of lower-income and immigrant populations. The health center's service area is represented by seven contiguous census tracts that consist of a densely populated urban area with a diverse mix of residents. Many seniors and extremely low-income families live in the center's service area. Additionally, the infamous Sixth Street Corridor, the well-known homeless/near-homeless, transient, and substance-abusing area of San Francisco, is located one block north of the current clinic site. Many single-room-occupancy hotels housing single adults are located along the Sixth Street Corridor.

A study conducted by the health center concluded that a greater proportion of SOMA residents live in poverty as compared to the city's residents as a whole. For example, the median household income of SOMA was half of that for the entire city, and the unemployment rate among SOMA residents was more than double that of citywide residents. The study also reported that the population in SMHC's service area had grown nearly 50 percent during the previous decade.

Although the dot-com boom of the 1990s was largely centered in the SOMA district, displacing many of its residents, new low-income housing supported by the city has since restored affordability to the area and drawn this population back.

To support the neighborhood's health-care needs, SMHC employs more than 40 full-time staff and offers an extensive array of family-oriented health services, including primary medical care, disease prevention, urgent care, dentistry, and podiatry. The health center also offers specialty programs such as women's health care (including family planning and prenatal and postpartum care) and management of high-risk diseases (such as HIV/AIDS services). Approximately two-thirds of the health center's patients are uninsured and one-third are homeless.

In 2007, the health center served 4,700 patients, generating more than 17,000 patient encounters, representing the maximum the current facility can accommodate. The health center has functioned at this capacity for more than ten years.

SOMA is in the midst of a project to construct a new site that allows the center to double its capacity as they move from a cramped and aged facility to a modern, more efficient one. The new health center is part of a campus that includes nearly 50 units of affordable housing (developed and financed by another organization). The new development will consist of two main buildings. The first building will be a five-story structure with three levels of housing over a two-level community health center. The second structure will be a four-story residential building situated along the rear boundary of the lot. The two structures will be separated by a courtyard. In total, the development project will offer 20,000 square feet for the community health center and 48 units of rental housing for low-income families. The new medical facility will have enough space to house the clinic administration as well as medical, dental, pharmacy, lab work, and x-ray services. Housing units will consist of one- to three-bedroom units, community rooms, and an outdoor playground.

The campus is located in a predominantly residential neighborhood with a handful of small service businesses in the immediate area. It replaces a former parking lot and is a notable improvement to the neighborhood. For every job the health center creates, it is esti-

mated that another 1.5 jobs will be created in the community to provide support services to the facility and its users.

Like many health centers, this facility was constructed with a combination of fundraising and debt. For this project, a strong capital campaign allowed the health center to raise a significant portion of the \$15 million budget, which combined with support from the City of San Francisco Redevelopment Agency allowed the health center to cover approximately half of the project costs. The balance was financed with debt from NCB Capital Impact, a nonprofit lender, and New Markets Tax Credit equity, making this large project very affordable for a medium-sized health center. The table below shows how the financing was assembled.

*Table 2. Sources and Uses of Funds*

<b>Sources</b>		<b>Uses</b>	
NMTC Debt	\$2,446,080	Land & Predevelopment	\$2,241,567
Soft Debt	\$6,903,701	Construction	\$10,163,137
NMTC Equity	\$3,184,564	FF&E	\$1,000,000
SFRA Land Grant	\$1,093,612	Soft Costs	\$625,773
Fundraising	<u>\$1,513,203</u>	Contingencies	<u>\$1,110,713</u>
<b>Total Sources</b>	<b>\$15,141,190</b>		<b>\$15,141,190</b>

Although community health centers face many challenges in providing care to low-income individuals, the challenge of facilities development is not insurmountable. Using a variety of funding sources, health centers have been able to construct modern, efficient facilities that enhance the quality of care provided while improving and empowering their communities, assuring their continued role as important components of the nation's health-care safety net. Beyond their role as health-care providers, health centers are also economic engines that create jobs, improve their neighborhoods, and have a positive impact on their surrounding communities.

*Scott Sporte is director of NCB Capital Impact's community lending group, where he has been responsible for the organization's lending to charter schools, community-based health care and affordable homeownership.*

*Annie Donovan is chief operating officer of NCB Capital Impact. She is responsible for leading the company's efforts in innovative community lending, expert technical assistance, strategy formation, product innovation, and policy development. NCB Capital Impact supports people and communities to reach their highest potential at every stage of life.*

**References and Resources**

[http://www.ibrc.indiana.edu/studies/Community\\_Health\\_Centers\\_2009.pdf](http://www.ibrc.indiana.edu/studies/Community_Health_Centers_2009.pdf).

[http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp\\_publications/pub\\_uploads/dhpPublication\\_A7BA8B9A-5056-9D20-3D3852F88AC4EF03.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A7BA8B9A-5056-9D20-3D3852F88AC4EF03.pdf).

<http://www.bphc.hrsa.gov>.

<http://www.implan.com/>.

Access Granted: The Primary Care Payoff. National Association of Community Health Centers, The Robert Graham Center, Capital Link, 2007.



# Building Healthy Communities Through Equitable Food Access

*Judith Bell*

*PolicyLink*

*Marion Standish*

*The California Endowment<sup>1</sup>*

In America today, millions of people leave their homes in a protracted and often futile search for healthy food for their families. Many walk out their front doors and see nothing but fast-food outlets and convenience stores selling high-fat, high-sugar processed foods; others see no food vendors of any kind. Without affordable fresh food options, especially fruit and vegetables, adults and children face fundamental challenges to making the healthy food choices that are essential for nutritious, balanced diets. And without grocery stores and other viable fruit and vegetable merchants, neighborhoods lack a critical ingredient of vibrant, livable communities: quality food retailers that create jobs, stimulate foot traffic, and bolster local commerce.

Local environments profoundly influence the choices individuals make about eating and exercise. Scientists and health professionals agree that poor diet, along with a lack of physical activity, is a key contributor to obesity. Foundations, advocates, practitioners, and policymakers are addressing the obesity crisis on multiple fronts.<sup>2</sup> Potential solutions include efforts to expand access to grocery stores and other healthy food retailers; improve school food environments; restrict the availability of convenience stores and fast-food outlets; expand park space and other opportunities for physical activity; maintain and strengthen government food programs; and develop education programs to influence individual choices about eating, exercise, and screen time (TV and computer). The goal of improving fresh food access in underserved areas must be viewed in the context of a broad-based movement to build healthy communities.

Limited access to fresh foods primarily affects inner-city communities, rural areas, and some older suburbs and is felt most acutely in low-income communities and communities of color. A 2009 study found that 23.5 million people in low-income communities have no

---

1 Portions of this article were adapted from the PolicyLink report *Healthy Food, Healthy Communities: Promising Strategies to Improve Access to Fresh*, “Healthy Food and Transform Communities,” by Rebecca Flournoy and Sarah Treuhaft. See [www.policylink.org](http://www.policylink.org).

2 See, for example, the Healthy Eating, Active Communities initiative of The California Endowment, which aims to fight childhood obesity by promoting healthier environments in neighborhoods and schools and by advocating for local and state policy change. <http://www.healthyeatingactivecommunities.org/>.

supermarket or large grocery store within a mile of their homes.<sup>3</sup> In California, lower-income communities have 20 percent fewer healthy food sources than higher-income ones.<sup>4</sup> In Albany, New York, 80 percent of nonwhite residents live in neighborhoods where one cannot find low-fat milk or high-fiber bread, a staple in any middle-class community.<sup>5</sup>

While advocates have worked on improving food access for decades, the obesity epidemic has helped propel the issue to the forefront of policy discussions. Obesity rates have nearly doubled among adults and more than tripled among children in the past 30 years. In 1991, no state had an adult obesity rate above 20 percent—indeed, the number was unthinkable. Today, 49 states and the District of Columbia have exceeded that rate—significantly, in most cases. And in 30 states, 30 percent or more children are overweight or obese.<sup>6</sup>

Like the inability to obtain fresh foods, obesity and related health problems such as type 2 diabetes and heart disease disproportionately affect low-income people and people of color. African American and Mexican American children are nearly twice as likely as white children to be obese. Children from poor families are twice as likely to be overweight as those from higher-income families.<sup>7</sup> Ten-year-old Latino girls have a lifetime diabetes risk of 53 percent and African American girls have a 49 percent risk, while white girls have a lifetime risk of 31 percent.<sup>8</sup> The racial risk profile is similar among boys.

The costs associated with preventable, diet-related chronic diseases continue to climb. Chronic diseases account for about 75 percent of the nation's \$2 trillion annual medical care expenditures, and the personal toll is incalculable.<sup>9</sup> Researchers estimate that for the first time in American history, today's generation of children will live shorter lives than their

3 USDA Economic Research Service. *Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences*. Report to Congress. Washington, DC: U.S. Department of Agriculture, 2009. Available from <http://www.ers.usda.gov/Publications/AP/AP036/AP036.pdf>.

4 California Center for Public Health Advocacy, PolicyLink, and the UCLA Center for Health Policy Research, *Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes*, 2008. <http://www.policylink.org/documents/DesignedforDisease.pdf>.

5 A. Hosler, D. Varadarajulu, A. Ronsani, B. Fredrick, and B. Fisher "Low-Fat Milk and High-Fiber Bread Availability in Food Stores in Urban and Rural Communities," *Journal of Public Health Management Practice* 12 (2006): 556–62. And see P. Kaufman, "Rural Poor Have Less Access to Supermarkets, Large Grocery Stores," *Rural Development Perspectives* 13, no. 3 (1998): 13:19–26. <http://www.ers.usda.gov/publications/rdp/rdp1098/rdp1098c.pdf> (accessed October 2009).

6 J. Levi, S. Vinter, R. St. Laurent, and L. M. Segal, "F as in Fat: How Obesity Policies Are Failing in America. Trust for America's Health, August 2008. <http://healthyamericans.org/reports/obesity2008/Obesity2008Report.pdf> (accessed September 2009).

7 C. L. Ogden, M. D. Carroll, and K. M. Flegal, "High body Mass Index for Age Among U.S. Children and Adolescents," *JAMA* 299(20) (2008): 2401–5. <http://jama.ama-assn.org/cgi/content/full/299/20/2401> (accessed September 2009).

8 K. M. V. Narayan, J. P. Boyle, T. J. Thompson, S. W. Sorensen, and D. F. Williamson, "Lifetime Risk for Diabetes Mellitus in the United States," *JAMA* 290(14) (2003): 1884–90. <http://jama.ama-assn.org/cgi/content/full/290/14/1884>.

9 <http://www.cdc.gov/NCCdphp/verview.htm#2>.

parents, due to the health consequences of obesity and being overweight.<sup>10</sup>

When personal choices are constrained, weights increase and health suffers. For example, a study of nearly 40,000 Californians found that people living in neighborhoods with few supermarkets or produce outlets, but crowded with fast-food and convenience stores, are at significantly higher risk of obesity and diabetes.<sup>11</sup> Studies consistently show that low-income neighborhoods have a higher concentration of fast-food restaurants and convenience stores than more affluent neighborhoods. Research also shows that better access to healthy foods changes eating habits and that these new habits lead to reductions in obesity.

Local advocacy and organizing campaigns have led the way in crafting policies and programs to bring healthy food retailers to long-neglected communities. These initiatives demonstrate that inequitable food access is a solvable problem and that all communities can benefit from the opportunity to make healthy food choices easy. Moreover, better food access can solve more than health problems. It also can benefit the economy, regional farm systems, community developers and investors, and local government, as well as improve employment opportunities. But building momentum for change has been slow and often has required significant philanthropic investment and massive community mobilization. And change has only taken hold in scattered places, still not reaching many communities in need.

Yet the most promising grassroots initiatives are beginning to inform state and local policy as government, civic leaders, and the business community recognize that a healthy food environment is essential to health and community economic vitality. A national policy response, based on innovations that have been shown to work and built on a foundation of social and economic equity, is urgently needed to ensure that everyone, regardless of where they live, can make healthy choices and ultimately has the opportunity to lead healthy and productive lives.

## The Grocery Gap

For people who live near typical supermarkets brimming with food or near farmers' markets selling seasonal bounty, it's almost impossible to imagine that there are places in the United States where an apple a day is hard to come by. But dozens of studies have found that the food environment varies dramatically from neighborhood to neighborhood, depending on the economic status and racial makeup of residents.

---

10 S. J. Olshansky, M. D. Passaro, M. D. Hershov, and J. Layden et al., "A Potential Decline in Life Expectancy in the United States in the 21st Century," *New England Journal of Medicine* 2005 352 (11): 1138–45. <http://content.nejm.org/cgi/content/short/352/11/1138>.

11 PolicyLink, *Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes*, 2008 <http://www.policylink.org/documents/DesignedforDisease.pdf>.

Nationally, low-income zip codes have 25 percent fewer chain supermarkets and 30 percent more convenience stores, compared to middle-income zip codes.<sup>12</sup> Predominantly black zip codes have about half the number of chain supermarkets as predominantly white zip codes, and predominantly Latino areas have only a third as many. In Los Angeles County, wealthier communities have 2.3 times as many supermarkets per capita as areas with high poverty.<sup>13</sup>

Transportation inequities exacerbate food access problems. The same groups that are less likely to live near a supermarket are also less likely to have an affordable, convenient way to travel to one. Low-income, African American, and Latino households have lower rates of car ownership than higher-income and white households.<sup>14</sup> To shop for groceries, residents of low-income communities often must hitch rides with friends or relatives, pay for a taxi, or patch together multiple bus routes.<sup>15</sup> For example, residents of low-income communities in the San Francisco Bay Area who rely on public buses to travel to a grocery store spend about an hour commuting to and from the store. The average resident in affluent communities in the area can reach more than three supermarkets by car within 10 minutes round-trip.<sup>16</sup> Low-income residents of Los Angeles face similar transportation challenges.

The combination of no nearby supermarkets and limited transportation leaves low-income residents with only small grocers and convenience stores near their homes. Not only do these stores stock mainly processed snacks, soft drinks, and alcoholic beverages, but they also charge higher prices.<sup>17</sup>

Rural communities have different circumstances but with the same result of poor food access.<sup>18</sup> Their limited access is all the more disturbing because many of these communities sit amid productive agricultural land. In fact, residents of these communities plant and harvest the fruit and vegetables that feed the nation, yet they have trouble obtaining fresh foods for themselves and their families. Twenty percent of all rural counties are “food desert counties,” which one study defines as counties where more than half the population lives 10

---

12 L. Powell, S. Slater, D. Mirtcheva, Y. Bao, and F. Chaloupka, “Food Store Availability and Neighborhood Characteristics in the United States,” *American Journal of Preventive Medicine* 44 (2007): 189–95.

13 Amanda Shaffer, *The Persistence of L.A.’s Grocery Gap: The Need for a New Food Policy and Approach to Market Development*, Center for Food and Justice, Urban and Environmental Policy Institute, Occidental College, Los Angeles, 2002.

14 U.S. Census Bureau. Summary File 3. 2000 Census. <http://www.census.gov/>. And see A. D. Gardenshire, “Economic and Sociodemographic Influences on Autolessness: Are Missing Variables Skewing Results,” *Transportation Research Record* 670 (1999): 13–16.

15 This is an especially significant problem for the rural elderly (Iowa State Extension, 2004).

16 Transportation and Land Use Coalition, *Roadblocks to Health: Transportation Barriers to Healthy Communities*, 2002 <http://transformca.org/resource/roadblocks-health> (accessed October 2009).

17 R. Philip Kaufman et al., *Do the Poor Pay More for Food? Item Selection and Price Differences Affect Low-Income Household Food Costs* (Washington, D.C.: U.S. Department of Agriculture, 1997).

18 L. Morton and T. Blanchard, “Starved for Access: Life in Rural America’s Food Deserts,” *Rural Realities* 1, no. 4 (2007). [www.ruralsociology.org/pubs/ruralrealities/issue4.html](http://www.ruralsociology.org/pubs/ruralrealities/issue4.html) (accessed April 2009).

miles or more from the nearest supermarket or supercenter.<sup>19</sup> While rural households generally have access to cars, those who don't find it virtually impossible to reach stores beyond their immediate neighborhood because rural public transportation is so limited. Many farm workers fall into this group and must rely on friends, neighbors, and food pantries for meals.

Study after study shows a direct correlation between access to fresh food retailers and a quality diet. A study that used data from North Carolina, Baltimore, and New York City found that adults with no supermarkets within a mile of their homes were 25 percent to 46 percent less likely to eat a healthy diet than those with the most supermarkets near home.<sup>20</sup> In rural Mississippi—the state with the highest rates of obesity and poverty in the nation—adults living in food desert counties are 23 percent less likely to consume the recommended amount of fruit and vegetables than adults in other counties, controlling for age, sex, race, and education.<sup>21</sup>

On the flip side, a multistate study found that with each additional supermarket in a census tract, fruit and vegetable consumption increased 32 percent for African Americans and 11 percent for whites.<sup>22</sup> In a New Orleans study, each additional meter of shelf space devoted to fresh vegetables was associated with an additional 0.35 servings of vegetables a day.<sup>23</sup>

## From Public Policy to the Grocery Shelf

The disparate food landscape did not result simply from blind market forces. Rather, the inequities reflect policies stretching back decades that have left people of color isolated from economic opportunity and services.

Federal and state policies have provided powerful incentives for white homeownership that have promoted white flight first from inner cities and then to the ever-distant suburban edge, and then left people of color behind in disinvested urban neighborhoods.<sup>24</sup> Until the

- 
- 19 T. Blanchard and T. Lyson, *Food Availability & Food Desert in the Nonmetropolitan South*, Southern Rural Development Center, 2006, Mississippi. [http://srdc.msstate.edu/focusareas/health/fa/fa\\_12\\_blanchard.pdf](http://srdc.msstate.edu/focusareas/health/fa/fa_12_blanchard.pdf). (accessed April 2009).
  - 20 L. Moore A. Roux, J. Nettleton, D. and Jacobs, "Associations of the Local Food Environment with Diet Quality: A Comparison of Assessments Based on Surveys and Geographic Information Systems: The Multi-Ethnic Study of Atherosclerosis," *American Journal of Epidemiology* 167 (2008): 917–24.
  - 21 Blanchard, T., and Lyson, T. Southern Rural Development Center, 2006. *Food Availability & Food Desert in the Nonmetropolitan South*. Mississippi, MS. [http://srdc.msstate.edu/focusareas/health/fa/fa\\_12\\_blanchard.pdf](http://srdc.msstate.edu/focusareas/health/fa/fa_12_blanchard.pdf). (accessed April 2009).
  - 22 K. Morland, S.Wing, and A. Diez Roux, "The Contextual Effect of the Local Food Environment on Residents' Diets: The Atherosclerosis Risk in Communities Study," *American Journal of Public Health* 92, no. 11 (2002): 1761–67.
  - 23 Bodor, J.N., Rose, D., Farley, T.A., Swalm, C., and Scott, S.K. 2008. Neighbourhood fruit and vegetable availability and consumption: the role of small food stores in an urban environment. *Public Health Nutrition* 11:413-420.
  - 24 Federal Housing Administration. 1938. *Underwriting Manual: Underwriting and Valuation Procedure Under Title II of the National Housing Act*. For an excellent history of federal housing policy and suburbanization, see Chapter 11 of *Crabgrass Frontier: The Suburbanization of the United States* by Kenneth T. Jackson.

practice was outlawed in 1970, the government mapped city neighborhoods by their “desirability” for lending (with red outlines marking African American neighborhoods, hence the term “redlining”), and systematically denied loans in communities of color. The maps became self-fulfilling prophecies that hastened neighborhood decline and the exodus of white families. Moreover, restrictive covenants in suburban communities across the country prohibited the sale of homes to African Americans. Supermarkets, along with many other businesses, also fled the inner city, taking their jobs and tax revenues—not to mention their selection of healthy-foods with them.

Supermarkets adapted their operations to their new suburban locations. Abundant, inexpensive land, flexible zoning laws, and a customer base with high rates of car ownership led to bigger stores with large parking lots located farther from residential neighborhoods. Big chain retailers developed business models catering to the predominantly white, middle-class suburban clientele and applied these models to all the stores in their chain.<sup>25</sup> To stock shelves at the lowest prices, retailers signed long-term contracts with large suppliers who offered price breaks in exchange for a chain’s vast purchasing power. Industry practices changed across-the-board, from development decisions to product selection and marketing.

A number of recent studies demonstrate how the marketing analyses that influence retailers’ location decisions systematically undervalue inner-city neighborhoods.<sup>26</sup> Marketing firms often rely on national data sources such as the U.S. Census, which tend to undercount city residents, especially people of color. A study of one primarily black and Latino community in Washington, D.C., found that the population was undercounted by as much as 55 percent.<sup>27</sup> Market studies also generally look at average household income rather than at total area income, a measure that more accurately captures the density of an urban neighborhood and therefore its purchasing power.

Some marketing firms use distorted, subjective generalizations and even gross stereotypes to assess the investment potential of neighborhoods. For example, one firm described the residents of predominantly African American neighborhoods in Milwaukee as “very low-income families [who] buy video games, dine at fast-food chicken restaurants, use non-prescription cough syrup, and use laundries and Laundromats.” The same company described the residents of a suburban community as “interested in civic activities, volunteer work, contributions, and travel.”<sup>28</sup> Setting aside the ethical and moral problems, such assessments can steer companies away from investing in underserved communities that may very well offer significant opportunities.

---

25 Initiative for a Competitive Inner City, *The Changing Models of Inner City Grocery Retailing* (Boston, 2002).

26 John Pawasarat et al., *Exposing Urban Legends: The Real Purchasing Power of Central City Neighborhoods* (Washington, D.C.: Brookings Institution, 2001). <http://www.brookings.edu/es/urban/pawasarat.pdf>. The Boston Consulting Group and the Initiative for a Competitive Inner City, *The Business Case for Pursuing Retail Opportunities in the Inner City*. [http://www.icic.org/research/pdf/pdf\\_2\\_The\\_Business\\_Case.pdf](http://www.icic.org/research/pdf/pdf_2_The_Business_Case.pdf).

27 D’Vera Cohn, “Retail Potential Found in Two Areas,” *Washington Post*, July 18, 2002. <http://www.socialcompact.org/pdfs/Washington%20Post%207.18.02.pdf>.

28 Pawasarat, *Exposing Urban Legends*. <http://www.brookings.edu/es/urban/pawasarat.pdf>.

Researchers and business leaders have begun to recognize opportunities in long-neglected communities, including density of purchasing power, limited competition, and an available labor force. Faced with saturated suburban markets and competition from mass discounters such as Wal-Mart, some supermarket operators have moved beyond tired assumptions about race and spending habits to locate in low-income communities of color—and with striking success. Food 4 Less, which opened eight years ago in the Diamond Neighborhood of San Diego as the anchor of a 10-acre commercial development, has been consistently profitable, even in difficult times. Two leading chains on the East Coast, Pathmark and Stop & Shop, have reported that their highest grossing stores are in low-income neighborhoods. Tesco, a large supermarket retailer based in the United Kingdom, is launching an ambitious plan to open hundreds of stores in California and Arizona, many of them in communities with limited or no access to healthy foods. In many urban areas, their efforts are being encouraged by local officials, supported by neighborhood residents, and closely watched by researchers.

There are pockets of progress in low-income rural areas as well. Dineh Cooperatives Incorporated, a community development corporation on the Navajo Nation, worked with the Bashas' grocery chain to build a store in Chinle, Arizona. It created more than 170 jobs for local residents and has been profitable since it opened.<sup>29</sup>

## **Diverse Markets, Diverse Models**

Supermarkets are a good proxy for access to healthy foods. Most Americans buy the bulk of their groceries at supermarkets, and most enjoy the wide selection of affordable, nutritious foods available there. But supermarkets are only part of the solution. Improving food access for everyone demands multiple approaches to meet the different needs of diverse communities. Four strategies are gaining momentum and offer useful guidance to communities and policymakers throughout the country as they tailor food access opportunities to local needs and circumstances. Among these approaches, the Pennsylvania Fresh Food Financing Initiative has demonstrated the important role that public incentives can play in seeding supermarket placement. Combined, these creative efforts provide new awareness and understanding of the potential that national policy might play in increasing food access for all.

### ***Develop Supermarkets***

Supermarkets offer benefits beyond nutritious, affordable foods. They often house pharmacies, banks, and other services that are scarce in underserved areas. They create jobs—100 to 200 permanent jobs per store, many of which go to local residents.<sup>30</sup> Large grocery stores bring desperately needed tax revenue to municipalities and often serve as high-volume “anchors” that spur local economic development in struggling communities.

---

29 Barbara Abell, *Overcoming Obstacles to CDC Supermarket Development, A Guide* (Washington, D.C.: National Congress for Community Economic Development).

30 *Ibid.*

Developing stores in low-income neighborhoods is challenging. The development process is lengthy and complex; start-up and operating costs are high, and financing is difficult to secure. Fresh food financing initiatives, which create public-private funding pools for store development in underserved communities, have shown remarkable power to break through the gridlock.

Other policy options are useful, too. The federal New Markets Tax Credit (NMTC) program, which provides tax credits to increase private investment in low-income communities, has spurred some grocery store development, especially paired with other building projects. At the local level, government agencies have reclaimed vacant property and cleaned up contaminated parcels to secure land for grocery stores. Some municipalities help grocery developers navigate through the planning and zoning bureaucracy, while others offer incentives such as relaxed parking requirements or increased density for developers who attract supermarkets as part of larger projects. Intermediaries—organizations that understand and are trusted in community yet are familiar with the supermarket industry as well as with local and state funding opportunities—are increasingly important partners in successful grocery-store placement efforts.

### ***Improve the Product Mix at Small Neighborhood Stores and Foster Healthy Small-Business Opportunities***

Revamping corner stores and small grocery outlets takes less time and money than building a new store and offers a tremendous boost to struggling communities by supporting small business development. Small merchants do not have the scale and price advantages of supermarkets, and many shopkeepers lack the equipment and training to handle perishable food. But some cities have used creative funding strategies to overcome these barriers, even when budgets are tight. For example, the City and County of San Francisco used tobacco prevention funds to shift the product mix at several local small stores away from an emphasis on cigarettes and alcohol and toward healthy foods.<sup>31</sup> Redevelopment agencies have become partners in improving small store infrastructure to store and preserve foods, especially fresh fruit and vegetables. Some cities direct small-business financial and technical assistance resources to small store owners in underserved communities who agree to sell more fresh groceries, helping proprietors to learn effective techniques for purchasing, stocking, and marketing healthy foods. Recent changes to the Special Supplemental Food Program for Women Infants and Children (WIC) offer new revenue for those small grocers that stock fresh fruit and vegetables.

Mobile vendors selling fruit and vegetables are another way to bring fresh foods into underserved areas while providing business opportunities for low-income entrepreneurs. In Oakland, California, Mexican American street vendors who sold fruit and vegetables and other foods organized; formed a partnership with the local health department; developed

---

31 [http://www.sfgov.org/site/shapeupsf\\_page.asp?id=90513](http://www.sfgov.org/site/shapeupsf_page.asp?id=90513).



a jointly operated, city-approved commercial kitchen; purchased approved pushcarts, and influenced city hall to create an ordinance permitting street vending of healthy foods. New York City is also experimenting with “Green Carts,” licensing produce vendors across the city to bring fresh vegetables into the mix of available sidewalk food options.

### *Start and Sustain Farmers’ Markets*

Farmers’ markets are proliferating: in August 2009, the U.S. Department of Agriculture counted nearly 4,800 nationwide, up from 2,863 ten years earlier.<sup>32</sup> Although most are located in higher-income communities, they are an important strategy for increasing food access in low-income neighborhoods. Customers pay less than at the supermarket—10 percent to 28 percent less, according to various studies—and they get fresher foods.<sup>33</sup> The dollars contribute to a robust regional food system—a grower’s return runs 200 percent to 250 percent higher at a farmers’ market than from sales to a wholesaler.<sup>34</sup> Further, farmers’ markets offer a toehold to entrepreneurship, where residents can sell baked goods, jams, crafts, and other items. Because the start-up costs are low, these opportunities open a pathway to upward mobility for residents who don’t have access to capital.<sup>35</sup> To be viable, farmers’ markets must attract enough vendors to bring in customers and vice versa. Local and state policy can encourage participation on both sides. Successful pilot programs in California, Colorado, New Mexico, and elsewhere facilitate the use of Electronic Benefits Transfer (EBT) technology at farmers’ markets, enabling customers to shop with food stamps.<sup>36</sup> These programs provide free wireless equipment to markets, waive transaction fees, and publicize the markets among food-stamp participants. WIC coupons, now redeemable for fresh fruit and vegetables, offer farmers’ markets important new revenue and customers. Some cities and states use incentives to attract farmers. For instance, the farmer who signs on at a low-income market is also invited

---

32 <http://www.ams.usda.gov/AMSV1.0/farmersmarkets>; See also E. Ragland and D. Tropp, USDA National Farmers’ Market Manager Survey, 2006. <http://www.ams.usda.gov/AMSV1.0/getfile?dDocName=STELPRDC5077203&acct=wdmgeninfo>.

33 California Federation of Certified Farmers’ Markets. <http://www.cafarmersmarkets.com/>; See also USDA Sustainable Agriculture Research and Education Program, *Adding Values to Our Food System: An Economic Analysis of Sustainable Community Food Systems* (Everson, Wash.: Integrity Systems Cooperative, 1997). As cited in Simon Bullock, “Economic Benefits of Farmers’ Markets, Friends of the Earth.” [http://www.foe.co.uk/resource/briefings/farmers\\_markets.pdf](http://www.foe.co.uk/resource/briefings/farmers_markets.pdf).

34 Southland Farmers’ Market Association, *Value Pricing at Southland Farmers’ Markets*. <http://www.cafarmersmarkets.org/consumer/pricestudy.shtml>.

35 The Ford Foundation, Project for Public Spaces, Inc., and Partners for Livable Communities, *Public Markets as a Vehicle for Social Integration and Upward Mobility, Phase I Report: An Overview of Existing Programs and Assessment of Opportunities*, 2003. [http://www.pps.org/pdf/Ford\\_Report.pdf](http://www.pps.org/pdf/Ford_Report.pdf).

36 Food and Nutrition Service, *EBT Farmers’ Market Demonstration Project Update*. [http://www.fns.usda.gov/fsp/ebt/ebt\\_farmers\\_markstatus.htm](http://www.fns.usda.gov/fsp/ebt/ebt_farmers_markstatus.htm); See also Letter from State of California Department of Social Services to All County Welfare Directors, All EBT Coordinators, and All Food Stamp Coordinators, March 29, 2004: “Client Outreach to Promote Use of Electronic Benefit Transfer (EBT) Cards Use at Authorized Farmers’ Markets.” [http://www.dss.cahwnet.gov/getinfo/acin04/pdf/I-15\\_04.pdf](http://www.dss.cahwnet.gov/getinfo/acin04/pdf/I-15_04.pdf).

to participate in larger ventures such as farm-to-school or farm-to-prison programs.<sup>37</sup> Other localities use land use or zoning to ensure that markets are centrally located and capable of attracting sufficient numbers of consumers.

### *Promote Linkages between Local Farmers and Low-Income Consumers*

There are many ways to connect farmers and low-income communities that can be a win-win for both groups. Residents get freshly picked foods (and what's more delicious or nutrient-rich?), while grocery dollars support local and regional food production. Among the most promising approaches to establishing such linkages are urban farms; farm-to-school and other institutional programs; community-supported agriculture, in which participants buy shares in a farm and receive crops; and community gardens, which offer a bonus: opportunities for physical activity. Like healthy foods, these are all too rare in many poor communities and are essential for fighting obesity and other chronic conditions.

Public policy and investment are important for scaling up these efforts. The Chicago City Council created NeighborSpace, which is authorized to buy properties and protect them as green spaces, which includes community gardens.<sup>38</sup> Cleveland's economic development department launched Gardens to Greenbacks, which provides grants and low-interest loans to urban farmers.<sup>39</sup> Farm-to-school programs received a boost from the 2008 Farm Bill, which made it easier for districts to buy local foods. More than 40 states and 2,000 schools have programs that bring locally grown fruit and vegetables to cafeterias.<sup>40</sup>

### **The Fresh Food Financing Initiative**

Ideas for improving food access are plentiful, but money to implement them is not. Fresh food financing initiatives offer a new opportunity to address this challenge. The idea was conceived in Pennsylvania in 2001, when the nonprofit Food Trust documented the lack of supermarkets and its health effects in Philadelphia. In response, the City Council charged Food Trust with convening a task force of leaders from city government, the supermarket industry, and the civic sector to develop and recommend solutions.<sup>41</sup>

Financing was identified as the single greatest obstacle to stimulating grocery retailing in underserved communities. Interested operators reported that the higher costs associated with developing stores in these areas were too burdensome and that conventional lenders

---

37 Barbara C. Bellows et al., *Bringing Local Food to Local Institutions: A Resource Guide for Farm-to-School and Farm-to-Institution Programs* (Washington, D.C.: National Sustainable Agriculture Information Service, 2003).

38 <http://neighbor-space.org/main.htm>.

39 <http://neighborhoodgrants.org/page10001728.cfm>.

40 <http://www.farmtoschool.org/>.

41 T. Giang, A. Karpyn, H. Laurison, A. Hillier, M. Burton, and D. Perry, "Closing the Grocery Gap in Underserved Communities: The Creation of the Pennsylvania Fresh Food Financing Initiative." *Journal of Public Health Management and Practice* 14, no. 3 (2008): 272–79.

did not meet their credit needs. To overcome these barriers, the task force recommended the creation of a statewide fund to support fresh food retail development. Pennsylvania subsequently appropriated \$30 million over three years to create the Fresh Food Financing Initiative (FFFI), thus acknowledging that the lack of supermarkets presents a threat to public health and that public resources should be committed to this issue.

The state contracted with the Reinvestment Fund (TRF) to manage the \$30 million and attract and leverage private capital. Over the next five years, TRF attracted \$165 million in private investment to create a multifaceted, flexible loan and grant program. Under the program, a qualifying store is eligible for one-time grants up to \$250,000 and loans up to \$2.5 million. The funds support all stages of a project, including pre-development, land acquisition, equipment financing, capital grants for project funding gaps and construction, and permanent finance.

Since 2004, the program has approved more than 75 new or improved grocery stores—1.6 million square feet of grocery retail—in underserved low- and moderate-income neighborhoods in cities such as Philadelphia and Pittsburgh, as well as in rural communities such as Derry and Williamsburg. More than 400,000 people have benefited, including many low-income residents who for years had no decent place to shop.<sup>42</sup>

The fund created or retained 4,700 jobs throughout the state. Studies of selected supermarkets in Philadelphia showed that most jobs went to local residents.<sup>43</sup> Evidence also suggests that the benefits of supermarket investment rippled through neighborhoods. TRF estimates that for every \$1 in direct wages, an additional \$1 is circulated throughout the community as multiplier effects were felt from the products and services purchased with workers' salaries.<sup>44</sup> The same analysis also found that homeowner values benefit. An analysis of the prices of homes near supermarkets in Philadelphia found a four to seven percent increase, an average of \$1,500, mitigating the downward trend in real estate values. In neighborhoods with weaker housing markets, the effect was even larger.

The U.S. Centers for Disease Control and Prevention, the National Conference of State Legislatures, and the National Governors Association have recognized the FFFI as an innovative model for improving public health. Last year, the Ashe Institute at Harvard University recognized FFFI as one of the top 15 innovative programs in American government.

The FFFI has demonstrated that there is demand for high-quality, nutritious, affordable foods in underserved communities. The impressive results in Pennsylvania in just a few years have spurred replication efforts. In May 2009, the City and State of New York announced a

---

42 The Food Trust. [www.thefoodtrust.org](http://www.thefoodtrust.org). Personal communication, John Weidman.

43 The Reinvestment Fund, "Access to Supermarkets in Inner City Communities: Studying the Costs of Supermarket Operations," Philadelphia: The Reinvestment Fund, 2008. <http://www.trfund.com/resource/downloads/policypubs/CDFIStudySummary.pdf>.

44 The Reinvestment Fund, "The Economic Impacts of Supermarkets on Their Surrounding Communities," Philadelphia: The Reinvestment Fund, 2008. <http://www.trfund.com/resource/downloads/policypubs/supermarkets.pdf>.

\$10 million Healthy Food/Healthy Communities revolving loan program to help finance food market construction in underserved communities.<sup>45</sup> In addition, the state will provide low-cost insurance for subsidized projects, incentives for affordable housing proposals to include food markets, a farmers' market grant program, and incentives for food markets to be green and energy efficient. New York City will launch the Food Retail Expansion to Support Health (FRESH) program, providing zoning and financial incentives to property owners, developers, and grocery store operators in underserved neighborhoods.<sup>46</sup> The states of Illinois and Louisiana have also passed FFFI replication efforts, as has the City of New Orleans.<sup>47</sup>

Promising as these efforts are, the scope and severity of food-access problems nationwide demand comprehensive, coordinated action at the federal level. Momentum is building for a National Fresh Food Financing Initiative (NFFFI) to ensure that residents of all states and communities – not just those who live in places with the capacity and will to address this urgent issue – have access to healthy food, particularly fresh fruit and vegetables.

Like the Pennsylvania initiative, NFFFI has garnered diverse support—and virtually no opposition. Support comes from a broad range of organizations from public health, children's health, civil rights, and economic development as well as from associations representing the supermarket and produce industries. NFFFI advocates have made a strong case that the initiative would boost the local economies of thousands of communities in every state and region while also improving healthy food access for millions of people.

## Conclusion

The crisis of obesity and chronic illness has combined with the dire economic needs of low-income communities and communities of color to create a perfect storm that harms public health, threatens the financial viability of our health-care system, and undermines the future productivity of the nation. Yet this storm is also propelling a powerful movement for change. After decades of work to increase access to healthy foods, we know what works. We understand what strategies benefit those most in need as well as those willing to invest in solutions. Promising programs and policies across the country demonstrate that the challenges to increasing access to healthy foods in underserved communities—from businesses' misperceptions about local purchasing power, to corner-store owners' fears about stocking new food items that might not sell, to the need for funds to hire a coordinator for a farmers' market—can be overcome.

---

45 New York State Press Release, May 16, 2009. Governor Patterson, Mayor Bloomberg, Speaker Quinn Announce Comprehensive Strategies to Expand Grocery Stores in Underserved Neighborhoods. [http://www.state.ny.us/governor/press/press\\_0516091.html](http://www.state.ny.us/governor/press/press_0516091.html).

46 The City of New York, Food Retail Expansion to Support Health. <http://www.nyc.gov/html/misc/html/2009/fresh.shtml>.

47 See Robert Wood Johnson Foundation <http://www.rwjf.org/publichealth/digest.jsp?id=10962>; See also <http://www.legis.state.la.us/billdata/streamdocument.asp?did=667987>.

Now is the time to bring this knowledge and experience to scale—the national scale. We must lift up what works and shine a light on those neighborhood, community, and state-wide innovations that have the potential to create enduring solutions. By ensuring that all communities have access to healthy foods, we can make a significant contribution to reducing chronic disease and improving the health of all.

Food access is about more than getting fruit and vegetables on every kitchen table, critical as that is. Food access is about social justice, and it's about economic vitality for inner cities, struggling urban neighborhoods, inner-ring suburbs, and rural communities coast to coast. Equitable food access is a cornerstone for healthy communities—communities in which everyone has opportunities to participate, work, prosper, and enjoy healthy, productive lives.

# The Disability Housing Market: Opportunity for Community Development Finance as the Americans with Disabilities Act Turns 20

***Charles D. Hammerman***

*The Disability Opportunity Fund*

***Samantha Bennett***

*Center for Wealth Preservation*

A home is more than just an address, more than just a place to hang your hat. For many of us, the first time we feel independent is when we sign our first lease, buy our first set of dishes, and pay our first bills. For many, the most strenuous part in finding a place to live is meeting the right real estate agents, or finding a home with enough bathrooms, or one with a decent-size kitchen and adequate sunlight.

For low-income persons with disabilities, their concerns consist not only of counter space, or hardwood floors, but also safety, affordability, and accessibility. For far too long, persons with disabilities have been deprived of the opportunity of renting or possibly even owning their own home. Many have been excluded from obtaining housing vouchers, and some simply have no access to the limited housing options that are currently available. For many, it has been a dream without much likelihood of coming true.

For the last 40 years, many articles, progress reports, and statistics have addressed this critical issue. Yet there is no current coherent policy to address the housing needs for persons with disabilities. Congress has struggled since the passage of the Vocational Rehabilitation Act in 1973 to develop a working plan through which persons with disabilities who want to live independently may be able to do so. Several other laws and regulations have been enacted since then in the hope of protecting the disabled and helping them find safe, affordable, accessible housing.

Although there is no coherent approach to providing housing, the demand for it is strong. There are more than 41 million noninstitutionalized Americans living with some form of disability. More than 23 million are between the ages of 18 and 65.<sup>1</sup> It is the inadequate supply that has ultimately hindered those with disabilities from attaining housing.

## **How Is the “Disability Market” Measured?**

Statistical information concerning disabilities is collected through several different venues. The American Community Survey (ACS), Cornell University’s “Disability Status

---

1 Statistics taken from Cornell University, 2007 *Disability Status Report*.

Report,” and the University of Colorado’s Coleman Institute for Cognitive Disabilities are just a few of the sources that provide thorough and comprehensive data and statistics.

The ACS, working with the Census Bureau and the Department of Commerce, hopes to sample close to three million homes a year. Currently the ACS strives to “provide data users with timely information each year on demographic, housing, social and economic statistics that can be compared across states, communities, and population groups.”<sup>2</sup> Working from information and data collected from the ACS, the Cornell “Disability Status Report” tends to classify individual disabilities through six separate categories: sensory, physical, mental, go-outside-home, self-care, and employment. The ACS defines disabilities in a more general way as a “long-lasting physical, mental, or emotional condition.” The ACS is intended eventually to replace the decennial Census, through which reports and statistics are reported and documented only every ten years.

Whereas the ACS primarily focuses on statistics for various disabilities, the Coleman Institute for Cognitive Disabilities centers on “mental retardation and developmental disabilities, acquired brain injury, Alzheimer’s disease, and severe and persistent mental illness.”<sup>3</sup> The Coleman Institute’s main intent is not the distribution of disability statistics, although it does willingly share the useful information it has acquired, but rather, since its establishment in 1991, has created a full avenue for sharing disability information and offering support. Most important, the Coleman Institute’s mission is “to catalyze and integrate advances in science, engineering, and technology to promote the quality of life and independent living . . . of over 20 million American citizens—seven percent of the U.S. population” living with cognitive disabilities.

## **How Big is the Market?**

By analyzing the ACS, the Coleman Institute, and Cornell University’s Disability Status Report as three primary sources for statistical research and data on persons with disabilities, we have found that the disabled housing market not only is expanding but also that it remains underserved. The ACS, Cornell, and Coleman Institute data are conclusive in stating that numbers and types of disabilities are growing exponentially. Consider the following:

### ***Wounded Veterans for Iraq and Afghanistan***

According to a published report from the John F. Kennedy School of Public Policy at Harvard, of the 1.4 million men and women deployed to Iraq and Afghanistan, nearly one-half will need medical attention from the Veterans Administration when they return from the wars. In addition, as a result of

---

2 M. J. Bjelland, W. A. Erickson, and C. G. Lee, “Disability Statistics from the American Community Survey (ACS),” November 8, 2008. Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics (StatsRRTC). [www.disabilitystatistics.org](http://www.disabilitystatistics.org).

3 David Braddock, Ph.D., Executive Director, UC Associate Vice President, Boulder 2005–2008, The Coleman Institute for Cognitive Disabilities. [https://www.cu.edu/ColemanInstitute/background\\_text.html](https://www.cu.edu/ColemanInstitute/background_text.html).

medical advances, the ratio of wounded soldier to fatality in these theaters is four to eight times higher than in any previous conflict.<sup>4</sup>

### **Autism**

According to the website for Autism Speaks: “A new study published October 5, 2009, in the American Academy of Pediatrics’ journal *Pediatrics* found a parent-reported autism prevalence rate of one in every 91 American children, including one in 58 boys. The study used data gathered as part of the 2007 National Survey of Children’s Health (NSCH), a national survey directed and funded by the Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC).”

### **Baby Boomers**

In the next 10 years, the major wave of baby boomers will be entering their seventies.<sup>5</sup> The estimates are that the current senior population of 34 million will double over the next 20 years. What do these statistics have to do with disabilities? In 2007 in the United States, 25 percent of individuals 65 to 74 reported one or more disabilities, and 50 percent of individuals 75 and older reported one or more disabilities.<sup>6</sup>

Excluded from these statistics and analysis are those of the disabled population that go unrecognized and unaccounted for. A substantial percentage of individuals living with disabilities are considered “hidden.” Some of these men and women, if not the majority, are living with aging parents, even though they are qualified to reside on their own or within supported living programs.

The 2005 HUD report on worst-case housing used Social Security Administration data to estimate that in 2004 there were more than one million low-income adults with disabilities living in households with worst-case needs. “Worst-case housing needs” is defined as households with incomes falling below 50 percent of median income in their geographic area who are paying more than half of their income for housing or are living in severely substandard housing. In all, more than 60 percent of unassisted very low-income households in which there is an adult member with a disability have worst-case housing needs, one of the highest proportions among low-income groups.

---

4 Linda Blimes, “Soldiers Returning from Iraq and Afghanistan: The Long-Term Costs of Providing Veterans Medical Care and Disability Benefits,” John F. Kennedy School of Government, Harvard University, Faculty Research Working Papers Series, January 2007.

5 George Friedman, *The Next 100 Years* (New York: Knopf Doubleday Publishing, 2009), 128.

6 Bjelland, *et al.*



## People with Disabilities are a Low-Income Target Market

Persons with disabilities have among the highest poverty rates. They are reimbursed for needed services, but the rate is substantially below what they need. In 2006, there were more than 21 million people between 18 and 65 in the United States with one or more disabilities. The Cornell report found that in 2007, 36.9 percent of working-age (21–64) individuals with disabilities were employed, compared with the 79.7 percent without disabilities. Those who do work typically earn \$6,000 less per year than workers who do not have disabilities. The income of households with a wage earner who has a disability is \$26,500 less than households without a person with a disability. Moreover, researchers found that 24.7 percent of working-age Americans with disabilities lived in poverty compared to 9.0 percent of those without disabilities.<sup>7</sup> These dramatic discrepancies are long-standing and continue to separate Americans with disabilities from their peers without disabilities.

Those individuals who do not or cannot work experience even greater economic challenges. More than half of the population in the United States between 18 and 65 and have disabilities rely on Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) for their income. Of these 11.9 million people:

- 6.5 million people receive SSDI only. The average 2008 SSDI payment in 2008 was \$12,048/year or 116 percent of the Federal Poverty Guidelines for one person.
- Four million people receive SSI only. The average 2008 SSI payment in 2008 was \$5,724/year or 55 percent of the Federal Poverty Guidelines for one person.
- 1.5 million people receive SSDI and SSI because their SSDI payment falls below the state’s SSI payment threshold. The average SSI payment in these cases is \$2,082/year, bringing the annual income of these individuals “up to” 135 percent of the Federal Poverty Guidelines.

*Note: These figures relate to the Federal Poverty Guidelines (FPG) and not the Area Median Household Income statistic, which is much higher than the FPG.*

In addition to receiving transfer payments that are far below Median Household Incomes in every state, individuals with disabilities must restrict their assets in order to qualify for these benefits. They cannot accumulate any more than \$2,000 in assets other than their house, car, and a life insurance policy (capped at \$1,500). Thus government programs can actually keep persons with disabilities in poverty. This policy is based on the old notion that individuals with disabilities are unable to work and therefore must rely on others (such as family members) for support.

There is a “chicken and egg” challenge when it comes to poverty and persons with disabilities: those living in poverty are more likely to have a disability and those with disabilities are

---

<sup>7</sup> Ibid.

more likely to live in poverty. Regardless of which came first, individuals with disabilities must have access to economic tools to rise out of poverty, achieve homeownership, and accumulate assets to improve their standard of living.

### **Can the System Work More Efficiently?**

The challenge is to determine a method that will efficiently deliver financial and other resources. Existing housing programs at the federal, state, and local levels do not necessarily work in concert, and they should. More efficient housing programs can also be combined with existing “disability” housing rental subsidies to increase the supply of available housing for persons with disabilities. A simple and current example is the federal government’s Neighborhood Stabilization Program (NSP). According to the HUD website, NSP funds are aimed at “the purchase and redevelopment of foreclosed and abandoned homes and residential properties.” The problem is that HUD never thought to incorporate persons with disabilities into the program. At present, a full year after the NSP funds were delivered, we have found that some local government housing agencies are still sitting on unused NSP funds. These same agencies are also holding on to the NHTD Medicaid Waiver rent subsidy, which allows individuals with disabilities to live in the community through a rental voucher system. Rather than let the NSP dollars go to waste, we have suggested that the local housing authorities convert the foreclosed and abandoned homes into rental units for individuals with disabilities who can use the Medicaid Waiver to pay the rent.

In 1990, Congress passed two important laws for low-income renters with disabilities: The Americans with Disabilities Act (ADA), and the Cranston-Gonzalez National Affordable Housing Act. According to the ADA: “Physical or mental disabilities in no way diminish a person’s right to fully participate in all aspects of society,” and further, “the continuing existence of unfair and unnecessary discrimination and prejudice denies persons with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity.”<sup>8</sup> The Cranston-Gonzalez National Affordable Housing Act contained Section 811 (the Supportive Housing for Persons with Disabilities program), which provided “funding exclusively to non-profit developers building and operating housing for low-income households with disabilities.”<sup>9</sup>

Both laws were thought to make a tremendous difference in the lives of the disabled and their families. The ADA has made great strides to help the disabled community by legally prohibiting discrimination in relation to work and housing opportunities, but Section 811 has seemingly fallen short of Congress’ original vision. The lack of new funding, the cost of renewing

---

8 The U.S. Equal Employment Opportunity Commission. February 23, 2009. <http://www.eeoc.gov/policy/ada.html>.

9 National Alliance on Mental Illness. July 27, 2004. <http://www.namisc.org/Advocacy/2004/Summer/Section8Advocacy.html>

vouchers, and the elimination of project-based capital has crippled the Section 811 budget.

In 1999, the U.S. Supreme Court handed down the *Olmstead v. Lois Curtis and Elaine Wilson* decision, citing the unlawful confinement of disabled persons as a clear violation of the ADA. Today, ten years after the *Olmstead* decision, “more than 500,000 people who have mental illness other than dementia live in nursing homes,” the majority of whom could and should live independently if they were given the appropriate support.<sup>10</sup>

## **The Disability Opportunity Fund — Filling the Gap**

The Disability Opportunity Fund (The DOF) was created to help improve the delivery of affordable housing. A market study commissioned by The DOF in 2007 found that there is not enough government funding to meet the needs of organizations (for-profit and nonprofit developers, social services agencies, and hospitals) interested in developing affordable housing for persons with disabilities. The market study also found that those who successfully developed affordable housing for the disabled relied on multiple capital sources, usually including local, state, and federal government programs, the Federal Home Loan Bank, Community Development Financial Institutions (CDFIs), banks, and occasionally, their own earned income. Expectedly, it was revealed that the lack of capital is the biggest restraint on the development of safe, accessible, affordable housing for the disabled.

CDFIs focus on the development of programs and strategies to meet the needs of low-income communities. Their mission is to make loans to entities that are unable to get loans from traditional banking institutions. They provide a range of products, including comprehensive credit, investment, banking, and development services. Some CDFIs are chartered banks, others are credit unions, and many operate as self-regulating, nonprofit institutions that gather private capital from a range of community-minded investors.

The DOF is a CDFI focused exclusively on disability projects. To date, it has acted as a loan fund in creating housing solutions for eleven persons with disabilities. We both originated loans and bought a participation in another loan originated by a fellow CDFI. In the participation, we provided \$100,000 of \$685,000 mini-perm financing for a newly constructed home in Darien, Connecticut, for six young adults who have developmental disabilities. The home provides the six residents with permanent housing in an environment that allows them to share their common interests in sporting, social, volunteer, religious, and work activities. A professional full-time staff assists the residents in making choices, enjoying everyday life, achieving goals, living with dignity, and taking care of their own needs.

In addition to this loan, The DOF originated structured financing of two single-family houses in Tennessee for five low-income residents who have developmental disabilities. The first portion of the loan allows three individuals to remain in their shared home through

---

<sup>10</sup> National Council on Disability, “OLMSTEAD: Reclaiming Institutionalized Lives,” August 2003. <http://www.ncd.gov/newsroom/publications/2003/reclaimlives.html>.

more efficient financing, while the second portion allows two of the residents to obtain better financing and remain in their home as well. Providing affordable capital and creating reasonable and fiscally responsible loan repayment strategies ensures that these individuals can continue to live independently in the community.

### **Debt, Equity, and Technical Assistance**

In the last year alone, The DOF was approached to develop financing for more than 40 projects in 17 different states. The composite-required financing is well over \$100 million and consists of both debt and equity. Most, if not all, of the future residents qualify as low income.

#### ***Debt***

The DOF regularly receives requests for bridge (or gap) financing. For example, a nonprofit on Long Island, New York, has applied for a \$350,000 loan with a 6 percent interest rate and a 5-year term. These funds would help retrofit existing units and allow two persons with disabilities to live independently. The nonprofit has already secured the necessary government funding to support the residents and pay the debt service.

In Chicago, there is a need for a line of credit that could be used by for-profit developers to retrofit unused space in existing market-rate rental apartment buildings. The space will be converted into accessible, affordable housing units for persons with disabilities. The city is prepared to provide rental subsidies for the units.

There is also a growing market for housing solutions for our returning soldiers from Iraq and Afghanistan. Those men and women who are wounded return to the United States and receive their treatment at a military hospital. Two major housing benefits are administered by the Veterans Administration (VA): a 25 percent guarantee on a VA loan, and a fund for retrofitting the home to make it accessible.

One problem with the two VA programs, however, is that it takes a long time to establish eligibility. The length of time is particularly difficult since the first few months of dealing with a new disability are extremely challenging. The DOF hopes to fix this problem with short-term financing. For example, an injured Navy SEAL in San Diego has finished his medical treatment and is ready to buy a home. However, he is still awaiting word from the VA, which has not yet approved his eligibility for benefits. If he finds a house in the meantime, The DOF will provide him with the necessary financing for closing. Then, once the serviceman becomes "VA eligible," The DOF will be repaid by a conventional financial institution, which will issue a standard VA loan to the newly designated "veteran". The DOF has identified approximately 2,000 to 3,000 servicemen and women who could use this type of program.<sup>11</sup>

---

<sup>11</sup> Author conversation with Noel Koch, Deputy Undersecretary of Defense, U.S. Department of Defense, office of Secretary of Defense Wounded Warrior Care and Transition Policy, December 2009.

### *Equity*

In light of the soft real estate market around the country, many developers have contacted The DOF seeking equity investments in either unfinished or unsold condominium units or homes. The trade-off is to set aside units of housing to be designated for persons with disabilities. We have developed certain models that could yield an 8 to 12 percent annual return on these types of investments.

### *Technical Assistance*

In addition to providing capital, The DOF continues to offer technical assistance in raising awareness of the resources available to develop affordable, accessible housing. During the market study, comments by key stakeholders suggested that many service organizations and housing developers are relatively self-taught when it comes to developing housing for the disabled. These service providers/developers simply recognized a demand in the communities they served or implemented required set-asides, and thus took the initiative to develop housing for the disabled. They have relied on any number of information resources, including their own trial and error, the inadequate government guidelines, end-user feedback, other developers, and industry peers.

To promote better communication and coordination among the players, The DOF has organized and moderated several roundtable discussions hosted by the Federal Reserve Banks of San Francisco and Chicago, the New York Stock Exchange and Delaware's State Council for People with Disabilities. In addition, The DOF was invited by Virginia's Department of Behavioral Health and Developmental Services to introduce the work of CDFIs as a possible leveraging solution to an \$18 million state budget set-aside to move 150 residents from state-run institutions into the community. Finally, The DOF has spent the last year introducing the power of CDFI financing to New York State's Office of Mental Retardation and Developmental Disabilities and is currently working with that office to "break down the silos" between other government agencies to develop additional housing solutions.

### **The Future Is Looking Bright(er)**

Future public policies that have evolved in the hope of providing housing for the disabled have already been initiated by the Department of Housing and Urban Development (HUD), which remains in charge of Section 8 and 811 housing. HUD will work closely with the Department of Health and Human Services (HHS) in 2010, which President Barack Obama has deemed the "Year of Community Living." Through the National Affordable Housing Trust Fund Act of 2007, the president has asked for \$1 billion to produce, preserve, and rehabilitate 1.5 million affordable homes over the next ten years. Housing for low-income families, including housing for the disabled, will account for 67.5 percent of that number.

Moreover, the Frank Melville Supportive Housing Investment Act aims to amend Section 811 by speeding up processing requirements. Along with a change of pace, this act also

aims to make Section 811 housing more affordable, and available, specifically for persons with disabilities.

Although these examples of a “reformed” public policy seem to be moving in the right direction, nongovernment solutions must also be considered. The lack of capital and the nominal size of government budgets remain the most severe constraints on supplying and meeting the housing needs of persons with disabilities. Given the current real estate market, it is a perfect time to reduce, if not eliminate, the “waitlists” throughout the country. Again, simple economic principles apply: (1) it costs less to house persons with disabilities in the community than to institutionalize them; (2) there are defined “waitlists” of eligible tenants, so we know where the demand is; and (3) there is ample supply of housing inventory.

The coming 20th anniversary of the ADA will surely be celebrated by the great strides that have been made since its passage—and they should. The occasion will also be marked by how much remains to be accomplished. Financial institutions and CDFIs should embrace this new market and provide it with leadership and solutions.

*Charles D. Hammerman is the president & CEO of The Disability Opportunity Fund.*

*Samantha Bennett is the special needs coordinator, Center for Wealth Preservation, Syosset, NY, an agency of Mass Mutual Financial Group.*

# The Small Business Perspective on Health-Care Reform

*Allison Kelly and Kirsten Snow Spalding*

*Pacific Community Ventures<sup>1</sup>*

California has 6.5 million uninsured adults, 55 percent of whom work for companies that do not provide health insurance.<sup>2</sup> This percentage accounts for 3.5 million individuals. According to a recent study conducted by the California Healthcare Foundation, roughly 30 percent of the more than 700,000 employers in California do not offer health insurance to their employees. In California, only 76 percent of businesses with 10–49 employees offer health coverage. Most of these noninsuring businesses are small- and medium-sized firms with up to 50 employees. These businesses cannot afford the insurance premiums and their low-income workers are unable to afford an employee match. Poor access to health-care takes a tremendous toll on individuals, the community, and the productivity of the state’s workforce.

Pacific Community Ventures has pioneered an innovative, market-based approach to meeting a critical need of California’s small- and medium-sized businesses and their employees—convenient and affordable access to basic medical care. This alternative, VidaCard, is relevant today despite health-care reform, which will still leave hundreds of thousands of people without access to health care. VidaCard gives small- and medium-sized business owners a new option for providing medical care to their employees: an employer-funded prepaid debit card that can be used exclusively at qualified health-care merchants, from providers to pharmacies. VidaCard MasterCard is not health insurance. Although we believe that health insurance is the gold standard of care, we designed VidaCard to try to meet the unmet needs of workers who currently do not have access to any health care.

## **The Health-Care Market for Small Business**

In its ten years of providing services to and building a network of business owners and leaders throughout California, Pacific Community Ventures has developed deep knowledge of the challenges that many small businesses face in providing health insurance. Specifically, PCV has worked closely with hundreds of small businesses that employ significant numbers of individuals who live in California’s low- to moderate-income communities in the Bay Area, Los Angeles, San Diego, and the Central Valley. While many of the businesses that PCV encounters would like to offer their hourly workers health benefits, they struggle to find health insurance options that (1) they can afford, given the size and stage of their business,

---

1 This article was made possible with support from The California Endowment.

2 Insure the Uninsured Project, May 21, 2008. Available at [www.itup.org](http://www.itup.org).

and (2) that will generate high enrollment and utilization rates among their employees. With limited alternatives, many businesses simply go into a holding pattern with health insurance until they are larger and better equipped to offer traditional, comprehensive plans.

### *The Health Policy Environment*

In the national health-care debate, the needs and role of small businesses in health-care reform have been argued vigorously over the last several months. From mandated coverage for workers to exemptions based on the number of employees, the size of revenues, and the geographic location of the business, it is still unclear what level of responsibility and accountability the government will ask small business to take in trying to improve access to health care for individuals. While the exact parameters of the final bill are unknown, there is clearly some consensus about what core reforms are needed. Congress and the Obama administration are committed to maintaining the current combination of private and public health-care providers and expanding access to care by requiring all individuals to purchase health insurance.

With the proposed universal insurance model, an urgent question is how to help low- to moderate-income individuals pay for it. It's commendable to have the guaranteed insurance mandate, but those plans still charge monthly premiums that must be paid. Most lawmakers agree that the federal government should provide subsidies to people with modest incomes to help make insurance more affordable. The model they see as having been most successful is Medicaid, which is why there is a push to expand the Medicaid program to provide health care for more poor people.

And finally, there seems to be general agreement in Washington that the government should save money by reducing the growth of Medicare payments to hospitals and other health-care providers. The Centers for Medicare and Medicaid Services (CMS) have created a value-based purchasing initiative designed to tie Medicare payments to performance on the quality and efficiency of care given and is part of the effort by CMS to transform Medicare from a passive payer to an active purchaser of higher-quality, more efficient health care. As House Speaker Nancy Pelosi put it, "We need to bend the curve of health-care costs."<sup>3</sup> In other words, health-care inflation must be capped. Capping Medicare payments could save hundreds of billions of dollars by shifting the emphasis on providers from volume of patients to quality of care. Lawmakers agree that we should reward high-quality care and emphasize preventive programs, which will save money in the long run.

This significant health-care reform initiative may improve access to care (because if everyone has insurance, they are more likely to get consistent health care), and it will implement cost-saving measures that will improve the system and, in the long run, partially control health-care inflation. What the current reform agenda is missing, however, is a cap on the costs of insurance. As a result, the current reform may be only a partial fix for small businesses that want to provide health insurance for their employees but face real cost barriers when they consider comprehensive medical plans.

---

3 Nancy Pelosi, Speech to City Summit: "Healthcare Reform and Economic Inspiration," Mission Bay Conference Center at UCSF, San Francisco, September 2, 2009. Hosted by San Francisco Chamber of Commerce.



### *The Private Health-Care Market*

Before health-care reform surfaced again on a national level this year, we identified the need to figure out the options for small businesses and found that in California a “small group,” defined as an employer with 2–50 employees, has several options, although none currently represents a perfect solution. On the federal level, the law has required for years that small-group health insurance be offered on a “guarantee-issue” basis for the group. In other words, a small business cannot be denied an insurance option because of the health status or illness of its employees or their dependents. Although this is a great benefit to the small-group status, “guaranteed issue” does not mean affordable access.

In 2008, the average premium for small group health insurance was \$346 per month (\$4,155 per year) for single coverage and \$913 per month (\$10,956 annually) for family coverage. This is a significant amount for any business and, when looking deeper into the various analyses, one finds that these costs are highest for the smallest employers, making it that much more out of reach for businesses that do not bring in large revenues.

To curb premium costs, many small employers are turning to an alternative to comprehensive health-care for their workers: low-premium, high-deductible plans. High-deductible plans (also called “catastrophic” or “major medical” plans) provide protection for major medical events but shift the burden to employees for all health-related costs with deductibles ranging from \$1,100 to \$5,000. These plans tend to have much lower monthly premiums. The concern then shifts to the low-income worker, who does not have the cash to cover his or her deductible, sometimes up to \$5,000. Employees covered by a high-deductible plan often forgo preventive health care and may not seek medical attention until a routine infection spirals out of control because they did not have the money to pay for an out-of-pocket doctor visit that could have cured the illness early on. This type of behavior leads to much larger burdens on our health-care system overall. Further, the individuals covered by these plans may have coverage should they suffer an accident, but paying that initial \$5,000 deductible could be enough to put that individual into severe medical debt. While potentially more affordable for the employer, many high-deductible plans simply shift the costs to employees who are least prepared to shoulder the burden.

MiniMed plans provide an even lower-cost alternative than high-deductible plans for significantly reduced coverage. In exchange for \$50–\$100 monthly premiums and no individual deductible, MiniMed plans cover a certain number of trips to the doctor each year, a monthly allowance for pharmaceuticals, and short-term inpatient and outpatient hospital care. The employee is responsible for anything beyond that simple package. Some MiniMed plans have high co-payment (over \$30), which can be burdensome for lower-income workers. MiniMed plans have also been criticized for being confusing, according to John Carroll in *Managed Care* magazine, “smoke and mirrors plans [that] look comprehensive, but . . . are designed to prey upon unsophisticated employees.”<sup>4</sup> Problems arise when employees seek

---

4 Carroll, John. “For More and More Workers, Small Pay Means Small Plans.” *Managed Care*, July 2005.

care and do not realize the true limits of their coverage benefits until after the fact. While on the surface a MiniMed plan might seem like a good alternative to a high-deductible plan, it too might have a construct that could mislead many employees and again result in cost shifting to those least equipped to pay.

### **Specialized Health-care Accounts**

There are three types of health-care accounts for small businesses that have tax benefits associated with them. These accounts vary according to who contributes to them, whether they are portable, what the tax benefits are, and, in the end, who owns the remaining money in the account at the end of the year or at the end of employment should there be a remainder.

Flexible Spending Accounts, or FSAs, allow an employee to set aside a portion of his or her earnings for qualified medical expenses. These contributions are deducted from an employee's pay and therefore are not subject to payroll taxes, resulting in a substantial payroll tax savings. The contributions, however, have limits and are based on a "use it or lose it" construct. If the employee does not use all of their set-aside funds by the end of the year, the unused funds actually go to their employer.

The second type of account is the Health Savings Account (HSA), which an employer can offer alongside high-deductible plans to help employees pay for day-to-day medical expenses. Both the employer and employee can contribute to HSAs. Most HSAs, however, assume that employees are able to contribute wages beyond their share of insurance premiums toward health care and that employees are equipped to pay for medical expenses up front and submit claims for reimbursement later. For lower-wage workers with limited access to cash and credit, paying up front is not an option. And it helps explain the Government Accountability Office's finding in 2005 that the average income among HSA holders in the United States was \$135,000. HSAs have even been criticized for providing wealthy people a means to avoid taxes while doing nothing to give the uninsured greater access to health care.

Finally, Health Reimbursement Arrangements (HRAs) are exclusively employer-funded accounts in which the employers can make tax-benefited contributions to their employees' health-care costs. This is an employer-friendly account because employers make their contributions throughout the year. This is a great advantage for smaller cash-constrained businesses in particular because any money the employee does not spend by the end of the year can return to the business.

While the market currently offers some choices for small businesses, for many these choices do not meet the health-care needs of their workers and their families. In some cases, the employees' shares of the premiums or their deductibles are so expensive that they cannot afford to take advantage of the plan even with the employer covering a portion of the costs. In addition, small businesses that want to help their workers obtain affordable health care face fundamental problems with access and affordability in the current insurance market.

In 2006 and 2007, average health insurance premiums in California increased by 8.4

percent, more than twice the rate of inflation (3.4 percent).<sup>5</sup> And consistent with the trend, smaller companies bore a disproportionate share of this burden. Companies with 50–199 employees saw rates rise by 8.2 percent in 2007, compared to 10.2 percent for companies with 10–49 employees and 13.5 percent for companies with 3–9 employees.<sup>6</sup> Rising costs limit the ability, particularly of small companies, to cover employee health premiums. Small business owners can hardly provide health insurance for themselves, and more than 26 million of the uninsured indeed are small business owners, employees, and their dependents.<sup>7</sup> These numbers contrast dramatically with the experience of large firms that held stable from 2000 with 99 percent consistently providing coverage. Employees at smaller firms pay a larger percentage of premiums than those at larger firms. The cost-shifting to employees can create significant hardships for lower-income workers and forces them to make difficult trade-offs in paying for other basic necessities such as food, housing, clothing, and transportation. Yet many businesses are finding themselves in the unfortunate position of having to reduce significantly or change their benefit plans because of rising and unpredictable premium costs.

Even those employers who have figured out a way to pay for health coverage cannot provide it to all of their workers. For example, only 10 percent of seasonal farm workers have employer-provided health care.<sup>8</sup> Only 21 percent of part-time and other nonstandard workers participated in employer-provided health insurance compared to 76 percent of standard workers. Nearly one in five family members of nonstandard workers were uninsured (18 percent of children and 16 percent of spouses).<sup>9</sup> When coverage is offered, nonstandard workers are significantly less likely to buy the insurance, either because it is unaffordable or because they have insurance through another family member.<sup>10</sup>

In addition to affordability and access problems for small businesses, many owners complain that the options, costs, and benefits are so complicated, even with the help of an insurance broker, that a human resources manager almost becomes a necessity.

Though it may represent a rational decision for most employers, the holding pattern they find themselves in—struggling between which health-care option is right for them—leaves many California workers and their families in dire straits in terms of paying for basic health care and maintaining their precarious financial stability.

Further, the crisis of being uninsured is more acute for some lower-income workers

---

5 California Healthcare Foundation Employer Benefits Survey, 2007.

6 Ibid.

7 Employee Benefit Research Institute, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey,” September 2008. Available at [http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content\\_id=3975](http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3975).

8 Sara Rosenbaum and Peter Shin, “Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care,” Kaiser Family Foundation, April 2005. Available at <http://www.kff.org/uninsured/upload/Migrant-and-Seasonal-Farmworkers-Health-Insurance-Coverage-and-Access-to-Care-Report.pdf>.

9 “Health Benefits Rare for Temps, Part-Timers,” Commonwealth Fund Digest, January–February 2006. Available at <http://www.commonwealthfund.org/Content/Newsletters/The-Commonwealth-Fund-Digest/2006/Jan/January-February-2006/Main-Features/Health-Benefits-Rare-for-Temps—Part-Timers.aspx>.

10 Ibid.

than others. Many of the employees in Pacific Community Ventures' investment portfolio earn wages that are well below the area median income level (average of 40 percent to 65 percent of AMI), putting them in the very low income bracket for their surrounding community. However, because they live in California, these workers earn wages that put them at 200 percent to 400 percent of the national poverty level, which disqualifies them from most public health programs as well as subsidized rates at community clinics. For this segment of the lower-income working population in California, not having health insurance is a double whammy. The situation not only creates adverse health outcomes but financial hardships as well. It is no surprise that medical debt is one of the leading causes of personal bankruptcy in the United States. Given this health-care reality for small businesses and their employees, PCV created the VidaCard Prepaid MasterCard® program.

### **How the VidaCard Works**

VidaCard provides an additional option for many current health-care challenges. The VidaCard program is affordable and empowers employers to determine the amount they can contribute each month to their employees' health care (\$25 minimum per employee); even the most cash-constrained business can participate. We designed the program for VidaCard to be entirely online and administratively light—it takes just ten minutes each month for employers to manage. Employers simply upload a roster of participating employees, select a standard benefit amount, select manual or auto-reloads, provide payment information, and personalized debit cards are issued within 15 days. Employers can reload VidaCards automatically and add or remove employee names at any time via [www.MyVidaCard.com](http://www.MyVidaCard.com). Funds can roll over year to year and are always returned to the employer 90 days after an employee's termination. Reloads can even be suspended without penalty fees in the event of a cash-flow shortage. VidaCard is the only HRA program with a discount dental plan integrated into a single point of purchase, and the program allows employees significant discounts at participating dentists and local clinics. Among the lower-income and predominantly Hispanic workers that PCV surveyed in its 2007 feasibility study, dental care was cited as the top health-care priority.

For employees, the program is even easier. VidaCard debit cards are activated over the phone and can be used anywhere that MasterCard is accepted to pay for doctor visits, medications, eyeglasses, flu shots, and blood tests. Each employee receives a "welcome kit," in English and Spanish, that explains how the debit card works and provides specific information on nearby retail and community clinics that offer basic, lower-cost care. One of the important attributes of the program is that there is no lengthy application process or additional documents required to enroll. Employees can call anytime to check their account balance or find a clinic near them. VidaCard and its benefits are available to any employee regardless of income level, age, immigration status, or area of residence.

By linking an HRA to an electronic debit card, PCV created a program that eliminates the need for employees to stretch their own credit or financial position to pay for basic health care. VidaCard relieves employees from having to navigate the confusing health-care system by themselves. While the VidaCard program is not insurance, it does give workers the tools and resources they need to access basic health care in the language and setting familiar to them.

In the context of health-care reform, the VidaCard program will continue to have a place in the market because, for the foreseeable future, an employer mandate remains a strong possibility. VidaCard is a way for small employers to feel more empowered about their contributions: it is more flexible than most options and gives both employers and employees more choices about how to spend their health-care dollars. Additionally, there could be a real gap for employees of small businesses who are required to have insurance (individual mandate), but who do not receive employer contributions. The VidaCard is a way for employers to help employees pay for their insurance. Further, the policy we have seen does not account for part-time and seasonal workers. PCV's VidaCard allows an employer to help contribute to these nonstandard workers' health-care costs in the new system. Finally, as a stop-gap measure, a stand-alone HRA product like VidaCard will always make sense for companies with long probationary periods before their health-care benefits go into effect, for seasonal workers, and for other individuals who are somehow excluded from the coverage as it evolves under the new policy plan.

The health-care market is complicated and current health insurance plans are often not small-business-friendly in terms of access and cost. Whereas federal health reform might offer some benefits that small business owners can support, there is no simple solution. Innovations such as the VidaCard will need to continue to proliferate and penetrate the market segments that unfortunately may be left out of policy reform to ensure that everyone has access to quality and affordable health care.

*Allison Kelly is a director at Pacific Community Ventures (PCV) where she's been leading the organizations VidaCard and health policy work for a year and a half. Prior to joining to PCV, Allison worked in both the private sector in pharmaceutical marketing and strategy and the non-profit sector in social marketing. Allison has a BA with honors from the University of Oregon, an MBA from Thunderbird, School of International Management and served in the Peace Corps in West Africa from 1996-1998.*

*Kirsten Snow Spalding is a consultant working on state and local health care policy, environmental initiatives and workforce development projects. From 2004-2006, Ms. Spalding served as Chief Deputy Treasurer of the State of California and as executive director of the California Pollution Control Financing Authority, and the California Alternative Energy and Advanced Transportation Financing Authority for the State of California. Prior to her term in government, she was chief of staff at the California Labor Federation, AFL-CIO for three years. She came to the AFL-CIO from University of California, Berkeley where she was research faculty at the Institute of Industrial Relations and taught at Boalt Hall, UC Berkeley's law school.*

# The Cash Market in Health Care: A Community-Based Approach

*Joy Anderson and Andrew Greenblatt*

*Criterion Ventures*

This article describes a new discovery in the health-care reform debate in America: the health-care market is not a single market. Rather, it is two markets, a dominant insurance market and a stunted, irrational cash market. The dysfunction of the cash market is an issue that affects all consumers in the health-care market but has a disproportionate impact on those in our society who are the most economically vulnerable. We also suggest a community-based approach to rationalizing the cash market intended to increase the value of the cash dollar in health care and thereby ensure access to services at appropriate prices and create the financial services that have an impact on the financial health of individuals and families.

The research and approach presented here comes from Criterion Ventures and the initiative, Healthcare\_Uncovered, that we began four years ago to look at the costs of health care not covered by public programs or private insurance. Criterion Ventures is a firm that launches social ventures that respond to complex social systems. Supported in part by grants from the Rockefeller Foundation, we spent nine months in research and design and another year in feasibility and development of the launch of a new venture that facilitates a community-based approach to providing appropriate financial services in local health-care markets to increase the value of the dollar in the cash market of health care.

## **Background**

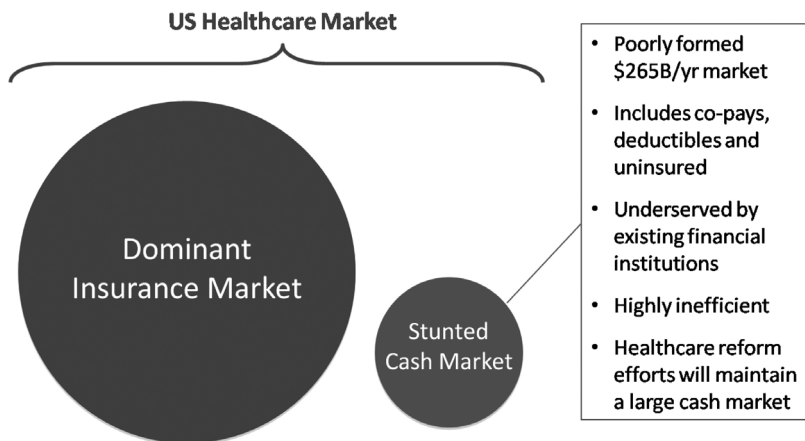
Cash expenditures have always been a component of health care, but it has been viewed as an “exception” to the broader insurance market rather than being effectively and efficiently developed into a market of its own. This has led to inefficiencies and unintended consequences that return less value per cash dollar spent on health care today with particularly detrimental impacts in poorer communities. We offer suggestions on how to create a more effective and efficient market and consider what impact this might have.

Hundreds of billions of dollars are changing hands outside private and public insurance, yet the systems and structures that manage these “uncovered” costs are relatively incomprehensible even to those inside health care. These out-of-pocket expenses are treated as an exception to the insurance market, which makes their tracking and management complex. Receivables management, bad debt, charity care, collection agencies, and health-care card services each represent systems of pricing and payments that add to this complexity.

For many Americans, particularly low-income families, these costs become debt. One in five Americans has medical debt; this debt is one of the leading contributors to bankruptcy, and it causes people to access health care late and in forms that are much more costly and disruptive to their lives, to providers, and to society as a whole. And medical debt is not just a problem of the uninsured. In a recent study by the Access Project, three out of five (62 percent) of all adults with medical bills or debt problems said they or their family members were insured at the time the debt was incurred.<sup>1</sup>

In the end, the players in the system treat the portion of health care paid outside public programs and private insurance as an exception to the norm, an aberration in an insurance-dominated market. And yet the exception represents 15 percent of the health-care market. In financial systems, exceptions create inefficiencies and friction and therefore cost more. However, they also represent market opportunities.

While dwarfed in comparison by the insurance market, the cash market in health care is large in absolute terms. It encompasses \$265 billion paid out of pocket, \$70 billion in unpaid bills, and \$27 billion in alternative medicine and more.<sup>2</sup>



In many respects, the cash market in health care is irrational. It operates with dysfunctional and unbalanced intermediation largely because the insurance market dominates the health-care industry and intermediation was designed to serve insurance, not cash payers. In addition, the capital flows in the cash market are fragmented and complex, which leads to

1 R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, "Gaps in Health Insurance: An All American Problem," The Commonwealth Fund, April 2006.

2 Agency for Healthcare Research and Quality, 2003: HU[http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/hc/state\\_expend/2003/table2.htm](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/state_expend/2003/table2.htm)UH; The Commonwealth Fund, 2005: HU[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=367876UH](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=367876UH); The Access Project, 2006: HU[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=367876UH](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=367876UH) H Institute of Medicine, 2005: HU<http://www.iom.edu/CMS/3793/4829/24487.aspx>U.H.

confusion and distrust of the system. Rational and efficient markets require common definitions, transparent practices, and greater information sharing, each of which is missing in the cash market for health care. Imagine walking out of a grocery store not knowing how much your food will cost. Instead, in the coming weeks and months, you received a flurry of bills from Kraft, the local baker, and others, along with another series of confusing letters prominently telling you that “this is not a bill.” Go through that enough times and you might consider avoiding grocery stores all together. But when it comes to getting health care, people do not have a choice, so these inefficiencies, which would be appalling in more transparent and competitive markets, have festered.

A more effective cash market will increase the value of a dollar in the cash market, value defined ultimately in terms of both access to care generally and access to the appropriate care specifically. This value can be improved through decreased cost of financing, optimized intermediation, and competitive pricing. In addition, developing and executing the changes in the cash market will lead to new ideas and opportunities for reforming the entire health-care system.

### Characteristics of the Cash Market

The current cash market for health care is comprised of health-care bills not covered by either public or private insurance, excluding the costs of catastrophic care. This includes charity care and other expenses written off by providers as well as the bills actually paid by consumers. Large bills incurred for catastrophic care by the uninsured or underinsured should not be part of the cash market. They are better understood as a failure in the insurance market.

What does remain—primary care, urgent care, co-pays, and deductibles—is a market that is ill-formed, with opaque pricing structures, confusing billing, few helpful intermediaries, and few appropriate financing options.

#### THE EFFECTS OF A POORLY FORMED MARKET

##### Poorly Formed Markets

△ High and erratic prices

△ Lack of transparency

△ Inefficient payment systems

△ Inappropriate and expensive financing

△ Lack of buyer-seller trust

△ Little innovation

△ Weak attraction of workers

##### Well Formed Markets

→ △ Lower, consistent pricing

→ △ Transparency

→ △ Efficient payment systems

→ △ Appropriate and reasonable financing

→ △ Predictable buyer-seller behavior

→ △ Innovation can flourish

→ △ Workers attracted and retained



Why don't we simply fix the systems that are creating the irrational cash market and work to limit or eliminate cash completely by advocating for a Canadian-style single-payer system? There are two answers. First, this change is not on the political horizon. The cash market is here and it is not going away any time soon. We write this article as Congress debates one of the most significant health care reform bills in recent history. As a whole, this is an insurance reform effort that will have an impact on the cash market but not eliminate the issue we describe here. Second, because of the nature of cash and the relative size of the payments, there is the possibility for innovation in pricing and payment mechanisms. As financial services push into the area of health care in the wake of the subprime mortgage crisis, we have a responsibility and an opportunity to define standards of practice that will sustain an effective, rather than predatory, market.

Understanding the cash market in health care requires an understanding of the overall capital flows. Funds to cover medical expenses incurred by consumers come from a variety of sources. Private insurance covers a significant portion, approximately \$750 billion. Government subsidies, including Medicaid and Medicare, cover another \$750 billion.<sup>3</sup> Hospital charity care and other philanthropic sources cover about \$50 billion of the costs. The remaining \$265 billion is paid by the patient.<sup>4</sup> This amount is either paid in cash, put on a credit card, or paid through other lines of credit.

In terms of the provider, cash flows into the system from two primary sources: insurance and patient receivables. Patient receivables can be broken into three sources: actual cash paid by the consumer or a credit institution, charity dollars or write-offs made by the provider, and debt or money still owed to the provider.

To better understand how these cash flows work, it is helpful to look at three market functions: (1) the pricing of goods and services, (2) delivery systems, and (3) financial services and intermediaries that support payments.

### *Price for the good or service*

A typical cash market includes immediacy in pricing and payment. Most of the capital flows in health care, however, are determined by prepayment to an insurance company (or to company reserves in the case of self-insurance) and then delays in subsequent payment to the providers. The insured pay a premium now for services in the future. The insurance company, in turn, employs a lengthy process of payment and adjudication that slows the outflows of cash. The time delays throughout this process stretch the transaction over months or years. What is not paid is often then dumped into the cash market. In contrast, typical cash markets, such as a grocery store, have payment at the time of the transaction

---

3 We believe government programs such as Medicaid can also be viewed as part of the cash market since the government is paying cash for services, not insuring against risk. This is analogous to food stamps, which are rightly considered part of the cash market for food.

4 <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

and therefore require clear pricing and on-the-spot-payment systems. Hospitals and other providers are moving toward collecting payments as the patient enters the building—in other words, up front, before the service is provided, reflecting these more traditional cash-market transactions.

In the health-care industry, there is not a single price for a service, nor is it clear what percentage of the price the consumer will be responsible for. Rather, the consumer experiences multiple types of payments—premiums, co-pays, deductibles—all for a single medical event. This fractured system makes it difficult to understand costs, to plan for expenses, and to make informed decisions about care. Currently, it is difficult to understand (or even see) the cash market because it is often scattered in bits and pieces across the insurance market. Because the cash market in health care is so opaque, the consumer is almost always confused or uncertain about the amount he or she will be responsible for paying.

### *Delivery systems that respond to price and create access*

Insurance companies use a number of methods to increase patient responsibility (deductibles, co-pays) as a means to cut down on utilization. The theory is that when there is no patient responsibility, the patient tends to overuse or misuse the system. As intended, the result is decreased use of the system. Unfortunately, in many cases this decrease has gone too far or come in the wrong places. People are not accessing health care when they legitimately need it because of the cost barriers. This often leads to more dire consequences that ultimately result in costlier interventions down the road.

New systems are beginning to emerge that more effectively respond to the needs of the cash market. For example, the rise of urgent care offices (sometimes called a “Doc-in-a-Box”) in Wal-Mart or in storefronts reflects this trend. These settings offer lower-priced care for basic services with transparent pricing and payment systems. They cannot and should not offer more expensive catastrophic care, but by offering services such as flu shots and strep-throat tests, they can perform an appropriate service in the cash market.

One goal of creating an effective cash market is to make sure consumers have access to the most appropriate care they need at any given time. For example, consumers should stop seeking primary care in emergency departments (where at least they can be assured access to care) and seek clinics that specialize in this type of service. Many local governments have set up these kinds of clinics in the hope of catching patients before they end up in an emergency department, but there are significant limits on this delivery system. While consumers can access primary care for little or no cost at these clinics, they usually cannot get access to diagnostics and specialized care without making large cash payments.

### *Financial services and intermediaries that support payments*

Today, consumers have several choices to cover out-of-pocket medical costs, including credit cards, health finance cards, health savings accounts, and flexible savings accounts. These payment options vary in their costs and complexity to the consumer in accessing

them, making them more or less effective. They also tap various sources of capital. For example, GE has provided over \$5 billion in direct financing to consumers to help them cover their medical expenses. In the end, financing medical costs is big business, and our discussions with financial services and capital-market participants suggest that investors are looking for ways to get into this market in a larger way.

An essential element to a more effective cash market will be more effective forms of intermediation that go beyond what is available today. These new intermediaries will need to bring capital to bear at rates consumers can afford, which may mean finding ways to adjust risk downward through the use of subsidies, risk pooling, etc. New intermediaries also will be able to provide financial services that link savings options to credit offerings and that aggregate buying power to negotiate transparent prices that are lower and billing systems that cut through the current opacity in the system.

### **Social Consequences of the Current Cash Market**

The irrationality and inefficiency of the cash market have significant social consequences. It affects one's ability to seek appropriate care, and it drives the delivery of service and the financial incentives of the system. For instance, with the lack of payment structures set up between primary-care facilities and specialists, patients often find themselves utterly mystified about costs when seeking a specialist. By creating a cash market with transparent pricing and billing that utilizes appropriate delivery systems and offers consumers effective financing and payment systems, we will be able to lower the overall cost of care within the cash market. This will not only save consumers and providers money but will allow greater access to care overall. The current system leads to dangerous and expensive delays in seeking care, as shown by statistics from a Kaiser Family Foundation report, "Medicaid Debt and Access to Health Care":<sup>5</sup>

- Those with medical debt are more than twice as likely to report being in only fair or poor health, and they are almost twice as likely to have an ongoing or serious health problem compared to others with private coverage (38 percent vs. 21 percent);
- Those who were privately insured but were also carrying medical debt were more than twice as likely to have failed to fill a drug prescription due to cost (24 percent vs. 9 percent; 27 percent for the uninsured);
- Those who were privately insured but were also carrying medical debt were four times more likely to postpone care due to cost (28 percent vs. 6 percent; 29 percent for the uninsured).

An alarmingly high proportion—59 percent—of uninsured adults who had a chronic illness, such as diabetes or asthma, did not fill a prescription or skipped their medications

---

5 KFF, 2005: HU<http://www.kff.org/uninsured/upload/Medicaid-Debt-and-Access-to-Health-Care-Report.pdf>.H.

because they could not afford them.<sup>6</sup>

To illustrate how the cash market touches all parts of the health-care industry and crosses social strata, we profiled the following iconic groups: undocumented workers, seniors on Medicare, middle-class workers with a large employer, small businesses and their employees, and low-income wage earners (part-time and full-time). Below, we look at the particularities of the impact of the cash market on these iconic groups:

**Undocumented workers** have a hard time accessing care in the current health-care system. These workers do not have social security numbers and fear contact with government officials. Thus, they have little to no access to the systems of public and private insurance. Many have cash and are willing to pay for their health care. However, they encounter provider systems ill-equipped to handle noninsurance payments, and they end up paying much more for their treatment than an insured person would.

**Seniors on Medicare** have experienced increased out-of-pocket expenses with the passage of Medicare Part D in addition to their premiums and deductibles, which continue to rise. In fact, nearly a quarter (23 percent) of the elderly Medicare population faced financial burdens from health care exceeding 20 percent of their income.<sup>7</sup> Supplemental insurance is expensive and still entails deductibles and co-pays.

**Middle-class workers** are faced with more out-of-pocket expenses as their employers shift to higher-deductible plans to offset increasing health-care costs. With higher deductibles, family medical expenses add up quickly, particularly if there is some sort of medical event, even if it is minor. As bills mount, the patient becomes embarrassed to go to the doctor for follow-up or additional care. The embarrassment of having unpaid bills impedes access to care.

**Small businesses** are crumbling under increased demands not only to provide health insurance but also to shoulder more of the financial burden through new cost-sharing benefit structures. Importantly, many small business owners and their employees are uninsured. For the small businesses that provide health insurance to employees, they pay more for their health care simply because they lack the buying power that larger employers have.<sup>8</sup>

**Low-income wage earners** often cannot afford their co-pays and premiums. Further, many low-income workers are part-time and therefore do not have access to insurance. Without insurance, it is difficult to maintain a relationship with a primary care doctor. This population is reliant on health clinics, which often are not available or, in many communities, are inferior. In addition, because low-income wage earners

---

6 Commonwealth Fund, 2006: HU[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=367876U](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=367876U).

7 KFF, 2005.

8 National Conference of State Legislatures, 2008.

live paycheck to paycheck, their cash flow cannot handle unpredictable events (i.e., someone suddenly gets sick and needs care). Because of the lack of relationships with primary care providers and often the lack of health-care clinics, they end up in the emergency room for treatment that would be more appropriately handled elsewhere.

The cash market is here to stay and is growing in scope and impact within the broader health-care industry. The social impact of the practices in this market are measured in terms of access to appropriate health care and the impact of those costs on the overall stability of an individual's financial well-being. In the end, the cash market has a disproportionate impact on those most vulnerable within our society. Therefore, any efforts to ensure universal access to health care need to address the products and practices that shape this market.

### **A Community-Based Approach to Building a More Rational Cash Market**

New markets are constantly emerging and being rationalized. Some may arise as a result of government action, such as the creation of carbon credits in Europe. Others arise from the introduction of a new technology, such as online advertising. Still others coalesce when new standards, benchmarks, and rating systems emerge in existing markets, such as the introduction of standard ratings for corporate bonds, which created a thriving commercial paper market.

Rationalizing the cash market for health care will similarly take the introduction of new products, services, and other innovations. Some of this work will need to take place nationally. But since health-care markets are currently very local in nature, much of the work needed to shape these markets will have to happen locally.

First, at the national level, thought leaders will need to introduce common ideas and even definitions to discuss this market. Second, common models for distribution of services will also need to coalesce at a national level, though implementation will probably need to stay local for the foreseeable future. Third, consumers will need support as they begin to navigate this newly invigorated market.

Criterion's market analysis led us to community-based innovations that can help shape a well-functioning cash market and therefore increase the value of the cash dollar in health care. If the cash dollar carries more weight, we will be able to shape delivery systems to increase access to primary care, in particular through aggregate buying power to shift pricing patterns and strip out costs associated with current inefficiencies. This effort will ease the financial burden on cash payers for health care and increase their access to quality health care—all with existing funds. Individual arrangements are made with each provider system, and care is sought in one's own community. For the most part, it is not a global market in that one cannot go online and order health care from any provider. Health service requires face-to-face contact and thus must happen locally. Further, provider systems tend to be local, from the smallest doctor's office to city-based hospital chains. There are a few large regional providers, such as Tenet Healthcare, but no dominant national brands.

Because of the need to build the kind of power needed to have an impact on the current

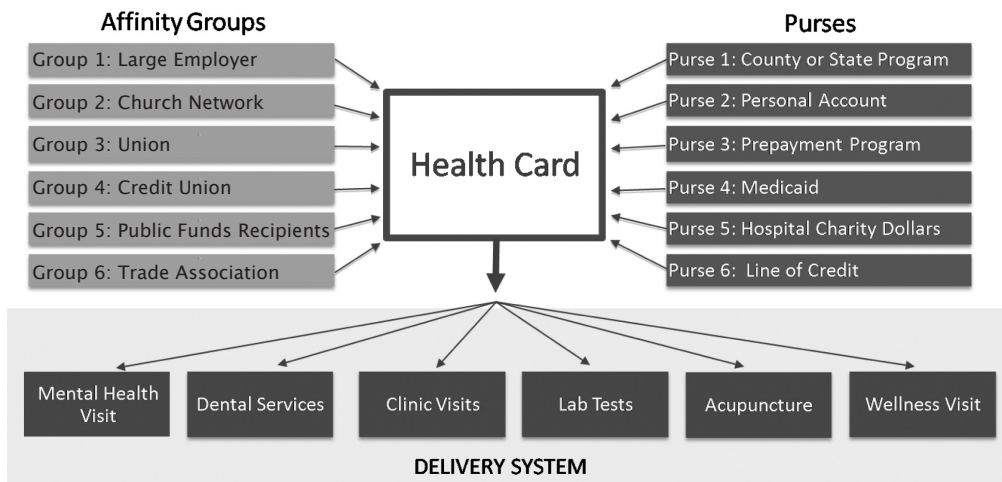
dysfunctional cash market, the solution cannot be to target products and services that will be made available one consumer at a time. Rather, we must use existing affinity groups (like church networks or unions) as a way to build power, and be able to negotiate with the large local health-care providers who currently dictate the nature and price of health-care delivery.

Criterion has been experimenting with introducing a new suite of financial products and services into communities as part of the project we call Healthcare\_Uncovered. We use these cutting-edge financial services to organize the existing assets within a community. Behind this product offering is a sophisticated rules engine that can be tied to a standard VISA debit card. This rules engine allows us to tie a single card to different accounts. The rules engine then draws from each of these different accounts at the appropriate time depending on where the consumer is and what they are using the card for. For example, a visit to an asthma specialist may be paid for out of an account the local county has established to serve children with asthma, while a dentist’s appointment would come out of the card holder’s Health Savings Account. Other accounts on a single card might include an employer-sponsored fund, a union trust, or a philanthropic program. Healthcare\_Uncovered is designed to sustain itself by charging small monthly fees to the cardholder (or other sponsors of the card) and by receiving small transaction fees every time the card is used.

A card-based electronic payment services platform with a rules engine allows for access to multiple funding allocations, or “purses,” with funder-defined eligibility requirements. The solution relies on existing infrastructure and processes by moving transactions through VISA or MasterCard debit systems to providers, thus allowing for swift implementation and impact. With the first program in a community, we create a platform for capital, access to that capital, and dignity to those in need.

### BUILDING THE CASH MARKET

**Community organizing to set up purses and identify affinity groups for the health card**



Over time we will be able to aggregate the work we are doing with each affinity group in the community to bring about larger changes to the local health-care system. We will be able to use the combined buying power to tie consumers and providers together into a “cash network” similar to the preferred provider networks currently in place in the insurance market. This network will create the foundation needed for transformational changes. Within this network we will be able to negotiate lower prices, have a rational billing system, and provide appropriate access to care. To achieve this level of influence over the market, we will need to organize consumers across the economic spectrum, but our intent is to have the greatest impact on the lives of lower-income workers. If we organized only these consumers, however, we would, ironically, fail to reach the scale needed to help them since they represent a minority of any community’s population and have a disproportionately low portion of the local buying power.

As we work around the country, standards for the market will emerge in various localities as different entities adopt and adapt products and adjust to operating in the cash market. However, these standards will need to be integrated and disseminated broadly. While driven at the local level, there is a need to deliver a coherent message and standardization across the emerging network to make the cash market less frightening and more recognizable and integrate solutions into national reform efforts.

### *Naming the cash market in the local health-care economy*

We have engaged with dozens of counties, municipalities, and state health-care leaders to test a process of dialogue and organizing. We began with an initial field trip that was designed to identify issues and opportunities and provide a context in which we can meet the key players already working to improve health outcomes for the community. We work with trusted connectors to reach out to the major health-care stakeholders in a given city or region to see what problems they face and what resources are at hand.

Organizing and shaping the cash market within a community requires the cooperation of multiple actors, including large health-care delivery systems, banking institutions, government funders, employers and other affinity groups, philanthropic institutions, and small providers. Each actor has a role to play in the market. Some, like small providers, may simply need to accept a more transparent form of receiving payment from patients. Others, like government funders, may be called on to use their might as a single large cash payer to support new initiatives that create platforms that reduce market fragmentation.

The first step in creating an effective cash market in a community is to properly name the problem and identify a vision for the future. Few actors within the cash market even recognize its existence as a separate market, yet when it is properly named they tend to have that “ah ha!” moment that leads them to want to engage quickly and collectively. By giving this hidden market a name, we frame the problem in a way that each player can connect to, giving them a way to understand their role and identify the common problem from which their individual challenges emerge. Having this common name creates initial cohesion and

affiliation among all the various and often disparate players in the market we are building.

For some, naming the problem and the vision for the future leads to skepticism. The problem seems too big to tackle. Others, however, see the potential of trying entirely new strategies to solve problems they have struggled with for decades.

Naming a big goal up front enables actors who at times see their work as quite different to understand a broader picture and creates a way to discuss the impact a well-formed cash market could have on all of their work. For instance, providers can see the cost savings to their system by working in a market where consumers pay on the spot in an efficient manner. Funders see new efficiencies in making payments using systems and intermediaries designed to handle cash payments and the new ability to experiment this would create. Banking institutions see a new role in the health-care market aligned with their core skills of moving and managing funds.<sup>9</sup> Customers see the benefits of clear negotiated prices and an easy way to pay them.

Identifying the cash market in a community allows these disparate players to see their role in the current cash market and how working collectively to reform that market would serve them while also serving the larger community. Creating this shared vision is a time-consuming up-front effort, but it is crucial to the success of the project. We achieve this naming portion of the process through written documents defining the cash market, one-on-one and in community meetings, and engagement of thought leaders and other validators within the community who serve as respected emissaries. This initial naming phase builds awareness of the cash market, engages key players and stakeholders by illuminating their role in the cash market, and reveals potential elegant starting points in creating the nexus of the organized system.

### *Map the assets, relationships, and challenges within a community*

As we enter a community, we map the existing assets, relationships, and challenges relating to the cash market. Health-care delivery in the United States is very localized and each community has a different set of experiences. Common to them all, however, is the fact there is already a cash market in place, though it may be poorly formed and opaque. Bringing the key players together to describe their experiences allows us to map out how the cash market functions in a particular community. To understand this, we seek answers to the following key questions:

- What are the key health-care delivery systems within a community that often define the market? Some communities are dominated by one or two large hospital systems that control enough of the market that a change in the way they handle the cash market could define that market. In many localities, the local government plays an

---

<sup>9</sup> Banks currently tend only to offer products like Health Savings Accounts that react to the insurance market. A few banks see the cash market as a new field where they can offer unique products designed specifically to serve that market.



enormous role in funding small dollar medical care. We have also found that poorer communities tend to have a disproportionate share of the cash market due to a high percentage of people with no insurance or insurance with high deductibles and co-pays. Providers tend to shun these markets, flocking instead to wealthier neighborhoods and the relative security of the insurance market, where they feel they have a better chance of getting paid.

- What are the key financial assets supporting the cash market? Government and philanthropic funders tend to play the lead roles in terms of organized resources to support the cash market. But a large percentage of cash market transactions happen between small providers and individuals and are not tied together in any formal way. This atomization of the cash market disempowers these purchasers and creates the inverse of a typical market, where a cash buyer is more coveted and powerful.
- What are the relationships among the key players? Most communities have been struggling with ways to deliver better health care for decades. These projects have created common tables bringing together government, for-profit providers, nonprofit providers, philanthropies, and the faith community. These points of connection have created trust relationships that can smooth the way as key actors work together to create a local cash market.

Once the initial systems map is created, we can ascertain the key leverage points that can be used to move the larger system. For example, a robust local government health system may be leveraged to create a payment system on a platform that it could open up to the broader community, tying cash payers together and building a rational market. Alternatively, a dominant private system might be in place that could play the same role.

The act of creating the systems map of the local cash market illuminates new possibilities and affects the goals first described in the naming exercise.

### *Invitation*

Both naming and mapping require a third task: an effective invitation process. Organizing a new cash market requires powerful players to sign on to the mission and agree to take particular steps. This may mean accepting lower fees in exchange for ease and guarantee of payment, using the power of pools of money a funder controls to link together affinity groups, or a bank offering a set of financial processing tools that the local community can draw on.

Bringing these key players together requires a local presence respected within the community. This must be someone who has the ability to navigate between disparate and often competing organizations while maintaining the respect of each one. The individual must be trusted to bring in good ideas and use their time effectively. This role can be played by a leader in government, a powerful executive in the health-care sector, a visionary nonprofit leader, or a respected academic. This role can almost never be played by an outsider.

It is important to understand that the invitation is not just to come and listen, but to come and be a part of creating something new. Each participant brings his or her own assets, relationships, and insights to the table. Participants will be moved to action only when they feel their voice will matter, that they can make a difference, and that they share in the desired outcomes they help create. Furthermore, this is the only group of people who can create a local cash market. No outside actor will have the depth of knowledge or the persuasive power to force the necessary changes.

As the process continues, the importance of early genuine invitation becomes more important. Partners in social enterprises often find quick alignment in visions and goals. All parties want to see a social problem solved, a pain alleviated, or funds created. As the enterprise develops and faces choices, however, more subtle differences in motivations and priorities surface, forcing partners to compromise and challenging communications and cohesion. In creating a cash market in health care, these differences usually arise over questions of who will add new money to the system. All agree that a well-functioning system tomorrow will save all actors money tomorrow. But today some actors need to take the first steps to build the market.

For example, a community may see the benefit of having a single system in place that ties together health-related checking and savings accounts and allows providers to draw from those accounts using debit card technology. When a critical mass of the local community uses the system, all the participants benefit. Providers get a quick and easy method of payment, consumers have a reliable way to tie together the myriad public and private programs they may qualify for to augment their own savings, and funders have a cost-efficient way to roll out their programs and connect to consumers.

In a classic market-formation dilemma, difficulties arise in attracting early adopters. Banking institutions may not want to offer the products that few people are using. Providers may not want to go through the administrative hurdles of accepting a form of payment few customers will be using, and consumers may not bother signing up for a card that few doctors accept. In all of this is a free-rider problem: all of this will be cheaper and easier for me to adopt after enough other people have already signed up and taken the initial risk.

Effective invitation early in the process helps deal with the early adopter problem. If key actors feel genuine ownership of the process and understand the long-term value of the early, costlier steps, they will be more likely to take them. Having key leaders work in concert can also shorten the time needed to get through the early stages. To secure early adopters, players should work together through invitation to create an incremental approach. The objective is to minimize risk and up-front capital requirements by establishing a broader dynamic network that can grow and yield additional benefits from scale.

### *Execute through a network to shape a market*

Achieving the vision of an efficient market requires getting disparate actors within communities to work together to create a dynamic and interconnected network of relation-

ships. The process mitigates implementation risk by establishing initial connections among players that will deliver immediate benefit to participating community members and establish a nexus for expanding the network, which achieves additional benefits through scale.

In the end, this entire process will only be as successful as the final execution. Market formation is an arduous process that requires managing relationships and assets over time. In a given community, this will mean rolling out an intermediation that is rapidly adopted by the key players within that community. Getting this done will require a certain stamina and willingness to deal with uncertainty among all the players. The rationalization of the market itself will create new problems and new opportunities.

One key to successful execution will be to find a durable source of revenue during the early period. Eventually the cash market needs to find a new, more efficient equilibrium that can sustain itself. But the period before then will see the creation of new entities designed for the coming market but struggling to survive in the existing one. An infusion of capital will be required, either in the form of philanthropic support or risk capital.

Over time the market will become more rational and disparate players will shift their roles to take advantage of new opportunities. Lower prices, greater ease and efficiency, and increased predictability will entice more actors to join this market.

## **The Impact of Intervention**

If the cash market for health care is rationalized, we believe costs to consumers and providers will decrease, the value of the cash dollars spent in health care will increase, and coverage for those most in need will expand.

As with any new venture, an influx of capital is needed to jumpstart development and implementation. With an influx of capital, innovative products can be developed and introduced, providing increased definition to the market. New products will create a demand that will increase the sense of possibility within the health-care system of what can happen inside the cash market as opposed to the insurance market. As products that address this opportunity become available and as more affinity groups organize themselves to make use of these products, the market will become more defined.

We can look to the insurance market in health care and other established markets to imagine what a well-formed cash market in health care could bring. Bringing consumers together into large buying pools could allow them to leverage their buying power to negotiate lower prices and press for more appropriate delivery systems. Providers, attracted to a better functioning market and the ease of payment it brings, will offer new services in neighborhoods they previously shunned. Financial and government institutions will see this new market as a fresh place to innovate as they look for new business or try to find new ways to reform the health-care system.

Over time and through replication, the market will standardize. Standardization of the market will enable it to scale up to a national level. At such a scale, a broad impact on access to appropriate health care, the cost of health care, and health outcomes is possible. As this

impact becomes visible, more investors will contribute capital to the products and services that enable the market to function efficiently.

As the cash market becomes increasingly recognized and acknowledged, a paradigm shift will occur. The cash market will no longer be treated as an exception to the insurance market but rather as a separate functioning entity with its own operating procedures. With this paradigm shift in how people view health care will come corresponding policy changes, which in turn will increase the scale of the impact.

Rationalizing the cash market could have unintended consequences. The most obvious is that this market could expand, caused by employers' simply shifting more of the health care cost burden onto employees. We believe, however, that the opposite will happen: by making the cash market more manageable, employers and others will be more likely to help consumers deal with the cash portion of health care by offering subsidies and services that complement their insurance offering. It is also important to note that if the cash market expanded because it offered cheaper and more appropriate care, patients would benefit. The question of whether a larger cash market is good or bad depends on who pays, not on the value of the dollar spent. More value is always better; using that increased value as an excuse to shift the burden is not.

As with any large reform program or any new market, unforeseen consequences will arise. We and others will need to monitor these changes closely as we move forward. The potential for unintended consequences should not paralyze us. If the cash market is not rationalized and it remains an exception to the insurance market, then the current issues surrounding transparency, financing, and overall value of the cash market will only get worse. Consumers will be continually saddled with various and differing forms of medical expenses. They will continue to be unaware of costs and what financial situations they might be getting into as a result of a medical condition. And we know from current studies that financial hardship limits people's access to care.

## **Conclusion**

The market for health care in the United States is actually two markets: a dominant insurance market and a stunted cash market. Treated as an exception to the insurance market, the cash market is ill formed with opaque pricing structures, confusing billing, few helpful intermediaries, and few appropriate financing options.

The inefficiencies of the cash market are highlighted by looking at three features: how services are priced, how prices affect the delivery system, and the financial services that intermediate the process of payment. Currently the consumer is faced with a fragmented and opaque pricing system (co-pays, deductibles, stop-losses), which is a result of intense negotiations between insurance companies and providers. The resulting fractured pricing system, however, makes it difficult for the consumer to understand costs, to plan for expenses, and to make informed decisions about care. These results have a disproportionate impact on those most vulnerable in our communities, those disenfranchised from

banking services, unable to access insurance, and ineligible for the cost savings created through bulk purchasing agreements.

By creating a cash market with transparent pricing and billing that uses appropriate delivery systems and offers consumers effective financing and payment options, we will be able to lower the overall cost of care within the cash market. This will not only save consumers and providers money but also will allow for greater access to care overall.

To rationalize the cash market, action will be necessary across many local areas because the local level is where health care takes place. The work of local groups will be important as a way to manage risk, build power, and negotiate. Working at the local level will require organizing a broad array of individuals who bring with them their own assets and relationships. By rationalizing the cash market for health care, we will be able to increase the value of the cash dollar, empower consumers to make wiser choices, and lay the groundwork to support new and innovative delivery systems.

*Joy Anderson is the president and founder of Criterion Ventures and a founder of Good Capital. Criterion's venture work is currently focused on the development of solutions to help form and rationalize the cash market in health care, an effort funded by the Rockefeller Foundation. Joy holds a BA from Wesleyan University and a PhD in American History from New York University.*

*Andrew Greenblatt is the director of products and innovation at Criterion Ventures. He has started numerous social ventures, including Pride Diamonds and a real estate holding company that works with charities. He graduated cum laude from Harvard Law School and is an adjunct assistant professor at NYU's Wagner School of Public Service.*

# Financial Stress and Its Physical Effects On Individuals and Communities

*Laura Choi*

*Federal Reserve Bank of San Francisco*

Everywhere you look, the symptoms of the current recession are clear: homes lost to foreclosure, job losses across almost every sector of the economy, dwindling retirement portfolios, and frozen credit markets. But the recession has also led to a number of other symptoms that haven't been getting enough attention: headaches, backaches, ulcers, increased blood pressure, depression and anxiety, just to name a few. Extended periods of stress can take their toll on physical, mental, and emotional health, compounding the difficulties that many low- and moderate-income communities face during troubled economic times. As we think about ways to strengthen health and community development finance at the institutional level, we need to remember the impact that financial instability can have on health outcomes at the individual level.

## **The Financial Health of Americans**

The poet E. E. Cummings summed up the financial condition of many Americans when he said: "I'm living so far beyond my income that we may almost be said to be living apart." The Federal Reserve estimates total household debt, including mortgage debt, at about \$13.7 trillion, or 125 percent of annual after-tax income.<sup>1</sup> Many Americans now face perilous balance sheets as household assets began their plunge in 2008. Household net worth fell by \$11 trillion in 2008, a decline of 18 percent from the previous year, according to data from the Federal Reserve. Unemployment continues to hover near 10 percent and millions of Americans are expected to exhaust their unemployment-insurance benefits soon. Despite the fact that the Commerce Department announced GDP growth of 2.2 percent in the third quarter of 2009, marking the possible end of the recession, the financial pain lingers and Americans' debt levels continue to mount as income streams and savings dry up.

## **Linking Financial and Physical Health**

When people are dealing with significant debt, they are much more likely to report health problems, according to an Associated Press–AOL health poll conducted in 2008.<sup>2</sup> Roughly 10 to 16 million people are "suffering terribly due to their debts, and their health is likely

---

1 Federal Reserve statistical release, "Flow of Funds Accounts of the United States, Second Quarter 2009."

2 AP-AOL poll, conducted March, 24 – April 3, 2008. See <http://surveys.ap.org/> for full results.

to be negatively impacted,” says Paul J. Lavrakas, a research psychologist who analyzed the results of the survey.<sup>3</sup> Lavrakas and his colleagues from the Ohio State University developed the “Debt Stress Index” to track the impact of worry about financial debt on health and well-being. The index hit a record high in July 2009 and has only slowly decreased with the first signs of economic recovery. Among the people reporting high debt stress in the AP poll, 27 percent had ulcers or digestive-tract problems, compared with eight percent of those with low levels of debt stress, and 29 percent who suffered severe anxiety, compared with four percent of those with low debt stress.

We can’t conclude from these findings that financial stress is the lone culprit in poor health outcomes, but medical research suggests that these types of symptoms are representative of chronic stress. The body reacts to stress with a “fight-or-flight” response, releasing adrenaline and cortisol, major hormones associated with stress. In situations of persistent stress, the body adapts to adverse conditions by establishing a new state of equilibrium, and the elevated levels of these chemicals can cause significant physical harm to vital bodily systems such as blood pressure, heart rate, memory, mood, and immune functioning.

On a more intuitive level, money is more than just cash and coins. Just ask anyone who’s suffered a layoff, witnessed their retirement savings vanish, or watched helplessly as the value of their house plummeted—money provides feelings of security, power, independence, and freedom. And the threat of ongoing debt or insufficient income can result in feelings of loss of control, anxiety, and other mental and emotional distress. In addition, chronic financial stress has been linked to a cycle of increased workplace absenteeism, diminished workplace performance, and depression.<sup>4</sup>

### Financial Stress and Children

The stress caused by overwhelming debt is also having a devastating impact on the well-being of America’s children. School psychologists and guidance counselors have reported an increase in the number of children struggling with stress because of their families’ financial problems.<sup>5</sup> In addition, the longer-term implications of chronic financial stress are even more alarming. A decade-long study at the Iowa State University Institute for Social and Behavioral Research has shown that children who experience socioeconomic adversity at an early age are at increased risk for experiencing mental health challenges during their teen

---

3 Associated Press. (June 9, 2008). “Debt Stress Causing Health Problems, Poll Finds.” Retrieved from <http://www.msnbc.msn.com/id/25060719/>.

4 R. L. Weisman, “Personal Financial Stress, Depression, and Workplace Performance,” in *Financial Stress and Workplace Performance: Developing Employer-Credit Union Partnerships*, The Center for Credit Union Innovation and Filene Research Institute, Madison, Wisconsin, 2002.

5 Brody, Leslie. (2009, September 20). Recession’s toll on children: Parents aren’t the only ones who suffer when jobs are lost and money is tight. *Chicago Tribune*.

years.<sup>6</sup> The study finds that young people from poor families are particularly vulnerable to becoming “trapped in the self-perpetuating cycle of adverse life circumstances and poor health.” K. A. S. Wickrama, one of the authors of the study, concluded, “What needs to be done is enhance the kids' resiliency factors—such as investing in kids' education and psychological competency programs. The policies and intervention programs need to focus on early intervention . . . because early levels of depression have a persistent influence.”<sup>7</sup>

### **Restoring Financial Control and Healthy Communities**

Although we certainly need to focus on the major influences on the macroeconomy, such as the availability of credit and stability in the housing market, we can't overlook the real physical pain that individuals and families are experiencing as a result of their precarious financial situations. Our community development responses must include efforts that put households on sure financial footing. These responses include job training and workforce development, access to education, affordable housing, small-business development, and, above all, sustainable capital to finance these efforts. In addition, we need to advance effective and efficient financial education efforts that empower people to make lasting changes in the ways they manage their personal finances. These types of community development efforts will be vital components of our collective recovery to economic and physical health.

*Laura Choi is a research associate in the Community Development department of the Federal Reserve Bank of San Francisco, where she serves as editor of the quarterly publication Community Investments and researches a variety of issues aimed at improving economic opportunities for low- and moderate-income communities. She received a BA in economics and a master of public policy degree, both from UC Berkeley.*

---

6 Iowa State University News Service. (2008). ISU study finds early family depression has lasting effects on teens, young adults. Retrieved from <http://www.public.iastate.edu/~nscentral/news/2008/dec/depression.shtml>.

7 Ibid.



# The Relevance of Health Reform to Community Health and Development

***Peter Long***

*Henry J. Kaiser Family Foundation*

***Neal Halfon***

*University of California, Los Angeles<sup>1</sup>*

Over the past twelve months, Congress and the nation have been engaged in a discussion about how to make significant changes in the provision of health insurance and the financing of health care in the United States. The debate has seen its highs and lows: from the raucous August town hall meetings and charges that the reform would institute “death panels” for the elderly and lead to government-run health care to more candid conversations about the affordability of health insurance for typical Americans and the real impact of an inefficient and underperforming health-care system on the U.S. economy.

Fundamentally, at their core, the bills recently passed by the House and Senate seek to increase access to health insurance, improve the quality of medical care, and control health-care spending. Although considerable evidence shows that health at a population level is determined by social and economic factors that fall primarily outside the medical-care system, 90 percent of the new health-reform dollars would be spent to make health insurance more affordable for low- and moderate-income Americans (McGinnis and Foege, 1993; Mokdad et al., 2001; Long, 2008). As a result, several commentators have suggested that the health insurance reform debate has very little to do with improving the health of the U.S. population (Halfon, 2008; Klein, 2009). Given the narrow focus of the debate and its still undetermined fate, we address two questions: Why should individuals engaged in community economic development get involved in the details of health reform, and why should they participate in the design of the implementation plan if and when the legislation is passed?

Beneath the surface of the contentious issues in the headlines and the hundreds of billions of dollars allocated to subsidize health insurance premiums, the final health reform bill is likely to contain a significant number of provisions that have the potential for community health infrastructure to deliver better population health outcomes. Although these public and population health initiatives represent a fraction of total proposed spending, and are considered relatively minor provisions by most observers, passage of a health reform bill would nonetheless present a number of promising opportunities for community health

---

<sup>1</sup> The views expressed here are those of the authors and not the Henry J. Kaiser Family Foundation or the University of California, Los Angeles.

and development. The emerging legislation contains a number of specific examples of new policy directions that could impact health and development at the community level and provide opportunities for engagement to shape their final implementation.

## Potential Benefits

There are both direct provisions designed to improve health at a community level and a number of indirect pathways that could influence community health and development. For example, both the House and Senate versions of the bill contain provisions that would create and fund major grant programs for public and population health functions (Senate bill passed December 24, 2009, and House bill passed November 7, 2009). Although small in comparison to total proposed spending, these grants represent a significant infusion of up to \$10 billion annually in new resources to support effective public health programs in states and communities across the country and enjoy bipartisan support. One specific example is the childhood obesity grant program in the Senate bill. This provision has been praised by foundation leaders as a means to reduce health disparities and promote equity (Healthy Eating Active Living Convergence Partnership, 2009). Community-based initiatives that address the multiple causes and impact of obesity are also likely to result in new investments and policy changes that extend beyond the traditional medical and public health sectors into other aspects of community and civic life. At their best, these grant programs have the potential to stimulate new pathways for promoting health and preventing disease that not only could be scaled and spread but could be adapted to other health conditions with similar complex causal pathways requiring broader community wide approaches for amelioration.

Both bills would support innovation networks and learning collaboratives<sup>2</sup> where evidence of successful practices in treating patients with chronic conditions could be diffused, scaled, and replicated. This support would reduce the time between the generation of knowledge, piloting, and its widespread diffusion.

Through the increases in insurance coverage, all bills would allocate significant new resources to health-care providers in local communities across the nation. Representing one-sixth of the Gross Domestic Product (GDP), the health-care sector is one of the largest sectors of the economy in many communities. Increasing the number of Americans with health insurance will also lead to increased demand for goods and services, generating additional health-care spending and demand for health care workforce (Office of the Actuary, Centers for Medicare and Medicaid Services, 2009). Previous studies have quantified the multiplier effects that federally funded health insurance expansions can have on local economies (Families USA, 2008).

A number of provisions in various bills are designed to “bend the health-care cost curve,”

---

2 ACOs represent a new organizational structure that could knit individual and population health outcomes together and link short- and long-term time horizons. While they have the potential to be the engine that drives a more efficient health-care system, many other necessary precursors are not in place.

such as bundling payments for services and incentives to prevent hospital readmissions (Senate Finance Committee, 2009). These provisions are grounded in the belief that if the nation can reduce spending levels in the inefficient health-care sector by one or two percent of GDP, additional resources will be freed up to generate more productive and efficient economic growth in green technology, education, or other sectors.

The potential expansion and use of health information technology (HIT) provides an opportunity for communities to update and upgrade their health measurement and monitoring systems, as well as the measurement of other social factors that influence health outcomes. While HIT innovations are beginning in the doctor's office and hospitals, advanced HIT systems will undoubtedly include community health measures. Similarly the focus on comparative effectiveness research is likely to begin with comparisons of drugs and medical procedures, but it could also advance our ability to assess how different community infrastructures and interventions can result in better and more cost effective health outcomes.

### **Potentially Adverse Elements**

As any introductory public policy text warns, every piece of legislation has intended and unintended consequences. With bills as complex as the emerging health reform proposals, it is not surprising that they offer some new tools and resources to promote population health like the ones noted above and make other policy choices that could inhibit community development or make certain activities more difficult.

For example, provisions in the bills that force employers to either pay into a health insurance pool or purchase insurance for their workers could have negative economic impacts on small and medium employers, who would be required to pay for a portion of health insurance premiums. Given that the cost of purchasing health insurance is roughly equal to the cost of hiring a minimum-wage employee for a year, provisions requiring employers to pay for insurance may prevent future hiring or limit job growth (Kaiser Family Foundation, 2009).

In addition, the exclusion of certain immigrants from health insurance subsidies and the portion of the population remaining uninsured after full implementation will necessitate the need to maintain a separate health-care safety net to provide them with free or low-cost medical care. These exclusions will have disproportionate impacts on states such as California, New York, Texas, and Florida and certain communities within those states that have the largest numbers of undocumented immigrants and remaining uninsured.

### **The Way Forward**

Because two bills are being combined into a final piece of legislation before a final vote by the House and the Senate, specific provisions within the House and Senate bills could change, but the overall direction is clear. Because of the complexity of the policy changes under consideration, the final bill is likely to provide only a broad policy framework, particularly for policies that would affect community health and development, leaving the details

to federal agencies, state governments, new commissions, and other entities. These details will be crafted over the next several years through regulations, program descriptions, other guidelines, and real-world experience.

Health reform is important to examine not only from a community economic development perspective, but these practitioners will be important actors in determining its ultimate success, since the final verdict on the value of health reform is likely to be delivered by communities across the country over the next decade or longer. As such, health reform provides many opportunities for practitioners working at the community level to promote innovation, share promising models from other sectors and identify new linkages among community development, a high-performing health-care system, and population health measures. Community development practitioners also have the tools and know-how that is needed to scale and diffuse successful pilots and demonstrations, which have real potential to transform health-care delivery systems and improve the nation's health.

*Currently, Peter Long serves as senior vice president for Executive Operations at The Henry J. Kaiser Family Foundation. In this role, he is responsible for the Foundation's U.S. global health policy analysis among other responsibilities. Before returning to Kaiser, Dr. Long was a senior program officer and then director of Research and Planning at The California Endowment in Los Angeles, CA, where he lead The Endowment's efforts to secure health insurance for all children in California. He received his AB in Modern European History from Harvard University; his masters in health science from Johns Hopkins University School of Hygiene and Public Health; and his doctorate in Health Services from the University of California, Los Angeles.*

*Neal Halfon is director of the UCLA Center for Healthier Children, Families and Communities, and also directs the Child and Family Health Program in the UCLA School of Public Health, and the National Center for Infant and Early Childhood Health Policy. Dr. Halfon is professor of pediatrics in the David Geffen School of Medicine at UCLA; community health sciences in the UCLA School of Public Health; and public policy in the UCLA School of Public Affairs. He is also a consultant in the Health Program at RAND. Dr. Halfon received a MD from the University of California, Davis and a MPH from the University of California, Berkeley.*

## REFERENCES

All congressional bills are available online at [www.kff.org/health\\_reform](http://www.kff.org/health_reform). Accessed October 14, 2009.

Families USA. Families USA Medicaid Calculator Methodology. 2008. Available online at <http://www.familiesusa.org/assets/pdfs/medicaid-multiplier-methodology-4-08.pdf>.

Halfon, N. April 21, 2008. "The Primacy of Prevention." *The American Prospect*.

Healthy Eating Active Living Convergence Partnership. August 17, 2009. "Leading National Foundations and Health-Care Organizations Make Unprecedented Call for Investment in Prevention." Available online at <http://www.convergencepartnership.org>.

Henry J. Kaiser Family Foundation. 2009. "Employer Health Benefit Survey." Washington, D.C. Available online at [www.kff.org](http://www.kff.org).

Klein, E. June 18, 2009. "Wealth-Care Reform." *The American Prospect*.

Long, P. V. 2008. "Estimating the Long-Term Health Effects Associated with Health Insurance and Usual Source of Care at the Population Level." PhD dissertation, University of California, Los Angeles.

McGinnis, J. M., and W. Foege. 1993. "The Actual Causes of Death in the United States." *Journal of the American Medical Association*. 270: 2207–13.

Mokdad, A. H, B. A. Bowman, E. S. Ford, F. Vinicor, F., J. S. Marks, and J. P. Koplan, 2001. "The Continuing Epidemics of Obesity and Diabetes in the United States." *Journal of the American Medical Association* 286 (10): 1195–1200.

Office of the Actuary, Centers for Medicare and Medicaid Services. "Estimated Financial Effects of the America's Affordable Health Choices Act of 2009." October 21, 2009. Washington, D.C.

