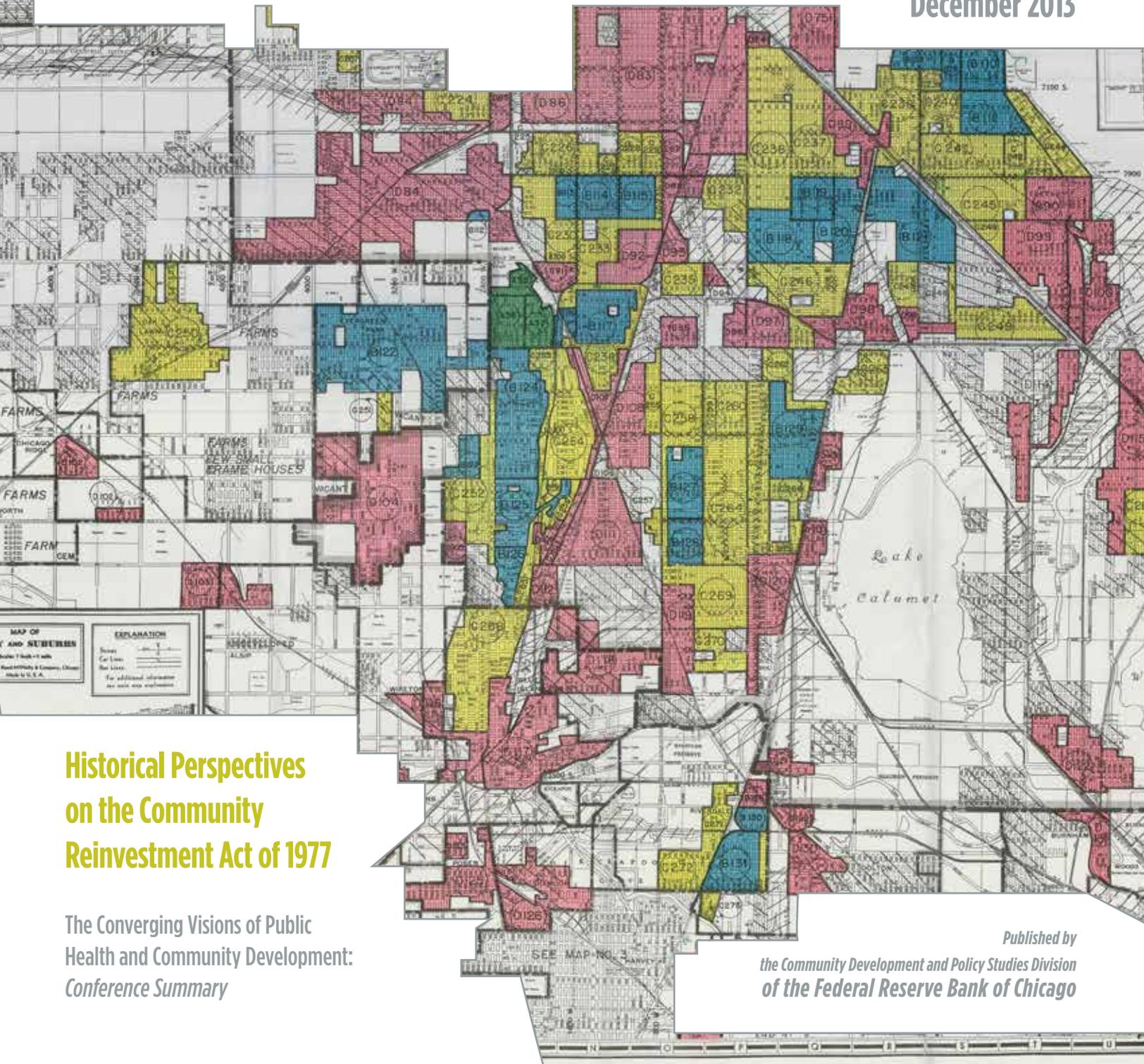


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news and views

December 2013



Historical Perspectives on the Community Reinvestment Act of 1977

The Converging Visions of Public
Health and Community Development:
Conference Summary

Published by
the Community Development and Policy Studies Division
of the Federal Reserve Bank of Chicago

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December 2013

This final 2013 edition of *Profitwise News and Views* provides a summary and some of the key takeaways from the CDPS department's Healthy Communities Regional Summit, organized with partners from both the public health and community development fields, including the Illinois Public Health Institute, the Adler School of Professional Psychology, Access Community Health Network, IFF, The Chicago Community Trust, LISC Chicago, and others. Helping to mark the Fed's 100-year anniversary, we also take a historical look at the Community Reinvestment Act, and legislation dating back to the New Deal that contributed to the practice of redlining.

Cover Image: Home Owners Loan Corporation (HOLC) Residential Security Map of Chicago, IL.
Prepared by HOLC Division of Research and Statistics. Source: urbanoasis.org.

The Federal Reserve Bank of Chicago

The Federal Reserve Bank of Chicago and its branch in Detroit serve the Seventh Federal Reserve District, which encompasses southern Wisconsin, Iowa, northern Illinois, northern Indiana, and southern Michigan. As a part of the Federal Reserve System, the Bank participates in setting national monetary policy, supervising banks and bank holding companies, and providing check processing and other services to depository institutions.



Historical Perspectives on the Community Reinvestment Act of 1977

by Michael V. Berry

Introduction

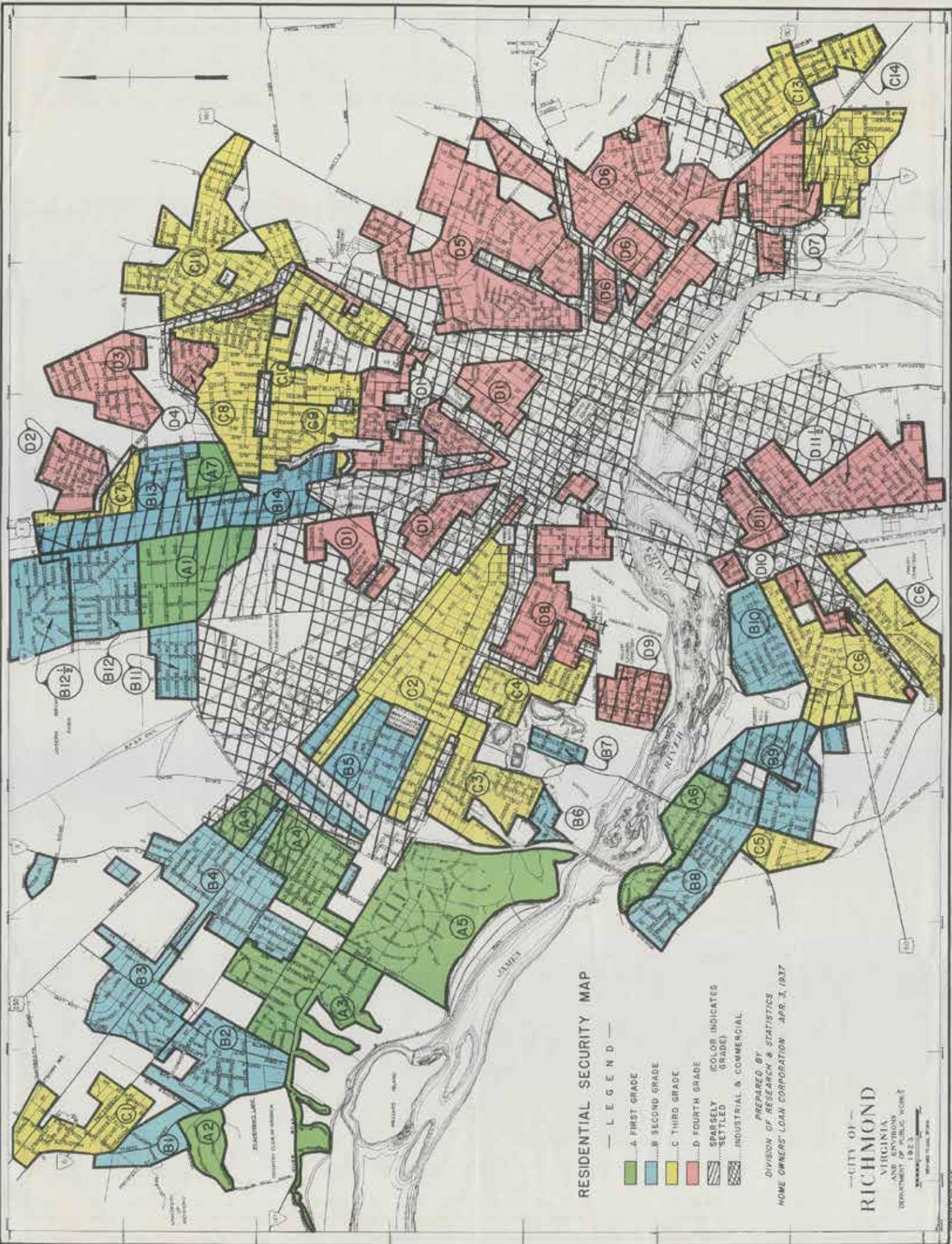
December 23, 2013, marks 100 years since passage of the Federal Reserve Act, which created the Federal Reserve System. (The Chicago Fed opened the following year, in November.) The Federal Reserve's central missions of maintaining price stability – a sustainable rate of economic growth – and a secure banking system, have remained constant since the Fed's inception, but the ways the Fed goes about its mission have changed dramatically over the last century. New laws and policy changes over time have impacted the Fed's responsibilities. This article provides historical perspective on a pivotal and at times controversial law that added new dimensions to the Fed's responsibilities late in the twentieth century.

Congress enacted the Community Reinvestment Act (CRA) to encourage banks and thrift institutions to serve the credit needs of their entire geographic markets, including low- and moderate-income neighborhoods. Specifically, the CRA requires depository institutions to “help meet the credit needs of the local communities in which they are chartered” in a manner “consistent with the safe and sound operations of such institutions.”¹ There have been a few amendments and updates to the law most notably in 1989 and 1994, though updates to the

Federal Register – “The Daily Journal of the United States Government” – and periodic interpretive memoranda provide updated guidance to the banking community. The CRA requires each federal bank regulatory agency to examine periodically the records of banking institutions in addressing these credit needs and to assign ratings to those records.² The CRA was one in a series of laws intended to protect consumer interests, affect more equitable access to credit for low-income communities and minority populations, and address blight wrought in part by lack of access to credit.

Some bankers and others who opposed passage of the CRA attempted to characterize it as encouraging reckless extension of credit, despite explicit language in the legislation itself (and in other, overarching bank regulations), requiring safe and sound lending. Most bankers who did not favor passage of the CRA also cited an already heavy regulatory burden. An overview of relevant banking practices and federal policy in the decades prior to CRA enactment provides necessary context for understanding the purpose and intent of the CRA.

Right: Home Owners Loan Corporation (HOLC) Residential Security Map of Richmond, VA. Prepared by HOLC Division of Research and Statistics.
Source: urbanoasis.org.



RESIDENTIAL SECURITY MAP

- L E G E N D —
- A FIRST GRADE
 - B SECOND GRADE
 - C THIRD GRADE
 - D FOURTH GRADE
 - ▨ SPARSELY SETTLED (COLOR INDICATES GRADE)
 - ▩ INDUSTRIAL & COMMERCIAL

PREPARED BY
 DIVISION OF RESEARCH & STATISTICS
 HOME OWNERS' LOAN CORPORATION APR. 3, 1937

CITY OF
RICHMOND
 VIRGINIA
 AND ENVIRONS
 DEPARTMENT OF PUBLIC WORKS
 1937

Practice of “redlining” rooted in federal policy

Before passage of the CRA, many banks did not market or make available their lending products and financial services to low-income and minority neighborhoods. This practice was known as “redlining,” maps with red borders around certain neighborhoods signified where an institution would not extend credit. The term stems, by some accounts, from the operating methods of the Home Owners’ Loan Corporation (HOLC), a New Deal agency established in 1933 by the (then) one-year-old Federal Home Loan Bank Board (FHLBB). The FHLBB was created to introduce liquidity and longer term mortgages in the midst of a mortgage and housing market crisis, but due to credit quality constraints built into FHLBB lending guidelines, was ineffective as an intervention, as delinquent borrowers did not qualify.³ HOLC, conversely, had immense latitude to lend.

At the time, mortgage loans typically had short terms⁴ by today’s standards (though banks had the option to refinance or renew these loans), and high down payment requirements. Short loan terms left home owners vulnerable to foreclosure if they could not afford to pay the unamortized balance, often (today) referred to as a “balloon payment,” at the end of the loan term.

Economic conditions during the Great Depression forced banks to curtail mortgage lending sharply, and unemployment forced still more borrowers into default and foreclosure. By 1933, approximately half of the mortgages in the country were in default, and foreclosures were occurring at a rate of 1,000 per day.⁵ The HOLC refinanced a very large number of foreclosed mortgages nationwide with new, 15-year mortgages, considered a long term at the time. After a bank initiated foreclosure, borrowers applied directly to HOLC for assistance. The agency then exchanged loans in foreclosure from banks for government bonds with guaranteed interest, and later principal payments. The program was initially slow to catch on, but after HOLC arranged that both interest and principal payments on the bonds would have government guaranties, banks were eager to exchange nonperforming loans for them.

Some accounts suggest that this very favorable exchange created a degree of moral hazard, as only loans in foreclosure were eligible for HOLC refinancing, and that bankers encouraged barely delinquent borrowers to cease payments and apply for assistance once foreclosed.⁶ Nonetheless, the HOLC has been characterized as having prevented a complete collapse of the mortgage and housing market of the period. It was the first of several major New Deal era interventions (in the form of new agencies, discussed briefly below) that eventually revived the market, spurred new construction, and opened home ownership to many through long-term financing.

As a means to gauge the relative risk of areas where HOLC lent, the agency eventually graded neighborhoods on a scale⁷ of one (least risky) to four (highest risk), and used color-coded maps to represent default risk levels, with red signifying the highest risk areas. (Examples of actual HOLC maps appear in this article and on the cover of the edition.) These “Residential Security Maps” are considered the forerunner of redlining maps. The red areas largely comprised communities with Black and immigrant populations, older housing stock, and/or industrial uses in addition to housing.

A 2003 paper on HOLC explores the actual lending record of the agency, and among many findings, notes that most of the agency’s lending took place before creation of its color-coding scheme, and much lending took place in neighborhoods the agency designated as highest risk. Many HOLC mortgages defaulted, and HOLC accordingly had to dispose of a great deal of foreclosed property. The paper concludes that while HOLC “did not avoid making loans to African Americans, Jews, or immigrants where they lived,” that “the corporation supported racial segregation and practiced discrimination in reselling the properties it acquired through foreclosure.”⁸

Other New Deal legislation contributed to redlining

Importantly, many federal and trade policies of the Great Depression era reflected discriminatory views on race. The Federal Housing Act of 1934 created the Federal Housing Administration (FHA) to provide

government-funded insurance on mortgages originated by banks. For the first time, banks could originate and fund loans with virtually no default risk, 20-year terms, and full amortization, meaning that monthly payments were uniform and the loan was fully repaid at the term's end. These innovations facilitated more lending volume and also reduced mortgage interest rate volatility. However FHA underwriting guidelines at the time had explicit language and directives dealing with race, and also with housing condition, in effect a proxy for race, as racial minorities were barred from neighborhoods with newer homes, as well as restrictions regarding proximity to industrial uses. The National Association of Real Estate Board's code of ethics at that time contained explicit prohibitions on "mixing races."⁹

Federal deposit insurance was introduced in 1933 through the Federal Deposit Insurance Corporation (FDIC). Deposit insurance has always carried an explicit mandate for insured banks to engage exclusively in "safe and sound" lending practices. FHA policy and rules surrounding deposit insurance¹⁰ each played roles in the advent of redlining. FHA mortgage insurance could not be issued on mortgages financing older housing stock. Without mortgage insurance, banks could not extend mortgage credit, and faced greater regulatory scrutiny and possible loss of deposit insurance if uninsured loans went delinquent. The Federal National Mortgage Association was created in 1938 to purchase and securitize FHA-insured mortgages exclusively, creating a further incentive for banks to eschew mortgage lending to any area where FHA insurance was unavailable.

Accordingly, while "redlining" may have a relatively specific meaning that is not synonymous with racial discrimination, it is difficult to ascribe the origins of the term, or the practice of systematic exclusion it denotes, to one agency.

Overt discriminatory lending and housing practices continued well into the second half of the century. Passage of the Civil Rights Act of 1968, commonly referred to as the Fair Housing Act, legally curtailed discriminatory practices in the sale, rental, or financing of housing. However, discrimination in housing finance persisted in many forms. The Home

Mortgage Disclosure Act of 1975, which required banks to disclose the location of borrowers, and the Equal Credit Opportunity Act of 1976, addressed many of these discriminatory practices.

CRA originated in the Seventh Federal Reserve District

The CRA has its roots in the Seventh Federal Reserve District. In the 1970s, activists in Chicago and across the country worked steadfastly and aggressively to compel banks to lend more equitably to communities from which they drew deposits, but to which they did not typically lend. The National Training and Information Center in Chicago (now called National Peoples' Action), led by the late Gale Cincotta, was at the center of these efforts. The original bill, S. 406, was introduced by Senator William Proxmire of Wisconsin,¹¹ who stated, in introducing the bill that "a public [banking] charter conveys numerous economic benefits and in return it is legitimate for public policy and regulatory practice to require some public purpose." The only banker to testify in favor of passage was Ronald Grzywinski, one of four founders of the nation's first community development bank, South Shore Bank, later known as ShoreBank.¹²

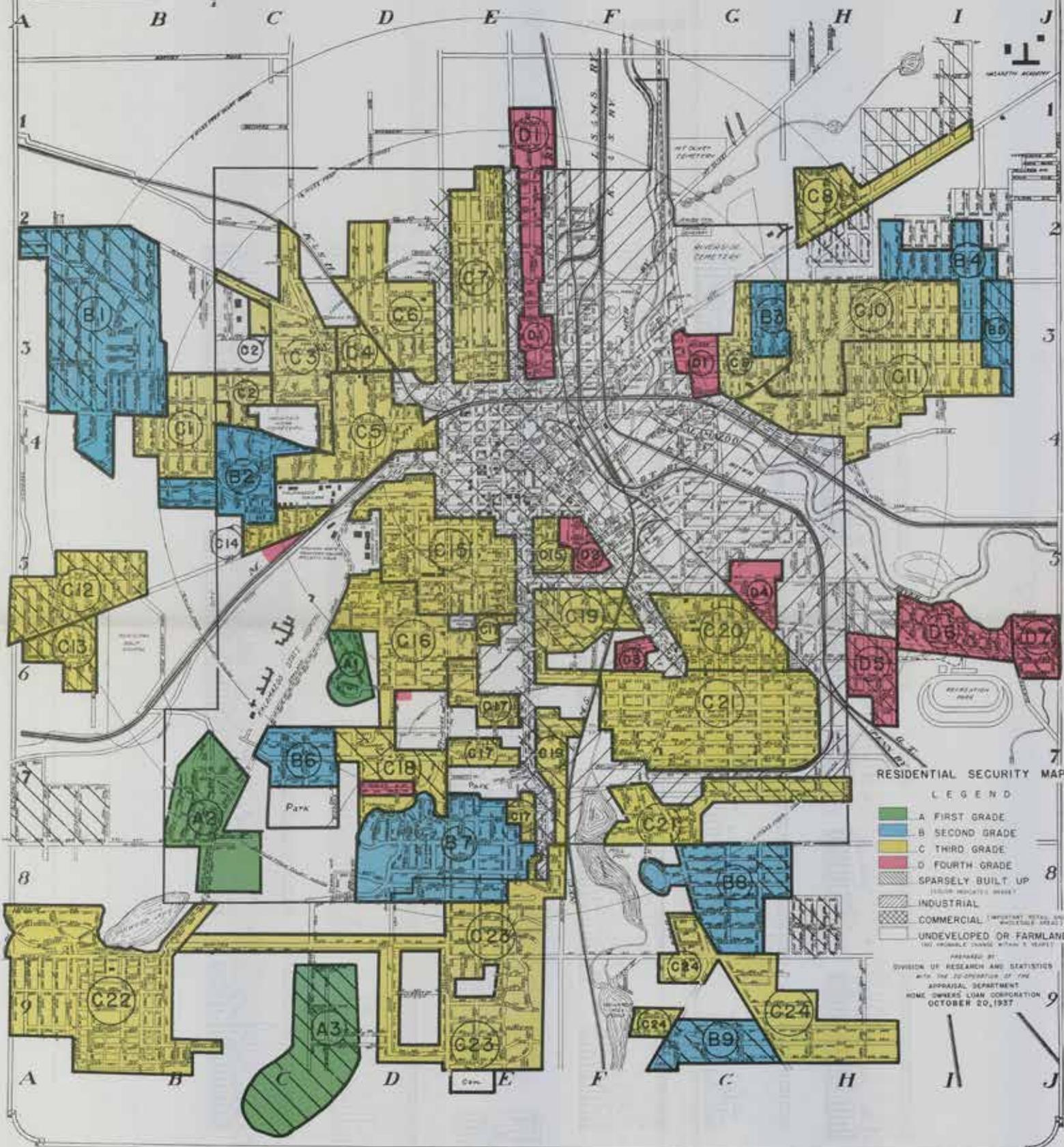
Original arguments against the CRA, that it would encourage risky lending behavior on the part of banks, still echo today. A great deal of research (see "Other reading") over many years shows that banks can extend credit in low-income communities, directly or through community development partners, profitably and with positive impact. Bankers and community development practitioners agree that as the financial sector evolves, so do the challenges of the populations and geographies covered under the Act. To remain relevant, they concur, the CRA must also adapt.

MAP OF THE CITY OF KALAMAZOO MICH.

COMPILED AND DRAWN
BY
GLEN C. WILSON
APPRAISER - PUBLIC & SCHOOL
KALAMAZOO, MICH.

SCALE
ONE MILE

EXPLANATION
CITY LIMITS
STEAM RAILROAD
ELECTRIC RAILROAD
PUBLIC BUILDING



RESIDENTIAL SECURITY MAP

- LEGEND
- A FIRST GRADE
 - B SECOND GRADE
 - C THIRD GRADE
 - D FOURTH GRADE
 - SPARSELY BUILT UP (LOW RESIDENT DENSITY)
 - INDUSTRIAL
 - COMMERCIAL (IMPORTANT RETAIL AND WHOLESALE TRADE)
 - UNDEVELOPED OR FARMLAND (NO PROBABLE CHANGE WITHIN 5 YEARS)

PREPARED BY:
DIVISION OF RESEARCH AND STATISTICS
WITH THE CO-OPERATION OF THE
APPRAISAL DEPARTMENT
HOME OWNERS LOAN CORPORATION
OCTOBER 20, 1937

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Notes

1. United States Congress. Public Law 95-128: Housing and Community Development Act of 1977. 95th Congress, 1st Session. College Park: Potomac Publishing Company, Inc., 1977.

2. The possible ratings include Outstanding, Satisfactory, Needs to Improve, and Substantial Noncompliance.

3. Jackson (1985).

4. Generally mortgage terms did not exceed 10 years, more typical was three to five years.

5. Jackson (1985).

6. Hillier (2003).

7. The actual scale was descriptive rather than numeric: "Best," "Good," "Definitely Declining," and "Hazardous."

8. Hillier (2003).

9. The landmark 1947 case of *Shelley v. Kraemer* struck down states' individual rights to enforce racially-based covenants in real estate sale contracts.

10. Greer (2013).

11. Approximately two-thirds of the geographic area of Wisconsin, including the capitol city of Madison and the largest city, Milwaukee, are in the Seventh District.

12. Dennis (1978).

Left: Home Owners Loan Corporation (HOLC) Residential Security Map of Kalamazoo, MI. Prepared by HOLC Division of Research and Statistics.
Source: urbanoasis.org.

Biography

Michael V. Berry is the director of Policy Studies, and the managing editor of *Profitwise News and Views* in the Community Development and Policy Studies division at the Federal Reserve Bank of Chicago.

The Converging Visions of Public Health and Community Development

Conference Summary

By Susan Longworth

Introduction

On June 12 and 13, 2013, the Community Development and Policy Studies (CDPS) division of the Federal Reserve Bank of Chicago, in partnership with the Illinois Public Health Institute, the Adler School of Professional Psychology, and others¹ hosted a convening to explore the shared goals and visions of the community development and public health fields. This Chicago metro-focused meeting was one in a series of meetings that have been held across the Federal Reserve System around the intersection of public health and community development. This article captures some of the key insights of the conference.

The Chicago Regional Summit focused on three broad areas of convergence – policy, practice, and finance. Community development and public health practitioners learned about their respective fields, how they are evolving, and where new opportunities exist for collaboration. The emphasis of the meeting was on the social determinants of health – economic and social conditions (and their distribution across the population) that influence individual and group differences in health status² and not necessarily on the provision of health care. However, a portion of the meeting was devoted to explaining and exploring the implications of the Affordable Care Act (ACA) for individuals, institutions, and communities.

Opening comments

Alicia Williams, vice president of the Fed’s CDPS division, noted that: “At the core of our mission is helping regulated banks fulfill their obligations under the Community Reinvestment Act, or CRA, by extending bank services, profitably and responsibly, to lower income areas. Banks often do that with help from community development financial institutions and other groups with local market knowledge. What we’ve learned over time is that we’re talking about, and trying to bring improvements to, the same places. And often, we’re also concerned with bringing about the same types of assets, ones that promote health and economic vitality – day care facilities, safe affordable housing, charter schools, grocery stores, and small business development groups. It makes sense to combine our efforts, since there are clear synergies to be realized.”

Terry Mazany, president and CEO of The Chicago Community Trust (the Trust) and Chicago Fed board member, noted the Trust’s 98-year commitment to the Chicago region, and to the summit topic: “a focus on health and community were woven into our declaration of trust.” The Trust’s current focus is on capacity building for community health centers, hospitals, and provider groups, to provide care for low-income, uninsured Chicagoans. “Our eye on

the prize was how do we connect the more than one million people in Illinois without health insurance, health coverage, and finally, with the Affordable Care Act, that reality is within grasp for us.”

Background

Health and well-being, in its broadest sense is defined by the World Health Organization:

Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.³

Adhering to this definition gave the conference planners a common platform from which to build not only an agenda, but a basis for follow-on activities. The link between health and financial and economic well-being has been well established. For example, research from the Robert Wood Johnson Foundation (RWJF) has shown that a stable housing situation from birth to pre-school and attention to the early development of children has a dramatic impact on rates of high school graduation – in isolation an outcome with significant ramifications for well-being and employment prospects – and other important aspects of health and longevity, a connection made by Fed Chairman Ben Bernanke, as well.

“Factors such as educational attainment, income, access to healthy food, and the safety of a neighborhood tend to correlate with individual health outcomes in that neighborhood. Because these factors are linked to economic health as well as physical health, health care professionals, and community development organizations are seeing new opportunities for cooperation in low-income communities.”

- Federal Reserve System Chairman Ben Bernanke at the Federal Reserve System Community Development Research Conference – April 2013

While the public health and community development sectors may work in the same places, and have similar overarching goals related to community and individual well-being, they go about their work

quite differently. For example, the community development field most often looks to stop or change a condition – such as neighborhood blight or lack of access to fresh food – by augmenting both the built infrastructure and supportive systems. The public health field emphasizes prevention and behavioral modification, but both look to reduce the impact of poverty and poor diet, among many other shared interests. Environmental factors cross both fields. Jane Lowe, senior advisor, Program Development, for RWJF, used the example of lack of safety and pervasive threats of violence to illustrate this concept. Places where street gangs hold sway, for example, have a public health problem, as threats of and actual acts of violence represent a source of severe stress for all ages, youth in particular. Improving neighborhood safety is a longstanding community development goal. To reduce violence, Lowe noted, the work needs to begin ‘upstream,’ with conditions that give rise to violence, including poverty, disenfranchisement, unemployment, and isolation.

Lowe described RWJF’s Commission to Build a Healthier America, which was in part a motivation for the Federal Reserve series of conferences. The Commission comprised a national, nonpartisan group of leaders that came together in 2008 to “examine the many factors outside of medical care that influence health.”⁴ Fifty percent of the Commission’s recommendations were directed at community change – relating to food, early childhood care, safety, physical activity, and infrastructure development.⁵ She offered these recommendations as evidence that prevention begins in community development.

David Erickson, manager, Center for Community Development Investments, Federal Reserve Bank of San Francisco, felt that it was clear that public health and community development professionals have, in many cases, “been working in the same places and serving the same populations” for many years without considering how to leverage respective talents, knowledge, and resources. He suggested that this Chicago summit, similar to the other System convenings, was but a first step in initiating this dialogue – a ‘meet and greet’ between two sectors that do not always speak the same language.

Elissa Bassler, CEO of the Illinois Public Health Institute, explained that under the Affordable Care Act, nonprofit hospitals are now required to conduct community health needs assessments (CHNA) and then demonstrate how they plan to respond to community needs by creating a community benefits agreement (CBA). This document will define a hospital's community interventions in ways that measurably respond to community needs. This mandate will take most institutions beyond the provision of 'charity care,' which, prior to the ACA, was how most hospitals served the needs of uninsured and underinsured patients. The ACA will address the lack of (sufficient) medical insurance; accordingly, hospitals are now challenged to affirm their nonprofit status (on an ongoing annual basis to the IRS) in other ways. Most likely many of these institutions will be pushed beyond the provision of direct care, into issues of prevention – many of which have roots in areas that community development strategies also address. For example, instead of providing smoking cessation counseling in a hospital or clinical setting, hospitals may work to address the root causes of smoking, such as stress stemming from chronic unemployment or other life issues. By going 'upstream' to these triggers – typically referred to as the 'social determinants' of health – care providers will find themselves increasingly in the realm of prevention efforts that will have more potential through coordination with community development initiatives. Participants remarked that community development has been – perhaps without realizing it – working in the area of prevention for decades.



Shifting the focus to prevention requires a paradigm shift, described Barbara Otto, CEO of Health and Disability Advocates, that was first introduced in the 1990s and commonly referred to as the “McGinnis Paradigm.” In a paper written in 1993, the authors Michael McGinnis and William Foege shifted the question from “what diseases kill people” to “why do people die [prematurely]?”⁶ The findings, which have since been revisited and sometimes disputed, showed that nine out of the ten leading causes of death are environmental. For example, the researchers documented heart disease as the leading cause of death (in 1990). However, the root cause of heart disease is in individual habits, such as poor diet (stemming from lack of access to healthy foods and/or nutritional awareness) and low levels of physical activity (which requires access to affordable exercise facilities or safe, recreational green spaces).

With this in mind, the Affordable Care Act also created the nation's first National Prevention Strategy (NPS), which (to date) brings together 20 federal departments and is aimed at disrupting siloes to promote well-being through collaboration across agencies. As shown in exhibit 1, the seven prevention priorities (as indicated by the outer ring in the diagram) focus not only on changing behavior, but changing or eliminating the factors that cause the behavior.

The strategy is supported in its efforts by the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. Otto, who was appointed by President Obama to the Advisory

Group, stressed that “prevention efforts have to be taken outside of the clinic.”

Earlier in the day, LaMar Hasbrouck, director of the Illinois Department of Public Health, also emphasized that health outcomes must be considered when answering questions regarding community resilience. According to Hasbrouck, the “health of the community depends on the resources of the community.” What matters at the community level includes: high unemployment, crime, race and ethnicity, and few educational opportunities. Hasbrouck continued, “These are some of the drivers of an environment that does not enable healthy behaviors, even if one were to so choose.” The Illinois State Health Improvement Plan is focused, among other priorities, on eliminating health disparities and addressing the social determinants of health.⁷

Policy

The conference panel on policy was organized around the theme of ‘health in all policies,’ which is defined by the World Health Organization as:

“an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.”⁸

The public health field has long understood that policy decisions can have unintended health consequences. Dr. Lynn Todman, executive director of the Institute on Social Exclusion at the Adler School of Professional Psychology, cited two examples, the first being a federal policy that allows prospective employers to consider arrest records in hiring decisions.⁹ She stated that this policy has a profound impact on the mental health of applicants who may have been arrested but never convicted of a crime. She then referred to how education policies that emphasized achievement measured by standardized tests often result in fewer opportunities for physical activity (recess and gym) among children.¹⁰

Todman also introduced the audience to Health Impact Assessments (HIAs). HIAs are “a means of assessing the health impacts of policies, plans, and projects in diverse economic sectors using quantitative, qualitative, and participatory techniques.”¹¹ Their purpose is to capture both the intended and unintended consequences of a policy on the health of a population, by engaging those affected in the decision-making process. The focus of an HIA is “distal” – focused on factors that may appear to be far-removed from the policy. Todman used the example of a 2010 proposed amendment to Chicago’s Vacant Housing Ordinance, which highlighted the impact of vacant and abandoned buildings on the mental health of community residents. At the ‘proximal’ end of the spectrum are the more commonly understood effects of vacant buildings: blight, increased crime, drug use, homelessness. What the HIA demonstrated was that these ‘known’ factors led to increased stress and anxiety among the surrounding populations, which led to obesity, anxiety, hypertension, diabetes, and death. Making the connection between vacant housing and increased incidence of disease is an example of how HIAs connect the proximal to the distal and compel policymakers to consider the full impact of their decisions.

The role of policy in encouraging and shaping health/community development collaborations was a central theme of the conference. However, participants were divided on its role and genesis. Todman stated, “There’s only so much you can do at the community level, if the policy construct constrains you.” Anne Haddix of the Centers for Disease Control countered, “But all good policy has its kernel of origin at the community level.”

Aligning grassroots innovation within a policy framework that encourages new approaches is a challenge that panelists acknowledged must be addressed if cross-sector collaborations are to take root. Barbara Otto cautioned that the common mindset is one of fear: “People are afraid to lose funding, especially if they do something ‘wrong.’” Panelists agreed that there is a need to have a policy structure at the federal, state, and local levels that supports and encourages collaboration and innovation within a framework of accountability.

Practice

Practitioners spoke candidly about the interaction of service delivery and place in the context of community development and health. Health care providers traditionally think of their role within a specific, designated place – such as a hospital or a clinic. The shift to prevention which measures changes in health inequities as a benchmark of success forces a change in service delivery that requires going to the community, rather than waiting for a member of a community to seek care within an emergency room or a doctor's office. Community development practitioners have understood this dynamic for decades and is it a natural part of their planning.

Joe Neri, CEO of nonprofit facilities lender IFF,¹² stressed that the context for their loans is an important part of the underwriting process. The human services system is critical to outcomes, he said; the built environment is where “systems of prevention and care come together.”

Where organizations such as IFF may focus their expertise on facilities (places), they rely on partners to create the systems. Susana Vasquez, executive director of LISC-Chicago,¹³ highlighted that the role of her organization is to create an infrastructure for service delivery that connects residents to resources. This blend of practice and place has long been a cornerstone of successful community development initiatives. As health care shifts to prevention as a measure of success, the need to reach into surrounding communities will present opportunities for collaboration between the two sectors.

Bechara Choucair, director of the Public Health Department for the city of Chicago,¹⁴ summarized that “community development is public health,” indicating that community development inputs frequently have public health outcomes.

The challenge, according to Randy Blankenhorn, executive director of the Chicago Metropolitan Agency for Planning (CMAP),¹⁵ is to incorporate health into all aspects of planning, including land use, transportation, economic development, etc. He hopes “that if health is a prominent part of the regional planning process, then it will filter to local planning and initiatives as well.” Susan Vasquez

countered that this linkage has already been made. “Ten years ago, health was not even on the agenda.” Today, she said, when communities do their planning, LISC sees health issues at the top of the agenda – both broadly and narrowly defined.

Practitioners are also making the link to health outcomes in new ways. For example, the CARA Program, described by its COO Maria Kim, provides job training and placement services for individuals affected by homelessness and poverty.¹⁶ She described how having a job motivates healthy behaviors. Simply encouraging people to pursue a ‘healthy lifestyle’ is not enough. The sense of belonging and responsibility that comes with employment (and earned income) impact mental health positively, and often leads individuals to place higher priority on their physical health.

The Reverend Bonnie Condon, system vice president for faith outreach and mission integration at Advocate Health Care, added, “the importance of faith in health and community” should not be overlooked. Community development practitioners have long recognized the anchoring role played by churches and other faith-based institutions. As primary gathering places, they are sometimes a community's united voice. As a result, they have the potential to play important roles in fostering healthy communities.

But, she stressed, this requires a shift in thinking on the part of hospitals and community organizations, alike. As part of the community health needs assessments, her network is trying to move from educational events, health fairs, and screenings – “which is what communities request, because that is what they are used to (getting).” Instead of the hospital handling just the “medical stuff,” her network is trying to shift to activities that are more outcome- and evidence-based and that try to get at the social determinants of health. At the same time, continued Condon, the hospitals must recognize and leverage the individuals, organizations, and entities that already exist in communities and work to engage these entities in healthier ways.

As an example she mentioned the Advocate Bethany Health Community Fund¹⁷ (the Fund), which funds programs in five communities on the west side of Chicago: Austin; East and West Garfield Park,

(continued on page 13)

Community development and public health: responses from the field

The Community Development and Policy Studies (CDPS) Division of the Federal Reserve Bank of Chicago regularly surveys contacts from the Seventh District involved in community development. Survey questions seek to illuminate conditions and issues of importance to low- and moderate-income communities.

Respondents represent various fields including: agriculture, banking, small business lending, housing, and human services.

While respondents offer thoughts on a recurring set of questions related to economic conditions, periodically we include additional questions to solicit feedback on a particular topic relevant to current CDPS work or interests. Multiple times in 2013, the following question was asked:

“Factors associated with poverty – such as poor education and inadequate housing – are also indicators of poor health. Increasing access to health care, while essential, is not sufficient to improve health. Social, environmental, and behavioral factors also impact health significantly. Given the importance of social determinants of health, what are some ways you think the community development field could help foster improved health?”

Responses clearly indicated that community development practitioners – regardless of area of expertise – understand the connections between their work and the health of their community. They also appreciate the urgency of addressing area-based public health concerns in order for community development initiatives to have greater impact.

Further, most respondents recognized that in order to positively impact the health of a community, the focus must be ‘upstream’ and address root causes of poor health – those societal factors that lead to chronic stress, obesity, violence, anxiety, etc., commonly referred to as the “social determinants

of health.” While respondents typically stayed away from discussion of direct access to health care, some specific areas – such as improved access to oral and mental health services – were mentioned.

Many responses illustrated the notion of development of ‘upstream’ assets as important to improving health. For example, one respondent stressed the importance of early childhood education, as well as improving the overall educational attainment levels in a community. Another respondent emphasized that job creation and retention would yield positive area-based health results. Respondents in general stressed that access to public transportation, as well as credit building services, lead to employment and financial health of job-seekers.

Others spoke directly of removing public health barriers. Chronic violence was one such barrier that respondents felt required both a community development and public health response.

Further, some respondents expressed urgency at moving away from “feel-good” programs, for example, ‘local foods’ and ‘farmers’ markets,’ and towards tangible activities that impart skills and opportunities to people residing in low-income areas.

And finally, other respondents recognized that the path to improve public health is lengthy and complex. They noted that investments into communities must match the extended timeline required to measure community-wide health improvements. They suggested better coordination between different agencies, banks, and nonprofits.

Responses indicated that the connection between public health and community development was obvious to our respondents. However, ensuring that resources were directed to activities with tangible outcomes will take ongoing, authentic collaboration across sectors.

Humboldt Park, and North Lawndale. The Fund, which works to provide training and employment opportunities for residents of these distressed communities, recognizes that employment is an important social determinant of health.¹⁸

Condon learned that, “doing community health has a long time line, often starting with relationships that you build at a deeper level.” In order to share and systematize these lessons, she further described the Health Systems Learning Group¹⁹ as a collaborative group of hospitals around the country learning how to engage the social determinants of health and impact health inequities.

It can sometimes be challenging for the community development field to appreciate the significance of the shift to prevention. Angela Haggard, system service vice president of Medicaid and community health strategies for Presence Health, reminded the audience that up until now hospitals have only been required to provide “charity care” to residents of their communities that lacked the ability to pay, in order to retain their nonprofit, tax-exempt status. In her opinion, however, the amount of charity care provided is actually a measure of ‘need’ and not of success. Charity care demonstrates how much illness there is in the community that is not being treated. The ACA will require hospitals to shift their community efforts to addressing that need. Haggard reported that Presence delivered \$52 million in free health care in 2012 and wondered what could be achieved if just \$1 million were made available for prevention.

Among the many challenges for health care providers, is to find a ‘medical home’ for everyone that provides consistent primary care. Many providers lament the inefficiencies and costs incurred when emergency rooms (ERs) are used as the primary care office. Haggard shared the results of an analysis of the care provided for their Medicaid population. According to her analysis, the most frequent diagnosis among this population was alcoholism, which indicated that the ER is seen as a safe, “sobering center.” “So we know we need to do things differently...improving the health of our community is not going to happen within the four walls.”

Finance

With changes happening at the policy level, that might encourage collaboration, and solid examples of places in which the collaboration is already taking place and places in which opportunities exist, the conference shifted to the issues of financing and funding. The perspective of the banking community was represented by Thurman “Tony” Smith of PNC Bank, who said that CRA officers tend to stick to a narrow definition of health care as something that takes place within a facility that may or may not qualify for CRA credit. The challenge for bankers is to think about ‘healthy communities’ more broadly, he said, and to develop a ‘defensible list of strategies’ that meet CRA requirements, while at the same time address the social determinants of health.

Other practitioners addressing the issue of financing stressed that a discussion regarding federal or government resources was challenging at this time. The past three years, with the support of the American Reinvestment and Recovery Act, many organizations – both health and community development – received unprecedented resources, which allowed them to acquire assets and implement programs far above previous levels. As these resources have sunset, and the government funding environment remains constrained, organizational leaders must confront the issue of sustaining expanded services as demand remains high.

Conference participants were interested in both new financing models and tools that would cut across multiple sectors. Recent examples of federal grant programs mentioned at the conference that make it easier for grantees to collaborate include:

- **Community Transformation Grant Program.** Grants are administered by the Centers for Disease Control, and enable awardees to “design and implement community-level programs that prevent chronic diseases such as cancer, diabetes, and heart disease. Awardees are engaging partners from multiple sectors, such as education, transportation, and business, as well as faith-based organizations to improve the health of their communities’ approximately 120 million residents. Awardees also provide funding to community-based organizations to ensure broad participation in creating community change.”²⁰

- **Partnership for Sustainable Communities.** An interagency collaborative between the Department for Housing and Urban Development, the Department of Transportation, and the Environmental Protection Agency, created to help communities develop in more economically and environmentally sustainable ways. The work of the Partnership is guided by six livability principals: provide more transportation choices; promote equitable, affordable housing; enhance economic competitiveness; support existing communities; coordinate and leverage federal policies and investment; and value communities and neighborhoods.²¹
- **Communities Putting Prevention to Work.** A grant program offered through the Centers for Disease Control is a locally driven initiative supporting 50 communities to tackle obesity and tobacco use—two leading preventable causes of death and disability in the United States.²²

While these are the examples of how federal policy and programs can drive collaboration, conference participants quickly moved to the question of measurement, and particularly how does one account for health care cost savings as a result of prevention, as a measure of return on investment (ROI), and how do those savings figure in project financing models. The cost is often known (e.g., obesity cost the U.S. \$147 billion in 2008²³), but how does one measure prevention? How are the savings from what did not occur measured and accounted for?

Conference speakers acknowledged several issues that needed to be resolved before that question could be definitively answered, for example:

- What is the impact of having access to affordable care on the financial stability of a family, for instance? It is difficult to quantify health effects in financial terms.
- Commonly referred to as the ‘wrong pocket’ problem, how can one ensure that savings are returned to/are recouped by the financing entity? For example, the health cost savings incurred as the result of the development of allergen-free housing will not be returned to the investor (in this case, a housing developer), but will be recouped by the hospital or local health care provider in terms of costs not incurred. If savings are to be included as part of the ROI calculation, then they need to be accounted for in a manner that allows their return to the investor – not just the beneficiary.
- How can different timelines be reconciled across funding streams? Most funding streams have timelines of three to five years. However, public health interventions, especially those involving children, often require a longer time horizon before any impact or change can be measured.
- Further, isolating the impact of a particular variable can be challenging. For example, enhancing the walkability of a neighborhood requires changes to the built environment, such as sidewalks or parks. It also requires, as pointed out by Adam Becker, executive director the Consortium of Lower Obesity in Chicago Children (CLOCC), increasing public safety and reducing violence.

Audience member, Douglas Jutte, MD, MPH associate director of the Master’s Program at the UC Berkeley School of Public Health wondered whether “we should look to other industries for guidance.” He queried whether a parallel could be drawn with the environmental industry where the immediate ROI is very low and any savings are “down the road.” Understanding how the environmental movement monetized its benefits – many of which were also in terms of prevention – may serve to inform the public health sector as well. Using existing models, such as hedonic pricing,²⁴ or assessing “willingness to pay” may help to monetize how society values prevention efforts, much as they were used to capture the value of environmental benefits.

Otto cautioned, however, that our culture values collective benefits over individual benefits (which are not expected to bear a cost to society). The environment is understood to be a collective responsibility with the costs and benefits incurred at the societal level. Health is still felt to be an individual responsibility. This cultural phenomenon will disrupt the direct applicability of environmental models to public health.

Nevertheless, under the NPS, there are financial incentives and these incentives can motivate or be combined with others. Marice Ashe, CEO of ChangeLab Solutions, cited the example of California where applicants for Low Income Housing Tax Credits (LIHTC) can receive additional points for creating smoke-free housing, as well as for including smoking cessation and other health improvement classes in their development plans.²⁵

Money that is not going to charity care can go to prevention strategies, as hospitals are now mandated to prevent disease in the population they are serving. In order to be fully effective, the hospitals will have to work with “different kinds of money,” according to Ashe. She suggested that the hospital could consider providing guarantees to CDFI funding, as one way to offset the risk of financing innovation.

From the foundation/philanthropic perspective, health is part of a platform of individual and community self-sufficiency. Panelists described their role as creating ‘sustainable change.’

Wendy Duboe, president of the United Way of Chicago,²⁶ showed how her organization is an example of this integration, with a programmatic focus on income, education, and health as the three building blocks of self-sufficiency. The United Way works to fund programs that integrate these three areas by generating networks of care and networks of service.

Ryan Maley, board member of the Aurora, Illinois, Dunham Fund, introduced social impact bonds (SIBs) as a “potentially fantastic way to attract private dollars, investor dollars, to get better social interventions.” He clarified that SIBs are not a bond in terms of a long-term debt instrument – they are actually a pay for performance contract. SIBs provide a mechanism to grow proven interventions to scale (through private investments) and then have the state repay investors through savings.²⁷

Kuliva Wilburn, senior program officer for Health at The Chicago Community Trust,²⁸ posed the question, “How does work at The Chicago Community Trust foster convergence of community development with an interest in health?” The Trust recognizes the important community development outcomes of access to care for lower-wealth community residents,

including: 1) financial stability; 2) work productivity; 3) personal/family well-being; 4) increased years of productivity; and 5) overall health outcomes.

She summarized, “Health is where place, spaces, and institutions meet. We need to think about ways we invest in health that are about our spaces, transportation, use of public spaces, green spaces, etc., and to engage populations with barriers to care.” Organizations and communities that are not usually part of the public health discussion “have to be part of this.”

Cook County Board President Toni Preckwinkle, who gave the luncheon keynote, summarized the urgency of the conference discussions, with a concrete example: “Cook County provides \$500 million in uncompensated care to a population with often complex, serious illnesses. It is hard for people to be healthy, if the people around you aren’t healthy.”

Conclusion

While community development organizations such as IFF and LISC, and philanthropies such as The Chicago Community Trust have long considered both health and economic/sociological outcomes in their work, the Healthy Communities Summit opened a more broad based dialogue in the Chicago region about this connection. This article was intended to capture some of the key insights from the summit. Various follow-on activities, designed to gain a more nuanced understanding of ways the fields can work together, are in planning or under way. Look for more details in upcoming CDPS blogs and announcements.

Notes

1. The conference planning committee included representatives from the Federal Reserve Bank of Chicago, the Illinois Public Health Institute, the Adler School of Professional Psychology, IFF, the Chicago Community Trust, the U.S. Department of Housing and Urban Development (HUD), Access Community Health Network, LISC Chicago and the Northern Illinois Public Health Commission.
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Biography

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