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Buoying Health By Building Communities

BY SUSAN DENTZER

Last month's *Health Affairs* explored the social and economic determinants of health that drive disparities, such as the places in which people live. This month we expand on that topic in articles that discuss emerging synergies among community development, health care, and public health.

The cluster results from the combined efforts of the Robert Wood Johnson Foundation and the US Federal Reserve to advance understanding that "safe, vibrant neighborhoods are vital to health," as the Fed's David Erickson observes. For years, there was little interaction between the public health and health care sectors and the nation's community development "industry"—the network of nonprofit and governmental agencies, real estate developers, and financial institutions that marshal public subsidies and other financing to transform poor neighborhoods.

COLLABORATION GAP

As David Williams notes, the foundation became acutely aware of the gap through its sponsorship of the Commission to Build a Healthier America, which the foundation convened in 2008 and of which Williams served as staff director. The Fed's awareness stems from its congressional mandate to achieve strong, low-inflation economic growth and to help low-income communities become full partners in that process.

So, as the foundation's Risa Lavizzo-Mourey and Sandra Braunstein of the Fed write, both sectors are now focused on what they might achieve together. Health care providers understand that they can make more headway against chronic disease if residents of a local housing complex have access to safe parks and healthier food. Community developers understand that beyond creating low-income housing, they should also invest in these amenities and even construction or expansion of community health centers.

BUDDING PARTNERSHIPS

Articles in this issue profile encouraging examples of partnerships. Working largely through the nation's network of so-called community development financial institutions, the federal Healthy Food Financing Initiative now channels $500 million annually into creation of grocery stores selling healthier food in low-income neighborhoods. Ronda Kotelchuck and colleagues highlight efforts by private investors and lenders to finance expansion of federally qualified community health centers in California and midwestern states.

As Williams observes, it will be critical to build the evidence over time that these partnerships truly advance health outcomes and deliver on the promise of healthier communities. Meanwhile, new tools can help focus attention and frame decision making on the health-promoting potential of community investment measures: so-called health impact assessments, of which more than 100 have been completed or are under way nationwide. A recent assessment in Nashville, Tennessee, for example, identified health benefits to be gained from greater use of mass transit—largely stemming from the fact that walking to and from the light rail station or bus stop can add up to thirty minutes or more of moderate physical activity daily.

We thank the Robert Wood Johnson Foundation for the generous support that allowed us to publish this article cluster—and welcome a new stable of authors from the Federal Reserve.

PAYMENT INNOVATION

Turning to matters more commonly addressed in our pages, we also focus this month on payment reforms to drive more efficient health care. Various articles invoke the old adage about bridal attire at weddings—something old, something new, something borrowed, and something blue.

Uwe Reinhardt explores an approach simultaneously "old" and "borrowed"—all-payer price negotiations, which have long characterized health financing systems in Switzerland and Germany and, closer to home, Maryland's system of paying hospitals. He asks again whether such a system might not be preferable to what the United States largely has now: one in which price differences are "opaque" and in which payers with market power force weaker ones to cover disproportionate shares of providers' costs.

In the "new" category, two articles focus on bundled payment approaches. David Miller and coauthors report that payments for inpatient surgical procedures under Medicare vary by 49–130 percent across hospitals and thus seem ripe for bundled payment. Peter Hussey and coauthors strike the "blue" note, reporting that implementing the PROMETHEUS bundled payment model in pilot sites has been slow going, partly because of the complexities of layering it on top of the existing—and problematic—fee-for-service system. ■