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By Mariana Arcaya and Xavier de Souza Briggs

ANALYSIS & COMMENTARY

Despite Obstacles, Considerable Potential Exists For More Robust Federal Policy On Community Development And Health

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ABSTRACT The implementation of the Affordable Care Act of 2010 and the Obama administration's urban policy create an opportunity to link community development with health in new and powerful ways. The administration's policy emphasizes improved access to and quality of care through coordinated local and regional approaches, expansion of access to healthy food, and the support of environmental health—including clean air, water, and soil—and healthy homes. New federal programs, such as the Affordable Care Act's Community Transformation Grants, seek to prevent death and disability through policy, environmental, programmatic, and infrastructure changes. But fragmented congressional jurisdiction and budget "scoring" rules pose challenges to needed reform. We argue that government agencies need to adopt so-called systems of innovation, or organizational practices and support mechanisms that seek continuously to test new models, refine promising ones, bring to scale those that work best, and restructure or terminate what does not. We also argue that a strong and well-focused policy advocacy coalition is needed to help drive reform focused on the social determinants of health.

The implementation of the Affordable Care Act of 2010 and the imperative to reduce the cost of health care while improving outcomes create the opportunity to forge closer links between community development and health. Fortunately, the evidence base is now strong enough to warrant a major focus on shaping the social determinants of health through community development.

Researchers have established that the social and physical environment, not just genetic makeup and individual behavior, influences health outcomes. It is clear, for example, that structural determinants of health such as socioeconomic status have serious health consequences.[1] Stress—including as a result of high demands coupled with little decision-making power or control at work—is linked to poor cardiovascular health.[2] Low and unstable income predicts worse cognitive, physical, and psychological functioning over time, compared to the functioning of people who do not suffer economic hardship.[3] Discrimination is a known risk factor for unhealthy behavior, psychological distress, and high blood pressure.[4]

More proximate social determinants of health, such as living conditions in the home and neighborhood, can affect exposure to both environmental and social risk factors for poor health. For example, both allergens and violence in the home increase the risk of developing childhood asthma.[5] Similarly, material exposures—such as air quality and food access—and psychosocial

exposures—such as social support and fear of crime—can increase residents' chances of suffering mental health problems, becoming obese, engaging in unhealthy behavior, and even dying.[6,7]

In addition, it is clear that social factors influence what happens when someone does get sick. For example, racial and ethnic minorities have been shown to receive worse health care than non-Hispanic whites, even after income, age, and health status differences are accounted for.[8]

Community development can be a useful tool for effecting change, especially in improving living conditions in homes and neighborhoods. There is much that we do not yet know about which health-oriented interventions are most promising for particular populations in particular community settings. Equally, we need more information about the scale of return on investment in community development.[9,10] But during the past decade, encouraging evidence has accumulated that well-run community-based interventions can effectively serve a number of at-risk populations, including the frail elderly,[11] low-income children,[12] those in the criminal justice system,[13] people with HIV/AIDS,[14,15] and the chronically homeless.[16,17]

These are overlapping populations that face multiple risks, and they account for a disproportionate share of costs in the health care and other support systems.[18] The evidence underscores, in particular, the value of supportive housing, which includes targeted social services and care.[19]

Community development should not be thought of as limited to improving conditions in poor urban neighborhoods or rural areas, or advancing the health and well-being only of vulnerable populations. The general public also stands to gain from the broader benefits of healthier neighborhoods and housing and what has been termed a broader "geography of opportunity."[20,21] Results can include improved indoor air quality; safer and more walkable streets; greater access to fresh food; mentoring programs and other efforts that buffer young people from violence; and networks of active and engaged neighbors who press for these priorities and also provide direct social support for individuals and families in need. Each is a vital contributor to the health of the public,[6] and together they achieve the goals that community development has long pursued.[22–24]

Community development and evolving efforts to promote reforms that reflect the social determinants of health share a social movement orientation, and both have social equity as a core value. More concretely, both seek to tackle the unfair structures of opportunity that produce large and persistent differences across socioeconomic and racial or ethnic groups in health, income, educational attainment, and other outcomes. That is, both community development and efforts to address social determinants of health seek to move beyond resolving individual-level problems and symptoms case by case to increasing opportunities for health and well-being across the population as a whole.

A Framework To Shape Health Outcomes

With so many possible interventions, it is important to identify those areas in which community development is best—even uniquely—positioned to shape positive health outcomes. It will be necessary to design rigorous, actionable frameworks that accommodate organizing principles from both community development and health.

FOUR PATHWAYS FROM SOCIAL CONTEXT TO HEALTH Finn Diderichsen, Timothy Evans, and Margaret Whitehead offer the foundation for one such framework by categorizing the major social determinants of health.[25] They propose four pathways from social context to health: upstream structural drivers of social position; health-relevant exposures; vulnerability to exposures; and reactive processes that mitigate or exacerbate the consequences of poor health.

Applying this model to childhood lead poisoning as an example, community development might intervene along the first pathway by increasing residents' incomes—through increased earnings, access to subsidies, or both—so that families could afford better-quality food and housing. But neighborhood-level intervention per se is typically able to raise incomes only somewhat, since the larger workforce system, tax code, capital markets, and other factors drive incomes. Access is just a part of the equation.

An intervention along the second pathway would be requiring lead paint removal from affordable housing. Such an intervention could reduce lead exposure for people living in such housing.

Providing education about hand washing (frequent washing makes it less likely that a child will unintentionally ingest lead in dust) and child nutrition (proper nutrition can reduce the amount of lead that the body absorbs) is an intervention along the third pathway. It could reduce vulnerability to lead poisoning for children in homes with lead-based paint.

Along the fourth pathway, examples of interventions include improved health care, special education services, and disability insurance. These interventions, although not usually products of community development, could all miti-

gate the consequences of experiencing lead poisoning.

THREE INTERVENTION TYPES To build on this basic framework of multiple pathways, one needs an "intervention type" dimension to help specify how community development policy and programs can affect each pathway. Three intervention types are particularly important. The first is policy change to create a population-level impact, such as—in this example—regulations banning the use of lead-based paint. The second is funding mechanisms and programming for place-based activities, such as grant funds for lead abatement in key neighborhoods. The third is knowledge generation and assessment, such as a health impact assessment of housing inspections and code enforcement, both to increase community engagement and to continuously improve other interventions.

Community development arguably has a role to play along all four of the pathways described above. But its most natural targets are the second and third—that is, reducing exposure to health risks and diminishing vulnerability to the risks that people do encounter. Community development can be thought of as a tool to address both access to positive health-relevant exposures and freedom from negative ones. These include psychosocial health drivers such as chronic stress and social support and material health drivers such as food, housing, and education (Exhibit 1). Priorities can be set based on expected results (how likely they are and how large and sustained they are expected to be) as well as the availability of funding, stakeholders' support, and other resources.

When key living conditions are considered in tandem with our three intervention types, specific solutions emerge, including some with potentially large and wide-ranging impacts. For example, federal health policy could explicitly encourage the promotion of decent, safe, and affordable housing as part of improving health.

The outlines of what constitutes smart funding mechanisms are also becoming clear. One example of a promising funding model to address living conditions through community development is the Community Transformation Grants program authorized under the Affordable Care Act. The program is designed to prevent death and disability through policy, environmental, programmatic, and infrastructure changes. From the perspective of community development and health, the program's essential quality is that it moves beyond the status quo of treating illness and disease after they emerge to recognizing the role of community context—the characteristics and dynamics of the community setting—in shaping health outcomes. The Commonwealth Care Alliance in Massachusetts, a respected delivery system model, is testing those causal connections, in particular by making home- and community-based alternatives to costly institutional care a central aspect of its practice, combined with careful analysis of costs and health outcomes.

HEALTH IMPACT ASSESSMENTS The increasing use of health impact assessments in the United States could call public attention to the health consequences of projects and policies that are seemingly unrelated to health.[26] Such assessments provide a framework for systematically examining the potential health effects of government decisions, development plans, or con-

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EXHIBIT 1

Community Development Intervention Points

Intervention point	Promotes access to	Provides freedom from
Provision of high-quality, affordable housing	Opportunities for capital accumulation Safer homes, streets, other neighborhood spaces, and schools (through the nexus with school attendance zones) Housing stability	Allergens Toxins Faulty wiring and other building-system hazards
Community organizing and outreach	Stronger social support and networks with wider function Assets targeted by organizing efforts, such as efficient public transportation, grocery stores with fresh food, and playgrounds	Risks targeted by organizing efforts, such as violence and pollution Chronic stressors, such as poor bus service Predatory marketing
Local economic development, including employment and workforce development	Higher and more secure income Job control Improved local goods and services through retail upgrading	Job strain Food deserts

SOURCE Authors' analysis.

Community development is about boosting the vitality of communities of all kinds.

struction projects before they are implemented so that health benefits may be maximized and risks reduced.

Although the use of health impact assessments is more common abroad, and assessment methods are still under development,[27] they constitute important knowledge-building tools. For example, they can help communities quantify the health benefits of building additional affordable housing or the health risks inherent in planned state transportation projects, while providing for community input into development processes. By highlighting these connections, health impact assessments could build knowledge that improves decision making and engages the public.

The Obama Administration's 'Place-Based' Policy

The Obama administration has made strides toward establishing a new federal "place-based" policy. Community development is inherently place-based. As noted above, *community development* is often taken to mean efforts to revitalize or otherwise upgrade socially and economically distressed urban neighborhoods and rural areas—places with high rates of poverty and joblessness, and often high rates of crime, environmental hazards, and sickness. In terms of federal support, since the 1960s community development has relied heavily on place-based aid programs targeting need and distress indicators, typically as a way to distribute limited subsidy dollars.

But more broadly understood, community development is about boosting the vitality of communities of all kinds, shoring them up as places to live, raise a family, operate a business, and meet other needs. And the field of community development is increasingly concerned with the ways in which wealthier and poorer communities are linked together within a region. One example is ongoing analysis of how underinvestment in urban infrastructure and sprawling pat-

terns of residential development on the suburban fringe of a city affects both access to jobs for city dwellers and traffic congestion for suburbanites.[28]

During his 2008 campaign for the presidency, Barack Obama signaled his intention to take a more regional view of community development, broadly defined. For example, in an address to the nation's mayors, he said, "We need to promote strong cities as the backbone of regional growth. And yet, Washington remains trapped in an earlier era, wedded to an outdated 'urban' agenda that focuses exclusively on the problems in our cities and ignores our growing metro areas—an agenda that confuses antipoverty policy with a metropolitan strategy, and ends up hurting both."[24(p3)]

Soon after taking office, President Obama established the first White House Office of Urban Affairs.[29] He noted, "About 80 percent of Americans live in urban areas, and the economic health and social vitality of our urban communities are critically important to the prosperity and quality of life for Americans." The new office was charged with developing "comprehensive urban policy," coordinating the actions of disparate agencies and programs to address the vitality of places, and working closely with the Office of Management and Budget "to ensure that federal government dollars targeted to urban areas are effectively spent on the highest-impact programs."[29(p8139)] Obama signed another executive order in June 2011, establishing a rural counterpart to this agency.[30]

In August 2009 the heads of the Office of Management and Budget, Domestic Policy Council, Office of Urban Affairs, and National Economic Council jointly issued the first-ever budget guidance to federal agency heads on "developing effective place-based policies."[31] They argued for a more integrated approach to places as a way to reform federal programs and achieve better results with the taxpayers' money. "Place-based policies leverage investments by focusing resources in targeted places and drawing on the compounding effect of well-coordinated action," the guidance language stated. "Effective place-based policies can influence how rural and metropolitan areas develop.... The prosperity, equity, sustainability, and livability of neighborhoods, cities and towns, and larger regions depend on the ability of the Federal government to enable locally-driven, integrated, and place-conscious solutions."[31(p1–2)]

The administration's guidance to agencies went on to define *place policy* as something more than a suite of aid policies for needy places. It did not propose to abolish vital aid programs but to improve them, and to focus more on assets and

root causes of problems rather than on need indicators alone. And it included several overarching goals for place policy that are particularly relevant to the social determinants of health.

The guidance said that policy "should promote improved access to care and quality of care through coordinated local and regional approaches, expansion of access to healthy food, and the support of environmental health—including clean air, water, and soil—and healthy homes." It also said that policy "must also work to generate opportunity for all and reduce discrimination and other barriers to opportunity, for example through equitable development within towns, cities, and regions," and must "protect communities from external threats and reduce insecurity, violence, and crime within communities, particularly in disadvantaged areas."[31(p5)]

Early in his administration, President Obama thus established a new leadership unit to coordinate action by a range of federal agencies on behalf of local communities, starting with metropolitan areas. And with an innovative budget guidance document, the administration established a framework for reform and charged agencies with reflecting that framework in their annual budget submissions. The framework included attention to the effects of "place quality"—the fundamental concern of community development—on human health.

These efforts have led to or expanded the integration of funding approaches across federal agencies and the use of collaboration in local economic development and environmental sustainability, as well as a range of proposals that await congressional response. One example of the latter is the interagency Neighborhood Revitalization Initiative. This proposal seeks to integrate competitively allocated housing redevelopment investments by the Department of Housing and Urban Development, evidence-driven safety improvements funded by the Department of Justice, and "cradle to career" educational improvements in the Department of Education's Promise Neighborhoods program.

Obstacles: Congress, The Budget, And Bureaucracy

What the president could not do was alter Congress's approach to authorizing, funding, and overseeing federal programs, to make it align neatly with the new vision. The congressional policy making, budgeting, and oversight processes—in particular, fiscal "scoring" rules—pose major obstacles to any reform agenda that aims to expand the role of community development in promoting health in a cost-effective manner.

First, the fragmented jurisdictions of the congressional committee system make it difficult to move forward with a policy proposal that seeks to integrate programs based in disparate federal agencies.

Second, in "scoring" the fiscal costs or savings of various federal programs, neither Congress nor the White House is likely to capture the expected gains from projects aimed at improving health through community development. Even the best-measured community development program effects on, say, health care costs do not count as budget savings in the "score" assigned to legislative proposals.

And third, much congressional oversight, as well as oversight by agency auditors such as inspectors general, remains focused on risk management—that is, identifying and preventing waste, fraud, and abuse—rather than on promoting positive accomplishments, such as better outcomes for the money spent.

Added to the above concerns is the larger issue of congressional gridlock. Passage of legislation typically requires a supermajority of sixty votes in the Senate. This means that ambitious, comprehensive reform legislation will be rare, and reformers often end up seeking "waiver" authorities so that implementers can experiment in potentially useful ways within the existing program structure.

Still another obstacle is what policy makers and fiscal experts have called the "wrong pocket problem." Much of the promise of community development to affect structural determinants of health hinges on programs funded through one set of agencies to affect health care costs and outcomes in another set. For example, programs in the Departments of Justice, Education, and Housing and Urban Development might be focused on jointly supporting integrated strategies to make at-risk neighborhoods safer, improve housing and schools, and link supportive services and community health.

As outlined above, the Obama administration has proposed exactly this sort of coordinated effort. But if expenditures out of one agency's "pocket" result in savings that accrue to another agency—perhaps as costs avoided by the Department of Health and Human Services—it is difficult for congressional authorizers and appropriators to recognize and act on such savings. This is even truer, of course, if the savings accrue at other levels of government. For example, some of the savings from federal spending on the chronically homeless is realized by county jails and other facilities that receive little or no federal funding, so those savings do not accrue to the federal government.[18]

In sum, for a variety of reasons, there are limited incentives for the federal government to make even the most rigorously designed and targeted preventive expenditures—unless the spending and savings accrue to a single agency or fall under the jurisdiction of a single congressional committee, and unless the evidence of probable impact is very strong. This is especially true in the current fiscal context. Community development reform efforts should be designed to reflect that reality—for example, by focusing initially on scaling up the most tested interventions through funding and savings based, as much as possible, in programs of the Department of Health and Human Services and tied as closely as possible to the implementation of health care reform.

Conclusion

There are compelling and timely reasons for the federal government and its many partners— state, local, and tribal agencies, as well as organizations in the private sector—to address social determinants of health through smarter and bigger investments in community development. But institutional challenges to broad reform are considerable, too. In this context, two strategies in particular will be important.

EMBED SYSTEMS OF INNOVATION First, it will be vital to firmly establish and embed systems of innovation in federal, state, and local agencies, particularly in the implementation of the Affordable Care Act. Systems of innovation are organizational practices and support mechanisms that seek continuously to test new models, refine promising ones, bring to scale those that work best, and restructure or terminate what does not—and to normalize this cyclical approach in the work of the organization (or network of organizations working together) as part of acting strategically on mission. Such systems are best known in the corporate sector. At Google and other technology companies, for example, they are considered crucial to sustaining a competitive advantage.

In the public sector, systems of innovation require investments of fiscal and political resources—including the sustained attention of managers, full-time advocates, policy analysts, and other determined reformers, whether they are inside or outside the agencies that fund or deliver services. Systems of innovation create not only the enabling environment for particular innovations but also the conditions for scaling them and updating them over time, as needs change and new discoveries are made. Tools such as health impact assessments are ready to be put to use in this capacity.

In the Obama administration, the Departments of Education and Housing and Urban Development have worked with other federal agencies to establish funds for innovation and fought to sustain them in tough budget battles with Congress. Nevertheless, in government agencies and other organizations that are key to this discussion, comprehensive systems of innovation are nascent at best. Increasing their use is vital to getting agencies to look beyond traditional models and modes of thinking and to support nontraditional approaches that have merit as a central part of the agencies' strategies for impact, not merely in the form of demonstrations that start and stay small.

ESTABLISH A POLICY ADVOCACY COALITION Second, a strong and well-focused policy advocacy coalition is needed. Such coalitions are critical to inventing and achieving reform.[32] Those who are a part of such coalitions help each other identify shared interests across disparate institutions and specialized policy and professional debates; test ideas in the field; provide political and fiscal reality checks for each other; help replicate promising approaches across states or in other "laboratories of democracy"; and play other useful roles.

Best documented in the environmental and national security fields, such coalitions tend to be particularly important in cases where achieving broad goals requires the participation of actors in multiple specialties and at multiple levels, collaborating to define those goals very clearly and pursue them very strategically—and allocating precious time, funding, political capital, and other resources to effect change.[32]

Such a coalition is just beginning to emerge at the intersection of health and community development, thanks to initiatives of the Robert Wood Johnson Foundation and other philanthropies, the Federal Reserve System, and other organizations. But there is no guarantee that this emerging coalition of like-minded, forward-looking players will become well established, strategic, or effective. Grounded in the framework and targets that we have highlighted, a well-focused policy advocacy coalition designed to connect those working inside and outside of the health field—both public health and medicine—could begin to shape policy focused on the social determinants of health in powerful ways, moving off the margins and into the mainstream. ■

NOTES

1 Link BG, Phelan J. Social conditions as fundamental causes of disease. J Health Soc Behav. 1995; Spec No: 80–94.

2 Schnall PL, Landsbergis PA, Baker D. Job strain and cardiovascular disease. Annu Rev Public Health. 1994;15:381–411.

3 Lynch JW, Kaplan GA, Shema SJ. Cumulative impact of sustained economic hardship on physical, cognitive, psychological, and social functioning. N Engl J Med. 1997; 337(26):1889–95.

4 Krieger N. Discrimination and health. In: Berkman LF, Kawachi I, editors. Social epidemiology. New York (NY): Oxford University Press; 2000. p. 36–75.

5 Suglia SF, Duarte CS, Sandel MT, Wright RJ. Social and environmental stressors in the home and childhood asthma. J Epidemiol Community Health. 2010;64(7):636–42.

6 Diez Roux AV, Mair C. Neighborhoods and health. Ann N Y Acad Sci. 2010;1186:125–45.

7 Corburn J. Toward the healthy city: people, places, and the politics of urban planning. Cambridge (MA): MIT Press; 2009.

8 Nelson A. Unequal treatment: confronting racial and ethnic disparities in health care. J Natl Med Assoc. 2002;94(8):666–8.

9 Adler NE. Community preventive services: do we know what we need to know to improve health and reduce disparities? Am J Prev Med. 2003;24(3 Suppl):10–1.

10 Anderson LM, Charles JS, Fullilove MT, Scrimshaw SC, Fielding JE, Normand J. Providing affordable family housing and reducing residential segregation by income: a systematic review. Am J Prev Med. 2003;24(3 Suppl): 47–67.

11 Jutkowitz E, Gitlin LN, Pizzi LT, Lee E, Dennis MP. Cost effectiveness of a home-based intervention that helps functionally vulnerable older adults age in place at home. J Aging Res. 2012;2012:680265.

12 Anderson LM, Shinn C, Fullilove MT, Scrimshaw SC, Fielding JE, Normand J, et al. The effectiveness of early childhood development programs: a systematic review. Am J Prev Med. 2003; 24(3 Suppl):32–46.

13 Freudenberg N, Ramaswamy M, Daniels J, Crum M, Ompad DC, Vlahov D. Reducing drug use, human immunodeficiency virus risk, and recidivism among young men leaving jail: evaluation of the REAL MEN re-entry program. J Adolesc Health. 2010;47(5):448–55.

14 Crepaz N, Lyles CM, Wolitski RJ, Passin WF, Rama SM, Herbst JH, et al. Do prevention interventions reduce HIV risk behaviours among people living with HIV? A meta-analytic review of controlled trials. AIDS. 2006;20(2):143–57.

15 Copenhaver MM, Lee IC, Margolin A, Bruce RD, Altice FL. Testing an optimized community-based human immunodeficiency virus (HIV) risk reduction and antiretroviral adherence intervention for HIV-infected injection drug users. Subst Abus. 2011;32(1):16–26.

16 Althaus F, Paroz S, Hugli O, Ghali WA, Daeppen JB, Peytremann-Bridevaux I, et al. Effectiveness of interventions targeting frequent users of emergency departments: a systematic review. Ann Emerg Med. 2011;58(1):41–52.e42.

17 Herman DB, Conover S, Gorroochurn P, Hinterland K, Hoepner L, Susser ES. Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatr Serv. 2011; 62(7):713–9.

18 Culhane DP, Metraux S, Hadley T. Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. Housing Policy Debate. 2002;13(1):107–63.

19 Tabol C, Drebing C, Rosenheck R. Studies of "supported" and "supportive" housing: a comprehensive review of model descriptions and measurement. Eval Program Plann. 2010;33(4):446–56.

20 Galster GC, Killen SP. The geography of metropolitan opportunity: a reconnaissance and conceptual framework. Housing Policy Debate. 1995;6(1):7–43.

21 De Souza Briggs X, editor. The geography of opportunity: race and housing choice in metropolitan America. Washington (DC): Brookings Institution Press; 2005.

22 DeFilippis J, Saegert S, editors. The community development reader.

New York (NY): Routledge; 2008.

23 Ferguson RF, Dickens WT, editors. Urban problems and community development. Washington (DC): Brookings Institution Press; 1999.

24 Obama B. A metropolitan strategy for America's future. Remarks presented at: 76th annual meeting of the US Conference of Mayors; 2008 Jun 21, Miami, FL.

25 Diderichsen F, Evans T, Whitehead M. The social basis of disparities in health. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, editors. Challenging inequities in health: from ethics to action. Oxford: Oxford University Press; 2001. p. 12–23.

26 Cole BL, Wilhelm M, Long PV, Fielding JE, Kominski G, Morgenstern H. Prospects for health impact assessment in the United States: new and improved environmental impact assessment or something different ? J Health Polit Policy Law. 2004;29(6):1153–86.

27 Mindell JS, Boltong A, Forde I. A review of health impact assessment frameworks. Public Health. 2008; 122(11):1177–87.

28 Pastor M Jr., Dreier P, Grigsby JE III, López-Garza M. Regions that work: how cities and suburbs can grow together. Minneapolis (MN): University of Minnesota Press; 2000.

29 Obama B. Executive Order 13503 of February 19, 2009: establishment of the White House Office of Urban Affairs. Fed Regist. 2009;74(35): 8139–40.

30 Obama B. Executive Order 13575 of June 9, 2011: establishment of the White House Rural Council. Fed Regist. 2011 76(114):34841–3.

31 Orszag P, Barnes M, Carrion A, Summers L. Memorandum for the heads of executive departments and agencies: developing effective place-based policies for the FY 2011 budget [Internet]. Washington (DC): The White House; 2009 Aug 11 [cited 2011 Oct 13]. Available from: http://www.whitehouse.gov/sites/default/files/omb/assets/memoranda_fy2009/m09-28.pdf

32 Sabatier PA, Jenkins-Smith HC, editors. Policy change and learning: an advocacy coalition approach. Boulder (CO): Westview Press; 1993.

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In this month's *Health Affairs*, Mariana Arcaya and Xavier Briggs note that a combination of the Affordable Care Act of 2010 and the Obama administration's approaches to urban policy creates an opportunity to link community development and health in new ways. The authors argue, however, that such efforts could be hampered by fragmented congressional jurisdiction and current federal budget "scoring rules." They recommend a variety of steps that government agencies and others can take to forge even tighter and more effective linkages between the two fields.

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