
ncrp
National Committee for Responsive Philanthropy

*A Philanthropy at Its Best® Report*

# TOWARDS TRANSFORMATIVE CHANGE IN HEALTH CARE
## High Impact Strategies for Philanthropy

*By Terri Langston*

# About the Author

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# Acknowledgements

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# Funding

NCRP operates with the financial support of more than 60 different foundations, and some of those grantmakers are mentioned in this report. A complete list of funders is available on our website, www.ncrp.org.

*Cover Photos — Bottom Left:As many as 5,000 people are estimated to have participated in Seattle's March and Rally for Health Care Reform on May 30, 2009. Photo Credit: Neil Parekh/SEIU Healthcare 775NW. Bottom Right: President Barack Obama delivers remarks on the health insurance reform bill at the Department of Interior, March 23, 2010. From left, Vice President Joe Biden, Vicki Kennedy, wife of the late Sen. Ted Kennedy, and 11-year-old Marcelas Owens of Seattle, Washington. (Official White House Photo by Pete Souza)*

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# Executive Summary

Our nation confronts vast differences in health outcomes that manifest themselves in one community to the next. Our unequal health care system has left us at a point where we can predict health and longevity by a person's zip code. Externalities including discrimination, institutional power and neighborhood conditions have a greater effect on health outcomes than do disease, injury or mortality. Poverty and the unequal distribution of wealth remain closely associated with unhealthful conditions.

Simultaneously, the American people seek health care from a system that is fragmented, inefficient and costly to the point of being economically unsustainable. Viewed broadly in terms of the interdependence of society and of the overall health of residents, the current health system ultimately is not benefiting anyone.

Despite these conditions, people in communities nationwide are making decisions on ways to improve their own health outcomes as well as those of their children. Foundations support many of these activities through place-based initiatives that work with people in the context of their communities. Alongside those efforts, leaders of health systems, hospitals, community-based service and advocacy organizations are transforming the health care system and are poised to do more as part of the implementation of the health reform law of 2010. We have an opportunity to change health outcomes and the health care system so that they benefit everyone.

The United States faces a profound challenge and an unprecedented opportunity. This report examines some of the salient problems with the health of the American public and our health care system. It describes the opportunities for foundations to work in communities and improve health outcomes; nationally, funders have an opportunity to be part of efforts to reform and improve the health care system. It posits that the values and principles presented by the National Committee for Responsive Philanthropy (NCRP) in *Criteria for Philanthropy at Its Best: Benchmarks to Assess and Enhance Grantmaker Impact* provide a guide for health foundations and other funders to maximize their impact as they address disparate health outcomes and begin implementing reform of the health care system.

Against the background of overall values that serve the public good and support civic engagement as part of a participatory democracy, NCRP's benchmarks give specific guidance for effective grantmaking. In 2009, NCRP challenged grantmakers to provide at least 50 percent of their grant dollars to benefit marginalized communities and to provide at least 25 percent of their grant dollars for "advocacy, organizing and civic engagement to promote equity, opportunity and justice." Intentionally prioritizing those communities that are persistently underserved within our society can produce lasting benefits for everyone in the country. Such targeted grantmaking includes the collective empowerment of people through the support of community organizing and advocacy.

New analyses of health grantmaking data suggest that of 880 sampled foundations, 31 percent devoted at least half of grant dollars to marginalized communities and 4 percent classified at least a quarter of health grant dollars for systemic change and social justice, a proxy for advocacy, organizing and civic engagement. If health grantmaking comprises more than $1 million annually for a foundation, that foundation is slightly more likely to meet both benchmarks.

**This report contends that grantmakers in health will have the most success in improving health outcomes and achieving broader reform if they focus a great deal of attention and funding on marginalized groups and if they do so by addressing systemic inequality.** The report posits health outcomes and health care reform as inextricably intertwined. It moves from a discussion of the health outcomes of people in the context of their communities to the structural challenges and opportunities presented by the health reform law of 2010, including the unprecedented emphasis on public health and improving the public health system. This brings the argument back full circle to the community level and issues of justice. This broad view is meant to encourage foundations and funders of various types to consider addressing the underlying economic and social inequities that hamper the performance of the health care system and that diminish us morally as a nation.

Using positive examples, this report presents the many forward-thinking projects, programs and long-term emphases that grantmakers have undertaken to address both health outcomes and health policy. They are truly exemplary. For those foundations designing programs and setting strategies for the next few years, this aspirational work deserves scrutiny and replication.

Although the civic sector makes progress every day, the philanthropic field and our nation cannot afford – economically, political or morally – to step backwards. Now is the time for more philanthropic leaders to step forward and support the movement toward health equity.

# I. Introduction

Health outcomes and health care in the United States correlate negatively with their origin in a country of vast power, wealth and opportunity. Chronic disease is a leading indicator of the country's failure to ensure good health outcomes and to provide an accessible, affordable and efficient health care system. Diseases such as diabetes, congestive heart failure, untreated depression, coronary artery disease and asthma are more prevalent in lower-income communities, communities of color and other historically disadvantaged groups that are affected disproportionately by persistent inequities. But they also strike into the general population so deeply that they account for well over 70 percent of overall health care costs.[1] Susan Dentzer, the editor-in-chief of *Health Affairs*, stated, "As in many things in health care and health spending, American 'exceptionalism' is the rule: The United States is doing an especially rotten job of delivering chronic care, at spectacular costs."[2]

In 2009, the U.S. spent 17.6 percent of its gross domestic product (GDP) on health care, more than any other industrialized country. Further, U.S. health inequities cost the nation billions of dollars each year in direct expenditures for the provision of care to sicker and more disadvantaged populations. When lost productivity, wages, absenteeism, family leave and premature death are factored in, the costs rise into the trillions.[3] Grantmakers charged with addressing health outcomes and health care currently have opportunities to work in communities to improve health and to work across the nation to implement the health care reform law of 2010.

In 2009, the National Committee for Responsive Philanthropy (NCRP) challenged the philanthropic sector to employ principles to function "at its best."[4] As articulated in its publication *Criteria for Philanthropy at Its Best: Benchmarks to Assess and Enhance Grantmaker Impact*, two of the metrics that focus on values call for grantmakers to serve the public good by contributing to a strong, participatory democracy that engages all communities. Specifically, it urges grantmakers to provide at least 50 percent of their grant dollars to benefit lower-income communities, communities of color and other marginalized groups. It also calls on them to provide at least 25 percent of their grant dollars for advocacy, organizing and civic engagement to promote equity, opportunity and justice.

In addition, NCRP identifies guiding principles that inform grantmaking that is transformational. First among the principles is the use of systems theory, which focuses on how complex structures work in relationship to each other. Inherent in systems theory and systems thinking is an appreciation for the kind of causation that is not linear but rather is reciprocal, mutual and cumulative.

To measure overall well-being, NCRP recommends using the American Human Development Index (AHDI), a composite metric comprising longevity, knowledge measured by access to education, and standard of living measured by median personal earnings. These measures can inform policies so that everyone has an equal opportunity to participate fully in society.

A guiding principle puts a priority on marginalized communities, including but not limited to economically disadvantaged people, racial or ethnic minorities, women and girls, people with AIDS, people with disabilities, the elderly, immigrants and refugees, victims of crime or abuse, offenders and ex-offenders, single parents and lesbian, gay bisexual, transgender and questioning (LGBTQ) citizens. Related to this emphasis is the prin-

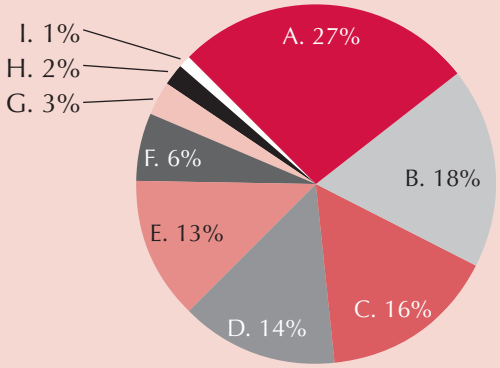
ciple of employing "targeted universalism," which holds that programs designed to target marginalized communities also benefit the broader population. Even elites suffer if any population within the country is marginalized or excluded because the impact is on the United States' ability to participate fully in the interconnected global context in which we now live.[5]

Targeted universalism also posits that each individual's particular circumstances, regardless of elite or marginal status, define a particular context for her or him. In short, the health of all individuals is influenced by their specific circumstances, an issue for which universal programs fail to account.

Finally, NCRP recommends funding significantly many levels of advocacy and policy engagement that are critical factors not only in improving the health of communities but also in helping to direct the largest investment of public resources in decades through health reform.

NCRP's values and principles make particular sense at this time for health philanthropy. Health outcomes and health care involve complex structures requiring systems thinking to improve them and make them cost efficient. Improving the health of people in communities necessitates social inclusion and expanding the definition of health to become mindful of the multiple dimensions of well-

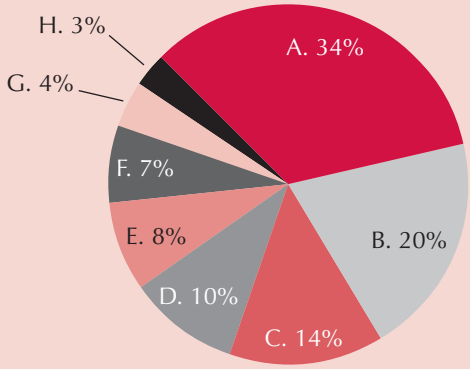
## GRAPH 1: Distribution of Grants from Foundations who Gave in 2007–2009, by Subject Area




| SUBJECT | AMOUNT |
|---|---|
| A. Education | $4,028,723,499 |
| B. Health | $2,600,230,673 |
| C. Human Services | $2,379,178,602 |
| D. Arts and Culture | $2,010,069,596 |
| E. Public Affairs/Society Benefit | $1,848,398,298 |
| F. Environment and Animals | $930,761,990 |
| G. Science and Technology | $499,290,232 |
| H. Religion | $295,945,689 |
| I. Social Sciences | $117,647,997 |
| J. Other | $11,531,254* |
| K. Unspecified | $38,333* |
| L. International Affairs, Development, Peace, and Human Rights | $14,816* |

**These amounts are too small to appear in the graph.*

## GRAPH 2: Distribution of Health Grants from Foundations who Gave in 2007–2009




| HEALTH SUBJECT AREA | AMOUNT |
|---|---|
| A. Hospitals and Medical Care | $872,413,466 |
| B. Medical Research | $521,855,691 |
| C. Public Health | $354,526,977 |
| D. Specific Disease | $264,508,500 |
| E. Other | $198,024,714 |
| F. Mental Health | $185,327,813 |
| G. Reproductive Health Care | $113,399,109 |
| H. Policy, Management, and Information | $90,174,403 |

Source: Foundation Center

being of people in communities. Targeting underserved communities and finding solutions for them would alleviate the moral and economic burden of health inequities and disparities in health care.

The combination of tough economic times, deplorable health outcomes and the inefficient health care system calls for philanthropy writ large – that is, more than health funders – to work for equity in health outcomes and health care throughout society. To funders that want to make a difference in the well-being of all of their neighbors, NCRP's principles provide a persuasive guide for their work.

Applying NCRP's principles of *Philanthropy at Its Best* to health funding makes sense because doing so helps to promote the *common good*, an enduring philanthropic and American ideal. Close to a half century ago, in 1965, John Gardner, a Republican and secretary of health, education and welfare for Democratic President Lyndon B. Johnson, spoke to the president's cabinet about the challenges of implementing the Great Society programs. Gardner told them, "What we have before us are some breathtaking opportunities, disguised as insoluble problems."[6]

The United States has a historic opportunity for transformative change in two places: in our communities and in the health care system that operates in those communities. The transformation must hold a laser-like focus on equity. Dr. Don Berwick, administrator of the Centers for Medicare and Medicaid Services, contends that America's largest health and health care issue is equity.[7]

This report approaches the issues of health outcomes and health care in two sections. First, it presents a view of health outcomes within the context of people's lives, including factors such as place, race and wealth. Second, it focuses on the health care system and the opportunity presented by the implementation of the Patient Protection and Affordable Care Act to improve that system. The primary audience for this report comprises health funders but the strategies and outcomes presented here also apply to funders working on other issues.

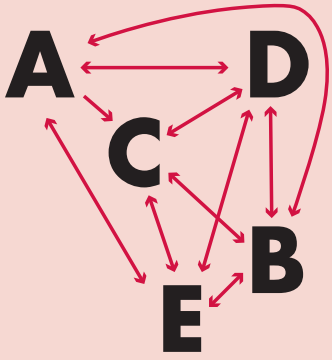
## DIAGRAM 1: Newtonian Perspective Vs. Systems Thinking

**THE NEWTONIAN PERSPECTIVE**

*Social phenomena may be understood by breaking down the sum of the constituent parts.*


**SYSTEMS THINKING**

*Causation is reciprocal, mutual, and cumulative.*




Source: *Criteria for Philanthropy at Its Best: Benchmarks to Assess and Enhance Grantmaker Impact*, March 2009.

NCRP believes that use of its values and aspirational benchmarks can enhance philanthropic work and increase its impact. Therefore, throughout both sections, the values and principles of NCRP are reflected in the positive examples of work taking place in communities to improve health outcomes and in the nation to improve the health care system.

The report states without reservation that the NCRP principles provide a guide to those interested in practicing transformative philanthropy through improving health and health care for all Americans. The report does not cover international health grantmaking, a field too large for the already broad scope of this report.

# II. Communities: People in Context

Imagine two communities in the midwestern United States. If you grow up in one, you can reasonably expect to live approximately 88 years or more. But if you grow up in the other, less than nine miles away, you can expect to live approximately 64 years. You would not think an 18-minute drive could take 24 years, but that is the very real difference in life expectancy between someone who grows up in Lyndhurst, a suburb of Cleveland, and someone who grows up in Hough, a neighborhood in the inner city of Cleveland.[8]

Unfortunately, inequities like these persist across communities throughout the country even today. Health outcomes clearly mirror the social determinants of health – the public health framework incorporating social and economic factors in the understanding of the health of people and of communities. The simple truth is, your zip code is predictive of your health and your longevity more than any factor known. As a result, inequities are starkly magnified at the community-level and it is here that the health care system succeeds or fails.

Dr. Anthony Iton of The California Endowment has challenged his colleagues to look into the eyes of the children to assess the health of a community. The kind of pattern recognition that a skilled clinician uses to assess and begin to diagnose a person's psychological and physical condition by looking at them has been imitated in recent years through research that diagnoses the health status of communities.[9] Such research has resulted in an understanding of the role of place in the health outcomes of Americans.

"Systemic, avoidable, unfair and unjust" are Dr. Iton's words for the inequities that result from "socio-ecological" factors, including discrimination, institutional power and neighborhood conditions. These social determinants of health play a larger part in health outcomes than do risk behaviors, disease or injury, or mortality, which comprise the usual measures of the "medical model" that has dominated the country's public health and medical care. The medical model fails to see people in context.[10]

Context helps us understand the root causes of health outcomes. For instance, social "stressors" have biochemical effects. The body releases cortisol in response to stress.[11] Higher levels of cortisol are correlated with lower life expectancy. Take away the negative stressors in people's communities – poor housing, the inability to read, discrimination, powerlessness, violence and poverty – and you improve health outcomes.[12]

While traditional medical care is critical and must be reformed, it can no longer be our sole focus. Dr. David Satcher, former U.S. surgeon general, notes that between 1991 and 2000, advances in medical technology averted 177,000 deaths, but he also notes that the elimination of disparities between African Americans and whites could have averted 886,000 deaths. He contends, "If we can achieve health equity and create healthy communities, we can do more to improve the overall health of the nation than is likely from advances in medicine."[13]

## RACE AND WEALTH

One of the most salient differentiating factors in American life is race. California Newsreel's video "Race – the Power of an Illusion," made for the Public Broadcasting Service in 2003, explains that race is a "biological myth" with no genetic basis. In American history, this myth gave rise to policies and judi-

cial decisions that were overtly racist.[14] Policies that worked to the advantage of whites were so pervasive and long-lived that whites came to accept the benefits of such policies as evidence of their often unspoken racial superiority. Those policies continue to influence life opportunities:

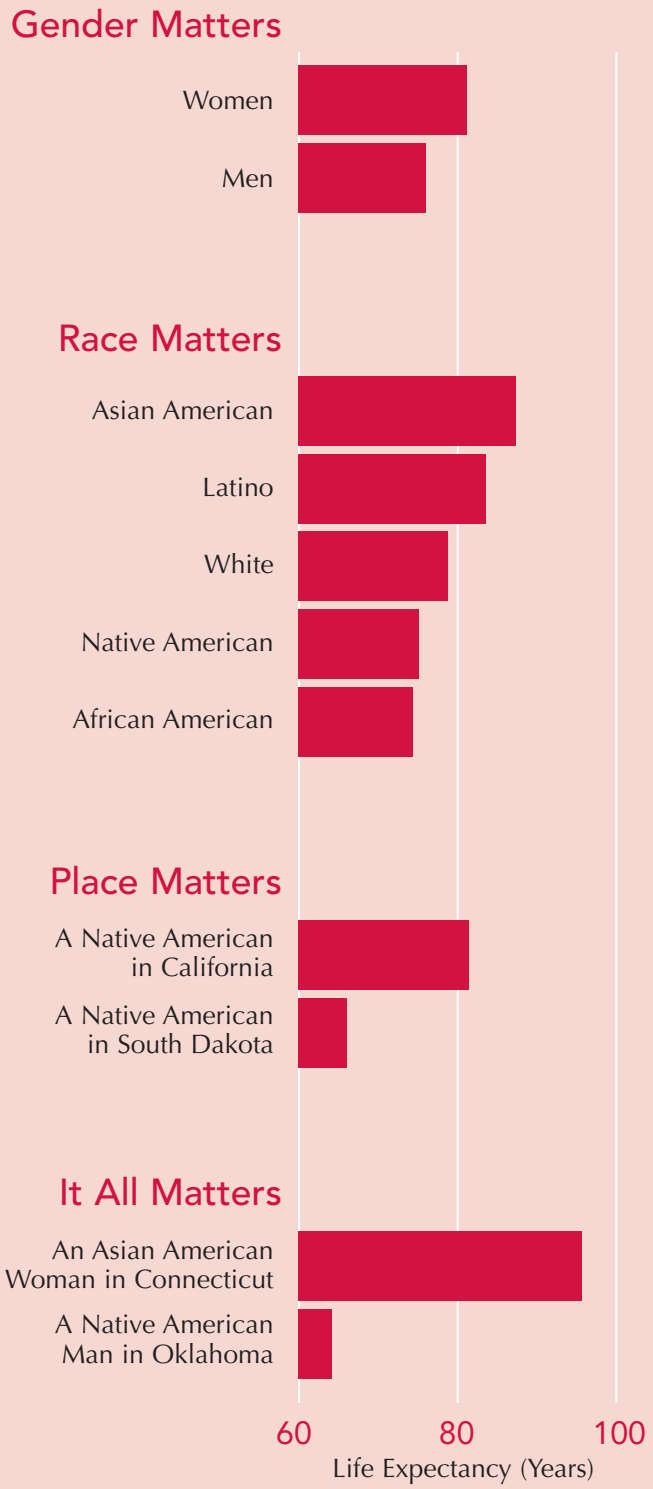
> "Today, the average black family has only one-eighth the net worth or assets of the average white family. That difference … is not explained by other factors, like education, earnings rates, savings rates. It is really the legacy of racial inequality from generations past. No other measure captures the legacy, the sort of cumulative disadvantage of race, or cumulative advantage of race for whites, than net worth or wealth."[15]

Between 1984 and 2007, the gap between the assets of white families, not including home equity, versus African American families increased fivefold.[16] Include home equity and the gap becomes even greater. Even analyzing income alone, in no states do African Americans, Latinos or Native Americans earn more than Asian Americans or whites.[17] Specifically, for every dollar owned by the median white family in the United States, the typical Latino family has twelve cents and the typical African American family has a dime.[18]

Place, race and wealth are intermingled and interdependent. The National Committee for Responsive Philanthropy (NCRP) encourages funders to employ several guiding principles as they approach society's complex problems. In this case, systems thinking explains how place, race and wealth are interwoven into the health of communities and therefore cannot be analyzed in isolation. Rather, their effects are mutual and cumulative.

*The Measure of America, Mapping Risks and Resilience,* published in November 2010, contains a data-driven argument using the American Human Development Index (AHDI) for "increasing resilience in health" from the standpoints of social determinants and health care reform.[19]

## GRAPH 3: Social Determinants of Health




*Source: HD Index and Supplemental Indicators by State, 2010-2011 Dataset, American Human Development Project, Social Science Research Council*[20]

## EXEMPLARY FOUNDATIONS EMPLOYING A CONTEXTUAL LENS IN HEALTH GRANTMAKING

Some foundations have played a critical role in creating an inclusive view of people in their contexts. The W.K. Kellogg Foundation supported the "Place Matters" initiative through the Joint Center for Political and Economic Studies that worked with 21 counties and three cities to establish community-based leadership focusing on specific social conditions related to health.[21] One site was Alameda County, Calif., part of the Bay Area Regional Health Inequities Initiative (BARHII), a regional collaboration of public health directors, health officers, senior managers and staff from ten counties and the City of Berkeley. Data from this work show that life expectancy in the Bay Area conforms to a "social gradient": the more wealth and income people have, the longer they live. Within the ten participating counties of BARHII, people living with the least poverty can expect to live ten years longer than those living with the most poverty. These findings affirm the insight that "Social Policy is Health Policy, Economic Policy is Health Policy, Education Policy is Health Policy."[22]

This understanding is reflected in The California Endowment's Building Healthy Communities strategy. This prevention-based approach fosters environments where children are healthy, safe and ready to learn in 14 communities where "the need is great, but the potential for transformation is even greater." Choosing priorities and selecting strategies are in the hands of community residents who form a "hub" through which they work together on how to improve conditions for families and children. The ten-year investment will provide long-term support to communities to make a sustainable difference in public health.[23]

Smaller foundations also lead such place-based work in their communities. The Health Trust, a private foundation working in Silicon Valley (see Spotlight) and the New Hampshire-based Endowment for Health, a statewide private foundation, are examples of local and state foundations that are changing the socio-ecological systems in their respective environments.

The Endowment for Health has chosen as two of its four priorities, or themes, for its work: Economic Barriers, and Social and Cultural Barriers. Taking a broad view of health, the foundation explains, good health is a product of where and how we live and work, our access to care, our individual and collective behavior, and our family and community history. In this mix, economic status has a far greater impact on health than our egalitarian society would like to admit. Economic barriers to health include lack of access to care, safe housing, healthy food and physical activity.[24]

The foundation's Social and Cultural Barriers theme hones in on rigorous data collection to document disparities and inequities, best practices for culturally appropriate care, diversification of the health workforce and empowerment of vulnerable populations to self-advocate.

The Endowment for Health, The Health Trust and The California Endowment reflect NCRP's principles for exemplary philanthropy: using systems thinking, they document the social determinants of health within communities; they place an intentional priority on disadvantaged communities and they enable the empowerment of the people in marginalized communities. They support community organizing and advocacy, and, finally, both explicitly and implicitly, they encourage greater civic engagement.

In North Carolina, collaboration between the Duke Endowment and Duke University Medical Center has advanced prevention and equity. The Medical Center was experiencing uncontrolled costs as a provider of care in Durham County's safety net. It was spending an estimated $45 million in yearly patient care costs for individuals who were unable to pay. In response, it started an experiment in community health seven years ago to reduce chronic illnesses among the uninsured as well as to reduce mounting costs of emergency room visits. It formed a partnership with the Lincoln Community Health Center to expand primary health services and make the community healthier through a yearly contribution of $7.5 million towards supporting primary care. The Duke Endowment

stepped in with critical early money to enlarge and equip the first clinic to open. To date, the partnership has created three clinics to complement the county's safety net, which treats patients who are 80 percent uninsured and 50 percent African American. In addition, the Medical Center also listened to administrators and teachers at a local high school who explained that students with chronic illnesses could not learn. The response was to staff and subsidize a school-based health clinic that now sees 1,750 patients per year and includes a full-service pharmacy. Significantly, Duke Medical Center's outreach and support have improved its relations with African American and Latino community members.[25]

The Duke Medical Center and the Duke Endowment identified inequities resulting from the way that complex structures and relationships in their community intersect: the role of the Medical Center in the safety net, the need for expanded community-based primary care, the need to target chronic diseases among high school students and the need to focus on marginalized communities. They made alterations to the delivery of health care taking those factors into their planning and execution of a more efficient and cost-effective safety net system.

## Spotlight: The Health Trust

The Health Trust, a private foundation working in Silicon Valley, is changing the "socio-ecological" context of health care by emphasizing six values – respect, integrity, innovation, collaboration, diversity and stewardship. It works through three initiatives: *Healthy Living* focuses on increasing access to physical activity and healthy food; *Healthy Aging* supports nutrition, physical activity and social engagement for older adults and improves systems for their caregivers; and *Healthy Communities* works to reduce health disparities through programs and policy changes that seek to improve health outcomes.

Demonstrating a deep commitment to addressing disparities and thus making changes that benefit everyone in the *Healthy Communities*, the foundation's work includes:

- Using *promotoras* (peer educators) to provide readily accessible information to the local community, as well as providing evidence-based Chronic Disease Self-Management.
- Conducting HIV/AIDS prevention presentations in high schools and colleges, and providing case management services, housing services and nutrition support services to more than 800 people with HIV/AIDS.
- Conducting oral health education for families, enrolling children in dental insurance, operating the Children's Dental Center and advocating for water fluoridation.
- Raising awareness about health disparities and their root causes, including poverty, poor education, lack of affordable housing and lack of diversity in the health workforce.
- Partnering with and funding the Public Health Department to analyze and present data that illuminate health inequities in Santa Clara County.
- Ensuring access to health insurance and to health care, such as through outreach and enrollment of children and providing patient navigation services.

*More information at: http://www.healthtrust.org/initiatives/communities/index_com.php.*

# III. The Non-System of Health Care

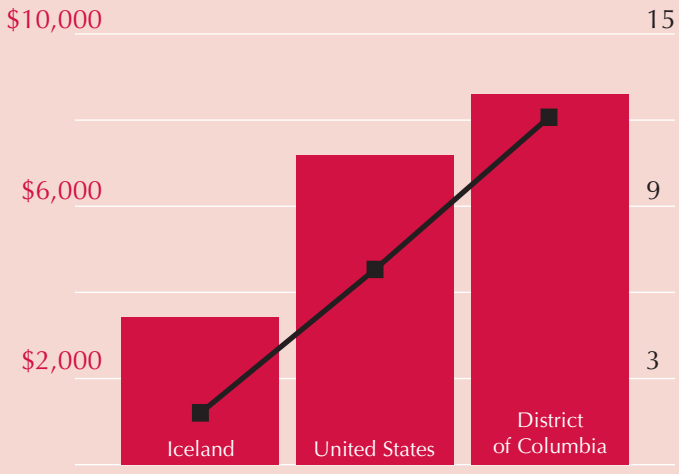
"Although common parlance often refers to the U.S. health care 'system,' it is anything but. It comprises many uncoordinated pieces, lacks a common strategy and seldom achieves the promise of consistently high performance seen in other sectors of the economy," assert Janet Corrigan and Dwight McNeill of the National Quality Forum.[26]

The present "system" fails with regard to coverage: the number of uninsured Americans has risen to 50.7 million or 16.7 percent of the population, according to Census Bureau figures released in September 2010.[27] And it fails with regard to performance. For example, "Thirty nations, including less affluent countries like Portugal, Slovenia and Malta, have a lower infant death rate than Washington State, which has the lowest rate of infant death among U.S. states." Washington, D.C., has the highest infant mortality rate in the U.S., performing slightly better than Belarus despite spending 13 times more on health care.[28] This links directly to the issue of resource inefficiency: "Americans are paying top dollar for mediocre results."[29]

According to the Center for Medicare and Medicaid Services, in 2009 health spending in the United States accounted for 17.6 percent of GDP.[30] In 2006, U.S. health spending as a share of GDP was higher than all other countries measured by the Organisation for Economic Co-operation and Development.[31] In June 2009, the White House Council of Economic Advisers projected that the share of GDP going to health care would reach 34 percent by 2040 if costs continue to grow at this rate.[32] Yet, in 2010, "the residents of twenty-nine countries live longer lives, on average, than Americans do - while spending as much as eight times less on their health."[33]

Any philanthropy concerned about addressing inequities in our current health

## GRAPH 4: Health Care Expenditure and Infant Mortality




n Health Expenditures per Person (2008 USD)
— Infant death rate, 2006 (per 1,000 live births)

In an analysis of all 50 U.S. states and the District of Columbia and independent countries with better infant death rates than at least the worst-performing U.S. state, researchers found that the United States experiences an infant mortality rate nearly four times higher than Iceland. Iceland has the lowest infant mortality rate even though the U.S. spends more than twice what Iceland does per person on health. The situation is worse in the nation's capital, which spends two-and-a-half times as much as Iceland and experiences infant mortality rates nearly seven times higher.


*As many as 5,000 people are estimated to have participated in Seattle's March and Rally for Health Care Reform on May 30, 2009. Photo Credit: Neil Parekh/SEIU Healthcare 775NW.*

care system must acknowledge the social determinants of health when considering its grantmaking strategy. Indeed, the recognition that the health care sector excluded too many people and cost too much provided a large impetus for health care reform. Philanthropic support for community organizing, coalition building and advocacy, described in-depth below, helped pave the way for the enactment of reform.

## THE PATH TO HEALTH REFORM: COMMUNITY ORGANIZING, COALITION BUILDING AND ADVOCACY

Community organizing, coalition building and many levels of policy engagement helped to successfully pass legislation that will begin to tackle the country's toughest problems with health care. Work initiated by organizers focused on health reform in the early 1990s continued for almost another two decades, culminating in the formation of Health Care for America Now (HCAN). Comprising more than 1,000 member organizations, HCAN was the "deepest single-issue coalition in modern American history."[34] HCAN worked with more than 800 local organizations in 44 states and with three national organizing networks, several national unions and national organizations representing women and people of color to bring about reform.

The Atlantic Philanthropies made the largest grants among several foundations and unions that provided more than $48 million for the effort. Some members of HCAN such as the Center for Community Change, U.S. Action and the Northwest Federation of Community Organizations also worked with other advocates to advance health reform. Working both with the HCAN coalition and with advocates throughout the states, the Herndon Alliance researched, proposed and executed communications strategies to explain to the people the need for major reform of the American health care system.

Advocacy throughout the states formed and grew strong throughout the same years of the 1990s through the leadership of Community Catalyst, Families USA, the Georgetown Center for Children and Families, the National Women's Law Center, U.S. Action, the National Health Law Program and the Center on Budget and Policy Priorities and its State Fiscal Analysis Network. In the states, "systems of advocacy" formed, which encouraged coordination of efforts with policy, organizing, legal and fiscal expertise.[35]

For several years, these systems worked on many levels, defending public programs and incremental reforms at the state level while simultaneously advocating for national reform from their state perches. Those

## SPOTLIGHT: The Affordable Care Act Advocacy Fund Collaboration Among Seven National Foundations

Broad in scope, the Affordable Care Act (ACA) cedes significant policy discretion to the states, where policymakers face daunting tasks over the next few years. As such, the role of state advocacy organizations in implementing ACA provisions is pivotal. Well-resourced advocates skilled in public education, administrative, legislative and legal advocacy, community organizing and policy analysis will be critical to ensure successful implementation of health reform.

The Atlantic Philanthropies, The California Endowment, The Nathan Cummings Foundation, Ford Foundation, The Jacob and Valeria Langeloth Foundation, The Rockefeller Foundation and The Wyss Foundation are the initial collaborators on the nascent ACA Advocacy Fund. The fund will provide a vehicle for national, state and local funders to collaborate in directing strategic grants to systems of advocacy, which consist of multiple organizations with varied skills working collaboratively. It also is intended to increase the overall level of support for state-based advocacy during health reform implementation.

An advisory committee comprising contributing funders will work with Community Catalyst, a national health advocacy organization with extensive experience in the states. Collaboration on this scale – with seven national foundations and pooled funds that will boost the impact of these foundation dollars – is rare in philanthropy.

years taught advocates about the interacting and cumulative effects of working collaboratively on a systems level, skills that are now essential to ensuring successful implementation of reform. Since the 1990s, the Public Welfare and The Nathan Cummings foundations nurtured state-based consumer health advocacy organizations while The David and Lucile Packard Foundation cultivated state-based children's advocacy organizations. The Robert Wood Johnson Foundation gave this trend strong support with its *Consumer Voices for Coverage* program working in 18 states.[36]

All of the aforementioned organizations emphasized social inclusion and marginalized communities, particularly the needs of racial and ethnically diverse groups, in their policy stances and their organizing work. The Joint Center for Political and Economic Studies (JCPES), the National Council of La Raza (NCLR) and the National Association for the Advancement of Colored People (NAACP) worked to keep the issue of racial and ethnic equity in the debate and analyzed original research and data on the human and financial costs of health inequities. The emphasis of the health reform law on addressing racial and ethnic disparities in health and health care builds on these organizations' prior work on equity.[37]

The strategies and skills developed in the many years leading up to passage of the Patient Protection and Affordable Care Act (PPACA, commonly referred to as the Affordable Care Act or ACA) provide a solid basis for the coming years of implementation. Grantmakers have access to an extensive cadre of experienced organizers, policy experts and advocates on the national, state and local levels to boost their impact and create sustainable long-term change.

There is growing momentum toward increased collaboration among foundations and national advocacy and policy organizations. Some who worked for reform shifted quickly to its implementation while others chose to wait and have now started to lead implementation at the state and local levels, where it will count most.

# IV. The Affordable Care Act

The focus on addressing health in the context of people's lives in communities blends well with the pressing need for reforming the health system through the full implementation of the ACA. *The Measure of America* articulates this need:

> "Variations in access to and quality of health care account for about 10 percent of the life expectancy gaps observed in the United States overall … And universal health coverage is vital both to saving lives and to addressing the leading cause of bankruptcy among U.S. households: medical bills. Health insurance contributes to both health security and economic security, essential foundations of a freely chosen life of value."[38]

The states will have major influence on the implementation of the federal law. Local officials understand on a daily basis the

## SPOTLIGHT: Patient Protection and Affordable Care Act – Summary of key provisions[39]

Signed into law in 2010 by President Barack Obama, the Patient Protection and Affordable Care Act (PPACA) is among the country's most transformative social policies in decades. Below is a summary of key provisions for funders to keep in mind as the law is implemented.

**Insurance Coverage Expanded**

- Insurance market reforms eliminate discriminatory practices and cap insurance company administrative expenses.
- Its mandate requires individuals to maintain minimum essential coverage and requires employers with 50 or more employees to offer coverage.
- Refundable tax credits are instated to ensure affordability of insurance.

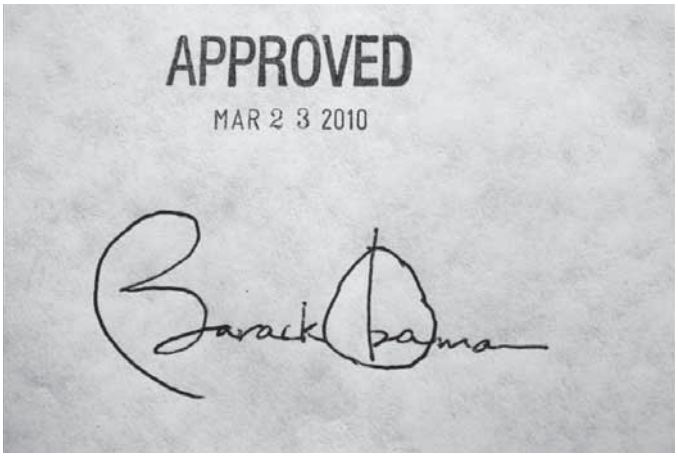
**American Health Benefits Exchanges Established by the States**

- Qualified health plan offering essential benefits with cost sharing limits.
- Quality accreditation for all plans; standardized presentation of benefits.
- State-level flexibility to establish basic health plans for lower-income individuals and to form compacts with other states for cross-state sale of health insurance.

**Public Programs**

- Medicaid expansion – by 2014, to all children, parents and childless adults with family incomes up to 133 percent of the federal poverty level; 100 percent federal financing for the newly eligible from 2014–2016; Community First Choice Option through Medicaid for community-based attendant services and support for beneficiaries with disabilities.
- Children's Health Insurance Program – income eligibility levels maintained through September 30, 2019. States receive an increase in the federal matching rate starting in 2014 through 2019.
- Simplified Enrollment – state-run websites established and enrollment among Medicaid, Children's Health Insurance Programs and exchanges coordinated.

*(continued on page 14)*




*President Barack Obama's signature on the health care reform bill at the White House, March 23, 2010. Official White House Photo by Chuck Kennedy.*

enormous pressure being created by poor health and high costs. As Alan Weil of the National Academy for State Health Policy states, "I have yet to meet a governor who has said, 'I'm going to intentionally do a bad job at this to make another level of government look bad' … They're accountable to the people, and the voters are too smart to let someone get away with that."[40] This is especially true if systems of advocacy on the national and state levels adroitly monitor and publicize the state-level decisions. Building local policy engagement and advocacy capacity is among the many critical ways that foundations can help ensure effective implementation.

**Improving Quality and Efficiency**

- National strategy to improve service delivery, outcomes and population health.
- Center for Medicare and Medicaid Innovation for payment and delivery models.
- Increased provider fees, protections for hospitals and bonus payments for emergency services in rural areas.
- Restructures Medicare Advantage payments according to fee-for-services rates. Discounts available for drugs during the coverage gap, with plans for gradual elimination of the gap.

**Prevention of Chronic Disease and Improving Public Health**

- Establishes a Prevention and Public Health Investment Fund and a national prevention strategy.
- Develops healthy communities and a 21st century public health infrastructure.
- Supports school-based health centers, establishes an oral health prevention education campaign, and provides 100 percent Medicare coverage for prevention and incentives for Medicaid preventive services.
- Funds for research in prevention and public health practices, including collecting data by race, ethnicity and primary language.

**Workforce**

- Improves loan programs and repayment requirements to support the workforce, particularly in medically underserved areas and populations.
- Supports training programs for primary care physicians and ancillary personnel and for training in team-based approaches.
- Expands funding for federally qualified health centers and co-location of primary and specialty care in community-based mental and behavioral health settings.

**Transparency and Program Integrity**

- Establishes Patient-Centered Outcomes Research Institute.
- Enacts Elder Justice Act to eliminate abuse, neglect and exploitation of the elderly.

**Long-term Care**

- Establishes Community Living Assistance Services and Supports (CLASS), a national voluntary self-funded long-term care insurance program.

The joint federal-state model complicates ACA's implementation and the long period of four or more years for implementation opens it to challenges. The widespread realization, however, is that the status quo cannot prevail, lest the U.S. seriously jeopardize its economic future.[41] Avoiding that outcome is an incentive for U.S. society and health grantmakers to help communities identify the root causes of bad health outcomes while reforming the health care system to improve the care of each patient, to improve the health of the entire population and to lower costs.

Many national advocacy organizations and foundations have provided the public with important descriptions, analyses and discussions about the challenges of implementing various elements of the ACA. Both major and minor provisions of the law afford opportunities to employ principles of exemplary grantmaking to increase impact and long-term sustainability.

## EXPANSION OF COVERAGE TO LOWER-INCOME PEOPLE

The ACA codifies specific health insurance reforms and the requirement for everyone to have insurance, two important changes that will spread risk and costs across the population more equitably. Two major features of reform are the availability of insurance coverage with subsidies based on income through state-based insurance marketplaces called "exchanges" and a major expansion of Medicaid coverage for all lower-income people. The ACA also focuses on prevention, chronic diseases, community health and health equity for the country's diverse population.

The Medicaid expansion to millions of uninsured Americans will reach into some of the nation's deepest pockets of poverty and neglect, with the southern states standing to benefit the most from the largest expansions.[42] Marginalized populations including the working poor and racial and ethnic minorities will receive defined benefits. Grantmakers can focus on the Medicaid population to complement the role of state governments in many ways. Using a targeted approach, they can reach out to and enroll eligible citizens,

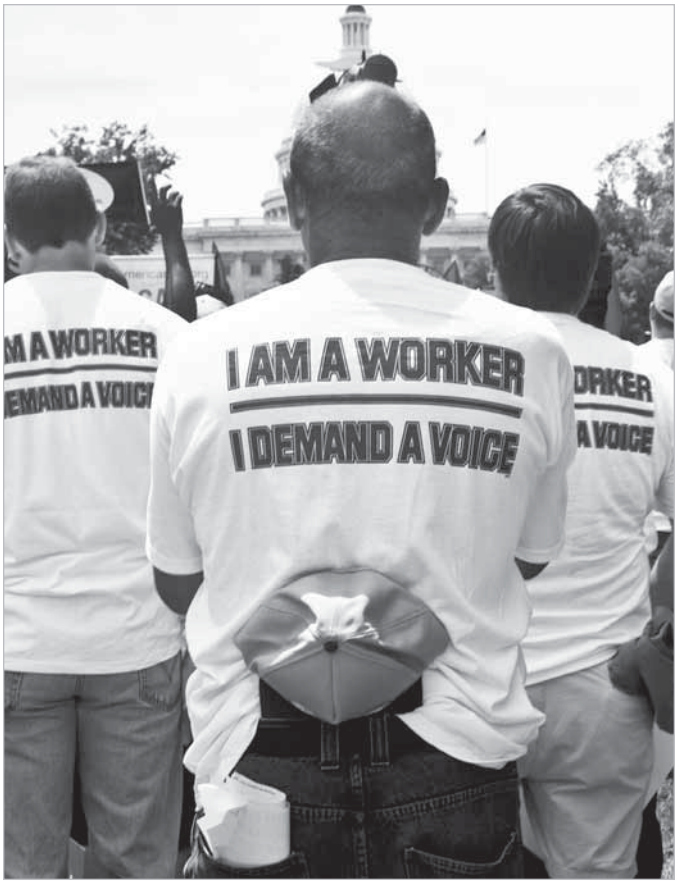
## SPOTLIGHT: Resources for Federal Health Reform Implementation in Kansas — A Collaboration among Five State Foundations

Five Kansas-based health philanthropies – the Health Care Foundation of Greater Kansas City, Kansas Health Foundation, REACH Healthcare Foundation, Sunflower Foundation and the United Methodist Health Ministry Fund – are pooling funds in support of efforts to ensure optimal implementation of the Affordable Care Act in Kansas. Grants ranging from a minimum of $5,000 to a maximum of $30,000 will go to state agencies and collaboratives of those agencies, consortiums of organizations doing regional work, nonprofit organizations and local governmental entities. Funds will support the submission of grant requests; legal, actuarial or policy development for state agencies; stakeholder engagement in implementation processes; participation in conferences and public education.

The philanthropies are working with the Kansas Health Consumer Coalition (KHCC) to secure health consumer engagement in the formulation and implementation of appropriate grant projects. These grantmakers also are partnering with the Kansas Association for Local Health Departments on technical assistance efforts. In addition, the fund will hire a grant coordinator to publicize the program, encourage responses to ACA opportunities, coordinate grant review, issue awards and process reports. The coordinator will work closely with KHCC, the Kansas Medicaid Agency, Kansas Insurance Department and other public health and research organizations.

Billie Hall, CEO of the Sunflower Foundation, explained the collaborators' rationale: "We have an obligation to make sure consumer groups are at the right place at the right time during this implementation process. This is an opportunity for funders to work with coalitions in the state and to ensure better connections with stakeholders."

Now that health reform has been enacted into law, funders are encouraging communities to participate in adopting practical steps and developing solutions to improve the health of all Kansans.




*Protesters during a health care reform rally in Washington, D.C., June 25, 2009. Photo by Syreeta McFadden.*

improve access to primary and specialty care, foster community-based options for long-term care and use payment policies to contain costs and improve quality. The Center for Health Care Strategies (www.chcs.org) and the National Academy for State Health Policy (www.nashp.org) are assisting nonprofits and local government in the states to make this public program for vulnerable populations into an example of high performance.

Experienced advocates on the state level not only help to expand the reach of Medicaid, but also to maintain and improve its quality. Nonprofit advocates will work closely with the new Consumer Assistance Programs established by ACA through federal grants to state entities.[43] The independent state and nonprofit efforts will serve a "sentinel function" by working "closely with government officials to alert them to emerging trends, issues and challenges faced by their shared constituencies."[44]

## INSURANCE EXCHANGES

State-based exchanges will provide a marketplace for consumers to find affordable and comprehensive insurance coverage. Through the exchanges, lower-income consumers will be eligible for subsidies through income-based tax credits. States have substantial leeway to establish exchanges ranging from those that may offer options for comprehensive coverage and affordability to those that offer minimum benefits. Three of NCRP's tactics for strategic grantmaking spelled out in its report *Criteria for Philanthropy at Its Best* can help to ensure that exchanges work in the public's interest: support for community organizing, increased civic engagement of consumers to demand sound policies at the state and national levels, and state-based advocacy.

State-based systems of advocacy (interreliant organizations that bring various skill sets to the advocacy system) grew in recent years with the support of national and local foundations. The systems combine community organizing by multi-issue and faith-based organizations with a strong component of civic engagement in local and national politics. Some of the same systems have policy and legal experts who can, for instance, pinpoint the vast difference between an exchange that is well-regulated and operates in consumers' interest and one that simply lists policies in the insurance industry's interest.

The capacities in state-based consumer advocacy organizations with regard to private insurance, however, are uneven across the states. Some of the organizations located in political environments opposed to reform are those that need the most support. Foundation assistance to help them cultivate this expertise is a current and future need.

The federal Office of Consumer Information and Insurance Oversight in the U.S. Department of Health and Human Services welcomes strong engagement from consumers. Its deputy director for consumer support, Karen Pollitz, and her staff are working for strong consumer ombudsman programs, responsive appeals systems, transparency and disclosure: "We cannot run health reform implementation on the honor system … Accountability in

health insurance is vital. We need consumer advocates to help make that work."[45]

The National Association of Insurance Commissioners (NAIC) also responds to the consumer voice. The industry's lobbyists to the NAIC number more than 1,000, whereas there are only about 20 funded consumer representatives.[46] Because insurance is regulated in the states, it is crucial to build and foster communication between national and state advocates and to keep up the pressure for establishing consumer-oriented exchanges.

## DELIVERY SYSTEM REFORM

Delivery system reform is a critical component to increase value in the health care sector, as it holds great promise for equity and controlling costs. The traditional model of fragmented service made worse by a system of fee-for-service payment that creates more fragmentation serves no one well, especially those most in need. Every community can begin to move toward medical homes or health homes that provide primary care and coordinate specialty care. In the Gulf region, national and local foundation collaboration has revamped the delivery of primary care in a way that could be replicated by other communities with added support from the ACA.

Efforts such as convening stakeholders and advocates in communities to address chronic care, to provide culturally and linguistically competent care and to advocate for community benefits are given new support through the ACA. Foundations have an opportunity to ensure that communities play a central role in leading and monitoring this work

Comprehensive and cost-effective care can be achieved even for the sickest and poorest patients. In Boston, with the help of the Open Society Institute,[48] Dr. Robert Master formed the Commonwealth Care Alliance, a cost-effective model for the delivery of care to people eligible for both Medicaid and Medicare. Among the sickest of patients, these "dual eligibles" account for 18 percent of Medicaid patients but 46 percent of Medicaid expenditures.[49]

In addition, the Campaign for Better Care, funded by the Atlantic Philanthropies and executed by the National Partnership for Women and Families in conjunction with Community Catalyst and the National Health Law Program, is addressing the same population of people who are eligible for both

## SPOTLIGHT: Measuring Impact to Support Effective Advocacy — Collaboration Around Primary Care in the Gulf Coast[47]

National foundations, a local funder and the federal and state governments' Medicaid program joined together in the Gulf Coast region to expand, stabilize and improve the primary care safety net. The Louisiana Public Health Institute managed the Primary Care Stabilization Grant from Medicaid, which supported a team-based model for delivering health care services. A personal primary care physician leads each team, which follows patients and cuts down on the use of emergency rooms. The federal and state governments funded local groups and tied grant money to service delivery results. The groups increased their capacity to collect and analyze data about their impact.

The Commonwealth Fund supported the formation of an expert panel on payment, evaluation and quality improvement and made a grant to evaluate the work. The Robert Wood Johnson Foundation made a grant to train primary health care providers in the new systems and procedures. The local funder, Baptist Community Ministries, contributed $300,000 for an outreach campaign to advertise the new sites and services.

The results have been dramatic. "We now have 40 certified patient-centered medical homes – more than any other area in the country," says Clayton Williams [formerly of the Louisiana Public Health Institute]. "The expansion, stabilization and improvement of the primary care safety net have not been done at this level in any other state."

Medicare and Medicaid. The campaign is involving patients, their caregivers and consumer advocates in identifying models of coordinated care for people with multiple chronic conditions. Models of payment system reform accompany coordinated care to make care delivery cost-effective. Referring to those patients most in need, the campaign articulates the principle of targeted universalism in its own words: "If we can make our health system work for them, we can make it work for everyone."[50]

### WORKFORCE

Development of a workforce to deliver primary care, particularly to marginalized populations, also gets a boost from the ACA through support for graduate medical education for primary care providers, community health workers and navigators trained to help patients get what they need. The law also supports increased racial and ethnic diversity in the workforce. In addition, communities are identifying a need for advocacy and state policy changes around scope of practice

## SPOTLIGHT: Integrated Care and Consumer Involvement — The Commonwealth Care Alliance

The Commonwealth Care Alliance (CCA) is organized as a "consumer-governed care system" to ensure that the empowered consumer voice is built into all its activities. Community Catalyst, Health Care for All and the Boston Center for Independent Living were the founding partners of this service delivery model.

The alliance works to improve health outcomes for people of all ages with special health care needs, whose care is complicated and often very costly. Dr. Robert J. Master developed the model in 2003, with a two-year fellowship from the Open Society Institute.

CCA's target population includes people with complex needs covered under Medicaid and those "dually eligible" for Medicaid and Medicare, including adults 65 and older, and individuals with serious physical, cognitive or chronic mental illness.

CCA's team-based approach to care embodies several principles from systems theory critical to improving care and managing costs. These include care management by the primary care clinician along with nurse practitioners, nurses and behavioral health practitioners; care coordination by the primary care team to optimize the management of medical and psychosocial issues and promote stability; 24/7 access to care providers; clinical information systems to support the entire network and promotion of enrollee participation in care planning.

CCA data show that:

- Care of severely physically disabled Medicaid patients under the pre-paid, capitated model cost more than $1,000 less per member per month compared to Medicaid fee-for-service.
- The team approach shifted care out of hospitals.
- The overall cost of the intervention was $86 per member per month.

With advocacy, consumer involvement and integrated health and payment system design, CCA demonstrates that the care of even the costliest and most complicated patients can be managed in an efficient and cost-effective way.

*More information at http://www.commonwealthcare.org/mcaid_files/frame.html.*

laws, collaborative practice agreements and reimbursement codes so that clinicians may practice to their full levels of competence and receive appropriate compensation.

It is critical to break down the silos of medical practice and to train new practitioners on every level to work collaboratively. For example, in 1996, the city of Asheville, N.C., improved its employees' health by connecting available resources within the community. The Asheville Project combined health education and extended services by pharmacists to track patients' compliance with diabetes medication and to provide interim check-ups. Employees, retirees and dependents with diabetes had lower blood glucose levels and took fewer sick days. The mean insurance cost per patient per year showed a trend of reduction from $6,502 the first year to $2,702 the fifth year.[51] Foundations can support such innovations to make maximal use of the existing and future workforce.

With regard to workforce development, the ACA includes programs to train lower-income individuals as home care aides and for other health professions as well as support for community health workers. Area health education centers will be targeted to underserved populations. Finally, the ACA supports the development and dissemination of cultural competence training and education curricula, as well as the establishment of minority health offices within key federal agencies.[52]

Health care for racial and ethnic communities is more effective if delivered by a diverse team of providers:

> "Concordance between patient-practitioner race/ethnicity has long been recognized as a strategy for improving the quality of care. Furthermore, racially and ethnically diverse practitioners are more likely to practice in medically underserved areas and treat patients of color who are uninsured or underinsured. Diversity among health researchers is also critical to pursuing a research agenda on the elimination of racial/ethnic health disparities."[53]

Some foundations have recognized this and focus some of their health grantmaking on diversifying the health care workforce. The "Building Human Capital" portfolio and the "New Connections: Increasing Diversity" program of the Robert Wood Johnson Foundation work to develop and retain a diverse, well-trained workforce in health and health care. This funding also aims to foster new researchers and scholars from historically underrepresented communities.[54] The California Wellness Foundation has taken a comprehensive approach to increasing diversity in the health professions, making more than $15 million in grants since 2002 to California nonprofits that increase diversity in the health workforce. This funding supported a public education campaign about how diversity in the state's workforce improves the health of all Californians. The campaign also provides information on health profession opportunities for non-white youth.[55]

## TRANSFORMING PUBLIC HEALTH

Perhaps the boldest transformation of the Affordable Care Act concerns the area of public health. There now is a strong emphasis on prevention and health promotion, and building an evidence base for both. There also is support to build out the public health infrastructure, to bolster the role of health departments and to shore up the safety net, which is the medical refuge for those not eligible or unable to access health care. The ACA contains mandatory appropriations

beginning at $500 million in 2010 and increasing to $2 billion in 2015 and each fiscal year thereafter for the Prevention and Public Health Fund.[56] More than 90 organizations from the public health community, including disease groups, advised:

> "Investments in the Fund should be used in a manner that leverages change throughout the public health systems - with a move away from a stove-piped, disease-by-disease approach to one that addresses the determinants of health in a cross-cutting manner … These funds should be used for transformational investments, helping lead the nation to a more community-oriented, accountable approach to public health."[57]

Nonetheless, the need for skillful advocacy in Washington, D.C., and state capitals will remain critical to ensure that funds are allocated for community-oriented public health. Two state-based foundations have made funding decisions to improve the health of their communities and to support public health. In early 2009, the Kansas-based Sunflower Foundation began to develop and support a grassroots campaign for a statewide law to prohibit smoking in public places, which resulted in the Kansas Clean Indoor Air Act only 15 months later. The campaign demonstrated that the "public" had to be part of public health, that is, grassroots advocacy involving the people of Kansas and bringing their voices to decision makers was proven to be a critical factor in changing policy.[58]

Using its guiding principle of population-based approaches to improve public health, the Northwest Health Foundation in Oregon employed the insight that young people were simultaneously jeopardized by risky behavior and also were ready for social change. Its Community Health Priorities project helped young people focus on the interconnected nature of ensuring good health outcomes by sponsoring a photo contest and creating a website that displays original content around public health issues. Two public health professors are requiring their students to participate in these web-based conversations about public health.

The foundation also is leading an assessment of community health issues and of the capacity of the state's public health system to address those issues: "[The assessment] would … help the Oregon Health Authority articulate a comprehensive 'systems' model of the key elements of a world-class public health system for Oregon that engages a vast range of stakeholders beyond public health employees and county commissioners." The foundation recognizes that both "the engagement of youth and the assessment of a world-class public health system are long-term endeavors. They require patience, persistence and commitment to change."[59]

What the ACA adds to such efforts – a well-established and funded public health infrastructure with the ballast of federal legislative, regulatory and financial support – creates an unprecedented opportunity to attack some of the nation's most pressing health problems, including obesity, diabetes and other chronic diseases. This holds the promise of constraining medical expenditures by emphasizing population health and preventive measures that can reduce the need for expensive medical intervention.

Three state foundations in Colorado (Caring for Colorado Foundation, The Colorado Trust and The Colorado Health Foundation) catalyzed a series of steps to extend the state's public health capacity by providing start-up funding for the Colorado School of Public Health. In 2006, Governor Bill Ritter convened a panel to explore health reform options for the state and the new director of the state health department set a priority to strengthen the state's public health system. The Caring for Colorado Foundation then brought together local and state public officials to examine barriers to accessing public health services, to envision a 21st century public health infrastructure and to implement change. The legislature responded with the Public Health Improvement Act that mandated the development and adoption of the state's first Public Health Improvement Plan and the designation of a public health agency in each county.[60]

# V. Other Opportunities for Reform Across the System

## THE TRIPLE AIM: GRANTMAKER-SUPPORTED DELIVERY REFORM TOWARD INTEGRATED CARE

A movement is afoot in communities across the nation and in Europe that could help transform the United States' health delivery system. Dr. Don Berwick articulates this need:

> "We have to change the way we deliver care in productive and healthy ways to patients. Patients, especially chronically ill patients, are journeying through very complex care systems now, and we too often drop the ball. Handoffs do not go well, patients get confused, we get confused, systems are not modernized. To me, the hallmarks of the care system that we need are integration, cooperation and seamlessness. And that means change."[61]

The Institute for Healthcare Improvement (IHI) "exists to close the enormous gap between the health care we have and the health care we should have," which the Institute of Medicine terms a "quality chasm."[62]

In 2007, facing the human and financial costs and inefficiencies of a siloed health "non-system," a multidisciplinary team from IHI created the The Triple Aim initiative. It has three primary goals: to improve the health of the population, to enhance the patient's experience of care and to control the *per capita* costs of care. Though the concept initially met with resistance, its inherent social and economic soundness took hold and now approximately 60 locales in the U.S. and abroad are official "Triple Aim" sites. Together, they have formed a learning community that benefits from technical assistance by experts in process improvement.

Grantmakers have supported and continue to support the Triple Aim and its replication. In Maryland, the Health Initiative Foundation supports Montgomery County's Primary Care Coalition, one of the original Triple Aim sites.

Both the funder and the grantee employ principles of targeted universalism: the Primary Care Coalition seeks to improve individual patient experience, population health and cost control as it focuses on the county's uninsured population. What benefits the uninsured population will benefit the general population, a primary tenet of targeted universalism. What the county learns and institutes for the uninsured with regard to the coordination of care, transitions among levels and types of care, control of chronic diseases, and improved lifestyles in the care of 100,000 uninsured residents is being designed to benefit the practice of health care for all one million residents of the County.

Collaborating with the effort in Montgomery County, the Regional Primary Care Coalition located at the Consumer Health Foundation in Washington, D.C., is the Triple Aim initiative's first site representing and working in an entire region. Foundation support of this approach has been integral to its work. The coalition is funded by the

Consumer Health Foundation, The Morris and Gwendolyn Cafritz Foundation, Eugene and Agnes E. Meyer Foundation, Northern Virginia Health Foundation and Kaiser Permanente of the Mid-Atlantic. Similar to other sites, this work reflects the Triple Aim vision that "integrated care should be textured, locally adapted and under local control."[63]

## CHRONIC DISEASE AND PUBLIC HEALTH: THE BUSINESS CASE

There are multiple pathways for any health grantmaker to allocate its funds; a critical one is identifying the most effective use of limited resources. Small investments can produce huge savings. If one looks at the example of asthma, that disease stands at the intersection of public health and health care and spans the age spectrum, affecting both old and young. About 23 million people in the U.S. have asthma and it disproportionately strikes lower-income people and racial and ethnic minorities. Among preventable pediatric hospitalizations, asthma is responsible for the highest costs. Direct and indirect costs of asthma in 2007 totaled $19.7 billion.[64]

With grantmaker support from The Boston Foundation and the Kresge Foundation, the Lowell Center for Sustainable Production at the University of Massachusetts Lowell and the Asthma Regional Council of New England, located at Health Resources in Action in Boston, developed a business case for asthma education as well as for health insurance for people with asthma. Working with the Centers for Disease Control; the National Heart, Lung and Blood Institute and the Agency for Healthcare Research and Quality (AHRQ), these organizations also developed a set of best practices for asthma management. These include objective measures of lung function, pharmacologic therapy, patient education and a partnership among the patient, his or her family, clinicians and employers, and environmental control measures to eliminate "asthma triggers."[65] In this case, multi-year funding by a city-based community foundation, added funding by a major national foundation, involvement of the National Business Group on Health and assistance from federal agencies produced a blueprint for improved quality of life for millions of people and savings in billions of dollars. Proper asthma management could prevent $5 billion in costs each year.[66] Making such a business case can help foundations advocate in their states and communities for holistic, cost-saving care targeted at some of the most disadvantaged people with broad social benefits.


Similar to applying a business lens to policy, the use of Health Impact Assessments (HIAs) can improve the efficacy of health policies. The World Health Organization, the European Union and Canada have led the development of the field of HIAs. A collaboration between the Pew Charitable Trusts and Robert Wood Johnson Foundation is supporting The Health Impact Project to promote the use of HIAs as a decision-making tool for policymakers in the U.S. Health Impact Assessments:

- View health from a broad perspective, taking into account a wide range of environmental factors, such as housing conditions, roadway safety and social and economic variables.
- Consider whether there are subgroups within an affected population that may be more vulnerable to a given impact.

- Promote civic engagement by engaging community members and other stakeholder groups who will be affected by a decision.
- Present an impartial, science-based appraisal of the risks, benefits, trade-offs and alternatives involved in the decision.[67]

HIAs use a structured yet flexible process to help decision-makers advance policies that avoid unintended consequences and unexpected costs. Foundations' support of HIAs, particularly at the state level, encourages approaching health from a holistic perspective that is most efficacious for marginalized populations and ensures that policies are cost effective.

## THE SAFETY NET

The safety net in most communities comprises public clinics and hospitals, community health centers, including federally qualified health centers, "free clinics" and the uncompensated care rendered by private sector hospitals, clinics and individual providers. As numerous as the health care system's failures are, they would be magnified but for the formal and informal safety net systems.

The ACA provides $12.5 billion for expansion of community health centers and placement of health professionals in underserved areas. In addition, the expansion of Medicaid will cover many formerly uninsured patients. However, major reductions in Disproportionate Share Hospital (DSH) funds will start in 2014. DSH payments through Medicaid and Medicare provide financial assistance to hospitals serving a large number of low-income patients. Reductions in those payments will curb hospitals' ability to serve people who remain uninsured, estimated to be approximately 23 million people.[68]

These persistently marginalized populations include undocumented immigrants and those who may be eligible for coverage but refuse it or lack access to use it. It would be a mistake for foundations and others working on health equity issues to think that the problem of the safety net will be solved by health

## SPOTLIGHT: Strengthening Maine's Safety Net — Grantmakers, Public Sector and Community Partnerships Yield Tangible Health Improvements

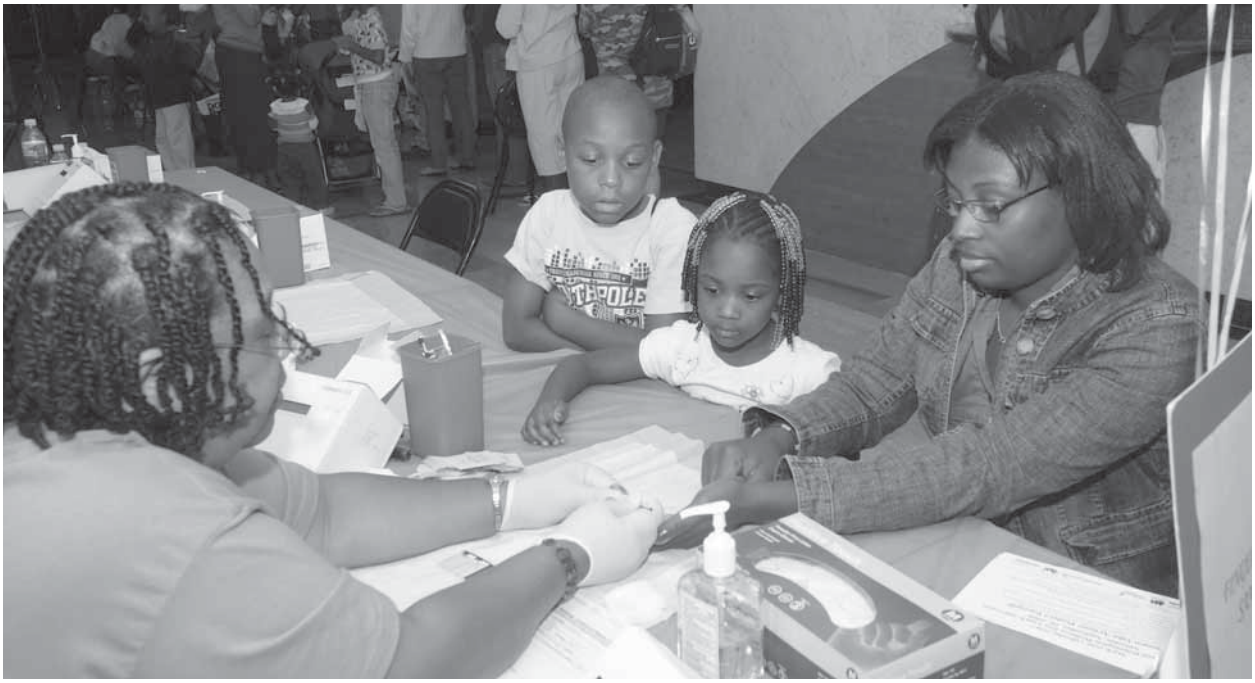
The Maine Health Access Foundation (MeHAF) commissioned a study, *Primary Care Safety Net Environmental Scan*, and talked with safety net providers and their patients to identify the key points of leverage to bolster Maine's safety net. Findings included the following needs:

- Improving access to and management of medications through partnerships with care and community service providers.
- Enhancing medication safety in Maine's critical access hospitals.
- Preserving Medicaid coverage under federal citizenship verification guidelines.
- Improving rural and low-income health care access through expansion of federally qualified health centers.
- Improving rural health care access through telehealth.
- Implementing collaborative strategies to strengthen the understanding, impact and value of MaineCare (Medicaid) for its members.

For the work to improve rural health and expand federally qualified health centers, MeHAF invested $160,000 in grants to the Maine Primary Care Association and in contracts with an experienced grant writer to help Maine's community health centers compete for federal grants. In addition, health center staff, board members, community partners and state and federal employees helped with the development of grants.

Of the seven health centers to apply for government funding, six received federal support and collectively receive $2.2 million per year. Among the six health centers receiving MeHAF support, the number of patients served grew from 35,835 to 65,107 in 2007, and an additional 161,880 medical, dental and behavioral health visits were provided. The centers also have recruited 15 new physicians, 10 new dentists and 2 new nurse practitioners.

*More information available at www.mehaf.org.*



*Christiana Care's Community Outreach team and members of the Wilmington Hospital staff were among the more than 50 hospital volunteers offering Wilmington residents free health screenings and health information at the 2008 Wilmington Wellness Day. Photo courtesy of Christiana Care Health System.*

reform. The safety net will continue to face multiple challenges that must be addressed for reform to be sustainable. It will need to improve community-based coordination of care, including referrals, working relationships among primary care, specialty care and hospitals; to improve health information technology for medical records and for tracking costs; to improve the overall experience of patients and to ensure cost effectiveness.[69]

Grantmakers can support outreach programs for the remaining uninsured, the development of delivery systems like medical homes, better referral mechanisms, efficient use of information technology and a cost containment strategy to ensure a smooth transition to a new safety net.

A significant part of safety net care is provided by hospitals with financial assistance policies. These community benefits are part of a nonprofit hospital's obligation to the community that gives it a nonprofit tax rate, a role that is reaffirmed and clarified through the ACA. The law promotes transparency about hospital care policies, billing and debt collection. Much, however, is left to interpretation and to practical implementation on the ground. Community Catalyst, a leading health advocacy group based in Boston, has clearly defined the lines between the law and its implementation and offered advice to advocates working on this part of the safety net.[70]

In Minnesota, Allina Hospitals and Clinics put their community benefits obligations into action by literally looking into their own backyard and learning to listen (see Spotlight). Allina's Backyard Initiative fulfills and exceeds its community benefit obligations to the community's safety net by addressing root causes of poor health outcomes, including social determinants and involving the voices of the community in decision making.

Aside from the exemplary funders noted in this text, this report is coupled with NCRP's evidence-driven contention that its values and principles for exemplary philanthropy could be of assistance to many other grantmakers who wish to affect health outcomes and to support the implementation of health reform. "Spotlight: First Steps Toward Transformative Grantmaking" (page 30) posits some ideas for grantmaking that reflect these principles.

# SPOTLIGHT: The Backyard Initiative (Allina) — A Community-Corporate Partnership to Improve Health in Minnesota

In the spring of 2008, as part of their community benefits work, the Allina Hospitals and Clinics looked at their backyard, the approximately one square mile around Allina's corporate headquarters in Minneapolis, Minn. Nearly half of Allina's 23,000 employees work there and some 500 live there.

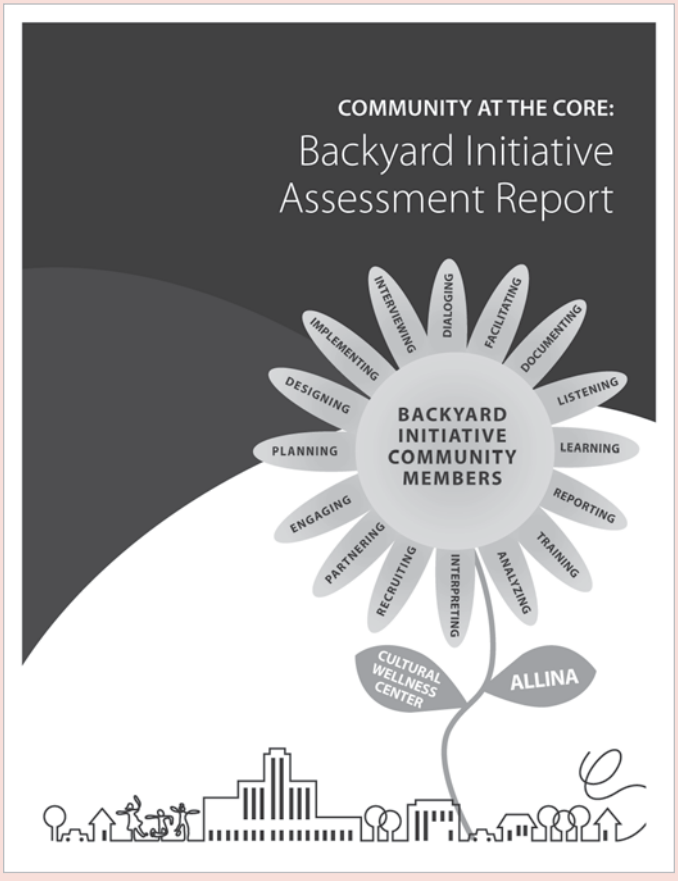
Allina also is home to one of the most racially diverse communities with a population that is 32 percent white, 26 percent African American, 22 percent Hispanic and 7 percent Native American. One-fourth of the community is foreign born. The unemployment rate is twice the state rate and 44 percent of the community is low-income.

Despite living in such close proximity to a world-class medical center, many residents experience poor health outcomes and difficulty obtaining affordable health insurance. In the process of community involvement, one member said, "We have more than we know; we know more than we say; we say more than you hear. Talking must be accompanied by listening."

Allina listened. The hospital partnered with the Cultural Wellness Center in south Minneapolis to hold community meetings in which residents developed a holistic definition of health, emphasizing the "connectedness within and among many systems – the body, the family, the community, the environment and culture."

By 2009, the initiative had developed principles that hold it together, including full participation of community residents in assessments of and decisions about their community. Allina also convened listening circles and conducted random interviews to assess the current state of health and well-being of the residents. Allina published the results in a 32-page report, which identified limitations to the residents' definition of health and set benchmarks to measure future improvements.

The Backyard Initiative became part of Allina's $50 million commitment to community health improvement, "The Center for Healthcare Innovation." The initiative embodies principles of systems theory and targeted universalism.




*More information available at: http://www.allina.com/ahs/cmtybenefit.nsf/page/Backyard_Initiative_Assessment_Report_April_2010.pdf/$FILE/Backyard_Initiative_Assessment_Report_April_2010.pdf.*

# VI. An Economic Necessity

The United States' high rate of spending on health care, now approaching well above 17 percent of GDP, irrefutably puts our nation at a competitive disadvantage in world markets. Professor Peter Morici of the Robert H. Smith School of Business of the University of Maryland contrasts the U.S. figure with that of Germany, where health care accounts for 12 percent of GDP, noting that "the United States simply can't afford that competitive disadvantage."[71]

China, too, is reforming its health care system based on a market system. "China Sees Challenge on Health System," an article in The *Wall Street Journal* from September 2010, should give any funder pause. Our health reform effort is aimed at expanding coverage to approximately 32 million people and instituting structural changes in workforce, delivery systems and public health for a price tag of up to a trillion dollars. China, the *Journal* reported, is in "the first phase of its $125 billion plan to provide affordable medical care for the entire population by 2020. China is striving by the end of next year [2011] to offer basic medical coverage to more than 90 percent of its residents. It also aims to improve the primary-care system and equalize public-health services across the nation."

The article reported that China spent more than $10 billion within the preceding year to expand basic medical coverage and provide reimbursement for medical expenses of up to 60 percent for 833 million people. Chinese Minister of Health Dr. Chen commented, "'Health-care reform is by no means an easy job for [any] country, particularly for a country of 1.3 billion people."[72]

The core challenge for the United States is to organize the health and health care sectors of American society in such a manner that they address key human concerns as factors of economic efficiency and productivity. We will continue to undermine our global economic competitiveness if we fail to do so.

The Affordable Care Act achieves something crucial in this regard because it integrates the belief of the American people in fairness with their support for the market economy. Economist Alice Rivlin, former vice chair of the Federal Reserve and former director of the Congressional Budget Office, maintains that the rhetoric of the reform debate set up a false dichotomy between advocates for market solutions, choice and competition on the one hand, and advocates for government intervention and regulation on the other: "Markets do not function efficiently unless regulations ensure that consumers have access and comprehensive choices and producers are actually forced to compete."[73]

Further, a well-implemented ACA can use the forces of competition, information, consumer support and inclusion of people of varied incomes and occupations in a revamped system that provides better health care, produces better health outcomes and costs less: "Advocates of market solutions must understand that the alternative to regulated markets is not the status quo. The status quo encourages inefficiency, uneven quality, soaring costs and declining coverage."[74] The status quo is not only untenable; it is economically perilous.

Health reform also affords the country a chance to alleviate poverty on a scale broader than what health care alone can do by integrating benefits and streamlining the access of benefits. The Centers for Medicare and Medicaid Services are supporting "vertical" connections among Medicaid, the Children's Health Insurance Program, the

exchanges and employer-based insurance with subsidies, which would intersect with "horizontal" connections among federal programs such as the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and the Earned Income Tax Credit.

The California Healthcare Foundation created and spun off a nonprofit (Social Interest Solutions) to tackle the problem of integrating benefits. Currently, Social Interest Solutions is working with the states of Arizona and Maryland to integrate their benefit systems.

Ford Foundation and the Open Society Foundations are supporting the work of the Center on Budget and Policy Priorities and the Urban Institute in similar work.

Local grantmakers can take the structural innovations being tested by their national peers and apply them at the state and the community levels. For instance, the Food Research and Action Center and partner states are developing ways to integrate access to food stamps; the Women, Infant and Children's (WIC) program; summer and school breakfast feeding programs and Medicaid. Funders can join this work by fostering links between state agencies and community-based organizations that deliver services, such as members of United Ways, area agencies on aging, child care centers or local pharmacies.

Addressing the structural barriers to accessing benefits is a matter of fairness as well as economic prudence, according to Luis A. Ubiñas, president of the Ford Foundation, who states that a 100 percent uptake in benefits would be comparable to another economic stimulus.[75]

# VII. Towards Transformative Grantmaking

This report provides several examples of foundations and health care providers that have demonstrated exemplary use of NCRP's *Criteria for Philanthropy at Its Best*. They know, as one funder articulates, "Grantmaking is not an end in itself. It is a tool. The end is transformation."[76]

Place-based initiatives, empowering communities, investing in people, supporting advocacy, organizing and the development of policy, making the business case for comprehensive approaches to care – all serve as models for support that any foundation can follow.

Health and human service foundations have played a crucial role in supplementing public sector health initiatives. Health grantmakers now face a historic opportunity to create lasting changes in one of the largest sectors of society. However, they need to act boldly.

NCRP's ongoing Grantmaking for Community Impact Project released recently its multistate report on the impacts of advocacy, organizing and civic engagement in the Northwest region. Collectively, 20 organizations working in four states won more than $5

## SPOTLIGHT: A Holistic Journey to Health Justice — the Consumer Health Foundation[78]

Despite expansion of health care access since its founding in 1996, the Consumer Health Foundation (CHF) in Washington, D.C., saw health disparities in its community increase. In response, CHF revised its mission "to achieve *health justice* as both a goal and a framework for understanding and addressing the ways in which health is determined by social, economic and political forces, including how structural racism affects the health of communities of color."

Structural racism refers to "a system of social structures that produces cumulative, durable, race-based inequalities."[79]

Five questions that CHF President Margaret O'Bryon and former Board Chair Diane Lewis answer can guide other philanthropies as they seek to adopt a more holistic understanding of health funding. The questions, with shortened answers, are:

**What motivated CHF to begin focusing on health justice to improve community health?**

- "Community Health Speak-Outs" that garnered the stories and ideas of more than 500 community members over a period of two years.
- The *Social Determinants of Health*, a public health framework, that demonstrates how social and economic factors determine the well-being of individuals and communities.
- Data, particularly from the federal government's *Healthy People 2010*[80] report, that showed a worsening gap in health outcomes between whites and people of color.

**How did CHF start the process of integrating health justice into its work?**

- CHF piloted the Racial Justice Grantmaking Assessment of the Applied Research Center and the Philanthropic Initiative for Racial Equity. This led CHF to develop a logic model and a theory of change to reflect its commitment to health justice.
- CHF created Wellness Opportunity Zones (WOZs), place-based initiatives seeking to transform a community's overall environment in order to improve health.
- CHF partnered with Grantmakers In Health to direct attention to the issue of HIV and women of color: 90 percent of women with AIDS in D.C. are black.

billion in benefits for disadvantaged groups and the broader public over the five-year time period studied. For every dollar invested in this policy engagement work, the return on investment was $150. The Washington Community Action Network (WCAN!) achieved a significant victory when it won the Washington Prescription Drug Card campaign, a multistate purchasing pool that makes prescription drugs more affordable. Had foundations not invested in this organization's policy engagement capacity, WCAN! would have faced a major resource deficiency and been unable to challenge the powerful influence of the pharmaceutical industry's lobbyists.[77]

For foundations to employ the values and principles emphasized in this report, they not only need to act more boldly in their choice of grants and grantee organizations; they also need to look closely at their own practices and internal structures. "Spotlight: A Holistic Journey to Health Justice — the Consumer Health Foundation" presents the example of a foundation on a journey to achieve justice within its own walls and to carry that justice into its community. It begins with the board and staff working as partners.

One seasoned grantmaker of 30 years, listening to a discussion of the recurring difficulties of getting poor children adequate nutrition, once remarked to the author of this report, "We *do* love the problem, don't we?" As a society, as foundations or as non-profits, the temptation may be to love the problem, whatever it is, such that one never really gets to solutions. Reaching solutions might require that one alter the definitions, advocate for shifts in power relationships or take some real risks.

Geography and certain issues betray an aversion to risk-taking: many funders avoid

**How are you addressing structural racism through your work?**

- "Changing the Conversation on HIV/AIDS," a community meeting, sought to understand HIV/AIDS as a symptom of the larger social conditions of women's lives.
- Supporting advocacy: training young people as advocates to dismantle the web of structural racism and funding more than 34 organizations to advocate for policy changes at the local, state and regional levels.

**What are the challenges involved in funding and engaging in health justice work? Is it difficult work for philanthropy to support?**

- Self-assessment is the most difficult part for any foundation. Despite all the good work, if health outcomes continue to worsen, you must start asking tougher questions.
- The board and the staff worked together to find the right path and then they looked for partners – with other funders, government, advocates and the community.
- Broadening traditional definitions of health to include social determinants such as housing and the environment, which is a challenge for philanthropy.

**What does this work look like going forward? What are CHF's short- and long-term goals?**

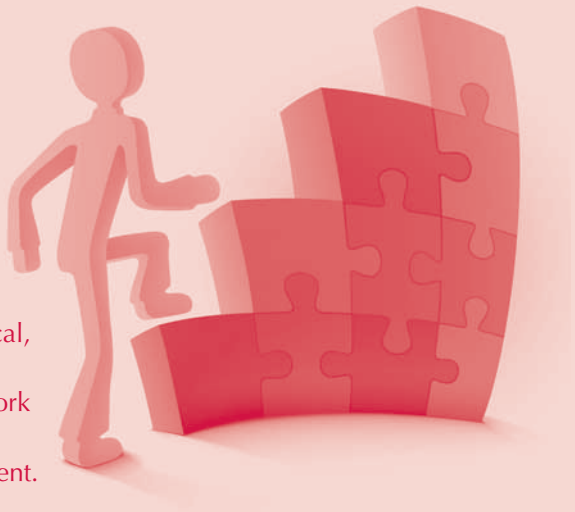
- The logic model and theory of change guide us, and we're going to put indicators and data around our short-term outcomes, but this is a long and evolving process.
- We're expecting others to join us on this journey.


*Grade school children get involved in an event by "Let's Get Healthy," a pilot project of Mary's Center for Maternal and Child Health in 2005. The project received funding from the Consumer Health Foundation. Photo by Michael Bonfigli.*

rural areas, conservative states, the South and marginalized communities, especially undocumented immigrants. While discussing risk, foundations in fact support work that will more likely bring them positive results. Ready outcomes and short-term focus are celebrated at the expense of the advocacy and community organizing work that requires patience but achieves long-term change.

In this era of global competitiveness and in the face of the United States' significant challenges with regard to human services, it is time to focus on the most disadvantaged and to support the efforts of those working in communities and with community people. The United States has the knowledge and the skills to create an efficient health care system and to eradicate inequities. Foundations can play a critical role in creating such a system.

## SPOTLIGHT: First Steps Toward Transformative Grantmaking



**1. Consider initiating "place-based" work in your community**

- Focus on a marginalized group(s) with your grantee partners.
- Listen to community members.
- Build shared purpose to encourage ongoing civic engagement.
- Confront racism and barriers to equality directly.

**2. Work collaboratively**

- Partner with other foundations, state and local government and local, state and national advocacy organizations.
- Support organizing and advocacy: find out which organizations work in your state on disparities and inequities, and health outcomes.
- Support organizations that lead the community in policy engagement.

**3. Learn about health reform activities in your state government**

- Check with state officials to see what their capacity is for implementing reform: consider providing personnel support, expert technical assistance, data gathering and analysis, help with public education and communications.
- Replicate proven approaches to community prevention and support innovation.

**4. Work on select aspects of reform**

- Ensure consumer input into the establishment of the exchanges.
- Monitor the regulation of commercial health insurance.
- Simplify and integrate eligibility systems for a range of benefits.
- Gather useful data, turning reliable analyses around quickly.
- Expand health system and provider capacity: the supply of primary care providers, scope of practice laws, team approaches to care delivery.
- Attend to the design of benefits.
- Focus on chronic disease and the dually eligible for Medicare and Medicaid.
- Improve the overall health of the population: make the business case for chronic disease and population health goals, get the public excited about a goal and pursue it.
- Focus on delivery system reform: demonstrate how improvement in the delivery of public programs can improve the entire health system.
- Community benefits: learn about the improvements through the Affordable Care Act and what your foundation can do to support a robust community benefits plan.

# VIII. Making this Report Relevant to Your Foundation

To help health funders take the necessary steps toward exemplary and responsive grantmaking, health grantmakers and other funders can consider the following questions for discussions within their organizations and among their colleagues:

- Does your foundation find systems theory and systems thinking useful in thinking about health outcomes and health care in your community and state? How can systems thinking used by health funders help counteract the fragmentation of the health care system?
- What marginalized communities exist in your catchment area? Are there any communities that funders in your area have not approached? Has your foundation ever supported convenings, community meetings or retreats?
- What percentage of your grant dollars is used to intentionally benefit underserved populations? How does that compare with exemplary grantmakers in your field?
- Does your foundation support community organizing? Are you familiar with the organizing groups in your area and have you sought them out to learn about their work? What are the obstacles that may hold you back from supporting organizing?
- Does your foundation support advocacy? If not, have you ever sought out the advice of other funders and national organizations that do support advocacy? What type of health care advocacy organizations exists in your state and community?
- Have you turned to local or state experts for information on the health reform law? What is your state's position on the implementation of the ACA? How can you find out? Does your foundation have a position and is it public?
- Do you see connections among national advocacy, statewide advocacy and local implementation? What national foundations are working in your state on health reform or on improving health in communities?
- Does your foundation support civic engagement? If so, what forms does the support take? If not, please consider why not.
- Does your foundation reflect the values of full participation and inclusion of everyone within its own walls? Do the board and staff work toward common goals? Do they work in the context of mutual respect?
- What other foundations does your foundation communicate and collaborate with? Does your foundation seek information and insight from established resources such as your local regional association of grantmakers or organizations like Grantmakers In Health?

## CURRENT TRENDS IN HEALTH GRANTMAKING

To help inform those discussions, NCRP conducted a detailed analysis of the most recent data available from the Foundation Center about domestic health grantmaking. It examined 880 foundations that made grants to domestic health over a three-year period from 2007-2009. NCRP worked with custom datasets developed with the Foundation Center, which include detailed information on more than 1,200 of the largest foundations in the United States. The search sets are based on the Foundation Center's grants sample database, which includes all grants of $10,000 or more awarded to organizations by a matched sample of 880 larger founda-

tions for circa 2007–2009 that made grants classified as supporting health. For community foundations, only discretionary and donor-advised grants are included. Grants to individuals are not included in the data. The Foundation Center's grants sample database represents at least 50 percent of U.S. grantmaking, allowing for broad field-wide trends to be gauged.

Grants were analyzed by intended beneficiary to determine the proportion of them that were classified as intending to benefit "marginalized" or "underserved" populations.[81] Further, grants were analyzed using the Foundation Center's "social justice" screen to determine, as closely as possible, which health grants had systemic change as a goal and, as such, likely included funds for advocacy, community organizing and civic engagement.

All figures presented in the analysis of health funding below represent a three-year average of giving from the 2007–2009 timeframe. NCRP uses a three-year average in its data analyses to avoid the influence of potential outliers, e.g., a large grant made only in one year that could influence the data. It then examined only those grantmakers that made an average of $1 million or more annually in grants for health over the three-year period to see if patterns held among larger health grantmakers.

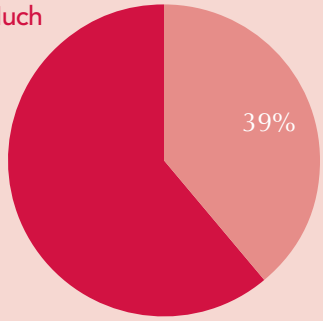
In the aggregate, the 880 foundations in the sample granted out an annual average total of $14,721,830,985. Of this, a total of $2,600,230,665 was coded for domestic health, comprising just under 18 percent of their total giving. Total average giving by the 363 grantmakers who made at least an average of $1 million in domestic health grants annually was $10,469,768,342, of which $2,451,179,600 was granted out for domestic health. For this subset of funders, health grants accounted for nearly one-quarter of their total giving in the time period analyzed.

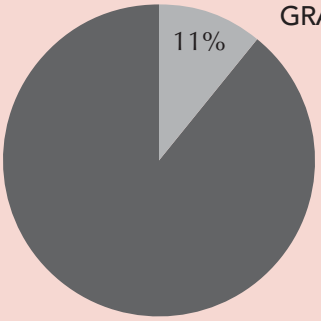
Among the 880 grantmakers in the sample, 274 foundations or 31 percent of the sample met the 50-percent threshold for giving intended to benefit disadvantaged groups and 39 of these grantmakers (4 percent) clas-

## TABLE 1: NCRP Analysis of Health Funding

| | Full sample | Sample foundations giving an average of $1 million or more annually for domestic health |
|---|---|---|
| Number of Foundations | 880 | 363 |
| Total Average Grant Dollars | $14,721,830,985 | $10,469,768,342 |
| Total Average Grant Dollars to Domestic Health | $2,600,230,665 | $2,451,179,600 |
| Percentage of Total Average Grant Dollars to Domestic Health | 17.66% | 23.41% |

GRAPH 5: How Much Domestic Health Grantmaking Goes to Benefit Marginalized Communities?



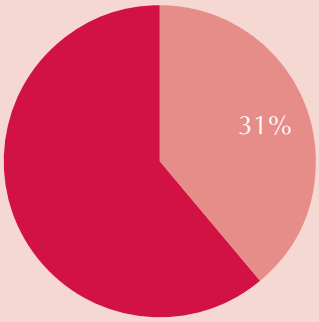



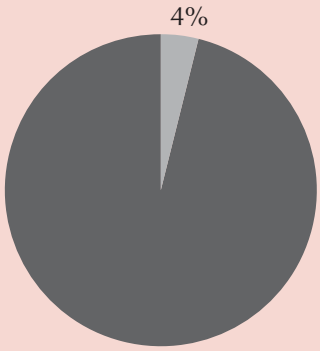

GRAPH 6: How Much Domestic Health Grantmaking Goes to Social Justice?

# TABLE 2: How Many Foundations Meet NRCRP's Benchmarks on Support of Marginalized Communities and Social Justice?

| | Full sample | Sample foundations giving an average of $1 million or more for domestic health annually |
|---|---|---|
| Number of Foundations | 880 | 363 |
| Number of Foundations Contributing 50% or More of Domestic Health Grant Dollars to Benefit Marginalized Communities | 274 | 101 |
| Number of Foundations Contributing 25% or More of Domestic Health Grant Dollars to Social Justice | 39 | 25 |
| Number of Foundations Meeting Both Benchmarks | 35 | 22 |

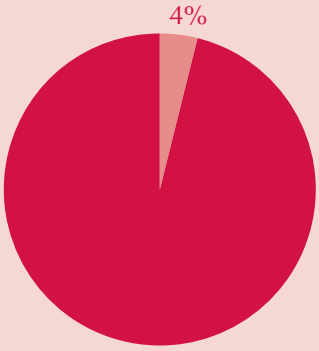
GRAPH 7: How Many Foundations Provide Half of Domestic Health Grant Dollars to Benefit Marginalized Communities?

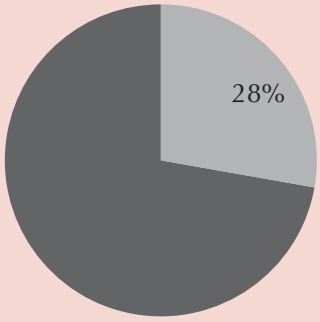



GRAPH 8: How Many Foundations Provide 25% of Domestic Health Grant Dollars in Social Justice?

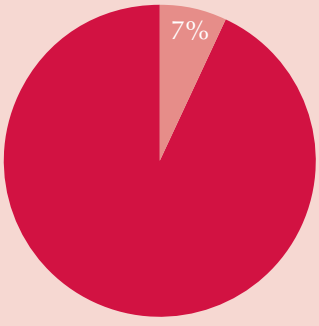
GRAPH 9: How Many Foundations Meet Both Benchmarks?

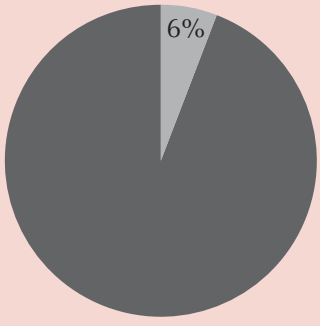



GRAPH 10: How Many Foundations with at Least $1 Million in Annual Domestic Health Grantmaking Provide Half to Benefit Marginalized Communities?

GRAPH 11: How Many Foundations with at Least $1 Million in Annual Domestic Health Grantmaking Provide 25% in Social Justice?




GRAPH 12: How Many Foundations with at Least $1 Million in Annual Domestic Health Grantmaking Meet Both Benchmarks?

sified 25 percent or more of their domestic health grant dollars as serving a social justice purpose. In this group, 35 foundations (4 percent of the sample) met both metrics. (If you want to know how your foundation scores on these benchmarks using Foundation Center data, contact research@ncrp.org and NCRP will be happy to share with you the data concerning your foundation.)

Among the 363 grantmakers that provided at least $1 million in average annual health grant dollars, 101 foundations or 28 percent of the sample met the 50 percent threshold for giving intended to benefit disadvantaged groups and 25 of these grantmakers (7 percent) classified 25 percent or more of their domestic health grant dollars as serving a social justice purpose. Of funders that provided an average of at least $1 million for domestic health each year, 22 foundations or 6 percent of the sample met both metrics (a full list of these grantmakers is provided below). It appears that larger health grantmakers (those making more than $1 million in average annual health grants) are slightly more likely to meet both benchmarks than sample foundations generally.

These 22 exemplary funders exhibit strategic grantmaking in action, demonstrating that the metrics NCRP proposed are both achievable and sustainable. Moreover, the 22 funders represent variable types of foundations – independent, family,[82] corporate and health conversion foundations,[83] suggesting that the metrics are adaptable, regardless of institutional type.

- BlueCross BlueShield of North Carolina Foundation
- The California Endowment
- The California Wellness Foundation
- The Caring Foundation (Ala.)
- The Annie E. Casey Foundation
- The Colorado Trust
- The Nathan Cummings Foundation
- The Educational Foundation of America
- Endowment for Health, Inc.
- Ford Foundation
- Richard and Rhoda Goldman Fund
- The William and Flora Hewlett Foundation
- W. K. Kellogg Foundation
- The John D. and Catherine T. MacArthur Foundation
- The John Merck Fund
- Charles Stewart Mott Foundation
- Open Society Foundations
- The David and Lucile Packard Foundation
- Public Welfare Foundation, Inc.
- Quantum Foundation
- The Retirement Research Foundation
- The Rockefeller Foundation

These are not, of course, the nation's only exemplary health funders. Some of the best health funders are too small to be included in the Foundation Center's data. And some remarkable larger funders do not meet the benchmarks but nevertheless do great work. The point is to add some rigor and some benchmarking to the discussion, so that all health funders can be more strategic and more responsive.

NCRP's principles from *Criteria for Philanthropy at Its Best* were meant to apply to an entire foundation's activities, not only to one program area. But considering the disparities in health and health care described throughout this report, it is encouraging that a solid proportion of foundations are operating in ways likely to produce the greatest impact.

NCRP is truly pleased at the high levels of priority that health grantmakers appear to place on funding for disadvantaged pop-

Considering the disparities in health and health care described in this report, it is encouraging that a solid proportion of foundations are operating in ways likely to produce the greatest impact.

ulations and policy engagement work. Some funders, for example, may employ these strategies – targeted universalism and systemic change approaches – but may do so with a relatively small portion of their health grant dollars. Knowing these percentages might help a foundation make better decisions.

Presented below in alphabetical order are profiles of five of the 22 exemplary grantmakers. They dedicated at least half of their average annual grant dollars for domestic health to explicitly benefit underserved populations, and at least one-quarter for "social justice" purposes, suggesting a commitment to systemic change and a high priority being placed on advocacy, community organizing and civic engagement work. NCRP is highlighting these five grantmakers because they represent different types of institutional grantmakers (private, health-conversion, corporate and family) and are spread across the country.

Some of these exemplary grantmakers have an explicit focus on health, while others made health grants that complement different priority areas within their portfolios. There are multiple entry points to being a health funder, and the issues facing underserved populations are complex, interrelated and multifaceted.

## THE NATHAN CUMMINGS FOUNDATION

New York, N.Y. • www.nathancummings.org

Founded in 1949, the work of The Nathan Cummings Foundation (NCF) is "rooted in the Jewish tradition and committed to democratic values and social justice, including fairness, diversity and community. It seeks to build a socially and economically just society that values and protects the ecological balance for future generations; promotes humane health care and fosters arts and culture that enriches communities."

Working across multiple issues, this private family foundation's goals for its health grants are to ensure access for all Americans to high quality and affordable health care

and to create a healthier, more equitable and sustainable quality of life. Its three objectives include: health access, environmental health and capacity building. NCF demonstrates a real understanding of the intersection of variable strategies and tactics needed for long-term, systemic reform and thus supports institutional reform and policy engagement work to meet its first objective.

For example, in 2008, NCF provided a $255,000 grant to the Center for Rural Affairs in Lyons, Neb., to broaden and enrich rural engagement in the public debate over ensuring access to high quality, affordable health care for all. Rural America faces a unique set of challenges: residents have less access to health networks and providers, greater rates of disability and chronic disease, less employer-provided health coverage and higher usage rates of use of all public health care programs than other Americans. With sustained funding, NCF has helped the Center to leverage and expand its network and enabled it to play a key role in advocating for improved health outcomes for rural populations in the Midwest and plains states. This is exemplary philanthropy because it recognized the special needs of a specific constituency often overlooked in all grantmaking and provided sustained funding to build local capacity, thereby ensuring continued success.

NCF's health program director, Sara Kay, explains this grantmaker's decision to fund intentionally the work of a rural group:

> "The 50 million people in rural America had not, for the most part, been directly engaged by the major consumer advocacy groups working on structural reform issues. The Center for Rural Affairs has tremendous credibility on a range of rural issues among policymakers, advocates and the public from its many years of working on the farm bill and other agricultural development matters, but it had not previously worked on health care issues. Recognizing its nascent capacity to contribute to health improvements, Nathan Cummings gave the center one of its first health care grants."

## THE ENDOWMENT FOR HEALTH

Concord, N.H.
www.endowmentforhealth.org

Founded in 1999, the Endowment for Health works "to improve the health and reduce the burden of illness for the people of New Hampshire – especially the vulnerable and underserved." This health conversion foundation focuses on the health needs of marginalized communities because of its values. Foundation President James Squires notes, "We have a set of six values that were created four years ago by the board and staff. The result was an ethical foundation that guides all of the endowment's work. Our values of integrity, stewardship, fairness, respect, compassion and courage are universal and inform everything we do."

Vice president and COO Mary Vallier-Kaplan expanded on the importance of the foundation's values, stating that this links with the organization's funding of advocacy, organizing and civic engagement work. As Kaplan states, "Policy engagement work on behalf of vulnerable communities requires courage. We feel it's a responsibility and it's what philanthropy is uniquely able to do, compared to other sectors. While the money we invest in projects is important, leveraging our voice has become a tool far greater than we anticipated."

This leveraging of voice is elucidated in the foundation's funding of the In SHAPE program. The Endowment for Health was approached by a local nonprofit community mental health leader who shared his concern that the average life expectancy of his clients with severe mental illnesses was 20–25 years less than for healthy individuals. Realizing the myriad ways in which mental illness limits life opportunities and leads to premature death, the foundation shared this leader's sense of responsibility to address this disparity and took action, says program director Jeanne Ryer. The mental health center funded by the foundation created a reimbursable Medicaid model that is being replicated in many states. It brought together a range of partners, including the Robert Wood Johnson Foundation, the Substance Abuse & Mental Health Administration (SAMSHA) and the National Institute for Mental Health (NIMH), which saw the potential of partnering with a local funder to develop a scalable model. The project worked with community groups such as the local college and YMCA to help those with severe mental illnesses take charge of their own health, integrate into community life and help alleviate the persistent stigma attached to mental disability.

Vallier-Kaplan noted the numerous partnerships across different levels that evolved from this work – local and national philanthropies, public and private sectors, local leadership and clients of the mental health center worked together to develop what is expected to become a nationally reimbursable model.

"This is the core idea – it's the role of a foundation that realizes there's a population that doesn't receive fairness, respect and compassion," says Kaplan, tying this work back to the foundation's values. "A foundation should take risks with a population that isn't one that people naturally want to deal with in an integrated approach."

Noting the importance of including community advocacy groups and constituents from the outset, she added that the work required patience and persistence. "We invest $400,000 a year to provide operating grants

with five-year commitments to statewide advocacy, knowledge and capacity building organizations early on because these organizations shouldn't go off-mission. We trust them. Everyone else in the system needs them."

Working in true partnership with its grantees, Ryer adds, "If a small funder can do this, it shows larger ones the importance of trust and community engagement as a tool to advance social inclusion through health grantmaking."

## THE W.K. KELLOGG FOUNDATION

Battle Creek, Mich. • www.wkkf.org

The W.K. Kellogg Foundation's mission is to support "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." Health grantmaking comprises more than one-fifth of its total grantmaking portfolio.

The foundation adopted recently a new framework for its programming that acknowledges explicitly the complexities and interrelated issues such as health education and employment that impact the chances of changing life opportunities for vulnerable children. This new framework includes programmatic foci on food, health and well-being coupled with an explicit focus on eliminating structural racism in pursuit of racial equity. Kellogg emphasizes the importance of community engagement to create long-term solutions to systemic problems and encourages civic engagement and democratic participation to this end. The new framework aims "to help children face the future with confidence, with health and with a strong-rooted security in the trust of this country and its institutions."

Dr. Gail Christopher, vice president for program strategy, oversees the foundation's Food, Health and Well-Being work in addition to its racial equity efforts. Discussing Kellogg's food systems reform work, she notes that while it was previously a separate programmatic area, it is now coupled intentionally with the health program's work because the two are interconnected.

The Food and Community Program involved working in nine communities where a significant portion of the funding was for community organizing. In Oakland, young people and residents conducted an environmental scan of available food to determine the cost and availability of healthy foods. In Seattle–King County, youth developed a food table where they convene 30-40 young residents on a weekly or monthly basis to eat a meal together and develop strategies for improving access to healthy foods collectively. In New York and Boston, the foundation focuses on local farmers and ensuring the availability of healthy food in urban areas and schools.

"It's about being fair to producers and providing access to healthy food alternatives to people and communities regardless of income," says Dr. Christopher. "You can talk about obesity reduction but if you don't talk about it in the context of communities, it's a 'disease conversation'; we have medicalized a problem that is in fact a social justice issue that has some medical and public health dimensions, which brings us right to the social determinants of health," she adds.

W.K. Kellogg-funded Place Matters work

"We have medicalized a problem [obesity] that is in fact a social issue that has some medical and public health dimensions, which brings us right to the social determinants of health."

— Dr. Gail Christopher, Vice President for Program Strategy, W.K. Kellogg Foundation

"You have to marry social services with advocacy in health grantmaking; the social determinants of health are far too important to use an either/or approach."

— Ms. Ilene Frye, Executive Director
The Retirement Research Foundation

at the Joint Center Health Policy Institute referenced earlier in this report involves 21 communities nationwide in partnerships that apply the social determinants of health to improve health outcomes in areas articulated by the communities.

Discussing the link between the foundation's racial equity and health work, Dr. Christopher emphasizes the importance of framing. They are working to remind people that the racial dynamic, the lack of racial equity is a life and death issue. "It's a health issue too, which we call disparities," she says. "One of the reasons that the equity work is framed as racial healing work is that people have to come to a willingness to see the urgency and the persistence of the attitudes and perceptions that lead to the structural realities, and they have to have the willingness to do the work to change that. This requires a change of heart."

## THE JOHN MERCK FUND

Boston, Mass. • www.jmfund.org

Founded by Serena S. Merck in 1970, The John Merck Fund is a family foundation named for her son. Its sole founding mission was addressing children's developmental disabilities. Sixteen years later, the fund expanded its foci to include climate and clean energy issues, a special Rural New England program and environmental health. The John Merck Fund embodies exemplary philanthropy by focusing on vulnerable groups explicitly and recognizing the interrelated systems confronting its constituents that influence their health.

The fund's Environmental Health Program focuses on preventing exposure to chemicals linked to negative health outcomes. The fund's work on mercury pollution through coal-fired power plants revealed that the commercial sector of the United States has more than 80,000 chemicals and that they are not isolated to industrial sites. Rather, they are ubiquitous in consumer products and the environment, allowing hundreds of these toxins to end up in our bodies. Shockingly, these chemicals are even found in newborn babies.

Compounding this situation is the fact that the government regulates chemicals in a "one-by-one approach," reinforcing the need for a systematic approach to regulation, similar to those in Europe and Canada. The fund set a goal of developing a comparable policy for the United States to ensure that no chemicals would be marketed until proven safe, with the responsibility for ensuring public safety lying with the manufacturer and not on the public sector. This goal was well-aligned with the fund's traditional interest in ameliorating developmental disabilities, as scientific research revealed additional correlations between chemical exposure and health problems ranging from Parkinson's and Alzheimer's diseases.

The fund devised an advocacy and policy strategy that engaged health advocacy organizations across campaigns in six states (Maine, Washington, Massachusetts, Connecticut, Michigan and Minnesota). In 2008, a broad

campaign of women's advocates, farmers, small businesses, health advocacy groups and many others, The Alliance for a Clean and Healthy Maine, led by Maine's Environment Health Strategies Center, resulted in the Kids Safe Products Act, the first law in the nation to approach chemical regulation in a comprehensive way. This law is a model for legislation pending currently in the U.S. House and Senate.

The fund demonstrates an understanding of the complex and interrelated systems that marginalize Americans and jeopardize their health. Ruth Hennig, executive director of the fund, explains, "Health is a huge motivator. Protecting your health and that of your family members is a critical goal for people across the board. If you've had a life-altering disease, you're even more motivated to understand why this happened and to prevent others from having the same unfortunate experience. Prevention is a strong motivating force."

The John Merck Fund's focus on prevention, systems reform, the appropriate balance of service provision and advocacy and funding of collective organizing demonstrates a long-term commitment to sustainable health improvements and aligns well with implementing provisions of the Affordable Care Act.

## THE RETIREMENT RESEARCH FOUNDATION

Chicago, Ill. • www.rrf.org

The Retirement Research Foundation is an independent grantmaker that has awarded grants nationwide totaling nearly $200 million since 1978. Like many funders that have made the decision to focus on vulnerable communities and to support advocacy, the foundation traces these commitments to its founder. Established in 1950 by John D. MacArthur, the foundation initiated grantmaking upon his death in 1978. MacArthur made a "very forward-thinking" decision, says Executive Director Irene Frye, choosing to center its work exclusively on the needs of the elderly. The choice proved prescient, with the first Baby Boomers reaching retirement age today, and people over 85 years of age comprising the fastest growing segment of the U.S. population.

The foundation's original mission charged it to address work-related problems confronting retirement age individuals "all for public welfare and for no other purpose." Advocating for policy change to correct injustices played an important role at the founding. One of the foundation's first goals was to "support selected basic, applied and policy research that seeks causes and solutions to significant problems facing the aged."

Recognizing that the issues confronting retirement-aged constituents are multifaceted and complex, the foundation's trustees refocused the mission in 2008 to concentrate especially on those who – for reasons of physical frailty, economic disadvantage or racial or ethnic disparity – are particularly vulnerable. Current foundation staff explained that "The board has retained the moral imperative that the quality of a society can be judged by how it treats people toward the end of life," says program consultant Naomi Stanhaus.

Further, while the elderly comprise some 13 percent of the population, Frye notes grants in aging account for a mere 2 percent of philanthropic dollars. In surveying the landscape of existing funding, the foundation determined that it could do more by focusing on advocacy.

The foundation's approach to its grantmaking is exemplary in many ways, particularly in its strategic and intentional comingling of service delivery with policy advocacy. It supported the coalition work of Make Medicare Work and the Center for Medicare Advocacy, using experiences of its constituents to identify training needs and drive successful policy advocacy. As Frye stated, "You have to marry social services with advocacy in health grantmaking; the social determinants of health are far too important to use an either/or approach. Moreover, it isn't just advocacy by one foundation that will result in long-term systemic reform that benefits our constituents. It's collective advocacy that will ensure that the needs of

vulnerable elderly community members are met in the future."

The foundation recognizes that a certain level of risk-taking is associated with funding advocacy. However, as Frye stated, "Even when our assets took a hit recently, we continued providing substantial funding for policy/advocacy work. There's also a business case to be made for getting involved in funding in this way – the high return on investment. When you help one person, you help one person. The whole opportunity of philanthropy is to change things for many for the long-term."

# IX. Conclusion

The health of the United States in its broadest sense is in jeopardy. The number of uninsured Americans is at a record high, and poor health outcomes are devastating the physical and economic fabric of the American people. Our most disadvantaged people continue to be treated poorly, including by our health care system. What we choose to do about health outcomes and the health system is a major factor in how we will emerge from the current economic crisis.

The American economy, private sector businesses and American families are at an unsustainable level of health care costs, individually, socially and in the aggregate, because of a fragmented system. In relinquishing so many to poor health outcomes and in continuing to cost so much, the system harms the American workforce and weakens the country's ability to recover. The inefficient and costly system was the impetus for comprehensive health care reform legislation. It is our responsibility and opportunity to fix this broken and inequitable way of organizing health care. As we fix the system, we need to enable communities to develop and use their knowledge and wisdom to lead healthier lives.

When government functions resolutely and effectively in the interest of the public, money is saved and community needs are met. More than thirty years ago, for example, the state of Maryland instituted an all-payer system for hospitals. The legislature left leeway for hospitals and providers to work out the details, but required them to work together under the regulation of a state agency.[84] If the United States had instituted equally effective legislation at the same time, it would have saved $2 trillion in hospitals costs.[85] In 1997, the federal government started the State Children's Health Insurance Program that has given coverage and care to millions of children throughout the country.

Government can work effectively and we need it to. Philanthropy needs to support and encourage the role of government to work in the public interest and to support people's participation in government at all levels. As communities are organized and empowered, they come to believe that policy engagement is worthwhile. Their faith in the public sector's ability to respond to their needs could also be restored.

Foundations of all kinds have an unprecedented opportunity to help address disparities in health and health care, and to supplement public sector implementation of the new law. Philanthropies experience a higher degree of freedom than most organizations, and with that freedom comes a profound responsibility to help reverse the trends of health inequality and to reinvest our health system with the American ideals of fairness, justice and inclusion.

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85. Robert Murray, "All Payer Bundled Payment Strategies, A Roadmap to Accountable Care Organization Development and Quality Improvement," Institute for Healthcare Improvement Executive Quality Leaders Network, October 8, 2010.

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*A Philanthropy at Its Best® Report*

# TOWARDS TRANSFORMATIVE CHANGE IN HEALTH CARE

## High Impact Strategies for Philanthropy



"This report presents an exciting vision for health philanthropy grounded in values of equity, racial justice and opportunity. It tells a powerful story of how foundations across the country are actively involved in deep and long-term work to change systems at the local level, using all of the tools at their disposal. And, most importantly, it presents a clear pathway for all of us in all of our communities to join this movement."

—Margaret O'Bryon, Consumer Health Foundation

"NCRP's report provides a blueprint with clear direction on what the philanthropic community can do to ensure that health equity is realized. NCRP recognizes the necessity and urgency of bringing marginalized communities to the decision-making table by building a platform for advocacy and civic engagement that operates at the national, state and local levels."

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"NCRP's new report describes concretely how its principles for effective philanthropy can be operationalized to promote transformational change. At this critical time created by passage of health reform, it points the way for bold action by health funders to reduce health inequalities and build a high-performing health system."

—Lauren LeRoy, Grantmakers In Health

Despite billions of philanthropic grant dollars each year being dedicated to health issues, Americans rely on an inequitable health care system that is fragmented, inefficient and costly. The consequences of allowing this ineffective system to perpetuate have led to where health outcomes are determined by social factors such as geography, wealth, race and gender. Can health philanthropy be more effective at deploying its limited resources to address this crucial but broken system? *Towards Transformative Change in Health Care* offers two high impact strategies for grantmakers to more effectively achieve their missions and help address disparate health outcomes resulting from unequal opportunities. It recommends focusing on the unique needs and circumstances of all communities, especially those that remain underserved, and funding heavily advocacy, community organizing and civic engagement for systemic reform.

This is the second in a series of reports from the National Committee for Responsive Philanthropy (NCRP) that invites grantmakers focused on specific issues to rethink their funding strategies to generate the greatest impact. A report on education philanthropy was published in October 2010. Future reports will be for funders concerned about the environment and the arts.

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