bridging sectors, improving health

Building bridges to improve health is not simply a cliché. It is a necessity for those working to reverse conditions that give rise to illness rather than promoting good health. The challenges for health grantmakers in building relationships outside of the health sector can be complex, but no more complex than the issues facing those whose lives they hope to improve.

Working across sectors can take many forms: health funders can work with funders, opinion leaders, or leading organizations from other sectors; they can work with government agencies, whether local, state, or federal; they can participate in networks and coalitions. Whatever the form, cross-sectoral work is a way for health funders to leverage their interests and influence program budgets to improve health outcomes. Through it, funders can both address specific health issues that by their nature involve multiple sectors and integrate health objectives into other domains such as education, criminal justice, transportation, and housing. Although these working relationships are challenging, there is good evidence of their effectiveness and ability to produce real and lasting change.

CROSS-SECTORAL HEALTH PROBLEMS

Most health problems that foundations choose to tackle – from obesity, to disparities, to chronic disease, to access – are multidimensional in their causes, effects, and cures. When health funders make strategic decisions to work across sectors and institutions, while maintaining their focus on health outcomes, they expand their capacity to change the forces that work against health. The experience and treatment of mental illness are illustrative of the reality of health problems that cross sectoral borders and resist sector-specific solutions.

It is estimated that 25 percent of Americans annually experience mental health problems ranging in severity from temporary psychological distress to serious depression, schizophrenia, and bipolar disorder (Kessler et al. 2005). Yet, despite the large numbers of people affected by mental illness, the mental health system is fragmented and scattered. With little coordination or information sharing, health care providers, schools, social service programs, prisons, and government agencies make critical decisions about the services people receive (LeRoy et al. 2006). To make matters even more complicated, the services within these sectors that can affect the health of the mentally ill – health care, housing, employment, and education – are similarly uncoordinated.

Imaginative collaboration both within and outside the health sector is required to successfully address the needs of the mentally ill. One example is the $24 million Special Opportunities in Mental Health funding initiative of The California Endowment. The goal of the initiative was to promote innovative, culturally responsive approaches to reaching underserved individuals and communities. Involvement of cross-sectoral stakeholders (such as consumers, parents, religious leaders, and health and human service providers) was fundamental to its design. Over four years, the initiative served 95,000 Californians through partnerships that heightened awareness of community needs; facilitated resource sharing, outreach, and referral; and enhanced capacity to deliver mental health services. Most important, the endowment found that successful partnerships helped reduce system fragmentation and increase program sustainability (The California Endowment 2004).

The homeless are another population for whom cross-sectoral collaboration is imperative. In addition to their shelter needs, homeless adults are very likely to also have a variety of chronic health problems such as heart disease, cancer, tuberculosis, HIV/AIDS, mental illness, and alcohol or drug addiction. Among the sectors involved in addressing their needs are shelters, health care providers, social services, community health programs, mental health providers, and the criminal justice system. To meet these needs effectively requires collaboration and coordination of municipal agencies, nonprofit organizations, and advocacy groups (New York City Departments of Health and Mental Hygiene and Homeless Services 2005).

One foundation effort to meet the challenge is a plan launched in Denver by The Colorado Health Foundation, along with The Colorado Trust, The Piton Foundation, the Bonfils Stanton Foundation, and The Denver Foundation. Based on the Housing First model, the plan aims to end homelessness by providing comprehensive services including housing, mental health and substance abuse treatment, and job training. In its first year, the plan accomplished several goals including developing over 200 affordable transitional housing opportunities, adding over 100 temporary emer-

gency shelter beds, providing anti-discrimination training to local agencies, increasing coordination between treatment providers, and increasing the number of outreach workers to assist the homeless.

CROSS-SECTORAL HEALTH DETERMINANTS

Another reason to work cross sectorally is to address health problems in terms of their larger determinants. Health care services are vital when people are sick and need them to recover, but it has been well documented that health care is not the most important factor in population health. In fact, health is influenced by factors in five domains – genetics, social circumstances, environmental exposures, behavioral patterns, and health care. When it comes to reducing early deaths, health care has a relatively minor role, contributing about 10 percent. Thus, even if the entire U.S. population had access to excellent health care, only a small fraction of deaths could be prevented. The single greatest opportunity to improve health and reduce premature deaths lies in personal behavior, followed by social circumstances and environmental exposures (Schroeder 2007; McGinnis et al. 2002).

One way to visualize the role factors outside of health care play in relation to individual health is the World Health Organization model, which places biological and genetic factors at the core of health, surrounded by layers of influence that include personal lifestyle; connections to others (social and community networks); and the broader environment of education, employment, environmental quality, housing, and health care (Organisation for Economic Co-Operation and Development 2003).

The connections between personal health and larger determining factors are particularly evident in the lives of the poor. When people have limited incomes, live in conditions of personal stress, are exposed to poor quality air and water and other environmental pollutants, and have limited access to healthy food, their health suffers. The poor tend to be employed in jobs that carry an increased risk of occupational exposure to hazardous materials. They are likely to live in the least desirable neighborhoods, which are characterized by older housing stock and close proximity to sources of environmental risk such as highways, dumps, and heavy industry. Childhood lead poisoning, injuries, and respiratory diseases such as asthma have been linked to the more than six million substandard housing units nationwide. Residents of these units are also at increased risk for electrical injuries; falls; rodent bites; and exposure to pesticides, tobacco smoke, and carbon monoxide.

Knowing that health, especially the health of vulnerable populations, is the product of so many factors that lie outside the health sector itself, funders who wish to have a significant impact on health and well-being must look for ways to influence the broader behavioral and social realms that include education, employment, income disparities, poverty, housing, crime, and social cohesion (McGinnis et al. 2002). They must be prepared to take a perspective that includes forming partnerships both within and outside the health care system. Thus, although access and coverage continue to be a top priority for many funders, it is also necessary to go well beyond the doors of hospitals and clinics to address areas outside the health sector where the potential exists to improve population health.

An interesting example of cross-sectoral funding that addresses both service delivery and environmental factors affecting health is a grant from the Allegany Franciscan Ministries to the Farmworker Association of Florida to support education and advocacy to improve the health and safety of low-income, minority, migrant, and seasonal farmworkers. Working in partnership with lawmakers and community organizations, the Farmworker Association of Florida's program provides pesticide trainings, reports violations of worker protection standards, distributes bilingual educational materials, and accredits health care provider training related to farmworkers' health problems.

Another effort that works with partners across many sectors is the Minnesota Environmental Initiative, funded by the Blue Cross and Blue Shield of Minnesota Foundation. The initiative, which includes state and county public health departments, schools, the American Lung Association of Minnesota, and bus contractors, is retrofitting Head Start buses to reduce exposure to diesel emissions for Head Start children in two counties. The project is expected to help improve children's overall health by reducing

We focus here primarily on funders working cross sectorally, but the needs and challenges of this work also extend to their grantees. Funders are in a position to learn about collaborative opportunities from their grantees and to facilitate grantees' efforts to build connections with organizations in other sectors.

absenteeism resulting from asthma and related illnesses and to improve air quality in the communities in which the buses operate.

WORKING ACROSS GEOGRAPHIC BARRIERS

An important dimension of cross-sectoral work involves surmounting geographic barriers. A recent report by the Joint Working Group of the Council on Foundations and the European Foundation Centre notes:

> International philanthropy is growing rapidly, in response to an increasingly globalized, interdependent and interconnected world in which the challenges posed by health, demographics, housing, and natural resource crises, and a growing gap between rich and poor, along with other societal problems are all too apparent. It is a world in which many "domestic" issues have international roots and require a global perspective in order to be dealt with effectively (2007).

The domestic-international connection is particularly relevant when it comes to health. Global travel enables infectious diseases to cross from tropical forests to big city streets in a matter of hours. Meanwhile, global immigration moves thousands each day to homes in new countries. These changes are an impetus for U.S. funders to put their work in a global context, both by drawing on what can be learned from funders and programs in other countries and by considering roles U.S. funders can play in improving health outside this country.

An example of this work is the Health Initiative of the Americas, which has been supported by The California Endowment, the Mexican secretariats of health and foreign affairs, The California Wellness Foundation, the California HealthCare Foundation, the California Department of Health Services, and Fundación Mexicana para la Salud. Begun in 2001, the initiative's achievements include launching Binational Health Week, stimulating research in universities and institutions in the United States and Mexico, producing the *English-Spanish Dictionary of Health Related Terms*, producing public service announcements for more than 100 Spanish-language radio stations in California, launching a program of on-site health services in Mexican consulates throughout California, and establishing exchange programs to provide culturally competent training for *promotoras* (lay health promoters) and medical students (GrantWatch 2007).

The MacArthur Foundation's Population and Reproductive Health program supports field-level programs in India, Mexico, and Nigeria – three countries that account for about a quarter of all women of reproductive age, as well as a quarter of all young people in the developing world. Through this funding, which not only crosses geographic borders but also crosses sectors within countries, MacArthur's goal is to understand and demonstrate how a mix of civil society advocacy and action can be combined with sensible government policy to help take good work to scale. In order to expand care and services to women and young people, MacArthur supports carefully selected model projects in each of the focus countries and provides assistance to help scale them up where warranted (MacArthur Foundation 2007).

BENEFITS OF WORKING CROSS SECTORALLY

There is a tendency for organizations to focus on what they know best, and for good reason: it is demanding enough to carry out a basic mission, train and direct staff, design potentially successful solutions, and cultivate effective working relationships with other organizations in a field. Moreover, a focus on specific areas generates specialized expertise that is a key part of attracting financial support, defining turf, creating an institutional identity, and other elements of organizational survival.

We do not have to look globally to recognize the impact of geographic barriers, whether legal borders or virtual boundaries such as those between urban and rural areas, across metropolitan jurisdictions, between different sections of states and counties, and between inner cities and suburbs.

Working across sectors increases the complexity of designing and implementing effective program strategies. Going outside of an organization's comfort zone requires considerable work to learn about issues and key actors; to understand the cultures, traditions, constraints, and operating styles of different institutions; and to develop effective and trusting working relationships. But it is also the key to long-term change. Short-term programmatic goals can be met within a sector, but sustained population health improvement requires cross-sectoral partnerships.

Cross-sector collaboration can take many forms, ranging from ad hoc problem solving; to targeted, finite projects; to longer-ranging, ongoing activities. Possible sectors with which health funders can work are health care services, public health, workplaces, schools, environmental organizations, agriculture, housing, faith communities,

Working to bring alignment of public health and health care missions is as much a challenge as working outside the health sector. Public health and health care delivery are, in many respects, separate and virtually independent components of the American health system. Their relationship is characterized by the progressive loss of any perceived need for the two sectors to work together; the lack of adequate incentives or structural foundations to support cross-sectoral relationships; recurring tensions deriving from overlapping interests; and the development of striking cultural differences (Lasker et al. 1997). The consequences of this lack of integration and coordination were brought home during and in the aftermath of 9/11. That crisis sharply increased support for coordinated preparedness for and response to terrorism, infectious disease outbreaks, and other public health threats and emergencies (CDC 2005). In many cases, the attention it stimulated on the need for better coordination generally has waned to the detriment of communities and the health of their residents.

businesses, the media, government, transportation, and criminal justice.

Cross-sectoral work has the potential to significantly enhance the reach and impact of health funders' efforts. While we are still learning how to identify the most effective cross-sectoral activities for improving population health, much of what we are learning comes out of the experiences of innovative grantmakers. The European Union's focus on cross-sectoral alliances is also contributing to the growing knowledge base. Eventually, funders and policymakers will be able to target cross-sectoral investments more precisely than they are able to do now (Kindig et al. 2003).

From efforts already underway, we know that cross-sectoral work has the potential to advance objectives that are fundamental to improving health outcomes. It can:

1) Address the broader determinants of health by:

- Integrating health objectives into other domains such as environmental protection, education, criminal justice, transportation, and housing;
- Forming ongoing partnerships outside the health sector;
- Raising awareness of priority health issues outside the health sector; and
- Advancing more comprehensive approaches to health problems.

2) Improve health care and health promotion by:

- Enhancing the delivery of health care services and increasing access to services,
- Widening the scope of health promotion, and
- Strengthening health advocacy organizations.

3) Broaden support for health by:

- Building relationships with government agencies, funders, community organizations, opinion leaders, and advocacy groups from other sectors;
- Providing technical assistance and building capacity;
- Supporting research;
- Institutionalizing sensitivity to health issues; and
- Increasing influence on decisionmakers through cross-sectoral coalitions.

4) Build ties with communities by:

- Involving trusted community institutions and leaders in addressing health priorities,
- Leveraging community assets to achieve shared goals,
- Developing new community-based health leadership, and
- Bringing new perspectives to the table.

THE PROCESS OF WORKING CROSS SECTORALLY

Like other work involving different types of partners, successful cross-sectoral work by foundations requires attention to process, particularly since institutional incentives for working cross sectorally are not going to be as strong as the incentives for working within a sector. Maintaining the engagement of another sector can require providing technical assistance; collecting data; frequently acknowledging progress and success; and continuous identification, training, and mentoring of new collaborative leaders. Moreover, effective communication is even more important than usual because crossing sectoral boundaries increases the possibility that messages could be distorted or open to misinterpretation.

There are four key stages in the process.

1) Problem setting

- The most important tasks at this stage are defining the problem clearly, involving the appropriate sectors, developing their commitment, ensuring that the work meets the other sectors' specific interests, and securing the resources to move forward. The work needs to be

guided by a common problem definition and a clearly defined public purpose. Time and resources will be needed to bridge institutional barriers, build capacity, and initiate activities. This stage could also include the decision whether to work with a single organization from another sector or to create a network or coalition to address an issue.

The biggest challenge is overcoming institutional inertia and resistance to change.

2) Direction setting

- The focus of this stage is exploring the problem in depth and reaching an agreement with partners about approaches. Key issues to be addressed need to be clearly defined, and there should be established agreements for working together. Performance goals and expectations need to be spelled out clearly. Partners need to perceive the partnership as being in their interests and adding value to what they can achieve on their own. It should be expected that organizational adjustments will have to be made on both sides. International work will require heightened sensitivity to differences in organizational culture, expectations, and concepts of accountability.

3) Implementation

- Poor management processes can completely derail any work, but cross-sectoral efforts and collaborations are particularly vulnerable in this regard. Ambiguities in roles and responsibilities and lack of accountability mechanisms pose particular risks and can be prevented by clear communication during the direction-setting stage. High-level management must stay involved to oversee the work, ensure that there is adequate support for it, and reward success.

4) Evaluation

- Evaluating the impact of cross-sectoral projects is not easy. Some evaluators have tried using cost-benefit analyses to compare the impact of non-clinical or cross-sectoral health interventions, but costs are often difficult to determine. Generally speaking in this area, as with many interventions, there is a need for better evaluation instruments.

CHALLENGES TO WORKING CROSS SECTORALLY

Cross-sectoral work is a long-term task that requires ongoing adjustments in organizational culture. Building successful partnerships requires understanding these organizational differences and then working on how to address them.

Other considerations to be kept in mind are that:

- Some issues may be very problematic for some groups but not at all for others.
- The costs and management challenges (such as negotiation of decisions and division of responsibilities) of working in other sectors may be higher than expected. International projects are likely to require more financial and management support than domestic activities.
- The work should clearly help all sides achieve priority goals.
- Sectors should offer complementary areas of expertise, knowledge, skills, technology, and resources.
- Ongoing awareness is needed for differences in aims among sectors; differences in organizational cultures and values; possible lack of trust; and possible confusion about staff accountability.

CONCLUSION

Whether health funders focus their work on health care for individuals or on improving health across the population, there is rarely an issue that either could not benefit from cross-sectoral approaches or that does not require partnering with other sectors to produce real and lasting change. Cross-sectoral work is challenging, but the potential benefits are clearly worth the effort. Working relationships are most effective when they include shared priorities; committed leadership; realistic and clearly defined expectations; mutual respect for each partner's contributions; and a mutual understanding of constraints, funding cycles, and accountability mechanisms.

As health funders gain experience in this area, it will be vitally important to incorporate the lessons learned into institutional learning and memory. Equally important is to find ways to communicate these lessons to larger audiences of funders and decisionmakers so that they can be adopted more broadly.

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getting down to business:

foundations and the business sector

WHY IT MAKES SENSE TO WORK WITH BUSINESS

On the face of it, health foundations and business may seem like rather strange bedfellows. Most foundations exist to make the world a better place, whereas most businesses exist primarily to profit financially. And while successful businesses make money, foundations give it away. Moreover, certain businesses – tobacco companies or the fast food industry – may be seen by health foundations as part of the problem rather than as part of the solution.

Despite their apparent differences, businesses and foundations – including health foundations – have found common interests and concerns and are working together on a wide range of issues. There are a number of reasons why, under the right conditions, it may make sense for them to do so.

First, the private sector, including the business community, controls the lion's share of the nation's resources. Over the years, many foundations have focused considerable effort on leveraging government resources; yet total government expenditures – federal, state, and local – account for only 28 percent of the U.S. gross domestic product (GDP). The remaining percentage falls within the private sector. Consequently, for grantmakers interested in leverage, it may be worth recalling the Willie Sutton principle: go where the money is. Furthermore, in addition to economic resources, the business community often has access to an abundance of high-caliber, technical talent and capacity that it can bring to bear on issues of interest to grantmakers. "They're organized, smart, and run by really competent people," says Karen Feinstein, president of the Jewish Healthcare Foundation of Pittsburgh (JHF), in describing her foundation's business sector collaborators.

Second, the nation's businesses affect the health and well-being of all Americans in countless ways: through the products they produce, which determine everything from what we eat, to what we drive, to what pills we take; through their marketing and advertising campaigns, which deeply influence our culture, values, and personal behavior; through their effect on the environment; and through the tens of millions of jobs they provide, including the income, working conditions, and benefits that come with those jobs. Even relatively minor changes in business practices or corporate policies, such as eliminating transfats from certain foods or providing health insurance and medical leave benefits to employees, can have a very real impact on the public's health.

Third, because it is one of the major purchasers of health care in this country, the business community collectively has significant clout that it can bring to bear on the nation's health care system, if and when it chooses to do so. One notable example is the Leapfrog Group, a consortium of large employers, including Boeing, FedEx, General Electric, Toyota, and Verizon, that has come together with support from the Robert Wood Johnson Foundation (RWJF) to try to improve the safety, quality, and affordability of the vast amount of health care that they pay for. Examples on the local level are the Pittsburgh Regional Health Initiative, launched in 1997 by JHF in collaboration with the local business community to dramatically improve patient safety, and Cleveland Health Quality Choice, an initiative supported by the Cleveland Foundation and most of the region's major employers to measure and improve the quality of hospital care.

Finally, the business community can often get the attention of lawmakers and other public officials in ways that foundations cannot. Businesses do not face the same legal prohibitions against contributions to political campaigns and lobbying on specific pieces of legislation that foundations face. In general, business and philanthropy have likely underestimated the extent to which their priorities and goals converge. As Steve Case, chairman and cofounder of the Case Foundation, noted: "there is no logical reason why the private sector and the social sector should operate on separate levels, where one is about making money and the other is about serving society. I believe we can and should be integrating these missions" (2006).

> ***"There is no logical reason why the private sector and the social sector should operate on separate levels…"***
>
> *– Steve Case, chairman and cofounder, Case Foundation*

An example of this kind of integration might be a foundation-business partnership to improve workplace

health. For the foundation, workplace health is a key element of its overall strategy to improve the health of the community; for the participating businesses, it is a means of improving employee productivity.

Another example of this kind of mission integration occurred when the Chamber of Commerce in Richmond, Virginia, took the lead on an RWJF Urban Health Initiative grant. The foundation's principal goal was to improve the health and safety of Richmond's children; the Chamber's business leaders shared this goal, but also saw it as a way to improve the city's quality of life, which they believed would help make the region more competitive in attracting new businesses.

One funder sums up the potential value of foundations working with business:

> Many of the resources people need to build the good life for themselves are provided by the private sector. They hire people, they fire people, they put productive facilities in places, they purchase goods and materials. It is hard to ignore a sector that has such a pervasive influence – potentially both for good and for bad. If we want to improve people's lives, we have to find ways to engage the private sector (GrantCraft 2004).

Arguably, the same could be said if the goal is to improve people's health.

WHEN IT MAKES SENSE TO WORK WITH BUSINESS

Although not every foundation initiative lends itself to collaboration with the business community, there are circumstances where working with business may make sense.

When the goal is to improve the performance of the health care system, business, because of its purchasing muscle, can be a powerful ally. But such efforts are not without potential pitfalls. The Cleveland initiative (mentioned earlier) floundered when one of the region's key providers dropped out, and an earlier RWJF demonstration program (Community Partners for Affordable Health Care), designed to engage local business leaders to contain health care costs, ran into a serious snag when it became apparent that many of the forces driving up health care costs were not, in fact, subject to local control.

When the goal is to gain the support of elected officials, business can be a potent advocate for policy change. In Hawaii, the Atherton Family Foundation and other foundations joined forces with the leadership of Hawaii's Business Roundtable in a successful effort to leverage more state and national resources for early childhood education. Steve Case of the Case Foundation notes that "adding the Business Roundtable's voice changed the early education debate. When philanthropists ask the legislature for more money, they are often seen as do-gooders… But the business community came across as forward looking do-wellers, adding compatible powerful messages of Hawaii's productivity and competitiveness" (2006). Meanwhile, Arizona business leaders working with the Flinn Foundation, the Virginia G. Piper Charitable Trust, and others have played a key role in advocating for hundreds of millions of public sector dollars for biotechnology infrastructure costs. By the same token, business can be a powerful adversary in the policy arena. For example, national health care reform during the early 1990s, which was supported, in principle, by many health foundations, was successfully opposed by the health insurance industry, the pharmaceutical industry, and the National Federation of Independent Business.

When the goal is to improve the health and health care of working Americans, employers are obvious partners. The Missouri Foundation for Health recently sponsored a summit with key business leaders from around the state to discuss strategies for improving employee health and wellness and reducing health care costs. The Health Foundation of South Florida, meanwhile, is working with area banks, accounting firms, law firms, and other employers, as well as with local health care providers, health plans, and health information technology firms, to develop employer-based registries for disease management.

When the goal is to improve health by raising people's standard of living, the experience of foundations that have worked in the economic development arena suggests that business partnerships are key. An interesting example is the McKnight Foundation's support for an ambitious, regional economic development initiative that has been underway for more than twenty years in rural central Minnesota. Not only is there a long list of businesses that have contributed to the initiative as funding partners, but the initiative has also *invested* more than $30 million in almost 800 locally owned businesses in an effort to preserve and strengthen the area's economic infrastructure.

When the goal is to leverage resources, the corporate sector can be a fertile source. A classic example is the Partnership for a Drug-Free America, established by the advertising industry to "denormalize" illegal drug use and supported by a number of foundations, including The Pew Charitable Trusts, Ford Foundation, The New York Community Trust, and RWJF. Over the 21 years of the partnership's existence, foundation support has totaled roughly $70 million, and corporations and individuals have provided another $80 million in operating support. That combined investment has leveraged over $3.5 billion in donated media from the nation's media industry, along with more than $350 million in donated advertising and marketing.

When the goal is to promote health in ways that might be seen as a threat by certain industries, reaching out to those industries can sometimes help to diffuse potential conflict. In 1989 the Kansas Health Foundation invited the livestock and dairy industries, as well as Pizza Hut (which was headquartered in Wichita) and a major grocery chain, to join its Kansas Lean coalition to improve the availability of healthy food in the state and provide healthier lunches to the state's school children. Marni Vliet, former president of the Kansas Health Foundation, recalls that "we brought them into the tent so that they would embrace the idea instead of putting up resistance, and so that they would become champions for it within their own organizations." Robert Ross, president of The California Endowment, says that the endowment made a similar decision in its work to promote language access in California's health care system for the state's large population of immigrants who speak little or no English. The endowment could have pursued a litigation strategy to try to force the state's health care industry to comply with federal Title 6 provisions requiring language access but decided instead to pursue "a more deliberate strategy of engagement with providers." Says Ross, "Our grantmaking resources are an obvious resource, but it's our *non*-grantmaking resources – including our relations with clinical providers – that are the hidden gem."

CORPORATE FOUNDATIONS

In addition to collaborating with independent foundations, many businesses also engage in direct philanthropy, both through their corporate giving programs and through their own corporate foundations. *The Chronicle of Philanthropy* recently reported that the 81 companies that responded to its survey of corporate grantmakers made cash donations totaling $3.8 billion in 2006, up from $3.5 billion the year before (Barton et al. 2007). The Pfizer pharmaceutical company alone gave away some $1.7 billion in 2006, including $1.6 billion in donated pharmaceuticals.

As a kind of foundation-business hybrid, corporate foundations are often equally comfortable collaborating with both sectors. In a striking example of collaboration between a corporate foundation and an independent foundation, the Merck Company Foundation teamed up with the Bill & Melinda Gates Foundation in 2000 in an ambitious endeavor to reverse the AIDS epidemic in Botswana, which has one of the world's highest HIV infection rates. The two funders each put up $50 million for the first five years, and in addition, the Merck Company donated free supplies of its AIDS drugs to the initiative (Bill & Melinda Gates Foundation 2006). The Infectious Disease Institute in Kampala, Uganda, on the other hand, is an example of a corporate foundation (the Pfizer Foundation) partnering with business (Exxon-Mobil, Gilead Sciences, Inc., and BD, a medical supply company).

HOW TO PARTNER WITH BUSINESS: SOME LESSONS LEARNED

Working with business is not without its challenges for those in the foundation world. After all, foundations and business have very different cultures. They operate under different time frames; they use different language; they think differently about risk and reward; and, at the end of the day, they exist for fundamentally different purposes. Moreover, businesses generally have clear, readily measurable metrics to keep track of their performance; foundations often do not, in part because many of their goals do not lend themselves to easy quantification. Finally, businesses are ultimately accountable to their shareholders, whereas foundations are essentially accountable to no one but themselves.

Despite these very real differences, there have been many cases of successful collaboration between foundations and business, and those experiences have yielded some useful lessons about what it takes to forge an effective partnership.

First, foundations can and should leverage their role as honest brokers who do not have a financial or political stake in the outcome to bring all parties – including business – together around an issue of common concern. By providing a neutral forum for business leaders to learn about the issue and to get to know the other players and their views, foundations can provide the business community with an invaluable opportunity for constructive engagement and participation.

Second, foundations need to listen carefully to what business leaders are saying and what they are looking for. Because business leaders generally have resources of their own and, therefore, are not looking for a grant, they are unlikely to respond well to not having their views seriously considered. Furthermore, because the language of business is not the same as the language of the nonprofit world where foundations usually operate, attentive listening is essential.

Third, foundations need to be respectful of business leaders' time. The tendency among many foundations is to devote a great deal of time to meetings and process, whereas business leaders must operate in real time if they are to survive in a highly competitive market environment. Foundations that have neglected this difference in cultures have often found themselves at subsequent meetings sitting across the table from more junior "business representatives" who have little real decisionmaking authority. It may nevertheless take time to arrive at the kind of mutual trust and understanding necessary for all parties to feel comfortable moving forward, especially given the cultural and structural differences between foundations and business.

Balancing the time needed to establish trust with the need to keep the senior leadership engaged is one of the real challenges of such partnerships.

Fourth, the collaboration must be of genuine benefit to business if it is to be successful. Without a clear stake in the outcome, business is not likely to make a serious commitment, or, if it does, to stay the course over the long haul. Caroline Roan, executive director of the Pfizer Foundation, emphasizes that partnerships with business "have to be seen as a win-win by everyone involved. That might mean alignment with corporate strategy, or, when it is an issue area, sometimes the corporation can take that issue on as a cause."

Fifth, collaboration with businesses – because they are not charitable organizations – may occasionally require special handling. For example, the McKnight Foundation obtained an Internal Revenue Service waiver before allowing its grant funds to be invested in locally owned businesses in central Minnesota.

Finally, and perhaps most importantly, despite the potential benefits from collaboration with business, *foundations should be highly selective and clear-eyed in approaching any particular business for purposes of partnership.* Given the intense economic pressures under which many businesses are operating in today's global economy, it is imperative that the foundation fully understands and is completely comfortable with the company's business practices and its motives for participation.

THE PAYOFF FROM WORKING WITH BUSINESS

Despite the many challenges, the payoff from partnering with business can be substantial. Among the examples:

- The Pittsburgh Regional Health Initiative, led by JHF and including most of the region's major employers, helped more than 30 area hospitals bring down the incidence of lethal, hospital-acquired infection by 68 percent, according to a study published in the *Journal of the American Medical Association.*
- An independent 2007 assessment by Battelle found that the Flinn Foundation-led, ten-year campaign to enhance Arizona's biotechnology sector has already resulted in significant increases in National Institutes of Health funding, biotech jobs, the number of biotech firms, and biotech wages in the state.
- As of June 2006, the Merck Gates Foundation partnership to combat AIDS in Botswana had established the first comprehensive, nationwide treatment program in sub-Saharan Africa, providing anti-retroviral therapy to over half of all those in the country who could benefit from it, and more than 85 percent of those with advanced HIV infection. Between 2003 and 2005, the percentage of HIV-infected infants born to HIV-infected mothers in Botswana fell by 45 percent.
- Kansas Lean, initiated by the Kansas Health Foundation in collaboration with key food industry partners, resulted in healthier school lunches in all public schools statewide and, according to the foundation, is still in operation almost 20 years after its inception.

CONCLUSION

Because of its sheer size and breadth, the business sector affects everyone's health and health care in innumerable ways, both positive and negative. For foundations seeking to improve people's health and health care – locally, regionally, nationally, or globally – business can be either a formidable adversary or, under the right circumstances, a powerful ally. Such alliances, however, are not automatic. In order for partnerships with business to work, all parties must enter into the relationship prepared to be flexible, yet with a clear and full understanding of one another's agendas. Done right, the track record so far suggests that the payoff from such partnerships in advancing a foundation's goals can be considerable.

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partners for the public good:
foundations and government

Perspectives on the appropriate role of philanthropy relative to government are varied and passionately held. At one extreme is the belief that philanthropy should remain completely distinct and isolated from government to ensure an independent, private force in civic affairs. At the other end of the spectrum is the view that philanthropy should focus its energies exclusively on reorienting public policies in order to foster lasting, systemic change. In between are positions that acknowledge the relative strengths and weaknesses of each sector and strive to align these different skills and capacities in complimentary, constructive ways.

The following narrative largely focuses on this "middle ground," presuming that some level of interaction between government and philanthropy is both advantageous and widely desired. As health funders know all too well, however, divining the right "mix" of public-private contributions can be tricky business. Foundation staff and boards frequently struggle to find the optimal balance between philanthropic and governmental action and may question whether they have positioned their resources effectively relative to the public sector.

YOU SAY TOMATO...

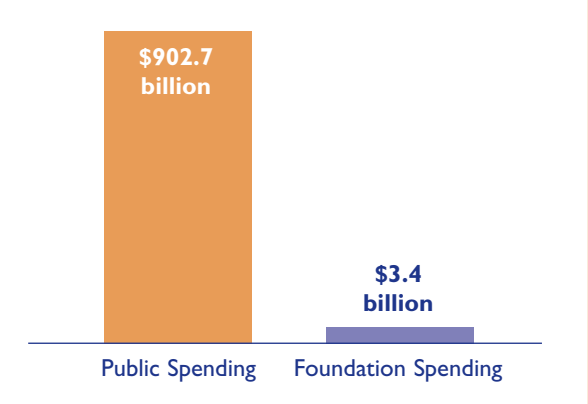
Partnerships between philanthropy and government are inherently prone to tension. These societal institutions share the common goal of promoting the public good. But the values, ideologies, expectations, and competencies each sector brings to this challenge are often very different – and frequently in conflict. These tensions can be a source of frustration and failed experiments. Yet when harnessed effectively, some degree of tension can also be healthy and productive, guiding discourse and promoting mutually reinforcing roles.

Neither government nor philanthropy is monolithic. Government operates through administrative, legislative, and judicial branches; has authority vested at federal, state, and local levels; and assumes an array of functions and organizational structures that vary significantly across jurisdictions. Each node in this complex web of governmental entities has its own culture, legal framework, and operating procedures. Similarly, philanthropy includes diverse organizations with differing missions, priorities, restrictions, postures, and resources.

Despite these complexities, broad generalizations regarding philanthropy and government are commonly made and are, therefore, useful to consider. Government is typically viewed as stable, accountable, and able to command the level of resources needed to bring interventions to scale in a sustained manner over the long term. These same characteristics also engender perceptions that government is resistant to change, overly cautious, slow to act, beholden to the status quo, and tolerant of mediocrity. Philanthropy is viewed as more nimble; receptive to experimentation; and open to nontraditional, creative approaches. These innovative traits can also be seen in a less positive light, with some feeling that foundations can be capricious, impatient, and faddish. These are obviously simplistic generalizations, but they help to explain both the power and pitfalls of partnerships between philanthropy and government.

Tightly integrated collaborations are clearly more challenging to implement than more loosely structured partnering arrangements. Both government and philanthropy are likely to opt for the minimal degree of entanglement needed to achieve shared objectives. These cross-sectoral collaborations can take many forms and rely on a variety of resource sharing arrangements. Some common models for how foundations partner with government are described below.

HEALTH SPENDING BY FOUNDATIONS AND GOVERNMENT, 2005



Source: CMS 2005a and Foundation Center 2007

HOSTESS WITH THE MOST-EST

The siloed, categorical nature of government can be a major barrier to engaging the public sector in holistic strategies, but health funders have played an important role in bridging these divides. The complexity and multiple units of government often hinder effective working relationships both among government agencies and with private sector collaborators – resulting in fragmentation of services and impenetrable regulatory structures. Philanthropic leadership can be instrumental in cultivating understanding and fostering cooperation among multiple stakeholders.

Foundations are uniquely well suited to act as neutral brokers in bringing diverse parties together because they generally command wide respect and are usually not perceived to have their own vested interests. These attributes give philanthropy the latitude to help government agencies rise above internal turf battles and to open dialogue with other private sector organizations (such as business, health care providers, and not-for-profit agencies) that may have had strained relationships with government in the past.

Convening stakeholders to focus on shared priorities can be a relatively low-cost investment that yields significant benefits. For example, a $2,500 grant from the Rhode Island Foundation provided support for a daylong conference to bring both public and private health professionals together to improve awareness of the mental health needs of veterans returning from deployments in Iraq and Afghanistan. This initial meeting led to a broader initiative, which mapped the needs of and services available to veterans and their families and created a blueprint for improving available services and filling service gaps. Philanthropic dollars provided important seed money to improve communication and coordination among the federal Veterans Affairs medical centers, the state National Guard unit, a variety of state health and human service agencies, the criminal justice system, and private health and mental health provider organizations.

Bringing multiple stakeholders together to share and plan is an important step, but implementation efforts frequently encounter barriers and take time to unfold. For example, a $30,000 grant from the Raymond John Wean Foundation to the Mahoning County (Ohio) Board of Health supported public-private collaboration on childhood immunizations. After using a self-assessment tool developed by the National Association of City and County Health Officials, the board of health identified the need for more private sector involvement to address low rates of preschool immunization. The county then sought foundation funds to launch an immunization coalition, which included area safety net providers. The coalition identified neighborhoods with concentrated needs, sought to encourage more private sector outreach, and attempted to increase private medical practice participation in the state's immunization registry. Staffing changes and technological difficulties related to the interoperability of data systems have slowed progress, but the board of health

NAVIGATING THE MANY FACETS OF GOVERNMENT

Addressing the broad social and environmental determinants of health requires the involvement of a wide array of government entities, moving well beyond traditional relationships with health departments and Medicaid agencies. Housing authorities, child protective services, criminal justice systems, welfare agencies, schools, employment bureaus, public transportation, and many other government functions play key roles in both influencing the conditions that mediate health status and delivering services that help individuals manage disease and disability. This maze of overlapping and unfamiliar government bureaucracies appears daunting and might dampen the collaborative interests of even the most committed health funder.

A model developed by the Council of Michigan Foundations may provide a template for unraveling these complexities and expediting government relations. At the council's urging, Governor Jennifer Granholm established a cabinet-level Office of Foundation Liaison (OFL) in 2003 to broker strategic partnerships between state government and philanthropy. Funded initially by the Hudson-Webber Foundation, Charles Stewart Mott Foundation, Kresge Foundation, W.K. Kellogg Foundation, and The Skillman Foundation, OFL has successfully linked philanthropic leaders and government officials to share ideas, develop plans, and secure investments in joint initiatives. Issues identified early for collaborative intervention include workforce development, early childhood, and land use.

The OFL has recently begun preliminary work on health-related endeavors. For example, OFL has supported the establishment of the Michigan Food Policy Council, which seeks to cultivate a safe, healthy food supply while building on the state's agricultural diversity to enhance economic growth.

The success of the effort is partially explained by the selection of mutually recognized priorities, but OFL staff resources have proved pivotal. OFL personnel have prior experience in both government and philanthropy. Their sophisticated understanding of both sectors favors the selection of feasible strategies and helps resolve conflicts that arise. Furthermore, access to and support from the governor ensure attention and response from agency personnel and minimize inter-departmental roadblocks.

continues to engage with private clinicians and can now more effectively position its immunization clinics relative to private sector capacity.

BUILD A BETTER MOUSETRAP

Interactive dialogue and information sharing often reveal the need for a more ambitious level of collaborative activity wherein philanthropy provides resources designed to amplify the impact of publicly sponsored activities. The influence of public programs permeates society, and health funders have wisely sought to build on these vast resources in a variety of ways. These strategic endeavors typically seek to add services, functionality, or competencies that are missing from existing government programs. Funding may be provided to grantees who also receive public dollars to augment their capabilities, or financial support may be given directly to government agencies.

Some of these efforts focus on expanding the reach of public health insurance programs in terms of both enrollment and covered benefits. Medicare and Medicaid together account for over 37 percent of total health care spending (CMS 2005b). The size and scope of these public insurance programs provide rich opportunities for improving access and quality. For example, The Commonwealth Fund and the Robert Wood Johnson Foundation have partnered to create State Solutions, an initiative focused on increasing enrollment in Medicare Savings Programs (MSPs). MSPs provide financial assistance for premiums and other cost-sharing requirements for low-income Medicare beneficiaries who do not qualify for full Medicaid coverage. Only half of the five million people eligible for this public subsidy are enrolled (Rutgers Center for State Health Policy 2007). The federal government determines eligibility and funds the MSPs, but enrollment is administered by the states, which have some discretion in establishing income and asset verification processes. The State Solutions project has effectively engaged with policymakers in five states to streamline application procedures and improve outreach activities. All five states participating in the project increased enrollment levels. This success was facilitated by the motivation and attention of state policymakers who recognized the untapped potential of these programs in improving access to care, as well as communication among grantees to share best practices (Summer 2006).

In a similar vein, the California HealthCare Foundation supported the development of Health-e-App, a Web-based, electronic enrollment process for Healthy Families and Medi-Cal for Children, California's joint State Children's Health Insurance Program (SCHIP). Deloitte Consulting, selected through a competitive bidding process, developed the on-line tool working closely with the state Medicaid agency, the Healthy Families administrators (Managed Risk Medical Insurance Board), and county health and human service agencies responsible for program enrollment. Pilot tested in San Diego County, Health-e-App proved to be extremely effective and efficient, reducing workloads for county personnel, decreasing time lags for application approvals, reducing error rates, and even identifying technical discrepancies between county and state application requirements (The Lewin Group 2001). The effort was bolstered by gubernatorial support and facilitated by careful work to analyze and address the structure and requirements of existing information systems. The tool has since been implemented statewide, and an enhanced One-e-App has been developed to incorporate county-based insurance expansion programs, indigent care programs, and Medi-Cal for adults.

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Other efforts have sought to improve the effectiveness of public insurance programs by focusing more directly on the nature and quality of covered services. For example, the John A. Hartford Foundation provided a $1.7 million, four-year grant to a home health agency to reduce medication errors in the dually eligible Medi-Cal recipient population. Under a federal home- and community-based services waiver, the state Medi-Cal program was funding home health services for low-income, frail elderly persons who would otherwise be eligible for nursing home placement. Waiver requirements mandated that home health providers track all medications used by program participants. These data were being collected and stored in patients' charts, but previously little effort had been made to analyze the information to ensure appropriate medication management. Hartford funds allowed home health agencies to invest in handheld computers that store prescription drug data along with select clinical information regarding patient conditions. Electronic transmission to consulting pharmacists and physicians allows possible errors or inappropriate medication management practices to be identified. The project has been successful in improving prescription drug use in a population extremely

vulnerable to adverse drug events that might lead to placement in a nursing home. It has also been useful to the home health agencies in their staff recruitment and retention efforts. In 2008 the project will be expanded to three other states.

Foundation-funded enhancements to public programs extend far beyond those addressing Medicaid and Medicare. Leveraging public insurance programs may be particularly attractive to private funders because these programs are entitlements that guarantee sustained public funding. Other types of government spending are subject to yearly budget and appropriation processes. These discretionary programs create special challenges for long-term planning. Despite these difficulties, many health funders have made major investments in improving the capacity and functionality of discretionary programs, particularly those targeting public health agencies.

Some political jurisdictions impose rather narrow restrictions on the activities of governmental public health, limiting public funding to traditional functions like sanitation and communicable disease control. In light of these limitations, philanthropic support has been an important catalyst for nurturing innovation within the governmental public health infrastructure. The Turning Point Initiative, jointly funded by the W.K. Kellogg Foundation and Robert Wood Johnson Foundation, improved the capacity of 23 state and 41 local public health departments to engage private sector partners in community health promotion. By providing staff, resources for communications and data collection activities, technical assistance expertise, and national collaboratives, the Turning Point Initiative helped health departments reorient their role in assuring population health. These grant resources allowed public health officials to mobilize community assets beyond those services directly provided by the health agency and to assume a broader leadership role in health promotion.

The Kansas Health Foundation has also pursued an ambitious effort to strengthen the state's public health system through multiple grants targeted at the public health infrastructure. This support has been credited with creating significant positive change in workforce competencies, information technology capacity, epidemiological and disease surveillance capabilities, leadership development, and organizational structure. For example, funding for the statewide association of local health directors played an important role in facilitating regional approaches to emergency preparedness planning. Increasing coordination among local health departments served to build the relationships needed for joint operations and resource sharing. Many believe that sustained support and informed participation from the foundation were instrumental in achieving these outcomes.

STIMULATING POLICY CHANGE

Foundations often undertake government partnerships in the hopes that the public sector will eventually adopt successful pilot programs more broadly, replicating the interventions beyond the demonstration sites to achieve universal penetration. These hopes can go unfulfilled for a variety of reasons. Often the value of a successful program is acknowledged by government partners, but the public sector remains unable or unwilling to take on the expense associated with the intervention. Alternatively, public agencies may deny responsibility for activities that are perceived to fall outside the scope of appropriate government action. The political climate of any given jurisdiction clearly influences receptivity to public spending, as well as the expansiveness of definitions regarding legitimate government roles. Interventions regarding behavioral health issues, such as safe sex, healthy eating, and substance abuse, frequently run afoul of political norms regarding "appropriate" government intervention in light of personal liberty concerns or, conversely, collective values.

In other cases, the evidence base does not support the effectiveness of experimental approaches. The benefits and associated costs of some successful efforts are not well documented and, therefore, vulnerable to political inertia. In other instances demonstration projects fail to prove their utility to policymakers precisely because prevailing public policies have undermined or limited their effectiveness. Existing regulatory strictures or statutory limits may make it difficult or impossible for creative approaches to function.

Foundations often undertake government partnerships in the hopes that the public sector will eventually adopt successful pilot programs more broadly.

Government officials can occasionally be allies in identifying "loopholes" to work around policies that frustrate innovation. For example, at the height of the HIV/AIDS crisis in San Francisco, public health officials declared a public health emergency every Friday to allow for a needle exchange program. Although the program was sponsored by a group of private funders, the city needed to suspend prohibitions regarding the distribution

of needles to ensure the legality of the program and protect not-for-profit volunteers from liability. In this case the stakes were very high, and the political climate was tolerant of bold decisions on the part of public health officials (Hernandez 2007).

Opportunities and motivation for government officials to push the limits of established policy are limited. More commonly, formal changes to ordinances, regulations, budgets, and statutory law are needed to clear a path for broad implementation of innovative approaches. Many health funders have recognized both the permissibility and importance of policy advocacy to advance their objectives. Some have done so in very visible ways, supporting grassroots advocacy organizations and communications campaigns. For example, the Connecticut Health Foundation has funded a variety of program and policy efforts to expand access to oral health services within the state. Foundation funds have supported advocacy, coalition building, and education by the Connecticut Oral Health Initiative, as well as a comprehensive policy analysis of the actions needed to improve the accessibility and quality of oral health services within HUSKY, the state's Medicaid and SCHIP program. Others have focused more specifically on developing and disseminating evidence to inform policy decisions. For example, The Henry J. Kaiser Family Foundation has sponsored a broad array of analytic products to support policymaking, such as a compilation of key legislation introduced in the 110th Congress to reduce racial and ethnic health disparities and a survey of public opinion regarding the quality of long-term care services.

Even those funders actively engaged in public policy work may struggle with the most appropriate ways to advocate for specific policy changes that emanate from their program grants. For example, a number of national, state, and local funders have sponsored programs to develop supportive housing opportunities for the chronically homeless. These programs provide a broad constellation of services to persons who have been homeless for long periods of time. These individuals generally need affordable housing options, employment assistance, income support, substance abuse and mental health treatment, other types of medical services, nutritional support, and a range of social services. Although such services can be accessed through multiple programs, the complexity of navigating multiple application processes is daunting. Supportive housing programs knit these disparate services together in a cohesive fashion to meet the unique needs of this vulnerable population.

Demonstration projects have successfully bridged fragmented programs and have reduced homelessness and improved health, but they typically rely on a patchwork of federal, state, local, and private housing and human service grants combined with rent subsidies, Medicaid payments, and disability insurance to accomplish these goals. Efforts to sustain these demonstrations or, even more challenging, bring them to scale are stymied by the need for policy change in multiple arenas, including affordable housing development, Medicaid coverage and eligibility restrictions,

WEATHERING CHANGING POLITICAL CLIMATES THROUGH FLEXIBILITY AND STRONG RELATIONSHIPS

While policy change is frequently viewed as the desired culmination of private-public partnerships, sometimes unanticipated shifts in policy can alter partnership arrangements in unexpected ways. For example, the John A. Hartford Foundation, The Atlantic Philanthropies, and the Starr Foundation have partnered with the National Institute on Aging (NIA) since 2004 to support biomedical research with practical implications for improving clinical practice. The partnership allowed the foundations to expand a program that, since 1995, has trained a cadre of over 120 MD-scientists to stimulate advances in the science of aging and care for older patients.

The Paul B. Beeson Career Development Awards in Aging provide three to five years of mentored development to clinically trained researchers. Philanthropic support provides approximately 30 percent of total award funds and allows the program to include a broad range of mentorship supports that are not standard in government career development grants. The collaboration required that philanthropic partners cede some control over scholar selection mechanisms, but the advantages of the more rigorous federal peer review process merited this flexibility. The program has been extremely successful with Beeson Scholars securing high rates of follow-on funding from the National Institutes of Health (NIH) as their careers develop.

Recent scrutiny over conflict-of-interest policies at NIH required that the collaborative mechanisms of funding and decisionmaking be substantially reworked. The program now operates as a series of grants made in tandem rather than a lump sum donation to the NIH from philanthropic partners. Despite the modifications, the effort has been able to preserve the priorities valued by philanthropy and the NIA, in large part due to strong relationships with professional staff at NIA. Politics almost guarantee a changing cast of policymakers, but professional civil servants often have longer tenure and offer important contributions to any undertaking that involves government partnership.

and disability determination processes. Progress will depend on policy advocacy on multiple fronts at all levels of government.

STEPPING INTO THE BREACH

In an ideal world, policy change represents a step forward, but in reality new policy directions can mean a step back for community health objectives. Severe cuts in government budgets can have a disastrous impact on programs or organizations important to health funders. Philanthropic organizations are extremely reluctant to step in and pick up the pieces when government retreats from a program or population. Many believe that "rescuing" services cut from public support only decreases the likelihood that government will ever assume responsibility for these services again. Circumstances, however, exist where the consequences of failing to address a government cutback outweigh the jeopardy of discouraging a renaissance in government support. Reductions in federal, state, and local budgets can threaten the continued viability of not-for-profit organizations and public agencies that are key to a foundation's grantmaking strategy and community well-being. Therefore, some foundations have found it prudent to reconstitute activities that many believe *should* be funded through public sector support.

The Missouri Foundation for Health (MFH) faced such a dilemma when the state significantly reduced funding for local public health departments. These local government agencies are critical services providers, particularly in rural parts of the state. Both state and local health officials subsequently reported unmet infrastructure development needs that threatened agency operations. While local health agencies are eligible to compete for MFH program grants, these grants support additive functions rather than basic operating capacity. Furthermore, the foundation's bylaws require that MFH grants supplement, rather than supplant, government funds. The staff and board resolved these tensions by creating a one-time grant program limited to capital investments, such as physical plant improvements, information technology hardware and software, laboratory equipment, and transportation. This approach ensured that important service gaps could be addressed without compromising the foundation's strategic decision to build on, rather than displace, public funds.

CONCLUSION

Philanthropic partnerships with government agencies and programs benefit from shared priorities; committed leadership; realistic and clearly defined expectations; mutual respect for each other's contributions; as well as a mutual understanding of each other's constraints, funding cycles, and accountability mechanisms. Whether the partnership involves cooperative funding, pooled funding, or direct support for government agencies, philanthropy can leverage the size and reach of government while stimulating creative new approaches. But issues of control and ownership are inevitable. Working with government can require patience and a long-term perspective. But this commitment also opens up avenues for creating and sustaining change that private funding alone is unlikely to accomplish.

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working on common goals:
foundations and labor unions

Health foundations and labor organizations have more in common than they may realize: both have missions focused on improving lives and achieving social benefits. They share a variety of social justice goals including improving access to quality health care, reducing racial and ethnic disparities, supporting fair compensation and benefits for workers, and creating safe and healthy working conditions. Foundations may not readily think of labor groups as potential grantees or partners. By providing a collective voice, however, labor unions and related advocacy groups can be powerful allies in both mobilizing memberships and bringing the concerns of workers and their families to the attention of policymakers and the public.

The American middle class was built largely on manufacturing jobs in the 1950s and 1960s. Labor union membership meant higher hourly wages, as well as health and retirement benefits. Today's workers, both unionized and nonunionized, face higher health insurance costs, benefit reductions, and wage compression. Employers are also feeling the financial pressures of increasing health care costs, coupled with a rising number of retired workers drawing pensions and other retirement benefits.

Some would argue that a declining union presence is at least partially responsible for both decreasing rates of employment-based health insurance and the rising share of health-related costs workers now shoulder. Union membership has been slowly declining for some time. Over the last 15 years, membership has declined about 8 percentage points, dropping from 20 percent of the workforce in 1983 to 12 percent – or 15.4 million Americans – in 2006 (U.S. Bureau of Labor Statistics 2007a). This decline is largely due to a shift from manufacturing to service-based employment, which has historically had lower rates of unionization. Other community-based organizations, such as worker centers focused on farm and garment workers, are forming to organize and provide services to workers and their families, but these centers typically lack the collective bargaining rights of labor unions. Overall, labor organizations remain important voluntary membership organizations providing workers with a collective voice.

LABOR UNIONS

Unions represent a variety of workers–from public sector workers to tradesmen and factory workers. They are also able to engage many audiences–from employers and policymakers to the broader public. Overall, government workers are more likely to be unionized than private sector workers. In 2006, 36 percent of government workers were unionized. The highest levels of public sector membership are among fire fighters, teachers, and police officers. Within the private sector, only 7.4 percent of workers were unionized in 2006, with the transportation and utilities (23 percent) and construction (13 percent) industries having the highest membership rates (U.S. Bureau of Labor Statistics 2007a). Within the health care sector, unionization rates among licensed professionals tend to be somewhat higher than the private sector average. Just over 12 percent of practitioners and technical staff (nurses, physician assistants, and therapists) participate in unions. In contrast, 10 percent of health care support workers (nursing and home health aides and medical records, food preparation, and custodial staff) are unionized (U.S. Bureau of Labor Statistics 2007b).

> ***In 2006 more than 16 percent of African-American workers belonged to unions, compared to almost 13 percent of white workers. In addition, 11.5 percent of Asian workers and 10.7 percent of Latino workers were union members in 2006.***

The membership of labor unions generally reflects the diversity of American workforce. Overall, union membership rates are slightly higher for men (13 percent), although women are a growing segment (11 percent). Women are more heavily represented in unions affiliated with health care and education. African-American workers, both men and women, have the highest rates of union membership, and they are more likely to be unionized than their white counterparts. In 2006 more than 16 percent of African-American workers belonged to unions, compared to almost 13 percent of white workers. In addition, 11.5 percent of Asian workers and 10.7 percent of Latino workers were union members in 2006 (U.S. Bureau of Labor Statistics 2007a).

WORKER CENTERS

Community-based organizations are playing an increasingly important role for immigrants, particularly undocumented workers who may be ineligible to participate in formal labor unions. Worker centers serving vulnerable populations are helping workers and their families access health and human services, enroll children in public schools, and find affordable housing. They also provide health education classes and training to identify and speak out against unsafe work environments. They also advocate for workers' rights and improved working conditions. In industries that have "become almost entirely non-union, these groups are calling attention to problems and providing opportunities for low-wage workers to come together and take action" (Neighborhood Funders Group 2005).

A study conducted for the Neighborhood Funders Group's Working Group on Labor and Community found that the strength of worker centers lies in their ability to "cultivate and develop immigrant leadership" (2005). They have been particularly successful in improving working conditions; winning back wages for immigrant workers; and compelling government to enforce minimum wage, health, and safety regulations.

Historically, the work of labor unions has yielded significant social benefits. Using collective bargaining and other tools, unions have improved wages, working conditions, and health care and retirement benefits for their members. For example, union workers are more likely to have employment-based health benefits than their nonunion counterparts. In 2003, 95 percent of union workers received health benefits from their employers compared to 77 percent of nonunion workers (Employee Benefit Research Institute 2005). Union workers also have higher earnings than nonunion workers. The median weekly earnings for union members was $833 in 2006, compared to $642 for nonunion members–a 30 percent difference (U.S. Bureau of Labor Statistics 2007a). Earnings differences are even greater for people of color. While researchers acknowledge higher wages of union workers, they note other influences including variations across industries, geography, and firm size (Anderson et al. 1990). High unionization rates within some sectors, such as nursing, education, and public service, have also created an upward pressure on wages for nonunion employees.

FINDING COMMON GROUND

Health funders may not automatically think of establishing partnerships with organized labor, and unions may be an underutilized ally. Foundations may be wary of working with labor groups for a variety of reasons ranging from making grants to labor unions that generally do not have nonprofit status to historical allegations regarding corruption within some union groups. In addition, health and health care may not be a top priority for some labor groups, which may be more focused on wages or other non-health related issues. Despite these challenges, unions can bring established infrastructure, motivated constituents, and financial resources to the table. Leo Canty, board chair of the Connecticut Health Foundation, suggests that unions' organizing structure and active memberships can effectively bring issues to the attention of policymakers by providing a collective voice. He also notes that unions can effectively reach out to the broader public on issues of concern through their communication networks.

Making grants to unions may represent a challenge to some foundations. The tax status of both parties is a primary concern. The tax status of private foundations, community foundations, and public charities have different, yet important, nuances regarding their ability to receive and grant funds, as well as limits on advocacy and lobbying. Labor unions and agricultural organizations typically have 501(c)(5) tax status, and most can lobby policymakers. The Internal Revenue Service prescribes specific procedures in order for foundations to award grants to non-501(c)(3) organizations. Foundation staff may also need to determine whether the activities supported by the foundation will serve a charitable purpose such as educational activities or provision of health care or legal services. Staff will also need to determine if the activities will serve the public good (Nober 2001).

Leadership at the Universal Healthcare Foundation of Connecticut identified unions early on as a critical partner in the foundation's campaign for universal coverage in the state. Legal research was required to determine if the foundation could award grants directly to unions in Connecticut. With the legal questions resolved, the foundation awarded a series

The median weekly earnings for union members was $833 in 2006, compared to $642 for nonunion members – a 30 percent difference.

of grants for public education activities to several local unions. Given the foundation's restrictions on lobbying, the foundation required union grantees to submit monthly reports on their activities and any lobbying work. Kate Garvais, a senior program and development officer at the foundation, noted another challenge: most of the unions had never received foundation grants before and were less savvy about the application and grant reporting processes.

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Given the range of social concerns shared by foundations and labor organizations, there are a number of strategies foundations can use to engage with labor groups. If a foundation's organizing documents do not permit grants to non-501(c)(3) organizations, support for coalitions that include community and labor groups or grants to a supporting organization of the non-charitable grantee may be alternative funding mechanisms.

Coalitions, for example, bring together multiple stakeholders to mobilize communities. They can help ensure that residents' concerns are expressed in decisions affecting their health and that of their families. Coalitions can involve training people to speak out on their own behalf and work for changes that lead to better health and prevent harmful policies and practices. Awarding grants to nonprofit coalitions can provide foundations with an opportunity to create change at the community level without the complexities of resolving tensions regarding the tax status or activities of any single entity. Frequently, however, coalition partners come to the table with varying levels of resources. Sara Kay, health program director at The Nathan Cummings Foundation, suggests it is important to make sure that both the labor and community sides of a coalition have a voice in the process since unions can be better organized and resourced than their community partners. She also cautioned that grantmakers need to strategically navigate various agendas that can be at play in any coalition.

Another strategy for foundations to engage labor groups is to act as a neutral convener. Foundations can provide access to office space, such as conference rooms, for stakeholder meetings. In the case of the Universal Healthcare Foundation of Connecticut, the foundation's offices were located close to a major highway and with ample parking to permit easy access for groups throughout the state. The foundation also allows groups to use its conference facilities after hours and on weekends. Having a neutral space for meetings has helped break down barriers and build strong relationships among disparate groups.

In an economy where working families increasingly lack health care coverage, affordable housing, and opportunities for career advancement, foundations and labor organizations can find much common ground (Neighborhood Funders Group 2007). The following section describes some of the ways foundations and labor groups are working toward common social justice goals.

EXPANDING HEALTH COVERAGE

In the United States, health care coverage and employment have historically been linked. Today, however, workers' insurance coverage is eroding, and they are being asked to assume increasing copayments and deductibles. Additionally, public programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), are at risk of decreased funding and stricter eligibility requirements that may make it more difficult for low-income, working families to enroll and receive services. As a result, a number of foundations are supporting campaigns to expand public programs or universal coverage at the state level.

The mission of the Universal Healthcare Foundation of Connecticut is to engage people and communities in shaping a health system that provides universal access to quality health care and promotes health throughout the state. The foundation sees itself as a catalyst and seeks to partner with a broad array of stakeholders. The foundation's orientation toward social change undoubtedly stems from its leadership – the foundation was created by labor organizers and consumer activists, many of whom sit on its board of directors.

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Labor has been an important partner in the foundation's work. The foundation launched healthcare4every1 in 2006, a statewide advocacy campaign committed to organizing an active and diverse network of concerned residents to build public and political support to achieve universal health care in the state. To educate and mobilize active and retired union members, the foundation awarded $25,000 grants to several labor unions including the Connecticut chapters and local affiliations of the American Federation of Teachers, Communication Workers of America, New England Health Care Employees Union, International Association of Machinists & Aerospace Workers, Service Employees International Union, Teamsters, United Auto Workers, and United Food and Commercial Workers Union. The constituencies of unions such as these were exactly who the foundation wanted to reach. For some union groups, such as Justice for Janitors, the issue of health coverage is a real and pressing issue. Health care coverage, however, was not the top priority of other union groups in the state. In these instances, foundation staff sought to motivate union members to engage on universal coverage as an economic and social justice issue.

The Universal Healthcare Foundation of Connecticut has also provided support to the John J. Driscoll United Labor Agency. Founded by the Connecticut AFL-CIO, the agency helps union and nonunion workers access health and human services such as unemployment and veterans benefits, health care services, workers compensation, Social Security and disability benefits, food stamps, and alcohol and drug counseling. In 2007 it awarded the agency a $37,000 grant for the production and distribution of a biweekly television series to examine and increase awareness of universal health care issues. The agency also used the resultant video on Web sites such as YouTube.

Rather than fund unions directly, some funders have strategically coordinated their grantmaking with advocacy investments made by labor unions in order to maximize synergistic opportunities. For example, the Public Welfare Foundation is helping advocates advance universal health coverage in Ohio, Pennsylvania, and Vermont. The foundation's Health Reform Program works in tandem with American's Agenda, an advocacy group founded by 20 labor unions to provide state and local advocates with the tools needed to campaign for universal health care coverage. The foundation awarded a $100,000 general support grant to the Vermont Campaign for Health Security. At the same time, America's Agenda assisted Vermont advocates to unite stakeholders and develop a public education campaign that included printed information and radio spots about the soaring costs of health care insurance. A brochure providing information on Vermont's three public programs for the uninsured was also developed. Terri Langston, a senior program officer at the Public Welfare Foundation, notes that the involvement of this group of unions, through the common organization of America's Agenda, has significantly contributed to the debate on health reform.

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IMPROVING OTHER HEALTH-RELATED BENEFITS

Workers without health coverage or related benefits are less likely to seek preventive health care services for themselves and family members. They are also more likely to put off getting care until an illness or chronic condition worsens. Inadequate leave benefits can exacerbate these dynamics. Workers lacking sick leave benefits face high out-of-pocket payments for care, as well as lost wages, if they need to miss work to seek health services or to care for a sick child or aging parent.

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The Public Welfare Foundation funded a two-year, $1 million sick leave initiative to leverage support from a variety of groups, raise awareness of the issue, and identify policy solutions. The foundation awarded its first grant under the initiative to the National Partnership for Women and Families to support the first Sick Day Summit held in July 2007. A key feature of the summit was to examine how

local coalitions working on the issue could expand their reach through collaboration with health reform advocates, labor organizations, and others. Additional grants under this initiative will support activities to organize stakeholders at the local, state, and national levels. In 2007 the foundation awarded the Multi-State Working Families Consortium, a group of eight, labor-community coalitions working in 11 states to make family leave more accessible and affordable. In California, the Work and Family Coalition, composed of unions and advocacy groups, successfully advocated for a number of family bills. One will expand California's Paid Family Leave law to cover grandparents, siblings, parents-in-law, and grandchildren. A second prohibits discrimination against workers based on family responsibilities.

REDUCING OCCUPATIONAL HEALTH RISKS

Health and safety issues are of large concern to workers, particularly in industries with less regulatory oversight. To address the growing needs of day laborers, the Public Welfare Foundation's Workers' Rights Program provides support to organizations, such as immigrant worker centers, that advocate on behalf of low-income workers on issues such as living wages and working conditions. The foundation has provided $250,000 in grants since 2002, for example, to the National Day Laborer Organizing Network. This collaborative of more than 30 community groups organizes day laborers across the country. It also advocates for systemic change to improve wages and working conditions for low-income workers.

California hosts the largest garment manufacturing industry in the United States, and the health and safety hazards associated with this industry are growing as its workforce expands. The Garment Worker Center (GWC) in Los Angles provides a collective voice for workers to put pressure on owners, manufacturers, and retailers to improve working conditions. Key to its success has been the creation of a multi-ethnic approach to organizing Chinese, Thai, and Latino garment workers. Garment workers are among the most vulnerable working populations in California because they are low-wage, uninsured, and face cultural and economic barriers in accessing adequate health care, noted the program director for The California Wellness Foundation's work and health priority area. To address this critical need, the foundation supports worker centers and other organizations providing health and safety education to workers, links them to health and social services, and advocates for workers' rights. Ongoing support from the foundation has allowed the GWC to coordinate outreach, conduct health and safety workshops, and improve access to health care services. For example, culturally sensitive classes are offered on topics such as nutrition, mental health, children's health, domestic violence, how to obtain medical services, and instructions for reporting health and safety violations.

ADDRESSING COMMUNITY HEALTH CONCERNS

Foundations and labor groups can help build community-based coalitions to protect the health and welfare of working people. These broad-based coalitions address issues ranging from economic development to increased access to health insurance. Labor unions engaged in such coalitions can assist with local and state advocacy efforts as well as help with public education campaigns. The Nathan Cummings Foundation, for example, is part of a growing movement to refocus local land use and community development planning to include "explicit consideration of community needs like healthy environments, access to health care, and good jobs with living wages and health benefits" (The Nathan Cummings Foundation 2006). In 2006 the foundation awarded a grant to the Colorado-based Front Range Economic Strategy Center (FRESC), which develops and negotiates community benefit agreements (CBAs) with local governments and developers. CBAs leverage city investment in large-scale, multi-use urban redevelopment projects to set standards for a healthy environment, safe construction, and family-supporting jobs. FRESC and its partners, such as the Colorado AFL-CIO and Denver Area Labor Federation, also work to promote contracting practices that reward responsible, locally based, "high-road" companies that create good local jobs, pay fair wages, and provide adequate health care and other benefits. FRESC's first CBA, based in its Campaign For Responsible Development, focused on a polluted, 50-acre brown-field, which is upstream from many of Denver's poorer neighborhoods. The site was selected because of the opportunity it presented to develop relationships between the city's environment, labor, and faith-based organizations.

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PROMOTING ECONOMIC MOBILITY

Low-wage workers often lack opportunities to advance in their careers or develop the skills necessary to obtain well-paying jobs. Workers may find themselves seeking new jobs requiring new skills due to lay-offs. Increasing workforce participation, however, is unlikely to yield meaningful health benefits for low-income workers and their families unless wage levels and working conditions associated with employment improve substantially. Health funders have a unique role to play in making employment a gateway to income security, self-sufficiency, and well-being.

The Nathan Cummings Foundation supports the Illinois-based Center for Labor & Community Research (CLCR), founded in 1982 by local union and community leaders in reaction to plant closings and the impact they had on local communities. CLCR's Illinois High Performance Manufacturing Initiative, a partnership of the Illinois Manufacturers Association and the state AFL-CIO, has developed "high-road" strategies working to establish improvements in benefits and working conditions for workers while also strengthening employers. As part of its work, the initiative is developing a new polytechnical academy. The academy will have relationships with manufacturing companies in the region and provide its students with work exposure, internships, apprenticeships, and access to careers in manufacturing. It is also working with Community Colleges of Chicago to help redesign manufacturing programs to more effectively meet industry's demand for a skilled workforce and to prepare residents for family-sustaining careers in manufacturing.

CONCLUSION

The social justice goals of foundations and labor organizations make them uniquely positioned to affect real change in the health and well-being of American workers and their families. Grantmakers can find strong allies in labor unions and their constituencies to work on issues including access to health coverage, living wages, and paid pick leave, as well as workplace safety. After carefully considering their goals and objectives, foundations can use a variety of strategies to support labor groups or partner with them.

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inspiring action:

foundations and religious organizations

Philanthropy has a long history of funding faith-based institutions because of their deep roots in communities and their strong commitment to doing good deeds. More and more, health funders are recognizing that, in addition to meeting the spiritual needs of their members, churches, synagogues, and mosques are offering health education programs, providing health services, and advocating on behalf of health policy issues. Partnerships between foundations and religious organizations can bring together two powerful community institutions in ways that extend the reach and effectiveness of both.

THE BENEFITS OF COLLABORATING WITH FAITH ORGANIZATIONS

Faith-based institutions can be good strategic partners for foundations for a number of reasons. First, there are a huge number of religious organizations in this country, most with well-established organizational structures. Many are used to operating on limited budgets and have become frugal stewards of available resources, which means that a small grant can go a long way. Churches, synagogues, and mosques often have existing relationships with hard-to-reach vulnerable populations. They also have ready access to a pool of active and committed volunteers and a commitment to leadership development, producing leaders through their religious education programs, youth development work, and financial or administrative structures. And clergy and congregations can often bring immediate and enduring credibility to projects, winning the respect and trust of community members more easily than many public agencies, academic institutions, and traditional social services and advocacy organizations.

Religious organizations also have a long tradition of being safe places and powerbases for people to gather and discuss difficult issues. They have a strong track record of meeting community needs and participating in social justice movements. Many are surprisingly diverse by race and ethnicity, socioeconomic status, gender, and age. Because faith and lay leaders have an intimate understanding of the daily challenges people face in life, they can often provide the stories that give a face and name to the statistics that drive public policy change efforts. Finally, many religious organizations have witnessed enormous change in the communities in which they sit and can help funders identify trends, challenges, and opportunities (McGraw et al. 2000).

Perhaps most importantly for health funders, faith-based institutions devote considerable resources to health care programming. In September 2007 the National Council of Churches USA, an ecumenical agency composed of 35 denominations, released the results of their *Congregational Health Ministry Survey*. The survey, conducted with support from the Robert Wood Johnson Foundation, was sent to a sample of 88,000 of the council's 105,000 local congregations. Nearly three-quarters of the 6,000 responding churches offer direct health services. Two-thirds run health education programs. Half give direct financial support to people struggling to pay their medical bills. Over a third engage in public policy and advocacy activities. Most congregations engage both members and non-members in these efforts (National Council of Churches USA 2007).

In addition to meeting the spiritual needs of their members, faith-based institutions devote considerable resources to health care programming. A recent survey found that nearly three-quarters of responding churches offer direct health services, two-thirds run health education programs, half give direct financial support to people struggling to pay their medical bills, and over a third engage in public policy and advocacy activities.

FACTORS THAT CAN MAKE COLLABORATION CHALLENGING

It is important to note that many foundations have policies that prohibit funding religious organizations. These policies are in place for a number of reasons. Some grantmakers mistakenly believe that philanthropic grants to churches, synagogues, and mosques are illegal. Others are reluctant to invest in religious organizations because they are unsure whether they can prevent proselytizing in funded programs. Still others are concerned about whether funding one faith or denomination might make it appear that they favor that one above others. In addition, a number of funders are

skeptical about organized religion's role in health and social services and pride themselves in their institution's religious neutrality (Lundberg 2004; Franklin 2005).

ARE GRANTS TO CHURCHES LEGAL?

If a grantmaker's organizing documents (certificate of incorporation, trust instrument, or bylaws) do not prohibit funding religious institutions, generally there is no restriction against making grants to churches, synagogues, mosques, or other religious institutions. The First Amendment to the Constitution, with its bar on governmental action that advances or inhibits religion, does not apply to private grantmakers.

Charitable purposes include the promotion of religion so that grantmakers with organizing documents that allow them to promote broad charitable purposes may make grants to religious institutions for their core religious functions. Some grantmakers choose to support only the nonsectarian activities of these organizations, but this is a policy choice, not a legal requirement.

Grantmakers with organizing documents that bar them from advancing religion may have to make fine distinctions between church-based programs that do and those that do not promote the religious beliefs of the sponsor.

HOW DO YOU KNOW IF A CHURCH IS A PUBLIC CHARITY?

Unlike most other charities, churches are not required to file an application for recognition of exemption from federal income tax with the Internal Revenue Service (IRS).

Nonetheless, many churches are covered by group exemption rulings obtained by their convention or denomination, and many churches not covered by such rulings have obtained their own determination letters. If a potential grantee asserts that it is covered by a group exemption, the grantmaker may confirm its status by reviewing a copy of the determination letter and finding a listing of the grantee in the denominational directory or other comparable record.

If a potential grantee claims that it is a church but does not have a determination letter or a group exemption ruling, it will be the grantmaker's responsibility to assess whether the entity is a church, and thus, a charitable organization. There is no definition of a church in the Tax Code, but the IRS has developed a list of common characteristics of churches.

Source: Nober 2007

Even if a foundation's organizing documents permit support for religious organizations, funders can be stymied by the heterogeneity of the faith community. Wide variation across the sector can make it difficult for funders to design a single initiative appropriate for all congregations or to determine quickly a congregation's readiness for foundation funding. Some religious organizations have long traditions of service to the community while others focus more on the needs of their own membership. In some congregations, the clergy will be the ultimate decisionmaker about programs; in others, lay leadership will dominate. Some religious organizations include evangelizing elements in social service and health projects and others do not.

The differences do not end there. Some religious organizations are independent and have very loose or no ties to regional, state, national, or international bodies; others will need permission from structures beyond the local church before a program can be started. Congregations have different levels of interest in interfaith efforts, with some readily participating in collaborative efforts with other faith communities and others avoiding arrangements that might diminish their independent decisionmaking or require modification of some of their practices. Finally, congregations vary in terms of available financial and human resources applicable to project work.

Despite these variations, there are a few challenges that funders agree are inherent in partnerships between foundations and religious organizations, all of which will be familiar to grantmakers with experience working with small community organizations.

- **Capacity is often a major concern.** Mega-churches may receive a great deal of media attention, but most religious organizations are small, understaffed, and not equipped with sophisticated financial controls. Many churches, synagogues, and mosques do not routinely conduct external audits and will not have the ability to handle financial reporting as some funders expect.
- **Accountability and evaluation can be another problem.** Most religious organizations receive ongoing funding from denominational agencies that require little, if any, oversight or monitoring. This causes many to be intimidated by site visits, surprised by the level of reporting required by foundations, and inexperienced in constructing outcomes evaluation measures.
- **Sustainability presents a third challenge.** If faith institutions do not plan to invest their own financial resources in a foundation-funded project or charge fees for the services they provide, they can find themselves struggling to keep programs afloat when a grant ends (Moore 2001).

TYPES OF COLLABORATION A FOUNDATION MIGHT CONSIDER

Foundations can engage in many types of collaboration with faith organizations, including relationship building, technical assistance and capacity building, education, social support, health promotion and service delivery, community organizing and advocacy, or research.

- ***Relationship Building*** – In the early 1990s the Lilly Endowment, Ford Foundation, and W.K. Kellogg Foundation established the Philanthropy and Black Churches Project at the Council on Foundations. Later known as the National Office on Philanthropy and the Black Church and housed at the Southern Education Foundation, the project's goal was to bring together foundations and black churches that were working on the same social issues but had not formed strong working relationships. The project identified clusters of grantmakers interested in building relationships with black church leaders; designed informational meetings at the regional level; developed publications on legal considerations and due diligence questions; and helped to forge formal collaborations, many of which continue today (Franklin 2005).

- ***Technical Assistance and Capacity Building*** – One of these ongoing collaborations is between funders and clergy in Boston, Massachusetts. Beginning in the early 1990s, the Boston-based Hyams Foundation began supporting the work of several black churches that had banded together to address gang violence in their communities. The clergy helped police identify gang members; made home visits; held community meetings; and started daycare programs, after-school tutoring programs, and peer mentoring programs. Eventually working in collaboration with the Mayor's office, the Catholic Archdiocese, and Jewish nonprofit organizations, the churches achieved dramatic results (the number of homicides dropped from 152 to 43 between 1990 and 1997) and received national attention. Led by the Hyams Foundation, Boston-area funders began to direct funds to these churches and their community outreach programs and established the Black Church Capacity Building Program, which provides training and individual technical assistance in program planning and development, grant proposal writing, leadership development, financial management, computer technology, and facilities development (Lundberg 2004; Franklin 2005).

  In 2002 the federal government created the Compassion Capital Fund (CCF) as a key component of President George W. Bush's faith-based and community initiative. The fund works through intermediary organizations to help faith-based and community organizations build their organizational capacity. Several of the Boston churches that had been nurtured by local foundations over the past decade were well positioned to access these newly available funds and came together with the United Way of Massachusetts Bay to develop a CCF intermediary organization called the Boston Capacity Tank. The tank provides capacity-building services to faith-based and community organizations that work with at-risk and high-risk youth in Boston, helping young people receive needed services and access relationships with supportive adults.

- ***Social Support*** – Volunteerism is a hallmark of congregational life. Even congregations that do not think of themselves as interested or involved in providing health services organize volunteers to visit the sick, prepare meals for the homebound, provide transportation to medical appointments, and help with health-related paperwork. These programs often occur informally and on a small scale. In the early 1980s, the Robert Wood Johnson Foundation began to see the potential of these programs to support and supplement the caregiving that families and friends provide to people who need chronic care. Aware that most individual congregations did not have the resources necessary to staff and oversee their volunteer programs adequately, the foundation began to test an interfaith volunteer caregiving model in which a group of congregations representing the community's various faiths came together, hired a paid director, and established a single caregiving program that drew its volunteers largely from the participating congregations to serve the entire community. Having a paid director made the program better organized and more structured, and the program's interfaith design avoided religious proselytizing, which

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> *"Faith communities have a long and important tradition of providing health services to the most vulnerable in our nation. Now that one in seven Americans has no insurance, and therefore has difficulty accessing needed health care, the work of our churches has never been more important. The bottom line, however, is that they cannot shoulder this burden alone. The health care crisis is a national problem that needs national, bipartisan solutions."*
>
> *– Risa Lavizzo-Mourey, Robert Wood Johnson Foundation*

often made the services more acceptable to those in need of care (Jellinek et al.1999). This demonstration project grew into the Faith in Action initiative, which currently boasts 719 programs in 48 states.

- ***Health Education*** – In 2006 the Kansas-based United Health Ministry Fund released *Health through Faith and Communities*, a study guide intended for Christian groups to explore the connections between spirituality, personal health, and social well-being. The book was more than five years in the making, beginning as an idea among members of the fund's trustees and staff and written by a team of social work and religious studies academics. Covering a wide range of topics from addictions and mental illness to faith-based community organizing, the book is designed to be easily adapted to adult Sunday school classes, workshops, and retreats, with the goal of helping congregations promote personal and social health in the church community, the local community, and beyond.

- ***Health Promotion and Service Delivery*** – Many churches, synagogues, and mosques offer sustained, ongoing health promotion programs that provide screenings, classes, and prescription checks and include content related to end-of-life issues, nutrition, high-blood pressure, drug and alcohol use, mental health, dementia, organ donation, diabetes, obesity, AIDS, smoking, and family planning. Other congregations provide more intensive health care services, including drug and alcohol counseling, health screenings, and the operation of health clinics.

  Knowing that faith-based institutions and small secular organizations serve an important role in the life of many communities in their service area, the Missouri Foundation for Health recently developed the Health Interventions in Non-Traditional Settings (HINTS) initiative. Grants made through HINTS are designed to support efforts of eligible nonprofits, not typically considered traditional health organizations, to increase access points to community health services. In October 2007 the foundation awarded a series of grants to 45 religious organizations for a variety of activities, many of which might provide funding ideas to other state and local grantmakers. They include:

  - providing transportation to health centers and interpretive services for area African refugees;
  - offering health assessment, screening, and exercise programs for area older adults;
  - expanding health services to homebound elderly;
  - helping area seminary students learn about healthy behaviors and exercise to both improve their own health and the health of future congregations;
  - expanding a dental treatment program to 300 additional low-income, underserved youth;
  - helping at-risk youth in dealing with depression and other emotional issues;
  - implementing a wellness and relapse prevention program for people dealing with mental illness;
  - providing information, counseling, and access to health care for lesbians, gay men, and people who are HIV-positive;
  - providing support services to young women facing unplanned pregnancies;
  - training adult youth leaders in mental health and first-aid practices;
  - expanding a training program for clergy on reproductive loss counseling;
  - training registered nurses to become parish nurses;
  - expanding counseling programs for individuals with addictions to drugs and/or alcohol;
  - expanding a clean air program, which works to reduce air pollution and asthma attacks;
  - supporting a program for low-income families that focuses on increasing healthy child development and reducing child abuse and neglect;
  - expanding services to homeless women with addictions to include anger and stress management classes, as well as relapse prevention classes and counseling; and

- enabling a domestic violence shelter to address the physical and mental health of its clients by adding a parish nurse component.

➤ ***Community Organizing and Advocacy*** – Their deep roots in communities and commitment to social justice have long made churches, synagogues, and mosques central actors in community organizing and advocacy efforts. A number of prominent health funders, including The Marguerite Casey Foundation, The California Endowment, The California Wellness Foundation, The Nathan Cummings Foundation, The James Irvine Foundation, and The San Francisco Foundation provide support to People Improving Communities through Organizing (PICO), a national network of faith-based community organizations working to create innovative solutions to problems facing urban, suburban, and rural communities. Since 1972 PICO has worked to increase access to health care, among other issues, working through more than 50 different religious denominations and faith traditions. With more than one thousand member institutions representing one million families in 150 cities and 17 states, PICO is one of the largest community organizing and advocacy efforts in the United States. In the past year, PICO affiliates have helped convince Florida policymakers to pass $1.1 million legislation that will open 5,000 new slots in the state's KidCare program; pushed for progress on children's health coverage in Alaska, Colorado, Missouri, and New York; and led a highly visible advocacy campaign for federal State Childrens Health Insurance Program (SCHIP) expansion.

➤ ***Research*** – When the Robert Wood Johnson Foundation funded the National Council of Churches to survey its members about their health ministries, they were breaking new ground. In the survey report, the authors lay out a series of research questions that merit follow-up. They encourage researchers to explore how these programs began and how they are maintained, as well as the number of persons served and approximations of the aggregated financial value of such programs within the national health care economy. They recommend that high priority be given to the development and application of research that might effectively explore communities of color and other marginalized communities where health disparities are acute. Finally, they recommend inquiries into the training, recordkeeping, and substance of advocacy activities in U.S. congregations (National Council of Churches USA 2007).

COLLABORATION STRATEGIES

Over the years, health funders have learned valuable lessons about how best to collaborate with faith institutions.

DUE DILIGENCE: QUESTIONS TO ASK FAITH-BASED APPLICANTS

1. Is this an organizational priority or the individual project of a member? Is the congregation solidly behind the program?
2. Has the congregation prepared itself for the unique governance challenges of this program? Who will make the program decisions?
3. What good are you trying to accomplish? Are the desired outcomes realistic and measurable?
4. How will this project work over the long haul and meet difficult financial times? Will the program be able to survive after foundation funding ends?

Source: Moore 2001

Their advice:

➤ ***Building the Relationship***

- Get to know faith-based institutions by involving them in all coalition-building efforts funded by the foundation.
- Begin with issues – access to primary care, children's health, care for the elderly – on which the foundation and religious organization can find common ground, allowing both to stay within their values-boundaries and not jeopardize constructive relationships with divisive issues.

➤ ***Developing a Special Initiative or Grant Program***

- If the foundation has policies that prohibit funding churches, synagogues, and mosques, consider collaborating with interfaith coalitions or programs with church affiliations.
- Establish a small pot of funds solely for investing in health projects of faith organizations that show promise but may be more risky than normal. Use these projects to help inform the funder's strategic planning process.
- Construct grant guidelines that make the foundation's expectations about inclusivity and proselytizing clear. Programs can contain an intentional faith element without excluding potential participants for religious or other reasons or seeking to convert.

➤ *Easing the Grant Application Process*

- It is often difficult for religious organizations to match grant-writing skills with more experienced foundation grantees. Tailor requests for proposals (RFPs) to include religious organizations or design separate RFPs for religious organizations when there is particular work they can accomplish.

> ***"The faith-based community has a big role to play in keeping our communities healthy...It is a part of our entrepreneurial outreach to make sure that we're helping those problem solvers out there get the work done."***
>
> *– Pat Brandes, Barr Foundation*

- Encourage faith-based applicants and grantees to involve individuals within the congregation who have outside experience with grants in program planning and implementation.
- Hold grantee pre-application meetings with religious organizations, which emphasize evaluation and reporting expectations.

➤ *Adjusting the Foundation's Guidelines*

- Recognize that it is difficult for many congregations to provide the financial documentation that grantmakers require and consider adjusting foundation guidelines.
- Consider funding facility and/or equipment costs, which may be necessary in order to make church, synagogue, or mosque facilities adequate for a health project.

➤ *Addressing Sustainability*

- Help address sustainability challenges by encouraging religious organizations to emphasize in-kind support and keep paid staff small, insisting on some church budget contribution from the start, and being clear about the prospects for grant renewal.
- Require the governing body of the religious organization to acknowledge key terms of the grant at one of its meetings and provide an adopted resolution as part of final grant documentation.

➤ *Helping to Ensure Success*

- Develop appropriate networking with other religious and secular organizations undertaking similar work to expose religious organizations to best practices.
- Acknowledge that the religious or spiritual elements of the program can be positive forces.

Faith-based institutions are often the organizations best positioned to affect lasting change in communities in need. While there are particular sensitivities inherent in collaborating with religious organizations, many funders have found that the benefits far outweigh the challenges.

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improving children's health:
foundations and schools

Public schools are an integral part of almost every community, enrolling nearly 50 million students across the country. The reach and influence of schools suggest that investing in the development of strong schools can significantly improve the well-being of children and their families. The links between education and health first emerged in the 19th century when states exercised the power to compel vaccination for children entering school (Hodge Jr. 2002). The power of this linkage is still seen today with immunization rates rising from 82 percent for preschoolers to over 95 percent for school-age children. (CDC 2008a; CDC 2008b).

Education and health are inextricably connected in American society. Young people who drop out of school face numerous health risks leading to increased mortality rates and higher medical costs. (Freudenberg and Ruglis 2007; Alliance for Excellent Education 2003). Conversely, poor health status can compromise academic achievement. Exposure to lead, low birth weight, and inadequate nutrition can adversely affect cognitive development, preventing children from meeting grade-level performance expectations (Grantmakers for Education 2006). Evidence suggests that children with chronic medical conditions, such as obesity, are less likely to achieve academic success than their healthy classmates.

For many health foundations interested in children's health, working with schools is a natural strategy allowing them to reach a majority of the school-aged population in an efficient, effective manner. In many communities, particularly vulnerable neighborhoods, schools are an important resource providing not only education for children, but also public information, opportunities for community building, and, in some cases, health care services. While the potential of working closely with schools is great, these initiatives are not without challenge. Schools, especially those in low-income communities, are often strapped for time and resources, which can slow momentum for innovative health improvement efforts.

TYPES OF SCHOOL-BASED PARTNERSHIPS

Funders pursue partnerships with educational systems with a variety of goals in mind: helping to improve transitions for students across developmental levels, increasing the capacity of school staff and parents to support children's healthy development, ensuring success in postsecondary education and life, and ultimately strengthening neighborhoods and entire communities (Jehl 2007). These partnerships can focus on a wide variety of interventions, including clinical health care services, wellness programs, and health promoting environmental change.

IMPROVING ACCESS TO HEALTH CARE SERVICES

For many health funders, supporting school-based health centers (SBHCs) is a logical approach to expanding children's access to health care services. SBHCs emerged in the late 1960s in Cambridge, Massachusetts, in response to the need for better health care for low-income children (Brodeur 1999). Today, over 1,700 SBHCs provide services to students for whom seeking health care advice in the school setting is both comfortable and convenient. Many centers are equipped to address a number of clinical health issues, including comprehensive primary and preventive care, oral health and mental health treatment, and health education services. Research from The Health Foundation of Greater Cincinnati indicates that SBHCs generate about two dollars in social benefits for each dollar spent on operating costs. SBHCs also increase access to health care for the most vulnerable children and keep children in school and able to learn (The Health Foundation of Greater Cincinnati 2005). Some SBHCs also provide expert medical advice to teachers and administrators to help them address broader school health concerns related

The Centers for Disease Control and Prevention's Division of Adolescent and School Health is devoted to preventing health risks among school-aged youth by conducting surveillance to monitor health issues, synthesizing and applying research, providing funds to nonprofit and educational agencies to develop HIV prevention curricula, and providing technical assistance to evaluate school health programs. Learn more about the array of programs at http://www.cdc.gov/HealthyYouth/index.htm.

to infectious disease control and positive behavioral interventions.

Understanding the connection between healthy bodies and healthy minds, The Colorado Trust awarded $1 million to expand SBHCs throughout the state. Beginning in January 2008, the funding will help existing SBHCs provide services such as primary care, immunizations, outpatient mental health and substance abuse treatment, and preventive dental health services; enroll children in Child Health Plan Plus (Colorado's version of the State Children's Health Insurance Program or SCHIP); and address other children's health concerns in the community. The funding will also allow the creation of new health centers in underserved parts of the state, and a separate grant will support a school health task force that will develop a statewide plan to strengthen the system of integrated school health.

Rather than funding comprehensive school-based primary care, some health funders have elected to focus their support on targeted services that may be particularly scarce in the community such as dental care, mental health treatment, or specialty asthma management services. The opportunity for reaching children is great: nearly 80 percent of children receiving mental health services first seek services in a school setting (Burns et al. 1995). The opportunity to improve school achievement also exists as nearly 51 million school hours are lost each year to oral health problems alone (The Center for Health and Health Care in Schools 2007). Similarly, uncontrolled asthma accounts for 14 million lost school days and is the third-ranking cause of hospitalization for children under age 15 (CDC 2008c).

TEACHING HEALTHY BEHAVIORS

Another option for health funders seeking to support healthy schools is health education focused on topics such as physical activity, nutrition, and substance abuse prevention. In many cases, these health-related curricula can be broadly disseminated. For example, in 2007 the Blue Cross & Blue Shield of Rhode Island Foundation provided funding to the Chad Brown Health Center to develop Mark, Set, Go!, a culturally sensitive, school-based, healthful eating and physical activity program. The program targets over 300 fifth- and sixth-grade students from Providence and their families. The program aims to increase the physical activity, nutrition awareness, and fruit and vegetable consumption of participants by implementing a comprehensive educational curriculum. Minority high school students serve as peer health educators in the classroom to provide an eight-week workshop that uses age-appropriate educational materials focusing on healthy lifestyle choices.

In California, the Alliance Health Care Foundation and The California Endowment provided nearly $380,000 to Hoover High School to develop and pilot a school-based program that integrates health education into core academic curricula. Math lessons, for instance, might incorporate examples of healthy nutrition and activity. The program, serving 2,300 San Diego-area students, will address behavioral risk factors and link high-risk youth to existing health and social services. The project developed health modules, including teacher lesson plans and support materials on sexual health, substance use and prevention, nutrition, and healthy eating, self-esteem, and anger management. Filling the school's need for comprehensive health education, the curriculum allows students to learn about and decrease their engagement in risky health behaviors.

School officials are increasingly concerned with the behavioral health of their students. Students experiencing a behavioral health problem will have difficulty learning, and their condition may also affect the quality of education of their classmates. The American Psychiatric Foundation developed the Typical or Troubled?™ program, a school-based, mental health education program to address the gap between recognition of mental illness and appropriate diagnosis and treatment in young adults. The program was implemented by 17 nonprofit organizations, schools, and school districts in a total of 73 high schools during the 2006-2007 school year. More than 4,000 teachers and other school personnel received in-service training conducted by school mental health staff

The American Academy of Pediatrics (AAP) has developed comprehensive health guidelines for schools. *Health, Mental Health, and Safety Guidelines for Schools* was developed with input from over 300 health, education, and safety professionals from more than 30 different national organizations as well as by parents and other supporters. Acknowledging the association between good health and academic success, AAP makes a number of suggestions for schools, including developing a health and safety advisory council, evaluating school health programs, and hiring health education teachers who have appropriate qualifications for teaching health and safety classes. The guide provides a useful assessment tool for funders and their partner schools seeking to identify improvement opportunities and can be found on-line at http://www.nationalguidelines.org.

in collaboration with mental health professionals from their local communities.

PROMOTING HEALTHY SCHOOL ENVIRONMENTS

Because most children spend such a large proportion of their time in school, the very nature of their classrooms, cafeterias, school yards, and bus stops exerts a powerful environmental influence on their health and well-being. For example, many schools, particularly those in urban areas, simply do not provide a safe space for children to play. Decreased playtime during the school day has been linked to increased behavioral problems and slower increases in brain development. Expanding cafeteria choices and vending machine selections to include nutritious meals and snacks, designing safe places for physical activity, encouraging children to walk to school when possible, and reducing diesel emissions by retrofitting school bus exhaust systems are all effective strategies that schools can use to improve children's health.

Through the Robert Wood Johnson Foundation's Active Living by Design program, communities around the country have established innovative approaches to increasing physical activity in and around schools. The Albuquerque Alliance for Active Living, for example, developed a "walking school bus" program, whereby children who live within one mile of their elementary school walk there together with an adult supervisor. A team, including a National Park Service representative, a school nurse, a neighborhood association representative, and students from the University of New Mexico, developed a structured route that provides a safe, healthy way to get to and from school (Desjardins and Schwartz 2007).

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EFFECTIVE ENGAGEMENT

Regardless of the intervention, there are some specific strategies and tactics that funders should keep in mind when working with schools. Making sure that each party's goals and priorities are in line, building the right relationships, developing strategies to address opposition, and ensuring sustainability are all keys to successful partnerships.

- ***Aligning Goals and Priorities*** – The No Child Left Behind Act (NCLB), enacted in 2002, expanded the federal government's role in public education and created unprecedented accountability requirements for local schools. Requirements of NCLB include annual testing of students in third grade through high school; stricter degree requirements for academic teachers; surveillance of achievement gaps between racial and ethnic groups; and equal achievement goals for all students, including those with disabilities or limited English proficiency (Grantmakers for Education 2006). Though some view these requirements as simplistically rigid, others laud the introduction of national standards. Regardless of one's view regarding the merits of federal oversight, testing pressures, particularly in low-performing schools, have undoubtedly increased, and these pressures have sometimes served to strip resources away from any activity not seen as an immediate boost to test results.

  In an attempt to redirect resources, schools often cut other important programs from their budgets such as physical activity programs, art classes, programs for gifted and talented children, and school nursing services. On a broader level, schools are facing numerous educational reform issues such as the emergence of charter schools, the continuing debate on the optimum student-to-teacher ratio, and the call by some for increased school choice through the use of vouchers. With these pressing concerns, health often falls to the bottom of the list of a school's priorities. In fact, health objectives have the potential to be at odds with some educational reforms. For instance, many believe that smaller schools, not just smaller classrooms, may lead to better educational outcomes, but school-based health services typically require a critical mass of students to be financially viable. An optimally sized student body for academic purposes may not provide the ideal population for school-based health services.

  In addition to experimenting with educational reforms, teachers, administrators, and school health personnel are also grappling with the increasing number of students with special learning needs who spend time in regular classrooms. Almost 14 percent of students receive special education services because they have a disability, and approximately 75 percent of these students are educated in regular classrooms with other children for a significant part of the school day (Grantmakers for Education 2006). Students with special needs are expected to achieve test

scores equivalent to their peers, and schools may feel overwhelmed attempting to meet the health and academic needs of these disabled children. Special education programs for disabled children have been highly litigious and can command a large percentage of a district's overall budget. In some districts, health-related resources may be largely committed to this vulnerable population with limited funding remaining for more proactive health investments for the general student population.

Funders should be certain that their efforts to accelerate change complement [schools'] goals and do not burden school leaders with new, tangential strategies or piecemeal reform efforts.

Before entering into a grant agreement, foundations and schools need to ensure that their goals and processes are aligned. Health funders need to recognize that the primary mission of schools is education and that health-related activities may appear to be an additive, unwelcome distraction from that mission. Most schools acknowledge that academic achievement can be thwarted by problems found outside the classroom door and are already working toward improving the lives of their students. Funders should be certain that their efforts to accelerate change complement those goals – and do not burden school leaders with new, tangential strategies or support piecemeal reform efforts (Grantmakers for Education 2006). Health funders should not assume that the academic payoff of health-related programs is obvious. A "business case" demonstrating that the proposed intervention will lead to improved academic performance may be needed to garner the support of decisionmakers in the educational system.

- ***Building the Right Relationships*** – As with any partnership, it is critical to develop trusting relationships with the appropriate stakeholders. For both health funders and school officials, working together may be unfamiliar territory. Schools may not have experience receiving private grants, and funders historically focused on the health care system may not quite grasp the landscape of education. To maximize their impact, funders should concentrate on gaining the support of the principal; as leaders with considerable authority, principals make most of the decisions within schools, from time allotted to physical activity to what products are available in vending machines.

Depending on the boldness or scope of the endeavor, it may also be important to consider how the particular district operates. For example, some school boards are instrumental in setting policies and budgets. In other localities, this practice is left up to other governmental bodies. In some places, funding for school nurses is provided through a specific county tax or through the local health department, rather than as a part of the school district's budget.

Involving other partners in the community is important as well. For example, parent groups, the United Way, other child-serving agencies, and county departments of health and education all have a vested interest in children's education and health, and collaboration among these groups may assure a more holistic approach to promoting children's well-being. In fact, in some instances, foundations have chosen to fund community agencies to work with schools. Foundations can also work as neutral parties to convene medical providers and school officials.

The Blue Cross Blue Shield of Massachusetts Foundation worked with a variety of community partners to develop a program that would prevent and promote early detection of mental health concerns and provide access to resources for children and families with mental health issues. In cooperation with Boston public schools, Massachusetts General Hospital, Harvard University, the YMCA, and the Big Brother/Big Sister Association, the foundation helped implement Responsive Advocacy for Life and Learning Youth (RALLY) at Curley Middle School in the Jamaica Plain neighborhood of Boston. RALLY combines developmental theory, research, and practice to provide young people with integrated academic and emotional support; helps build students' resilience through relationships with positive adult figures; pulls supports into the classroom rather than pulling students out for specialized services; and works in collaboration with families, teachers, school administrators, community programs, mental health professionals, and others to support students' academic success. RALLY's interventions have helped students achieve better grades, and those with behavioral or conduct disorders were better able to manage their condition. As a result of its success in Boston, RALLY has been replicated in middle schools in Hawaii, New York, and Washington.

- ***Facing Oppositional Forces*** – Funders should not assume that school-based programming to improve children's health will be non-controversial and widely embraced. There are a variety of adversarial forces that schools may face when trying to integrate health into classrooms and

clinics. For example, SBHCs can face a high level of opposition ranging from parental objections regarding the provision of birth control or counseling about safe sex practices to competitive concerns from community-based health care providers that they may lose patients to the SBHC. Despite such opposition in some communities, SBHCs have flourished because of parental support and recommendations by the American Medical Association, the U.S. Public Health Service, the American Academy of Pediatrics, and other expert health groups. Compromises are often necessary, however. Many SBHCs may forgo family planning services to preserve support for primary care. In these cases, referral relationships with community-based providers are typically established to ensure comprehensive service availability.

Business interests can also undermine efforts to change the school health environment. A number of school districts believe that shifting cafeteria and vending offerings to decrease or eliminate unhealthy foods will result in significant revenue reductions. Studies show that school districts recoup one-third to over half of the revenue earned from soda sales. Some districts also receive signing bonuses, exclusive marketing right payments, and other financial incentives not tied to sales volume that can range from $55,000 to $1 million depending on the size of the district (Isaacs and Schwartz 2006).

Work by The California Endowment has helped to counteract such opposition. The endowment funded analytic studies that identified healthy options for vending machines and provided strategies for fundraising that did not involve junk food. Governor Arnold Schwarzenegger subsequently signed legislation that banned junk food and soft drinks from schools and provided funding to incorporate more fruits and vegetables in school breakfast programs. Resistant schools, and the vendors who wanted to keep their business, were forced to offer healthier options for students.

- ***Ensuring Sustainability*** – Sustainability is a critical factor in maintaining school health initiatives. Failing to identify and address sustainability concerns can lead to the discontinuation of effective programs. Can SBHCs or health-related curricula continue without foundation support? How can schools raise money or convince districts to include these programs in school budgets? In the early 1990s, SBHCs had been supported primarily by large foundations, local health departments, and block grants from the Maternal and Child Health Bureau; only seven states had allocated state funding for SBHCs. Through its Making the Grade program, the Robert Wood Johnson Foundation explored ways to open funding streams. Over the years, states have developed a variety of contractual arrangements and funding strategies to keep health centers running in schools. In the past, controversies regarding inappropriate Medicaid billing practices related to school-based health services led some school administrators and state Medicaid officials to be extremely cautious about seeking Medicaid reimbursement. Some funders have found that SBHCs led by traditional medical providers end up being more sustainable because they have developed the documentation systems necessary to support insurance claims. School officials are often not as familiar with Medicaid billing and the dizzying array of funding sources (Brodeur 1999).

  Foundations can help schools secure sustainable funding by providing technical assistance and other resources. For example, the W.K. Kellogg Foundation, along with Blue Cross Blue Shield Michigan, has supported the School-Community Health Alliance of Michigan. The alliance will use the funds to purchase and develop a centralized third-party billing and reporting system that will enable SBHCs in the state to bill insurers for covered health services provided to students with public or private health care coverage. The new system is also expected to track health services provided to students that are not covered by private or public insurance, providing data that can help in the future design of health insurance for children. The alliance also succeeded in securing $8 million in federal funding to expand SBHCs in the state and helped create policy change that expanded the population eligible to receive services at SBHCs to children from birth to age 21.

CONCLUSION

Schools are in a unique position to improve the health of children. The educational system, however, poses its own challenges that may detract from educators' attention to health services. Support from the broader community, including providers, families, and local government, is needed to ensure that schools remain healthy places for children to learn and grow.

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