

Supporting Local Efforts

to Improve Health Care Access

The number of Americans without access to health care has continued to climb due to rising medical costs, ongoing declines in employer-sponsored coverage, and recent cuts in public programs. With no national solution in sight, many cities and counties across the country have designed local initiatives to provide coverage and care for their uninsured residents. Over the last decade, millions of dollars have been invested in these local projects. National, state, and local foundations have been key players in these efforts; in many places it is unlikely that large-scale expansions would have taken place without philanthropic support (Ryan 2005).

The structures of these community initiatives have varied, and some have been more successful than others (Ryan 2005). Those that have enjoyed the greatest attention seem to have a combination of several factors: stable funding, supportive policymakers and advocates, and an established safety net. These programs are of enormous value to enrollees and provide key lessons for future health care reform efforts. Because of inherent financing challenges, however, few of the programs provide coverage or care to more than a small percentage of their community's uninsured residents. They are necessary but temporary solutions, and no substitute for broad national reform. It is, therefore, critical for funders, health care experts, and community leaders to be realistic about what such programs can achieve and how these efforts fit into larger strategies for improving health insurance coverage and access to care (Taylor et al. 2006).

COMMUNITY APPROACHES TO PROVIDING CARE FOR THE UNINSURED

The customary community approach to providing care to the uninsured is through safety net providers, such as community health centers and clinics (Taylor et al. 2006). Foundations have long been strong supporters of local safety nets, in many cases providing seed funding for new sites of care. One good example is that of the Central Susquehanna Community Foundation, which, in 2002, worked with an array of community organizations to establish a dental clinic to serve a small city and surrounding rural areas in central Pennsylvania. Prior to the clinic's opening, many low-income residents traveled 45 minutes or more to see a dentist who would accept medical assistance patients, or simply went without dental care. Today, the clinic serves nearly 3,000 patients. The foundation made a \$500,000 investment in the clinic's start up and has made smaller grants over the years to enable the clinic to increase staff salaries.

Grantmakers have also supported pioneering ideas to develop the safety net into an efficient system of care for low-income people and innovative models to meet the needs of vulnerable populations. For example, the W.K. Kellogg Foundation has been a key proponent of training community health workers, changing state licensing policies to address workforce shortages, and streamlining enrollment in public programs through computer technology (Meyer et al. 2004).

Another popular approach has been the donated care model, in which participating providers agree to see a certain number of patients or to provide a certain number of visits for free each year. Most donated care programs were inspired by Buncombe County, North Carolina's *Project Access*, which received early support from the Robert Wood Johnson Foundation (Ryan 2005). Quantum Foundation recently made a \$585,000 grant to the Palm Beach County Medical Society in Florida to replicate *Project Access*, in an effort to organize existing ad-hoc physician charity care.

Several communities have also developed new insurance products to cover the uninsured. The premier example of this model, *Access Health* in Muskegon County, Michigan, began in 1993 with a partnership grant from the W.K. Kellogg Foundation and the Community Foundation of Muskegon County. Under the plan, which began enrollment in 1999, the employer and employees each pay 30 percent of the cost of coverage (\$46 per month), and *Access Health* covers the remaining 40 percent (\$56 per month). The *Access Health* share is made up of a combination of local government, community, and foundation funds, in addition to federal disproportionate share hospital (DSH) funds. Four hundred and thirty businesses now provide coverage to 1,500 employees and their families through the program (Ryan 2005).

In California, 30 counties are in the process of replicating the *Santa Clara County Children's Health Initiative*, an innovative effort to guarantee that all children have access to health coverage. Each initiative has two parts. The first is a new insurance product, Healthy Kids, for children in families under 300 percent of the federal poverty level who are not eligible for Medicaid or SCHIP. The second is a comprehensive outreach campaign that finds uninsured children and enrolls them in whichever of the three programs is appropriate. Funding for the Healthy Kids coverage and for the Medicaid and SCHIP outreach comes from tobacco tax revenues, local and state contributions, and California's grantmakers, who have provided support for planning, technical assistance, outreach, technology, and premium subsidies. Together, these counties

have enrolled more than 70,000 children in their Healthy Kids plans and tens of thousands more under Medicaid and SCHIP. Program planners have been intentional about making the county initiatives as similar as possible, in the hopes that they may be expanded into a statewide program (GIH 2006; The Commonwealth Fund 2005).

LIMITATIONS OF LOCAL STRATEGIES

Many of these programs have been carefully evaluated, and their limitations have been thoroughly catalogued. The fundamental problem is that the limited resources available to community programs prevent them from taking their models to scale. The accessibility of committed funds – long-term dollars allocated exclusively for a particular local initiative – is essential to a community program’s survival and growth (Taylor et al. 2006). Although foundations have devoted considerable resources to these initiatives, philanthropy cannot entirely support their ongoing costs (Ryan 2005). It has been estimated that national proposals for covering the uninsured would result in an increase in national health spending ranging from \$23 billion to \$57 billion; total giving by foundations in 2004 was only \$15 billion (Sheils and Haught 2003; Foundation Center 2006).

INVALUABLE SERVICES AND USEFUL INSIGHTS

Local initiatives should not be dismissed simply because they struggle with sustainability and expansion. As long as their limitations are identified and acknowledged, these programs can provide an invaluable service in their communities and useful insights to grantmakers and policymakers alike (Chang 2006). Perhaps most importantly, these programs provide health care services to people who were not previously receiving them (Silow-Carroll et al. 2004). An added advantage of many models is the ability to pay providers who have been offering uncompensated care to the uninsured. Local initiatives are also clearly well-suited to adapt new programs to community assets and priorities, such as reaching out to specific populations or meeting particular needs (Taylor et al. 2006). And it is often the case that local policymakers, providers, patients, and advocates can best build the type of partnerships necessary to integrate care across fragmented health care settings and systems at the local level (Harvard 2006).

Much has been made of the local access initiative’s role as a laboratory for innovation and assessment, determining what works and identifying promising ideas for broader adoption (Harvard 2006). The more successful local initiatives offer a set of best practices that, with state or federal support, could be replicated and expanded. One interesting by-product of even the less successful programs is that the development process helped create a cadre of informed local stakeholders who are now knowledgeable about health policy and well-equipped to promote, implement, cultivate, and maintain broader reforms (Meyer et al. 2004). Finally, it can easily be argued that the philanthropic support of these initiatives has improved grant-making practice. Funders have learned several lessons from

their experiences with these initiatives, several of which have broad application (GIH 2005).

NO SUBSTITUTE FOR NATIONAL SOLUTION

Community access initiatives are, by nature, partial responses rather than complete solutions. Few cities or counties have the wherewithal to tackle the crisis of the uninsured without state and/or federal help (Taylor et al. 2006). Even if they did, depending on scattered, diverse, small-scale efforts to cover the nation’s uninsured would result in uneven access and a system of care highly susceptible to cutbacks during tough economic times (Meyer et al. 2004). Herein lies the dilemma: local initiatives are no substitute for a national solution, but in the absence of broader reform, they will probably continue to be a major strategy in covering the uninsured (Taylor et al. 2006).

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