BIG IDEAS TO BLUEPRINTS: Decisive Grantmaking in Dynamic Times

Each summer, Grantmakers In Health's (GIH) staff members consider possible themes for the following year's annual meeting. We were struck in 2012 by the sheer number of factors challenging grantmakers' work: a wave of retiring CEOs, the wildly fluctuating stock market, growing rates of poverty and inequality, and the complexities of improving Americans' health status and access to quality health care—to name but a few. We wanted grantmakers to remember that in times of change and uncertainty, it is doubly important to be thoughtful, strategic, and unafraid. Big ideas and big thinking are essential elements of the grantmaking toolkit that, once translated into workable plans, can provide a way through choppy waters.

> *An idea that is developed and put into action is more important than an idea that exists only as an idea.*
>
> *–The Buddha*

GAZING INTO THE CRYSTAL BALL: IMPROVING HEALTH CARE AND POPULATION HEALTH

Within the context of the "triple aim" of improving health, improving health care, and reducing costs, issues are emerging now, or are on the horizon, that are a good indicator of areas in which the next big ideas from philanthropy can play an important role. What does the crystal ball tell us to expect over the next few years?

As a result of the Affordable Care Act (ACA) and other factors, health care is likely to undergo major changes over the remainder of the decade. To keep their grantmaking relevant, funders who focus on health care settings will need to understand what will change, how it will change, and how these changes are likely to affect the populations they care about.

A key example is the sector's focus on new service delivery models. The goals of these new models are to improve quality, reduce costs, and create incentives to invest in community care and prevention. Meeting these goals will require changes to strengthen delivery of care for patients who already have good access to services, as well as changes to improve care for patients who find it harder to get the care they need (GIH 2012).

Many issues in this area are ripe for big thinking by health grantmakers. Some of the many ways in which funders can play a role, whether locally or nationally, include:

- helping reduce health care costs (for example, by improving access to primary care through medical homes);
- supporting ways to reduce hospital readmissions;
- supporting ACA implementation, such as outreach and enrollment efforts;
- supporting safety net services for people who are not covered by the ACA—about 25 percent of this group will be undocumented immigrants (Buettgens and Hall 2011);
- supporting efforts to close gaps in the size, training, and diversity (both occupational and racial/ethnic) of the health care workforce;
- supporting innovations in hospital rate setting with an eye to creating incentives for hospitals to invest in community care and prevention and to develop stronger relationships with community-based providers;
- supporting improved use of health information and the development of partnerships among care providers, schools, local health departments, and employers;
- assessing the effectiveness of alternative models of accountable care organizations;
- improving community-based care transitions, that is, improving patients' transitions from hospitals to other settings and reducing readmissions for high-risk Medicare beneficiaries; and
- looking into the factors that contribute to effective patient and family engagement in health care decisions.

In contrast with the health care arena, the next five years are not expected to bring major changes affecting the health status of Americans because the social, environmental, and behavioral factors that affect people's health evolve slowly. In general, we know that the health status of U.S. adults ranks poorly in international comparisons. For example, in 2007 this country ranked 27th and 26th out of 33 similarly developed countries for life expectancy at birth for females and males, respectively (healthypeople.gov 2012). Moreover, in 2008, 107 million Americans—almost one out of every two adults age 18 or older—had at least one of six reported chronic illnesses (cardiovascular disease, arthritis, diabetes, asthma, cancer, and chronic obstructive pulmonary disease).

For funders whose work focuses on population health, big thinking will involve applying, and building on, lessons learned from previous efforts. Recognizing the importance of addressing the environmental factors (like race/ethnicity, education, and neighborhood) that have been documented to affect health will continue to be vitally important. Moving out of health silos to address these broader factors will be challenging and require innovative thinking.

Areas ripe for big ideas include:

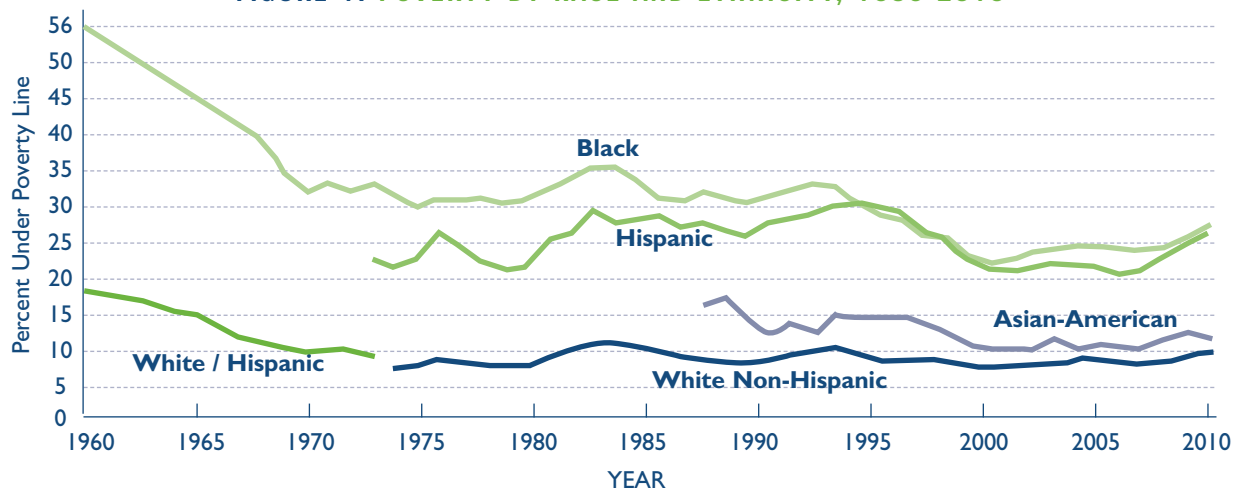
- documenting and evaluating best practices in the field of prevention, so that they can be more widely replicated;
- testing ways for scaling up effective models—and paying for them;
- improving health literacy, especially for groups with limited English skills;
- building the effectiveness of local public health departments;
- improving people's involvement in their health care decisions;
- supporting the next generation of community health leaders;
- improving understanding of the social and economic conditions that shape people's health;
- developing strategies as health funders for tackling issues outside the formal health sector;
- working collaboratively with other health and non-health funders to improve population health; and
- working across sectors (such as with schools or the business community) to improve health.

THE CHALLENGE OF THE CHANGING U.S. POPULATION

Populations are dynamic; that is, they are always changing. Two major ways in which the U.S. population is evolving underscore the need to think big about both health care and improving health status. They also present additional opportunities for health funders to act decisively and provide much-needed leadership.

One of these changes is the increasing diversity of the U.S. population. Twenty-two of the country's 100 largest metropolitan areas, including New York City and Washington, DC, are now "majority-minority," meaning that ethnic

FIGURE 1: POVERTY BY RACE AND ETHNICITY, 1959-2010



Source: Matthews 2012

minorities account for more than half of the population. There were just five such cities 20 years ago (Frey 2010). The demographic shift is especially evident among younger age groups. Today, roughly half of U.S. children are non-white (statehealthfacts.org 2012).

Because of historic patterns of racial and ethnic differences in income among American racial and ethnic groups, many of today's children are very likely to grow up in poverty. As Figure 1 illustrates, poverty dropped significantly for both blacks and whites between 1959 and 1970 (data for other groups were not collected then), but the rate has slowed considerably in the last 40 years. It is now rising for all groups except Asian Americans, with the most extreme increase among groups that were already the country's poorest.

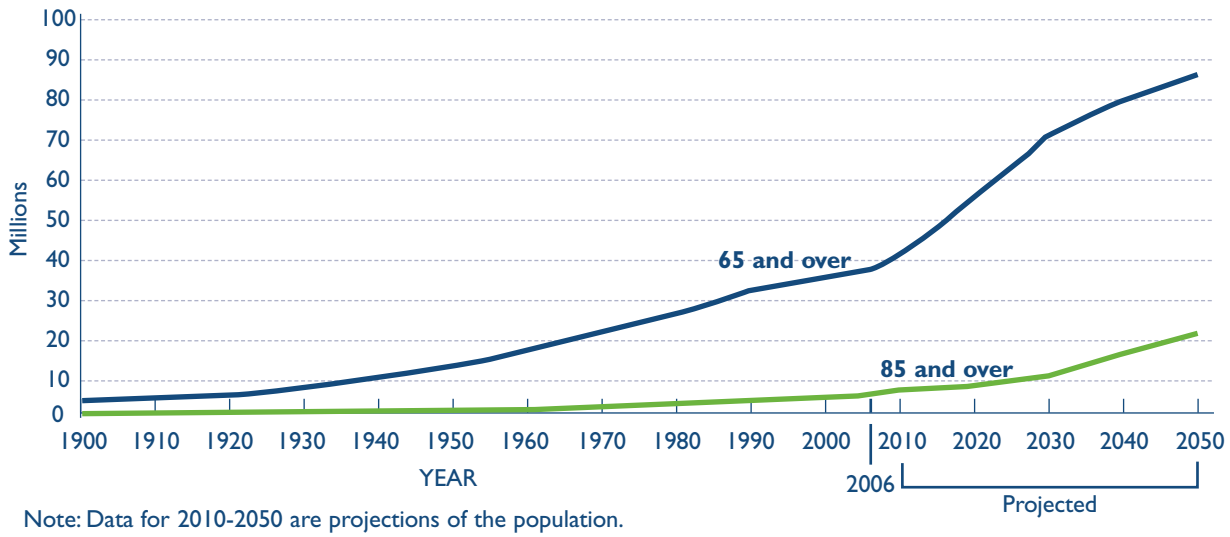
In other words, a large number of American children are members of racial/ethnic groups for whom poverty has increased in recent years. This means, among other things, that health problems related to poverty are likely to increase in coming years unless there is aggressive action. It also puts a spotlight on identifying ways to increase equity, whether in the context of a changing health care delivery system or as an element of improving population health. In light of what research tells us about the lifelong corrosive effects that poverty, childhood stress, and childhood illness have on health, it will be important for health funders to find ways—beginning prenatally—to improve the health status of American children. There is growing evidence that effective interventions during childhood can forestall mental and physical problems in later life that take a toll on both quality of life and health care costs.

At the other end of the age spectrum, the rapid aging of the U.S. population will also pose major challenges. As shown in Figure 2, the population over age 65 is growing at a steep rate. In 2011 there were 40 million people in the United States ages 65 and older. This number is projected to more than double to 89 million by 2050. Although the "oldest old"—those ages 85 and older—represent only 15 percent of the population ages 65 and older today, their numbers are also projected to rise rapidly over the next several decades. By 2050 the oldest old will number 19 million, over one-fifth of the total population ages 65 and older (Jacobsen et al. 2011).

Older age groups are high users of the health care system. In light of the expected growth in their numbers, there are several areas that are ripe for foundation investment and innovation. These include:

- ensuring seniors' access to health care and the quality of the care they receive;
- understanding what is needed to support individuals who

FIGURE 2:
SIZE OF THE POPULATION OVER AGE 65, 1900-2006 AND PROJECTED 2010-2050



Note: Data for 2010-2050 are projections of the population.
Reference population: These data refer to the resident population.

Source: agingstats.gov 2012

wish to continue living at home;

- identifying workforce needs for an aging population;
- supporting the training of an appropriate workforce for both institutional and at-home care;
- developing strategies for protecting and improving the quality of life of individuals living in communities;
- ensuring health equity at older ages, as the aging population becomes more diverse; and
- improving end-of-life care.

GIH 3.0

GIH is experiencing its own transition, which we call GIH 3.0. It is our opportunity to build on the past accomplishments of the organization while positioning it to continue to be a relevant and high-quality resource for the field.

One big idea that is part of GIH 3.0 is understanding the changing face of health philanthropy. The field is continuing to evolve, not only in terms of the issues it takes on, but also in terms of the funders involved. When GIH began in 1978 as an ad hoc, informal, part-time program of meetings and workshops, health philanthropy consisted primarily of private and community foundations and corporate giving programs. Then—as now—many foundations had small staffs who found it difficult to keep abreast of the information they needed in order to help their organizations make informed decisions. By helping these funders connect and share ideas, GIH (formally established in 1982) constituted an important step forward in the evolution of health philanthropy.

In the late 1980s, the field was revolutionized by the creation of conversion, or legacy, foundations. Although the first conversion foundation was created in the early 1970s, their rapid emergence is associated with a 15-year period beginning around 1985, during which more than 134 were established. These "new foundations" doubled the dollars available for health-related grantmaking and made assets of more than $15 billion available to local communities (Benbow and Roybal 2008; Yates and David 2002). Their creation brought leaders into the field as presidents and board members who were often new to philanthropy. In some cases, community advisory processes that were a sharp departure from traditional foundation operating styles were also part of the picture. GIH played a vital role for the field during this period by providing technical assistance to new funders, being a source of information about best practices, and creating learning communities that connected foundations of all types to enhance peer learning.

New types of funders and approaches to philanthropy continue to emerge. For example, private philanthropic consulting firms like Wellspring Advisors, private foundation management companies like Foundation Source, and private and nonprofit mission investors are all active in the health arena. To get a better understanding of the amount of new money in the field, how it is being directed, and its potential impact, GIH 3.0 will include a major scan of the changing face of health philanthropy. This scan will inform our programming going forward, help us think about ways of engaging with the increasingly diverse community of health funders, and help us develop new ways to enhance learning and exchange among funders. We hope that our Funding Partners will also find the scan's final report useful in their work.

GIH 3.0 also includes the development of new programming for CEOs and program staff. Building on our positive experience with the *Terrance Keenan Institute for Emerging Leaders in Health Philanthropy* fellowship program, and in response to requests from Funding Partners, we are exploring new ways to build the skills of foundation staff. The programming might include:

- information about grantmaking strategies that address the specific challenges and concerns of health funders;
- learning groups for sustained engagement on selected issues;
- institutes for discussion of the issues funders struggle with (such as long-term vs. short-term grantmaking, engaging communities, the value of core support, support that goes beyond writing a check); and
- retreats to develop leadership skills.

The goal is to support health philanthropy not only by providing information about specific health content areas, as we have been doing, but also by strengthening the ability of program officers and CEOs—the field's infrastructure—to grow, work strategically, and learn from one another. In so doing, we aspire to raise the work of health philanthropy as a whole.

Thank you for joining us at the 2013 GIH annual meeting. We encourage you to think big and look forward to navigating these dynamic times with you.

Faith Mitchell

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