

Taking Risks at a Critical Time: Partnering with Government to Improve Health

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This is a critical time for health care and philanthropy. In the last year, Congress, consumer advocates, business interests, and others have sparred over how to reform our health care system so that many of the 42 million Americans without insurance can get coverage. As health foundations, we have a stake in how this debate is resolved. If reform is enacted, some of us will be funding implementation work and monitoring the impact of the new law. If no bill passes, or if the legislation is extremely limited in scope, health care reform will recede into the background, most likely overtaken by efforts to deal with the economy. Our work to improve the health of our communities will become even more difficult than it already is.

It is striking to note the one constant to the myriad responses to the health care debate: a deep skepticism that government exists to serve our collective interests. As the U.S. House of Representatives debated a health care reform bill last August, the public was gripped with the idea that the bill would establish “death panels” that would be charged with deciding who among the sickest would get to live. The “death panels” rumor persisted despite clear, factual evidence to the contrary. Much contributed to bringing this rumor to life (and is traced in an August 13, 2009 *New York Times* article titled “False ‘Death Panel’ Rumor Has Some Familiar Roots”), but surely public sentiment against “government control” that runs strong in all parts of the nation played a role.

While many of us are troubled by these fantastic pictures of government, we do not believe it is our problem to address. Or is it? At this critical time, we must ask ourselves: At what point does public mistrust of government – resulting in predictable calls for “less government” – begin to impede *our* work?

Think for a moment about the approach many of us take when we fund efforts to improve health care. A common tactic is to support an innovative effort that holds the potential to have great impact in solving a pressing problem. We then document the model

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and promote its sustainability through additional funding sources, replication, and system change in support of its adoption. Hopefully you are nodding as you read this over-simplified “theory of change,” because it is the process you have more or less followed for many of the grants you have made over the years. This approach has had many notable successes over the years, as foundation initiatives like public libraries and the 911 emergency response system became part of our national infrastructure. But what happens to this approach if government is not nimble enough to embrace new ideas? Does the capacity to sustain wide-spread adoption of new models exist anywhere else? If we are honest, we have to admit that it does not.

So what *do* we need from government as a partner in implementing successful innovations in care delivery and improving health outcomes? What do individuals and organizations need from government to make our communities healthier? And how much information does the community have and need from government to do its work most effectively? All of us in philanthropy should be asking these questions, and the answers will vary greatly among health foundations. Requirements based on geography, multiple organizational missions and cultures, and a mix of strategic priorities mean that our relationship to government and all the other entities comprising the public sector is complex and dependent on local circumstances. And, of course, there is the policy advocacy variable: some foundations support policy work and are much more comfortable

with an overt focus on creating change within the public sector. Many others do not engage in such work and do not see themselves as engaging much with the public sector.

Regardless of where your foundation falls on this spectrum, there is much we all can do to improve the chances that the public sector will be the resource we need. The Blue Cross Blue Shield of Massachusetts Foundation, where I work, is considered to be very policy oriented. When the foundation was established in 2001, its mission – which continues to this day – was to expand access to health care. The foundation’s board included several individuals who had served in government, and at their first meeting the board immediately recognized the limits of the foundation’s resources when contrasted with the state’s \$3.5 billion Medicaid budget. They instinctively knew that to maximize the foundation’s impact, it needed to leverage additional resources by focusing on public policy.

Many of you may know the work of our foundation from the role we played leading up to passage of Massachusetts’ health care reform in 2006. We sponsored research that helped inform the debate over what measures should be included in the law. Our health care “summits” were seminal events for learning about and discussing key aspects of reform. We funded consumer advocates who brought the voices of low-income

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and vulnerable state residents to the policymaking table. Since the passage of the state’s health care reform law, we have continued to sponsor research, convene key players, and promote advocacy in monitoring the implementation of the law.

While we are an example of a foundation with a strong focus on policy and advocacy, there is more we can do to foster constructive relationships between decisionmakers and the community. For example, our most recent round of health care disparities grants supports coalitions comprised of community organizations and health care providers. As these coalitions have planned their projects, they have defined the changes coalition members can make to help reduce disparities. They have also begun to define some changes that require action by decisionmakers in the public sector. Despite our knowledge of policy change and advocacy, we must now learn how to build the capacity of these coalitions to engage the public sector so they can achieve maximum impact.

Then there are foundations that do no policy work or do not see themselves as having strong relationships with the public sector. Regardless of why that is, these foundations can still help themselves without having to adopt a formal, strategic policy agenda. Say there is a foundation working to increase the number of children who have access to dental care in a specific community. This kind of effort does not require a focus on policy change to have a positive impact. However, the foundation’s staff members probably communicate regularly with school officials, clergy, business leaders, health care providers, and the heads of other local organizations. With these kinds of connections the foundation likely has the relationships to bring decisionmakers and community members together to discuss their roles and common interest in better access to dental care. It may not be necessary to do this for the immediate success of the project, but over the long term this kind of convening can serve many purposes. It can provide an opportunity to build positive relationships between the community and decisionmakers, as well as helping define expectations about the project’s sustainability.

Collectively, foundations are a link between vulnerable populations and key decisionmakers in our communities. There are many ways in which we serve as this bridge. It is critical that we make the most of our opportunities to enhance the impact of our work. Most states are now facing massive budget problems and structural deficits. Health care costs continue to rise and provider shortages promise to limit access to health care in all parts of the nation. Whatever your preferred solution to these and many other problems, the public sector must play a role in devising those solutions. And government’s ability to address these issues, and embrace the solutions we are testing and proving with our grants, is jeopardized by massive budget deficits and a lack of trust from the general public. If we need government to assist with public and private sector adoption of our grant-funded innovations, then we must rethink how we – and our

communities – relate to government.

Fostering positive relationships between community members, providers, business leaders, community organizers, and public officials is essential for improving government’s ability to build community health. The following examples from the Blue Cross Blue Shield of Massachusetts Foundation show what such work can look like.

- During site visits and other meetings with grantees, foundation staff regularly discuss the status of health reform implementation. The conversation incorporates research sponsored by the foundation, insights gained at meetings and conferences the foundation staff attend, and from the frontline perspective of the grantees. The goals of these discussions are to understand what has been accomplished to date, to identify the upcoming challenges of reform, and to discuss how it could be improved. An essential part of this conversation is avoiding the assignment of blame and focusing on how the common interests of the foundation, the government agencies involved, and grantees can best address the needs in the community.
- As a new health insurer was beginning to provide a more limited version of subsidized coverage to legal immigrants at the end of 2009, we convened a meeting among grantees who work with legal immigrants, key public officials, and the head of the new insurer for a daylong meeting. The purpose of the meeting was to give those working with legal immigrants an opportunity to better understand the new coverage plan and provide them with an opportunity to directly ask questions of the new insurer and public officials responsible for implementing the plan. While the session had significant moments of tension among participants, those who attended gave it high marks. In the evaluation form filled out by attendees, one wrote: “Communication between the decisionmakers and the people affected by those decisions is critical if we are really working toward preventive care.” Another noted, “Learning about the legislative part of this decision made it clearer to me.”
- In 2006 we funded a community advocacy group that wanted to measure how much low-income residents could afford to spend on health care. Although much policy work had been done in this area, it looked at families from the 30,000-foot level. By contrast, our grantee met with individuals in their homes and collected detailed information about family budgets: how much was spent on basics like food, rent, utilities, and transportation to work. The resulting data gave a concrete picture of what families realistically could – and could not – afford on health care premiums and prescription drug coverage. The process helped those families understand why and how the government was working to define the “affordability” of health coverage. The data was eventually shared with policymakers working on affordability standards for health plan cost sharing.

As readily witnessed in the debates over issues such as national health reform, many in our nation mistrust government or are unwilling to bear the cost of having a well-resourced and proactive government. And while each one of us may have reasons to be skeptical of government, we in philanthropy cannot sit idly while others clamor to limit and diminish government. Rather, we need government to have the capacity to embrace and adopt good ideas. Whether or not you fund direct policy advocacy, all health foundations need to consider the role government can play in achieving their goals.