Better Outcomes, Lower Costs:
How Community-Based Funders Can Transform U.S. Health Care

A Conversation with Dr. Atul Gawande

Mark R. Kramer
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About Grantmakers in Health

Grantmakers In Health is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the health of all people. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness.

Introduction

Over the past three years, Dr. Atul Gawande's articles and books have profoundly altered thinking about the U.S. health care system. Although he has not written specifically about the role of philanthropy, his research demonstrates that the cost and quality of health care in the United States are heavily influenced by local practices, and can be profoundly influenced by community-based efforts with modest levels of funding. As a result, we see a tremendous philanthropic opportunity that has been almost entirely overlooked: hundreds of health foundations, community foundations, and corporate or family foundations are ideally positioned to lead a national movement to transform the U.S. health care system by lowering costs and improving patient outcomes in their local communities.

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Most smaller, local funders have steered clear of health care reform because of the vast magnitude of health care spending and the vituperative national controversy over health care policy. In this, they have conflated *access* to care with the *cost and quality* of care. Providing *access to care* by addressing the needs of the uninsured is a costly and controversial national issue that cannot easily be addressed at local levels. However, Dr. Gawande's research demonstrates that the *costs and quality of care* are driven by local behaviors that vary dramatically from one community to the next. Here, there is surprisingly little correlation between the cost of care and the quality of patient outcomes. Instead, Dr. Gawande cites many examples of simple and inexpensive changes in practice within local communities that have produced dramatic improvements in patient care and reductions in cost.

We often refer to our "health care system," but in reality it does not function like a system at all. Health care today has become so complex and fragmented that each participant does his or her own part without any awareness or control over how his or her choices affect the larger system overall. Perverse financial incentives prevent any single participant from making substantial improvements by acting alone, even if

> *Innovations that save lives and money do not spread from one provider or community to the next.*

the improvements serve the interests of the patients, the public, the payer, and the provider. We have no localized data that can give us an accurate understanding of how patients are cared for in our community and whether our practices are better or worse than other, similar communities. There are no neutral coordinating councils that can bring all relevant players together to gather the necessary data and solve problems collectively. As a result, the system is paralyzed. Innovations that save lives and money do not spread from one provider or community to the next. Improvements that are neither controversial nor costly remain stymied.

One solution that has worked in multiple communities across the country is the formation of a coordinating council that includes CEO-level representatives and key local influencers from all major organizations affected by medical care in the community: doctors, hospital administrators, insurers, government agencies, and business leaders. This council must identify a specific problem to be tackled, such as improving end-of-life care or reducing post-surgical infections or excessive testing; conduct local research to analyze the problem; identify solutions that have been implemented elsewhere or that might be piloted locally; test and refine these solutions; and then drive implementation through all relevant organizations in the community.

In this, health care is no different from many other large-scale social problems we face, such as education reform or childhood obesity. Lasting solutions must come not from any single magical solution, but from bringing together dozens of local players to set a common agenda, gather shared data about the problem, develop mutually reinforcing activities, and maintain ongoing communication supported by a backbone organization. This is an approach we call "collective impact," and it has achieved demonstrable success on a wide variety of issues.[1]

Community-based funders across the United States, such as community foundations, health foundations, and family or corporate foundations, have the stature and resources to organize and fund collective impact health care initiatives in their communities, and to share their learning with other communities across the country. It is precisely because of their local focus and convening power that regional funders can play this crucial role in ways that national funders and government agencies cannot. Individually, these foundations have the opportunity to make a profound and lasting impact on the health of their communities; together, they have the opportunity to create a national movement to achieve better outcomes at lower cost.

In the following conversation, Mark Kramer and Dr. Gawande discuss this untapped potential for community-based funders to transform the cost and quality of health care in the United States.

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[1] See John Kania and Mark Kramer, "Collective Impact," *Stanford Social Innovation Review*, Winter 2011.

National Access vs. Local Cost and Quality

Mark: Good morning, Atul, and thank you for taking the time for this interview. I have been deeply influenced by your research and writing over the last few years, and through our work with foundations at FSG, I have come to believe that there is a tremendous opportunity for community philanthropy that is implicit in your writing. You have never explicitly written about that opportunity, but that is what I'd like to discuss today. First of all, let me ask you: Why is it that most private foundations believe that health care reform is too large and controversial an issue for them to tackle?

The cost of treatment and the quality of patient outcomes turns out to be about local systems of care.

Atul: When we think about the health care troubles in our communities, we first tend to think about our uninsured populations. And to help the uninsured, we do need national solutions. We've been debating different solutions for access to care for the past four or five decades: single payer, multi-payer, private coverage, and so on. The media attention on that debate has led us to think that all of the solutions for making our health care systems better have to come from Washington. I think that's a big mistake. Helping to make health care systems better at dealing with the cost of treatment and the quality of patient outcomes—that turns out to be much more about local systems of care—and those issues aren't controversial at all. It is hard to find anyone who would object to fewer post-surgical deaths, better management of chronic disease, or honoring patients' wishes at the end of life—especially when those improvements also reduce cost.

The Disconnect Between Cost and Quality: A Tale of Two Cities

Mark: You say that, by working locally, you can improve outcomes and lower cost at the same time. That seems completely counterintuitive. Don't we need to spend more money on health care to get better patient outcomes?

The places getting the best results are usually in the bottom half of the cost curve.

Atul: Not at all. There is a wide swath of difference in cost and quality among hospitals in different communities. The variations fit a typical bell curve, with most doctors and hospitals in the mediocre middle. The really unnerving thing, though, is that our curve for quality doesn't match our curve for cost. The most expensive places in the country are not necessarily getting the best patient outcomes, and vice versa. On the contrary, we see very consistently that the places getting the best results are usually in the bottom half of the cost curve.

I'll give you an example: McAllen, Texas, is the second most expensive place in the country for Medicare patients. They are a very poor community, yet they spend more than $16,000 per person per year. Of

course, they've got significant health care problems: there's a lot of diabetes, obesity, and alcohol abuse, and there are a lot of illegal immigrants that are stressing the public health systems. At first, I thought that explained the high costs, but then you go a few hundred miles up the border to El Paso, Texas, which is just as poor, with exactly the same demographics and health problems, and you find they spend only half as much per person. And the really astonishing thing is that, to the extent that we have metrics, El Paso has a higher quality of care across their half-dozen hospitals compared to the half-dozen hospitals in McAllen that are spending an average of twice as much per patient. These two places with very similar challenges are getting remarkably different results.[2]

Mark: How do you explain the difference?

Atul: In McAllen what I saw, for better or for worse, was a medical community that made the profit-making side of medicine a very high priority. There's always a balance between making medicine work as a business and meeting the needs of the community. But focusing on profitability can lead you to overemphasize certain tests and procedures and underemphasize other areas, such as primary care, mental health, and geriatric care, because they're not as profitable. El Paso, on the other hand, seemed to have a medical culture that puts at least some more emphasis on meeting patient needs regardless of profitability.

All medicine is like all politics: it is local. A few key community leaders shape the way medicine is practiced and the kind of health care their community gets. It's not just the medical community that determines how medicine is practiced, but also the major local employers who set expectations about acceptable levels of health care costs and quality, and the local and state governments that hold people accountable and measure what is actually going on. It's the local community that is fundamentally responsible for the success or failure of its own health care system.

Community Efforts that Work: Success Stories

Mark: Can you give me some examples of communities that have been able to improve patient outcomes or lower costs through entirely local efforts?

Atul: Absolutely. Cedar Rapids, Iowa, formed a coalition of local employers and leaders in the medical community to look at the use of CT scans. First of all, no one actually knew how many CT scans were done in a year. We know that, at a national level, CT scans are way overused: there are 62 million scans a year in the United States. But it's an abstract, meaningless number that doesn't seem relevant to someone in Cedar Rapids. You need to know what is happening in your own community. And it turns out

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[2] For a more detailed description of the contrast between these two cities, see Atul Gawande, "The Cost Conundrum," *The New Yorker*, June 1, 2009.

that it's very hard to get that answer, because each hospital and medical practice keeps separate records.

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It took three months of really digging, and what they found out was that there were 52,000 CT scans in a single year in Cedar Rapids, a community of only 300,000 people. The doctors were astonished at the number, and they were not happy about it. They immediately set a goal of reducing unnecessary CT scans. For example, 10,000 of the scans were for headaches—of which only about a dozen patients had any abnormality, or one-tenth of one percent. In fact, most patients really didn't meet the criteria for needing a CT scan. Plus, all that radiation exposure probably increased the risk of certain kinds of cancers. Perhaps malpractice litigation was one reason why the doctors were doing so many of these scans. But once the community got together across disciplines—including citizens and employers—to ask hard questions with real data, they were able to arrive at guidelines that would make much more judicious use of these scans.

Or take another example: In 1991, for whatever reason, the local leadership in La Crosse, Wisconsin recognized that the way we care for people with terminal illness in America doesn't meet their needs. We are not great at making sure people don't suffer, that they're able to have more control over their lives as they come to an end, that they don't die in an intensive care unit with invasive technologies that not everybody wants. What they recognized was that people needed to make these choices ahead of time, before they arrived at an emergency room in complete crisis. And so the doctors in La Crosse were encouraged to have these conversations with their patients during routine check-ups or, even more importantly, when people were first admitted to a nursing home or hospital. As a result, by 1996, the number of people admitted to the hospital with living wills that described their desires for end-of-life care increased from 15 percent to 85 percent.

This simple change reduced the cost of end-of-life care by half, and La Crosse became one of the lowest-cost places in the country for end-of-life care—which is a large portion of the total costs of medical care. And they did it with no sign whatsoever that the longevity of people in that community has been harmed in

any way. Despite average rates of obesity and smoking, the life expectancy of La Crosse residents outpaces the national mean by a year. And other studies have shown that people who have these discussions and choose palliative care not only reduce their hospital stays by half, they have better quality of life at the end of life, and they live 25 percent longer.[3]

> *Mark:* It's remarkable that just bringing community leaders together to focus on a specific problem, collecting data about what is really happening at a local level, and encouraging simple changes in local behavior can bring about such dramatic cost savings, while also improving health outcomes. The example of La Crosse doesn't involve anything more than an outreach campaign to get people to fill out a form, yet it has a large impact on costs and quality. It seems like an especially important lesson for community-based foundations, because convening community leaders, raising awareness about an issue, and funding local research studies are all activities that come naturally to them and require very modest levels of funding. It suggests that even small regional foundations could have a big impact on health care in their communities—and yet we see smaller funders often steer clear of health care issues because they see the vast amounts of money spent in the health care system and think that there is no place $100,000 or even $1 million could make much difference.

> *Even small regional foundations can have a big impact on health care in their communities.*

Atul: I can give you an even more dramatic example of the impact a small amount of money can have. We were asked to take on a project to reduce deaths in surgery. At first, I thought the answer would be about training programs, licensing requirements, or shifting patients to high-volume hospitals. But what we learned was that a simple checklist of about a dozen things that surgeons could do in the operating room has a tremendous impact. So, we worked with Boeing to develop a two-minute checklist based on the checklists that pilots use before takeoff. It covered simple things like making sure antibiotics were given appropriately, blood was available, and everybody on the team knew each other's name and understood the plan before a knife ever hit the skin.

We tested it into eight hospitals around the world, and we deliberately included poor hospitals in rural Tanzania, Delhi, Manila, and Jordan, as well as some of the top hospitals in the world, such as the University of Washington in Seattle, Toronto General Hospital, and St. Mary's Hospital in London. Every single hospital reduced its complication rate by more than 30 percent. The average reduction in complication was 36 percent. The average reduction in post-surgical deaths was 47 percent.

The whole project probably cost about a million dollars ... and it is saving hundreds of thousands of lives every year.

And the checklist costs nothing to use. Hundreds of billions of dollars are spent every year on new equipment or drugs that don't begin to have the life-saving impact of this simple checklist. The whole

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[3] The La Crosse example is described in Atul Gawande, "Letting Go," *The New Yorker*, July 26, 2010.

project probably cost about a million dollars for us to design and test, and it is saving hundreds of thousands of lives every year.[4]

Promoting Adoption: The Culture Barrier

Mark: The checklist seems so simple, and has such stunning results, that one would think it would be picked up and implemented everywhere immediately. What has adoption been like?

Atul: It's tremendously frustrating. We recognize that this could be saving thousands of lives, and yet it's being used in less than one-third of U.S. hospitals—and even in the hospitals that picked it up, we know implementation is quite variable.

It took me a while to realize why professionals would not want to try the checklist even when it's been demonstrated that using it helps people. And what I realized is that the checklist contains a set of values. Those values are first, humility: recognizing that you—a surgeon, anesthesiologist, or nurse—make mistakes. That's a starting point not everybody is ready to embrace. The second value is teamwork: the belief that the wisdom of a roomful of people is greater than just the wisdom of the top dog. And the third value is self-discipline: the belief that doing things in a very simple, straightforward, regimented way, like on an airplane or a pit crew for a racecar, doesn't mean dumbing down.

The challenge is in changing the medical culture. We surveyed surgical teams three months after trying the checklist; 80 percent said they thought it made surgery easier and safer for patients and that they had actually seen it catch an error. But 20 percent still hated it. They thought it was a waste of time: they didn't think they needed it. Then we asked them, if you were having an operation, would you want the checklist? Ninety-three percent of them wanted it.

Mark: Can local foundations help in spreading adoption?

Atul: Yes. For example, we got backing from a small family foundation to help us launch an effort in one state, South Carolina, where we're measuring infections, deaths in surgery, and other failures of operations, and then implementing the checklist into all 67 of their hospitals in partnership with their hospital association. It takes working at that local level to bring people on board in a field where there is resistance to change. And we need local funding partners in every city and state if we are going to spread the adoption of these improvements.

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[4] See Atul Gawande, *The Checklist Manifesto*, Metropolitan Books, 2009

Perverse Payment Incentives

Mark: It seems like no individual doctor, hospital, or insurer can bring about these kinds of changes. Instead, a neutral party, like a foundation, has to bring all the parties together to solve the problem collectively. In fact, there are often perverse payment incentives that discourage improvements in care because the savings to one party come at the expense of another.

Atul: Right. Take a topic like asthma in the inner city, a very big problem affecting children. Children's Hospital here in Boston recognized the problem and decided to start a project focusing on the kids with the most severe asthma attacks, who came to the emergency room or were admitted to the hospital. They said, first of all, let's identify what great care looks like for those kids. And essentially they came up with a checklist: a half-dozen things that can make a big difference, ranging from home visits to make sure there was no mold and mite infestation in the house to making sure a nurse checked in and the family had actually filled their prescriptions for inhalers and knew how to use them. They even bought families vacuum cleaners, because they found a quarter of families in the inner-city areas did not have them. After one year, the number of asthma admissions to the hospital emergency room dropped 80 percent. It was a stunning success. But guess what the number one source of revenue for Children's Hospital of Boston is? Asthma admissions. That's how the hospital makes its dollars. And if a place has to choose between doing the right thing and going bankrupt, that's not much of a choice at all.

> *The hospital can't do it on its own, the community can't do it on its own, and the insurer can't do it on its own. It can only happen through collaboration.*

So even though Children's found a solution, they couldn't implement it without changing the reimbursement system. They went to their major insurers—Medicaid and Blue Cross—and said, here's what great care looks like. We've proved it, and it can save you a lot of money, because the extra cost of these services is a lot less than the cost of hospital admissions. But we need to renegotiate our contract so that we're paid for providing great care even though these kids aren't being admitted to the hospital. And they worked out a deal. Neither the insurer nor the hospital could have solved the problem alone. But, working together, they recognized a problem, they found a solution, and then they addressed it. This is what a great coalition can do at the community level in a way that you'll never invent in Washington.

Mark: So you are saying that the hospital can't do it on its own, the community can't do it on its own, and the insurer can't do it on its own. It can only happen through collaboration.

Atul: That's right, and even though Children's Hospital renegotiated for themselves, that doesn't mean that asthma care for kids who go to other hospitals in the community is going to change, let alone kids in other communities across the country. Here's a solution that could save significant dollars for the health care system and save kids' lives, but it's not going to happen unless we focus on the larger picture. That takes collaboration, and the problem is that those kinds of collaborations almost never happen. It takes a community leader to bring the medical, business, and government communities together to find solutions and figure out how to fund them.

The Urgency of Impact

Mark: It seems as though this is a massive challenge for our country—and that there is a real urgency for funders to take action.

If America is to be a prosperous nation in the future, then getting the health care system under control is the mission and challenge of our time.

Atul: Absolutely. The thing that is so unnerving about tackling this problem is that our time horizon is short. We'll never solve the problem of the uninsured until we get costs under control, and that means improving the quality of care and not wasting resources. We're going to bankrupt our state governments within seven to nine years if health care costs continue to rise at the current rate. We are going to continue to kill 150,000 people a year just from complications of surgery. Employers in our communities are going to watch their health care costs go from 10 percent to upwards of 17 percent. We are heading to a point where 20 percent of our economy goes to health care, and we know a substantial portion of that investment is not providing high quality— and that these are resources we need to go to other urgent needs like education or energy. This issue is fundamental. If America is to be a prosperous nation in the future, then getting the health care system under control is the mission and challenge of our time.

The Non-System System

Mark: So are you saying that instead of spending money on laboratory research about diseases, or new equipment and hospital facilities, funders who want to improve health care in their communities should be focused on helping different parts of the local system work better together?

Atul: That's right. We call these local health care systems, but they're not really systems at all, they are fragmented institutions filled with people doing isolated jobs, whether it's in mental health or surgery or

whatever. No one is in a position to see how the system comes together, how it impacts people economically, or because of issues of poor quality

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and poor service. The truth of the matter is that the health of our community and the effect that we as doctors and hospitals have on that health is invisible to most of us. I just do my surgery and feel like if I'm doing a good operation for the patients I'm seeing, that's what I can do. I don't see what all of the different surgeons are doing throughout the community and then what everybody else in the health care system is doing—how many emergency room visits there are, how many infections there are, and whether we're making a difference.

So the investment we really need to make is in systems change. And changing systems of care is not something that the National Institutes of Health is designed to do. But a community-based foundation can make the invisible health care system become a visible one by collecting data, and just by doing that, people begin to act differently. The non-system starts to become more of a system and is better able to solve problems for the community.

The reality today is that the complexity of care is at the point where innovation to improve systems of care—even through simple things like checklists—requires research, and that type of research is just not getting funded.

The Role of Funders: Collective Impact in Health care

Mark: What fascinates me about this is how it relates to other work that FSG has been doing on a completely different set of issues. Whether it is the juvenile justice system in New York state, secondary education in Seattle, diabetes care in India, or impoverished cocoa farmers in Cote D'Ivoire, again and again we are finding that the solution to major social problems doesn't lie in some new program or innovation. Each of these problems is the result of a "non-system system," where the different actors—government agencies, nonprofits, foundations, and corporations—are each acting independently, without any sense of how their efforts fit together, and the result is disastrous for the people who are supposed to be helped.

FSG's work on "collective impact" seems to fit exactly the process you are describing in health care reform.

We increasingly see that the most powerful role funders can play is to help convene, coordinate, and align the different participants so they can agree on a common agenda, develop a shared measurement system so that all participants are using the same data to track results, promote continuous communication and mutually reinforcing activities, and,

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above all, provide an infrastructure—what we call a "backbone organization"—to facilitate progress and hold the initiative together. It's an approach we call "collective impact," and we've developed considerable research about how funders can initiate and sustain these efforts.[5] It really seems to fit exactly the process you are describing in health care reform.

But let's get more specific: If you were speaking to a group of smaller community-based funders, what would you advise them to do?

Atul: I would tell them that what we need to make health reform succeed is to build a community that actually *demonstrably* raises the quality and safety of care and lowers its costs, without harming a soul. For a foundation to make a difference in helping a community do that, I think there are four places they can make a contribution—and none of them cost large amounts of money.

Collecting the data is where I would start. Show the community a snapshot of how their health care system works and where the costs are. Don't make it overly complex; make it simple enough that some basic questions can be answered, like how many people are coming into the emergency room, and why? Knowing data at the national level, like the 62 million CT scans, isn't meaningful to drive local change. Some states are collecting local data, but their databases are generally at least four years old. You can't drive a car when the speedometer tells you how fast you were going four years ago. And you need to keep the data current to guide communities about how well they're doing, where new problems are emerging, and whether they're making progress over time.

What we need to make health reform succeed is to build a community that demonstrably raises the quality and safety of care and lowers its costs, without harming a soul.

What it takes is for the funders to bring together the major hospitals, insurers, and medical groups to share their data. Often they are reluctant to collaborate, but that can be brokered. It's not hugely expensive. Sometimes it just takes one persistent person. I saw one family physician collect the data by foot: He walked to the data departments of the three local hospitals, got permission to put the data on his laptop, figured out how to mesh it together, and in six months he had a community-wide snapshot of how many people were visiting the emergency room, how many imaging studies were being ordered, and so on.

Once you have the data, then I would invest in having the stakeholders come together to set priorities. The data tells you where the problems are; now we need to agree on which problems we're going to tackle. I'd want to attack the big killers that are also the sources of high cost and low quality. So, I'd want to have safer surgical care; safer childbirth; better primary care; improvements in end-of-life care for the terminally ill patient; a way to ensure we're not overusing imaging that is not only expensive but exposes

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[5] See John Kania and Mark Kramer, "Collective Impact," *Stanford Social innovation Review,* Winter 2011. See also Hanleybrown, Kania, & Kramer, "Channeling Change," *Stanford Social innovation Review* online (2012), and other resources about collective impact at www.FSG.org.

people to potentially harmful radiation. You can't do it all at once, but any one of these areas will have a big impact on the health of the community.

Investing in system solutions is no less complex and no less necessary than investing in a cancer cure.

This is especially true in smaller communities. My sense is that in communities of up to about 500,000 people, the health care system is something that people can get their arms around. You find there are a few leaders that people look to as setting the values that permeate the community. You can bring those people together into a workable group that can make priorities clear and then begin to tackle them.

The third step is innovation. We need to foster and support the innovators that can work at the local level—or even at a national level—to find solutions for these sets of system-wide problems. Investing in system solutions is no less complex and no less necessary than investing in a cancer cure. A lot of solutions are already there, but they aren't yet ready to use off the shelf.

If you want to tackle end-of-life care, for example, La Crosse has already succeeded. Well, what exactly did they succeed at doing? What's the end-of-life tool kit that I can bring into my community? We need to invest in the generation of those tool kits. This isn't expensive research, like developing a new cure for a disease. Sometimes the solution is as simple as a checklist, or buying vacuum cleaners. It's the kind of research any funder could afford to support, but right now, we underinvest in these things. We think they should already exist, but the reality is that they don't, and it takes work to make a tool kit that any community can really use well. There are people who are ready to take on these challenges, but we aren't funding them.

Then the fourth component is implementation. That takes funding, too. I mentioned the family foundation that is funding the implementation of the pre-surgery checklist in South Carolina. That is a sizable project—about $4 million over three years—but that is to implement the checklist in 67 hospitals across the state and rigorously track the results, so the cost works out to about $60,000 per hospital. It's not a lot of money to reduce post-surgical deaths by large numbers.

My own team is focused on all four of these work streams, but the shocking thing to me is how hard it is to fund this work. We are small, but our first priority is to make sure our surgical checklist is implemented nationwide, and then worldwide. But I also want to build a portfolio of solutions for communities in childbirth, end-of-life care, and primary care. We already know how to make the checklist for the 15 things that should happen to make every childbirth safer for the mom and the baby—and, by the way, to

The shocking thing to me is how hard it is to fund this work.

reduce costs. We could do the same thing for terminally ill patients or hospital discharges. We want to create a portfolio of tools that communities can use right off the shelf.

From the Local to the National: Sharing Solutions

Mark: It seems like a few individual communities are finding solutions for a few specific problems, but they aren't learning from each other to spread best practices nationally.

Atul: I think there's no question that communities aren't learning from each other. We held a conference in Washington, D.C., bringing together about a dozen communities that had lower costs for Medicare patients and were also in the top quartile of quality on the metrics we have available. We asked them to bring business leaders, hospital heads, and others from different parts of the community to talk about what their own numbers and data looked like. The first thing we found is that the communities had never seen their data in comparison to the others—they hadn't realized how differently they were doing things from other communities.

We also found that these communities were much more likely to have stakeholders who got together regularly to look at the quality of health care in the community. In places like Grand Junction, Colorado, for example, there's a coalition of physicians, the head of the major community insurance plan, and the heads of the local hospitals who meet regularly to ask how they're doing in terms of quality in primary care. In essence, they put together a health care information exchange and set goals for what they were going to accomplish in the community.

Improving the quality and lowering the cost of U.S. health care is a uniquely powerful place for community philanthropy.

So the real opportunity is that many communities are each doing something really well. They bring stakeholders together, set priorities, and collect data on some key measures. One community might be strengthening primary care, another might be reducing unnecessary back surgeries, a third might make surgery safer. But no community has a full portfolio of these projects that address all the really important dimensions of health in their community. None of these projects are easy, but I think that such a portfolio can be created at the community level. God knows it can't be done in Washington.

Mark: It seems to me that this is an opportunity for community-based foundations as well—to share information with each other about successful initiatives in their local communities and so spread these isolated projects into a national movement for comprehensive health care reform.

Atul: I agree. It's an exciting thought. It will be challenging because you are asking us in the medical community to think of ourselves as citizens responsible for the health and economic well-being of our community as a whole, not just for our individual pieces of the puzzle. But foundations have the leadership potential and the resources to make this happen. It is a role that community-based foundations—even those with modest resources—can play extremely well. In fact, it is precisely because they are focused on their local communities that they can play this role better than national foundations, and certainly better than government ever could. Most funders haven't yet recognized it, but improving the quality and lowering the cost of U.S. health care is a uniquely powerful place for community philanthropy.

For questions or comments on this report, please contact:

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