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Achieving Philanthropy at Scale: Transforming Hospital Systems into Models of Success

Rising problems of the nation's population health are increasingly complex.

As we have learned the hard way from COVID-19, problems of community healthcare access and social and cultural behavior create underlying compromised health that can make whole communities victims in a moment. The underlying problems themselves do not represent a narrow definition of health. They are the product of education, nutrition or lifestyles—of the resources, knowledge and behaviors of communities themselves. Diabetes, cardiovascular disease, stroke, obesity, respiratory compromise – all are population health challenges with roots in systems far broader than health.

The emphasis on health equity underscores this reality. The Centers for Disease Control defines health equity as a state in which every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health equity is not, then, just a matter of healthcare, but of the social determinants of health within and across communities.

Given this, hospital systems have a particular advantage. Health systems are comprised of community hospitals that serve within communities – across all ages, income levels, backgrounds, ethnicities. At their best, they are of and by communities. Yet, as part of health systems, individual hospitals have the ability to amplify solutions across communities, raising them to the level of national impact.

With sixty percent of the nearly 5,200 community hospitals in the U.S. belonging to a health system, this unique capability, shared by no other category of nonprofit, has significant range.

Philanthropy Strategy in Hospital Systems

A third of community hospitals operate on a negative total margin. The cost pressures on reimbursement levels creates a constant stress in managing healthcare as a sustainable community asset. And, while philanthropy is almost never the full solution to that financial stress, philanthropy can provide a critical supplemental resource with three advantages.

First, it is often unrestricted, allowing funding to flow to areas of hospital operations that are underfunded by reimbursement systems. Critical examples include community health education (something that, perhaps, we will now take seriously after COVID-19), internal workforce strengthening and population health research.

Second, it represents capital that can be invested in technology and infrastructure that reimbursement entities will not finance and slim to negative margins cannot finance. Philanthropy is often the pathway to state-of-the-art medicine for community hospitals.

Third, and as we have said many times before, philanthropy is not just about the money. It is an expression of individuals' commitment to their own health infrastructure and future. Whether the gifts are large or small, they are the monetized expression of the ties that bind hospitals to communities. And, therefore, the stronger the philanthropic funding, especially if it reflects gifts – however small – from a wide swath of the community, the greater the evidence that the hospital and the community are one.

How can health systems organize themselves to capitalize on both the monetary and nonmonetary assets that philanthropy represents?

Most systems have fundraising operations and/or foundations at the level of each community hospital or group of hospitals. This is a huge advantage, in theory. It means that hospitals can be deeply part of community. The more deeply these relationships are based on intimate understanding of community need and aspiration, the more effective fundraising will be and the more completely community leadership will engage in its own healthcare. Deep engagement can lead to better access. Deep engagement can extend the hospital into the many other areas of community life (education, nutrition, employment, etc.) in which societal drivers of health are embedded. And as such, deep engagement can open up the pathways for health equity.

In theory.

Supplementing those local fundraising institutions, many (at this point perhaps most) healthcare systems have established central foundation or philanthropic offices. These have different functions, many of which are evolving as we write.

In some cases that central function is administrative, making sure that the peripheries report accurately but carrying out little overarching fundraising. In others, the central capacity does fundraising and moves grants to the periphery. In still others, the central funds stay at the center for overall system needs or the center carries out both functions.

In some cases, the center is still trying to figure out its role.

The advantage of hospital systems is that all the pieces for effective philanthropic strategy are on the chessboard. There is deeply knowledgeable local capacity, and there is central capacity that can both support the community effort and lift common community health problems up to national funding opportunities in ways and with credibility that no single community could.

The problem is that this symbiotic alignment rarely takes place. Pieces are moving independently on the chessboard, but there is no unifying strategy and, as a result, no progress toward common goals and/or a common vision for scale. Movement does not equal progress.

On the one hand, community hospitals are not always deeply engaged in community. They may not sit on local community boards or have close professional relationships with the non-health community institutions that hold the true reins of health equity solutions. In this model, local hospital philanthropy operates at the level of institutional need within the hospital's four walls, not as a mechanism for both leading and funding community health solutions that emanate from the hospital into the community. Fundraising becomes limited to individuals with deep personal experience with the hospital, not individuals with widespread commitment to the advancement of the overall community. This limits both funding and leadership.

On the other hand, central health system philanthropic efforts can also be difficult to pursue. Campaigns to reach major donors for system-wide efforts can be seen as competition by the local hospital foundations or fundraisers who may seek to protect "our donors." Even more fundamentally, creating system-wide agreement on what the focus of those campaigns would be, what problems to address and how local knowledge is reflected in the campaign, can be difficult. The center becomes the "them" to the local "us." Even creating central policies and procedures to systematize philanthropy across the organization can be seen as fixing something that is perceived as not broken.

It is not an overstatement to say that all of this is tragic.

These problems stand in the way of optimizing and scaling health system philanthropy to address local needs and simultaneously lift those solutions to system-wide improvements across communities for improved health in all of its dimensions. In effect, it means that this jewel in the crown of the nation's healthcare – hospital systems with local roots – cannot be fully mobilized to fund solutions to the very problems that burden not only communities but hospitals themselves.

Key Principles to a Solution

This does not have to be. Our experience teaches that there are five key elements to solving for these tensions.

We can create philanthropic strength in hospital systems that both reflects local knowledge and community, and creates opportunities for scale through central support to local foundations and for cross-system campaigns that drive resources to healthcare at local levels.

First, listen. Listen with big ears. Listen to what local hospital foundations do and know. Equally importantly, listen to what communities have to say about their own needs, their own aspirations, their own priorities. Don't assume. Truly and humbly listen, not as a leader, not as an expert, but as a servant.

If the hospital, if the hospital system, if philanthropy itself is to truly position the hospital and system as integral to community, then start by listening to communities themselves.

Second, walk the talk of system collaboration. Use that learning to identify opportunities locally and opportunities that can be shared. White board solutions together – local hospitals/foundations and the system center. Everyone may not agree. But everyone will be heard.

Third, together establish clear fundraising systems that are positive sum. The objective is to increase the size of the fundraising and leadership pie, not to reallocate its pieces. Give local foundations revolving seats on the central foundation Board. Establish decision systems that value local voices. Create central resources that local foundations/hospitals can tap to increase their own skills, their own capacities, their own strategies for addressing local needs.

Fourth, agree on the approach to leverage. Be sure that the central foundation overtures to major philanthropic players in the system (corporations, foundations, major donors) actually lever up those institutions'/individuals' commitment to local needs. Gifts to central causes/operations do not replace gifts to local needs, they are in addition to gifts to local needs. Institutions/people of interest to the center live in places; those places may be the backyards of local hospitals and their foundations.

Fifth, understand that the overall goal is not about the four walls of hospitals, but about community. Fundraising strategy that is effective at both the center and at the periphery is about being in community. Therein lies sustainability. Therein lies the unique role of hospitals as resources for everyone of every age and background in every walk of life on every block of every community.

The philanthropic strategy must be about more than raising funds, it must be about engaging the health system and its components fully and completely in community.

We have seen this approach succeed in aligning philanthropy with a health system's growing emphasis on population health and regional expansion through our work with The Genesis Health System, a multi-hospital system serving the Quad Cities region in Iowa and Illinois. Together, we brought into being Genesis Philanthropy, a shared entity among partner community hospital foundations that focuses on improving the health of regions by leveraging larger philanthropic funding than any of the individual foundations could raise on their own for local facilities.

Why Bother?

This is a lot of work. It is delicate work. And it requires not just fundraising strategy and systems, but community engagement strategy and systems.

Why bother indeed?

The answer is on two levels.

On the one hand, because that is what health equity requires. It requires healthcare to become community. Without that perspective, health institutions cannot achieve their highest calling – to advance the health of all. And with community hospitals seeing 766 million outpatients, 34 million admissions, employing 6.2 million workers and fueling over $3 trillion of output in the U.S. economy (according to the 2020 Chartbook of the American Hospital Association), the lost opportunity is tremendous.

On the other hand, it makes sense. Being coordinated, using systems for scale and local presence for responsive implementation will raise more money. It will create opportunities for national-level philanthropic resources, which could not be accessed otherwise, to flow to local initiatives. In turn, the very presence of those resources can generate greater local giving for more robust community health programs that reach into the myriad community interests of local donors.

A Final Thought

All of this assumes that the C-Suite of the healthcare system sees, understands and values philanthropy not just as money but as an expression of community commitment and leadership.

Philanthropy is about local, regional and national leadership commitment to the health of communities. It is a measure of the commitment of communities to their future. There are no "small" donors in healthcare philanthropy. There is no distinction between patients and people, the wealthy and the middle class, the haves and the have nots. There are only people. People who believe in their future and that of their children. That future is the business of hospitals and hospital systems. And it is this business of hospital systems that is the fundamental goal of healthcare philanthropy.

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