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Interview

James M. Ferris*

An Interview with Robert K. Ross, M.D.

Abstract: Robert Ross, the President and CEO of The California Endowment, reflects on foundations choices for public policy and systems change, the involvement of The California Endowment in efforts to expand health care access through the Affordable Care Act, and the foundation's 10-year initiative: Building Healthy Communities.

Keywords: philanthropic strategy, public policy, systems change, affordable care act, healthy communities

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Robert K. Ross, M.D., is President and Chief Executive Officer for The California Endowment, a health foundation established in 1996 to address the health needs of Californians. The California Endowment was formed as the result of Blue Cross of California's creation of its for-profit subsidiary, WellPoint Health Networks. In 2012, The California Endowment had assets of $ 3.7 billion, and its annual grantmaking was over $116 million.

Dr. Ross has an extensive background as a clinician and public health administrator. Prior to his appointment as President and CEO in September 2000, Dr. Ross served as Director of the Health and Human Services Agency for the County of San Diego from 1993 to 2000 and Commissioner of Public Health for the City of Philadelphia from 1990 to 1993. Dr. Ross received his undergraduate, Masters in Public Administration, and medical degrees from the University of Pennsylvania in Philadelphia.

This interview took place at USC on June 28, 2013 on the subject of philanthropic strategies for public policy and systems change; it was conducted by James Ferris, The Emery Evans Olson Chair in Nonprofit Entrepreneurship and Public Policy and the Director of The Center on Philanthropy and Public Policy at the University of Southern California.

Public policy and systems change

Jim Ferris: During your tenure at The California Endowment, the foundation has been committed to engaging public policy and systems change. Of course, not all foundations are interested, prepared, and willing to take that work on. Although there is a growing number, many still don't want anything to do with it. But not The California Endowment – it has always been in the middle of doing public policy work. Why is that so important?

Bob Ross: I wish I could say this was part of the grand master strategic plan when I walked in the door. It really wasn't. The policy advocacy work really grew on me. I would say the biggest single difference we've made as a grantmaker in my time at the Endowment – I would say, when I first got to the Endowment, in my first couple of years here, probably 70–80% of our grants were direct service grants. Maybe 20–30% of our grants were policy systems change and advocacy. That ratio has probably flipped over my dozen plus years.

The reason? I wish I could give you a nice short, crisp, tight reason here. So a couple of thing came together for me and for us. Number one, I have a public health background. Public health is a prevention discipline. Public health is about creating conditions under which people can be healthy. It's different than the patient care. The community becomes your patient rather than the individual. And that's about conditions and environment. And, not just environment in terms of being healthy or unhealthy, but environment in terms of opportunities and choices that people have.

I would say the two biggest significant public health victories in the last century have been immunizations and tobacco. Probably, no two public health policies have saved more lives. But, they're really different. Immunization was a technology fix. The data showed that you can prevent disease, and, if you give people these vaccines, the stuff goes away. And so, immunizations and the vaccine program scaled up pretty quickly. In fact, the Rockefeller Foundation was at the front-end of a lot of this work. And so, once it was proven that the vaccines were effective and safe – you know – bang! Vaccine programs are part of public policy.

Tobacco is a different story. We knew in the medical literature that tobacco was terrible for your health back in the 1920s. It took us 45 years before you could get the Surgeon General to put the warning on the side of the cigarette pack that said: "Warning – This product may be harmful to you." And that was 1964. And then it took another 30 years just to get smoking out of restaurants in California. We've been in an 80-year war on tobacco which we haven't won yet. But the way we've been winning the tobacco battle has been this combination of

science and advocacy. And, paired together, it just has given us much more impact than either one singly.

Point number two: after my first five years at the Endowment, I commissioned a report – an internal report – that looked at everything we had done and to say: what worked and what didn't. And what I found was the areas where we had the most significant and meaningful impact was where the work on the ground was intentionally married to the policy work. We saw bigger more sustainable victories. So, that was children's health coverage; that was childhood obesity; work and prevention; that was some children's mental health work we did. Now the problem is these battles are never – you think they're done – they're never done. Because, you know, the state budget or recession comes in and wipes away much of the progress. And then you're back at it again. But, that said, the problem we have in solving social problems – health included – is that it's really not an innovation problem, it's a scaling problem. It's not that we don't need innovation – we do – but the problem is that even once we hit upon an innovation that's effective, we don't know how to scale it. And so, it's the policy change and systems work that allows you to scale the innovation. And so for us that's the prize.

Jim Ferris: Bob, you are fond of talking about the grassroots and the treetops when you talk about policy work. Can you talk a bit about what you mean by that?

Bob Ross: Every policy issue we look at, whether it's childhood obesity, youth violence, school health, we take a look at our assets and we try to marry the assets at the grassroots level with the assets we have at the treetops level. I'll talk about a battle that's not won yet, and it may take a while for us to win it: soda taxes. A major, significant contributor to the childhood obesity epidemic and the diabetes epidemic in this country is sweetened beverages and sodas. As we've seen with tobacco, you can influence usage and influence the right kind of behavior with smart taxes. You make the product a little more expensive, fewer people buy it. You designate the resources from the tax to the prevention approach, as we did with tobacco in California. Many of our advocates in Sacramento are working on this issue. It's a tough, uphill climb, but we connect them with our grantees at the local level and some of them are looking to do soda taxes in their local communities. And so, when you marry the data-research-heavy experience of the statewide advocate in Sacramento with local grassroots organizations that are trying to push a soda tax, let's say, in Richmond, you get a very nice synergy. Sometimes, what we have to do is just introduce these people to one another and then get out of the room. But, if you

don't have the grassroots advocacy, it is hard. We saw with school suspensions: very energized, local youth leadership organizations working with statewide policy advocates like PolicyLink to great positive impact in terms of getting policy changes.

Jim Ferris: How do you work with the board on issues that are at the forefront of doing policy work: risk-taking, patience, and metrics?

Bob Ross: Yes. If you're not going to be results-driven then don't do it. Results drive everything. In discussion with our board we've been very clear that we want to create healthier environments where children can thrive. We've picked some big results that are the "true north" for us – the compass. Those big results are: reduction in childhood obesity, improvements in school fitness, reductions in youth violence, and 100% children [health insurance] coverage. Now the debate we have in the boardroom was: "Okay, define success, Bob. What does it look like? Is it a particular percentage reduction in childhood obesity? Is it a particular percentage reduction in youth homicides? Is it just in health and community sites? Is it statewide in California? What's the 'it' here?" We continue to have those debates. Where we're landing is – because our theory of change is about policy and systems change – we should define success there. If we actually see meaningful population indicator reductions by the time we get to the end of the 10 years, we'll consider that a bonus. But, we're not going to declare failure if the obesity reduction rates are not lower. Partly because so much can happen in between now and then that can take you north or south that's completely out of the control of your strategy and grant making portfolio. The short story is you agree upon a set of results as best you can with as much clarity as you can achieve. You pick a theory of change and a strategy to get there and you constantly revisit it. It is important to have a logic model and a theory of change and a strategy. You've got to have one but don't get married to it. Commit to learning and what's working and what's not because you're going to tweak some things. You may have to throw some stuff overboard.

Jim Ferris: So the board has signed on to this 10-year strategy. Are there metrics that you use along the way that gives them sort of confidence [the *Building Health Communities* Initiative] to keep moving ahead?

Bob Ross: The other shift we made in going from the pre-building of the *Building Health Communities* to the building of the communities plan. The one thing that has been the single most frustrating element for me – the bear to wrestle with in my work with philanthropy – has been evaluation. As a general rule, evaluation is a challenge for much of philanthropy. Evaluation around systems change and advocacy and policy work is… it's a beast. What we did was

we re-engineered our evaluation approach. We called it "Learning through Impact." Learning from many of our colleagues, The California Wellness Foundation and others, we went away from the big, mega-dollar mega-year academic, RAND-based kind of evaluation. I didn't want to commission a five- or seven-year study at some enormous cost and not learn a blessed thing along the way. It doesn't do me any good to get a report in 2018 saying we screwed up in 2012. And I'm stereotyping to make a point here, but I really wanted something dynamic. So, we have our evaluation partner – Foundation Strategy Group – helping us identify metrics and measures along the way. You know: Do we have meaningful community participation? Are community leaders and organizations stepping up on the issues? Are we seeing policy movement locally and statewide and what does it look like? So we do have metrics and measures that – if you think about them – they look like mileposts on the way. But, as a general rule, policy work is messy. And community change work is messy. And we're trying to do both. And so it's messy.

Jim Ferris: Extra messy!

Bob Ross: Yes. But it's also euphoric. We continue to have conversations at the board level around how do you make messy work simple and understandable. If there's one thing I'd like to be able to give the field of philanthropy when we're done with this, it is how do you enter into this space and know whether you're winning or losing, and have a learning approach along the way. We're not there yet, but I suspect that within 2–3 years we'll be in a much better position.

Affordable care act

Jim Ferris: I want to turn to some of your work around the Affordable Care Act. Access to healthcare is very central to The California Endowment's mission. Obamacare passes, and then it is challenged in the Supreme Court. It gets past that and now it is being implemented. Will you talk about the foundation's involvement?

Bob Ross: Yes. So this gets back to an earlier observation about how messy and untidy all of this policy work is. So when we did the strategic plan, I don't even know whether we'd heard of Obama by then. He was in the Senate. But who knew this guy was going to become the President? And who knew that he was going to make healthcare reform one of his top issues? So, that wasn't in the plan, but it showed up at our doorstep. When we understood what Obamacare – the

Affordable Care Act – was about and we put it side-by-side against our mission, we said: "Wow! This thing – this law, if successfully implemented and executed, could be an accelerator – a significant accelerator toward our mission." That led to two different kinds of conversations in the boardroom. One conversation was: What should our role be? And, obviously, we couldn't get involved in the legislative stuff because we don't cross the lobbying line. But, from the standpoint of non-lobbying advocacy, we began to feed more dollars to our grantees that were in the space of access to healthcare. We ramped up our advocacy support of our grantees and that kind of work. Then, it was clear that the law was significantly controversial and hyper-partisan. It wasn't the health plan that I would have wanted. You know, I would have been much more comfortable with a public option, Medicare for all, even single payer, quite frankly. And so, what Obamacare did was that it affirmed private health insurance.

Jim Ferris: Markets, right?

Bob Ross: Yes, markets. We thought it was a huge opportunity. The biggest opportunity before Obamacare was Medicare and Medicaid. That was 50 years ago. And seeing the bows and arrows and slings that were being hurled at the President on this, our view was no one is going to do this again for another couple of decades. The discussion we had at the board level was that this is probably one in a 75 year shot to accelerate, reform the health system toward our mission. And we better throw everything at this, including the kitchen sink. And so, we funded our grantees. We decided to do an amicus brief when the law was before the Supreme Court, which was unprecedented for us. We had never done anything like that. Not sure it helped, but certainly our grantees appreciated it. That was another bully pulpit sort of opportunity.

When it got through the Supreme Court and it was clear that Obamacare was actually going to happen, that's when we closed the door and said to the board: "Ok, here's what the implementation of this thing looks like: California cannot fail... it can't fail. And, however much federal money is in it, it doesn't look to us to be enough – on the education side, on the outreach side. And we need some extra money to spend on this." And so, we deviated from our spending policy to do a special allocation, which was a minimum of $225 million over 5 years above and beyond our base spending. That was a healthy fight in the board room, whether we should do that, but it was a good and vigorous debate. From a leveraging standpoint, if you can take 7 million uninsured Californians and reduce that number to 3 million or 2 million, that's a major step toward our mission. We saw it, again, as risky, because it put us on the dark side of the political right. But we felt that was the right thing for California. And, we felt it was the right thing for our mission.

Jim Ferris: What about the amicus brief for the Supreme Court? Was that a separate conversation?

Bob Ross: It was a separate conversation, along a series of conversations. I don't know how Daniel Zingale, our policy director, got the idea. But he was the one who brought the idea to me. And I said, "Can we do that?" And he said, "Yeah, I've checked with the attorneys. It's not crossing the lobbying boundary." And, I said, "Let's bring it to the board." The conversation was not hard. It was actually relatively easy. Susan Berresford (former President of the Ford Foundation) is on our board – an influential, experienced board member – and she helped us walk through the pros and cons. That's what I mean by using the generative leadership in your board members.

Building healthy communities

Jim Ferris: I would like to talk a bit more about Building Healthy Communities that you referenced earlier. This 10-year, comprehensive community initiative begun in 2009 to create a new way Californians think about and support health in their communities was a major shift in the foundation's grantmaking strategy. What was the genesis and rationale behind this approach? What have you learned thus far?

Bob Ross: A combination of being inspired by seeing stuff that had worked and being frustrated with being spread too thin. As you know, we had this spate of healthcare conversions in the 1990s. And the California Endowment was created in 1996 as a result of the Blue Cross of California conversion. Even our birth was controversial.

Here's the dynamic that happened. It kind of happened in phases. Phase one was – we open the doors. We're this new foundation, with a lot of money. But we're also the bastard offspring of for-profit healthcare. A lot of eyes are on this place. And so, the very first phase was get money out. I know that sounds pretty crude and raw. It was get money out! And, get money out into as many people's hands and organizations' hands within the context of our mission as possible. And, in my first board meetings, I remember that the staff would present a map of California and it had green dots every time we made a grant in a place. We were judging our success by how many green dots we could fill in. It was ludicrous to think about it. But that's kind of the politics of where we were: is this thing getting money out to communities or is it lining the pockets of the health insurance industry?

Then in phase two I brought the first strategic plan. It wasn't tight, but it at least took the work that we were doing and gave it kind of a construct and a framework. After five years of that strategic plan, I felt that we had done some good

things but that we were still spread too thin. I was watching the Harlem Children's Zone. I was watching Market Creek Plaza. These took 10 years to succeed. So, I went to the board and I said, "Listen. We need to figure out a way to more strategically marry, and intentionally marry, our grassroots community work with our policy work. We've got to figure that out. Let's pick a limited set of communities that we stick with. Let's pick a limited set of child health issues that we focus on. Let's see if we can marry them up and move them forward." The "Aha!" was that even though a lot of things change in a 10-year timeframe, you don't get meaningful community change or transformation in a timeframe less than that. And the policy work takes time. So I wanted a 10-year plan. I wanted to focus on a narrow number of issues, and I wanted to focus on a narrow number of communities. That was a hard discussion for the board because we went from funding in 100 zip codes to funding in 14. But that wasn't an easy conversation. That was another hard conversation with the board. And, even when the board approved the plan it was kind of a sense of, "You know, ok, Bob, this thing had better work. And if it's not, we'd better know." But the board's been great and patient.

We are now two-plus years into the implementation of a plan, and I can safely say that it has been the two most exciting years of my career in community and public health. We have "dropped anchor" in 14 distressed California communities for a 10-year period to work in partnership with community leaders to improve the health and life chances of young people. In addition, we are supporting change at the regional and state levels through funding advocacy, organizational capacity building, and communications on our key health issues.

It is our intent to have these place-based and "bigger than place" strategies complement one another, and for the moving parts to develop a powerful synergy. At the local level, the 14 communities are engaging multiple sectors to develop innovative efforts to advance health. As these innovative strategies emerge, we're looking for ways to scale the ideas up through policy change and communications at the state and regional levels. Through acting on multiple levels with complementary strategies, we expect to make a greater contribution than if we were to work only at the place level or only through supporting statewide advocacy. This is central to our theory of change. In a sense, it is fair to consider it is a "place-based plus" community change campaign. We have had three "aha" moments thus far.

The message matters

When one talks about the "social determinants" – the roles that poverty, education, and housing play in health status – outside the public health world, eyes glaze over. We experienced this communication gap early as local communities strived to

decipher our jargon-laden list of ten targeted outcomes and four big results. Our communications team, inspired by the engagement of community leaders and residents in the planning process, took this obstacle head-on and have created what I believe is one of the first successful decodings of the social determinants research: Health Happens Here. If you put the phrase *Health Happens Here* on a photo of a healthy school lunch, or a bike path, or a father and daughter hugging each other, we immediately communicate the norms change we are promoting. We took this message a step further by incorporating it into our grantmaking. We found that 80% of our grants were focused around three areas: neighborhoods, schools, and prevention. This led us to create three themes – Health Happens in Neighborhoods, Health Happens in Schools, and Health Happens with Prevention – that have become the essential building blocks for our work. In fact, we call them campaigns, another use of language that communicates our intent as a foundation to use our brand to push for policy and systems change. And we are investing in aggressive media strategies to promote this message through partnerships with influential messengers including First Lady Michelle Obama, Dr. Oz, and Jamie Oliver. A simple, compelling message carried by influential messengers, can shape a new narrative of change.

Trust young people to lead

Early in the process, we chose to bring young people into leadership roles. Little did I know it would impact how we view our work. Young people and adults view health issues differently, and it makes perfect sense to engage young people directly in developing strategies to improve their health. It makes sense, but in the past we didn't. We operated like most organizations and didn't engage young people in our thinking. We've seen first hand that young people can be powerful leaders for social change. When they tell their stories through the arts, spoken word, social networking, and journalism, they compel action. They are not only about our future; they are leaders of today. Now that we have taken this step, we're learning a lot. Young people brought to our attention the scandalous epidemic of suspensions and expulsions in our schools and helped us understand how this issue connects to their health. Young men of color led us to a greater understanding of the role of trauma in the lives of youth growing up in homes and neighborhoods plagued with violence and gangs and lifted up the need for social/emotional health and healing. The youth leaders involved in our work, working in coalitions with the organizations that support them, have begun to rack up a series of policy victories that will put a check on the epidemic numbers of school suspensions, calling for alternative, common-

sense discipline practices (like restorative justice approaches) that keep kids in school. They are not only about our future; they are leaders of today. We're evolving into an organization informed by adult and youth perspectives.

Build power, not just knowledge and innovation

Frederick Douglass said that power concedes nothing without demand. The world doesn't change because of the release of new data. It responds or concedes when people demand change. Institutional philanthropy tends to worship at one of two altars: new knowledge and innovation. Both are overrated, overhyped, and over-subscribed to in our field. It can be argued that the primary value of philanthropy to civic society is the issue of problem-solving at scale. In a wonderfully linear, logical, and intellectually-driven world, good data, research, and new knowledge would be king. But that is not the world we live in. Recently, I noted that the state legislature in North Carolina effectively banned the use of scientific projections on global warming-induced tidal changes, because they stand to impede the path of business development. More recently, the NRA-led prohibition against gun violence research by the CDC was recently challenged by President Obama after Newtown. I wish these represented isolated events, but history has shown that good science is frequently set aside by political and economic forces to the detriment of society.

On a related front, philanthropy seems hopelessly in love with "innovation" as well. In the corporate, for-profit world, innovation quickly scales through profit – the iPhone being a classic example. In the social sector, innovation rarely paves the way toward scale on its own merits. Too many politically powerful forces are in play. Power, voice, and advocacy matter, and matter greatly. Data and innovation, without the recognition of political power and advocacy, is in vain. The school suspensions battle was a perfect illustration of this point, as youth leaders and youth advocacy organizations utilized suspension data that demonstrated a disproportionate impact on African-American and Latino young men as a result of the practices.

In Building Healthy Communities, we've decided to be clear; we want to help community leaders and residents build the power they need to promote healthier places for young people. We want to support people and organizations that think power, act with power, and demand change. Power concedes nothing without demand, and as Douglass added, *it never has and it never will.*

Jim Ferris: Thanks Bob for sharing your perspective on how philanthropy can make a bigger impact through public policy and systems change and how The California Endowment approaches this work.