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HEALTH PHILANTHROPY IN CALIFORNIA: THE CHANGING LANDSCAPE

UNIVERSITY OF SOUTHERN CALIFORNIA

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FOREWORD

The landscape of health philanthropy in California has been transformed over the past decade and a half. The greatest source of change has been the introduction of 20 new health foundations created from the proceeds of the conversion of nonprofit healthcare organizations. These foundations, all created since 1980, have assets in excess of $7 billion. Eleven of these foundations have been created since 1995.

These foundations are having a profound impact on health philanthropy in California. With the substantial amount of philanthropic assets directed towards health, California grantmakers devote a larger share of their grant dollars to health than U.S. foundations – 20.1 percent vs. 16.5 percent. Given this unique dimension of California philanthropy, this report examines the size, scope, reach, and potential impact of health philanthropy in California, with a particular focus on the role of these new health foundations in health grantmaking and the context of other grantmakers in health. This analysis helps to clarify the role of health grantmakers and considers their expected impact given the public policy environment in California. This assessment is intended to inform health grantmakers, public policymakers, and their partners as they work together to meet the health needs of Californians.

The Center would like to acknowledge the support of The California Endowment for funding the study upon which this report is based. We would also like to thank Lucy Bernholz, Kendall Guthrie and Gabriel Kasper of Blueprint Research and Design, Inc. The study was done in association with them under contract with the Center on Philanthropy and Public Policy. Of course, the authors are responsible for the views expressed in this report.

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Director
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INTRODUCTION

The landscape of health philanthropy in California has changed dramatically in the past decade and a half. The driving force has been the creation of new health foundations born from the conversions of nonprofit healthcare organizations.[1] Healthcare finance reforms during the past two decades have produced significant structural shifts in the healthcare industry, providing strong incentives for nonprofit healthcare organizations to change their legal status. An unprecedented number of nonprofit providers – hospitals, HMOs, and insurance providers – have converted to for-profit entities through sale, merger, joint venture, or restructuring. Under the state's charitable trust law, the assets created in the conversion process must be transferred to a foundation or public charity for purposes consistent with the mission of the converting nonprofit. As a consequence, there has been a tremendous increase in philanthropic dollars devoted to health garantmaking with a dramatic impact on the landscape of health philanthropy in California.

More than 20 health conversion foundations, with assets totaling over $7 billion, have been created in California, constituting more than half of the collective $13 billion in assets of all health conversion foundations nationally.[2] These new funders represent a substantial increase in health grantmaking capacity. In particular, the establishment of The California Wellness Foundation in 1992 from the conversion of Health Net, and the creation of The California Endowment and the California HealthCare Foundation in 1996 from the conversion of Blue Cross of California introduced three of the largest foundations in the United States into the state-funding arena. However, many of the others often operate under restrictions on the activities they can fund and the communities where they can do their grantmaking.

With such profound changes in the philanthropic landscape, it is useful to examine health philanthropy in California. This study provides a snapshot of the size, scope, reach, and potential impact of health grantmaking in California today, based on the contributions of the state's new health foundations, community foundations, and other state and national foundations doing significant health-related grantmaking in California. Information on 50 foundations with significant health grantmaking within California was collected. The foundations are listed by type in Appendix 1. Included are virtually all of the state's health conversion foundations,[3] the state's major community foundations, and a selection of the major state and national private foundations with articulated health interests. These 50 foundations represent a substantial majority of the significant health grantmakers in the state of California. Appendix 2 briefly summarizes key information about these grantmakers, including funding priorities and targeted geographical areas.

The size of health funders gives an indication of the capacity for health grantmaking within the state. The scope of grantmaking reveals the funding priorities of these foundations, the type of support they make through their grantmaking, and their funding methods. The reach of philanthropy is indicated by mapping the philanthropic capacity for health-related grantmaking in California's communities, based on geographic focus. This analysis helps to clarify the role of health grantmakers and explores their expected impact given the public policy environment in California.

[1]These foundations were initially referred to as health conversion foundations. In more recent years, many of these grantmakers have come to prefer the term "new health foundations." For example, see the statement by Gary L. Yates and Thomas G. David, "Don't Call Us 'Conversion Foundations' …Please", in the Grantmakers in Health series – Views from the Field, February 28, 2000. Both terms are used in this report.

[2]Grantmakers In Health, Philanthropy's Newest Members: Findings from the 1999 Survey of New Health Foundations (Washington, DC: March 2000)

[3]Two funds created from health conversions are housed within community foundations, the Union Labor Health Foundation and the Centinela Medical Funds, and are categorized for this analysis as health conversion foundations.

THE SIZE AND STRUCTURE OF HEALTH GRANTMAKERS

Changes within the foundation world have had a dramatic impact on the capacity of health-related grantmaking in California. The growth in health conversion foundations, both in numbers and assets, has increased the philanthropic assets targeted toward health. In addition, the increase in the numbers and assets of community foundations has provided an increased capacity for grantmaking, including health-related grantmaking, in many communities throughout the state.

The 50 foundations included in this study have quite different histories. As would be expected, the health conversion foundations in this study are considerably younger than their private and community foundation counterparts. The new health foundations created from the first wave of nonprofit conversions in California were established in the mid- to late-1980s, beginning with the creation of the Sierra Health Foundation in 1984. Over half of the health conversion foundations in the study were established since 1995.

By contrast, all but one of the state and national private foundations were created before 1973. Community foundations also have considerable legacies in California, with the oldest dating back to 1915. Since then, the creation of community foundations has been spread out relatively evenly, with an increase in new community foundations during the 1980s

Table 1: Number of foundations established over time, by type.

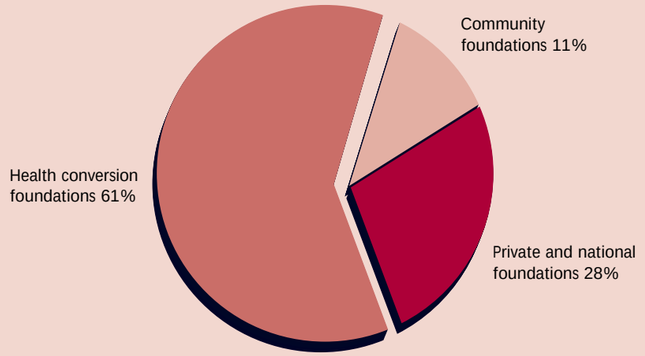
	1910-1919	1920-1929	1930-1939	1940-1949	1950-1959	1960-1969	1970-1979	1980-1989	1990-1999
State and National	1		2	2	2	1	1		1
Community	1	2		3	3	2	2	7	
Conversion								6	13

N=49

Health Grantmaking. Total 1999 fiscal year grantmaking for health-related activities statewide amount to more than $325 million. Almost two-thirds of these grants came from health conversion foundations, which awarded almost $198 million in philanthropic funding for health-related programs within the state. An additional $93 million in health-related grants came from private state and national foundations, and community foundations awarded approximately $38 million. Overall, 1999 health grantmaking increased almost 15 percent over the previous year.

The disproportionate amount of health grants made by health conversion foundations (relative to their number) results from their exclusive focus on health. These foundations dedicate virtually all of their grantmaking to health-related needs. Other foundations, however, devote just a portion of their awards to health-related activities; much of their funding is directed toward other elements of their missions. On average, health-related grantmaking by community foundations constituted approximately 11 percent of giving by those foundations. And health grantmaking by the private state and national funders included in this study represented approximately six percent of their total awards.

Figure 1: Foundation health-related grantmaking in California, by type of foundation



N=49

While there are many foundations supporting health-related activities in California, health grantmaking in the state is dominated by two primary funders: The California Endowment, which awarded more than $103 million in grants in 1999 (almost a third of all foundation health funding in the state), and The California Wellness Foundation, which gave over $46 million (approximately 14 percent of all state philanthropic health grantmaking). These foundations in combination with the David and Lucile Packard Foundation (10 percent) and the Robert Wood Johnson Foundation (9 percent) provide 64 percent of all health-related grant dollars in the state. Table 2 provides a complete listing of the health-related giving by the 50 foundations included in this study.

Table 2: California health grantmakers, listed by size of giving

Foundation Name	Foundation Type	Health Grantmaking in California
The California Endowment (Woodland Hills, CA)	Conversion	103,295,139
The California Wellness Foundation (Woodland Hills, CA)	Conversion	46,061,006
The David and Lucile Packard Foundation (Los Altos, CA)	Nat/Cal	32,382,307
The Robert Wood Johnson Foundation (Princeton, NJ)	National	29,183,610
The Pew Charitable Trusts (Philadelphia, PA)	National	14,618,000
Marin Community Foundation (Larkspur, CA)	Community	13,700,000
California HealthCare Foundation (Oakland, CA)	Conversion	12,350,640
California Community Foundation (Los Angeles, CA)	Community	8,703,897[4]
W. M. Keck Foundation (Los Angeles, CA)	California	6,125,000
UniHealth Foundation (Burbank, CA)	Conversion	5,500,000
W. K. Kellogg Foundation (Battle Creek, MI)	National	5,063,401
The Health Trust of Santa Clara Valley (San Jose, CA)	Conversion	4,897,125
Alliance HealthCare Foundation (San Diego, CA)	Conversion	4,845,033
The San Francisco Foundation (San Francisco, CA)	Community	4,726,773
QueensCare (Los Angeles, CA)	Conversion	4,615,000
Sierra Health Foundation (Sacramento, CA)	Conversion	4,559,200
The James Irvine Foundation (San Francisco, CA)	California	3,105,000
Centinela Medical Funds (Los Angeles, CA)	Conversion	3,000,000
Archstone Foundation (Long Beach, CA)	Conversion	2,259,050
Community Foundation Silicon Valley (San Jose, CA)	Community	1,750,000
The M Health Foundation (Walnut Creek, CA)	Conversion	1,600,000
Weingart Foundation (Los Angeles, CA)	California	1,400,000
Sisters of St. Joseph Healthcare Foundation (Orange, CA)	Conversion	1,383,216
The Henry J. Kaiser Family Foundation (Menlo Park, CA)	Nat/Cal	1,065,019
John Muir/Mt. Diablo Community Health Benefit Corporation (Walnut Creek, CA)	Conversion	1,039,100
East Bay Community Foundation (Oakland, CA)	Community	910,000
Community Health Corporation (Riverside, CA)	Conversion	895,550
Irvine Health Foundation (Irvine, CA)	Conversion	851,533
The Pasadena Foundation (Pasadena, CA)	Community	826,243
Community Foundation for Monterey County (Monterey, CA)	Community	610,000
Orange County Community Foundation (Irvine, CA)	Community	606,000
Santa Barbara Foundation (Santa Barbara, CA)	Community	578,258
Peninsula Community Foundation (San Mateo, CA)	Community	573,000
The Commonwealth Fund (New York, NY)	National	539,884
Sonoma County Community Foundation (Santa Rosa, CA)	Community	270,602
The San Diego Foundation (San Diego, CA)	Community	252,415
Sonora Area Foundation (Sonora, CA)	Community	209,526
Community Foundation of Santa Cruz County (Soquel, CA)	Community	197,202
Union Labor Health Foundation (Bayside, CA)	Conversion	191,000
Fresno Regional Foundation (Fresno, CA)	Community	166,495
Humboldt Area Foundation (Bayside, CA)	Community	156,500[4]
Community Foundation of Riverside County (Riverside, CA)	Community	115,890
Sacramento Regional Foundation (Sacramento, CA)	Community	98,852
Glendale Community Foundation (Glendale, CA)	Community	75,099
Desert Health Care Foundation (Palm Springs, CA)	Conversion	0
The HealthCare Foundation for Orange County (Santa Ana, CA)	Conversion	0
Lucile Packard Foundation for Children's Health (Palo Alto, CA)	California	0
Pajaro Valley Community Health Trust (Watsonville, CA)	Conversion	0

NOTES:
1. Data reflect fiscal year 1999 information, with the exception of figures for The Commonwealth Fund, the David and Lucile Packard Foundation, the Henry J. Kaiser Foundation, The Pew Charitable Trusts, and the W. K. Kellogg Foundation, which were computed using 1998 figures obtained from the Foundation Center. The figures for these national funders include only awards directed to health-related activities within the state of California.

2. Data on health grantmaking were not available for the Pacific Hospital Charitable Trust and the Ventura County Community Foundation.

3. Community foundation grantmaking includes discretionary and donor-advised funds, and excludes pass-through health grantmaking.

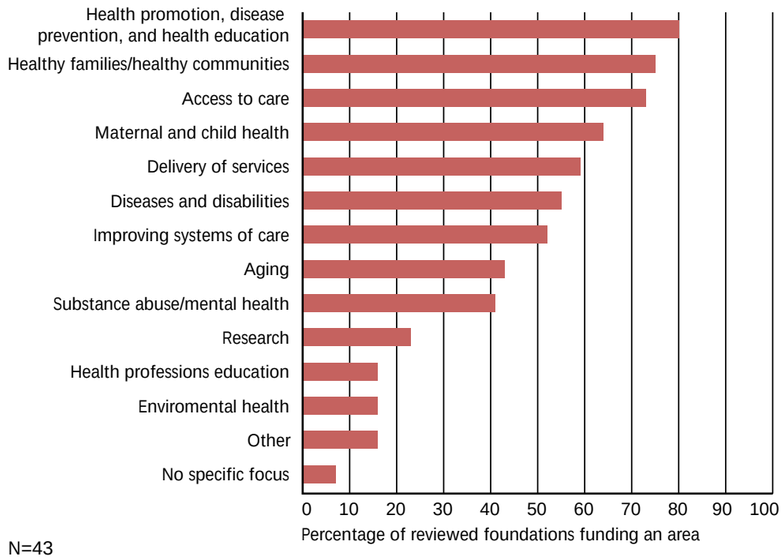
4. Grantmaking by the California Community Foundation excludes the Centinela Medical Funds, and grantmaking by the Humboldt Area Foundation excludes the Union Labor Health Foundation, both of which are listed separately.

THE SCOPE OF HEALTH GRANTMAKING

As the capacity for healthcare philanthropy grows, it is important to understand the scope of health grantmaking. Of particular interest is the extent to which grantmakers in health vary in their funding priorities, grantmaking strategies, and grantmaking processes.

Health Funding Priorities. The foundations reviewed in this study support a wide variety of health activities in their communities (Figure 2). Health promotion, disease prevention, and health education; healthy families/healthy communities; and access to care were identified as priorities by approximately three-quarters of the foundations. About two-thirds reported a focus on maternal and child health, and more than half of the foundations cited service delivery, diseases and disabilities, and improving systems of care as grantmaking priorities. Within these areas, many funders specifically dedicated their giving to support activities directed to helping the medically underserved, including children, uninsured, underinsured, elderly, and indigent populations.

Figure 2. Health grantmaking priorities, all foundations.



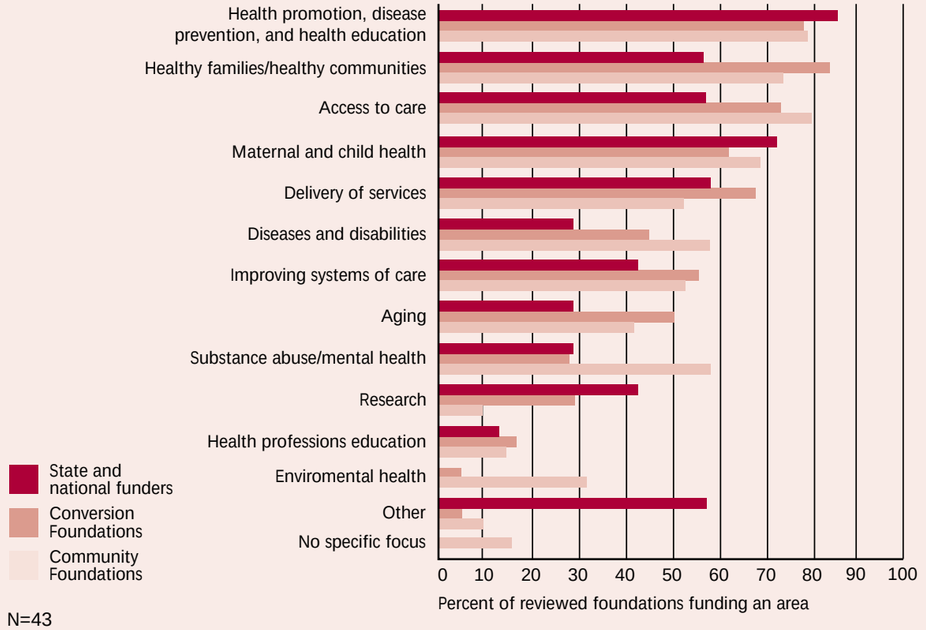
N=43

Grantmaking priorities did not vary dramatically between the different types of health funders (Figure 3). Community foundations as a group typically cast a wider funding net, identifying an average of eight priority areas, compared to six for both health conversion foundations and private national and state foundations. Perhaps in part because of this, more community foundations identified diseases and disabilities, substance abuse and mental health, and environmental health issues as funding priorities, than did other types of funders. On the other hand, more health conversion foundations provided support for direct service activities, and more state and national funders supported research efforts.

The most frequently-cited priority areas for health conversion foundations were healthy families/healthy communities; health promotion, disease prevention, and health education; access to care; delivery of services; and maternal and child health. Among community foundations, the main priorities were health promotion, disease prevention, and health education; access to care; healthy families/healthy communities; and maternal and child health. And for private state and national funders, chief priorities included health promotion, disease prevention, and health education; maternal and child health; access to care; delivery of services; and healthy families/healthy communities.

Underlying the patterns of funding priorities are the restrictions under which many of the conversion foundations operate. Many are subject to legal restrictions about the programmatic uses of their funds and the geographic areas they are able to serve. This ensures that foundation assets are used for purposes similar to those of the organizations from which they were originally created. Eighty-five percent of the health conversion foundations reviewed in the study had specific legal programmatic restrictions defined in their articles of incorporation. The emphasis noted above on the delivery of services is a reflection of these restrictions. Foundations created from nonprofit to for-profit hospital conversions, especially after the Attorney General's office became involved in the process, have had their grantmaking tied to the mission and patterns of activity of the original nonprofit entity.

Figure 3. Health grantmaking priorities, by type of foundation.



N=43

Grantmaking Strategies.

Foundation grantmaking strategies are revealed, in part, by the types of support they provide to their grant recipients. The types of support range from funding new projects to providing core operating support, and from providing technical assistance to sponsoring conferences and workshops. Each foundation employs multiple strategies to support health-related activities.

More than 80 percent of the foundations reviewed in the study provided program support for new and demonstration projects and/or established and exemplary projects (Figure 4). But this traditional programmatic funding was typically complemented by other types of support. Over three-quarters of the foundations provided money for organizational capacity building and infrastructure development, and about 60 percent provided technical assistance and matching or challenge support. Research funding is the least- frequently mentioned type of support.

Patterns in the types of support among the three types of foundations are presented in Figure 5. Program support and capacity building/infrastructure development were the most commonly used grantmaking strategies across all foundation types, although health conversion foundations used capacity building/infrastructure development slightly less frequently. In addition, health conversion foundations were also less likely to provide core operating support, and more likely to provide research support. State and national foundations, on the other hand, more frequently provided matching and challenge support and less often supported conferences, workshops and seminars. Community foundations more often provided core operating support for local organizations.

Funding Method.

Foundations also utilize a variety of methods for making grants. Most of the foundations (89 percent) accepted grantee-initiated proposals, where grant seekers are encouraged to send unsolicited proposals that fall within general funding guidelines. Just under half of the foundations reviewed (46 percent) used foundation-initiated proposals, where for projects they seek to fund, they issue a request for proposals. In addition, many foundations (48 percent) develop strategic initiatives to coordinate grantmaking around particular issue areas, such as teen pregnancy, underage smoking, or gang violence. Use of these funding methods did not differ significantly across the different types of foundations.

Figure 4. Grantmaking strategies, all foundations.

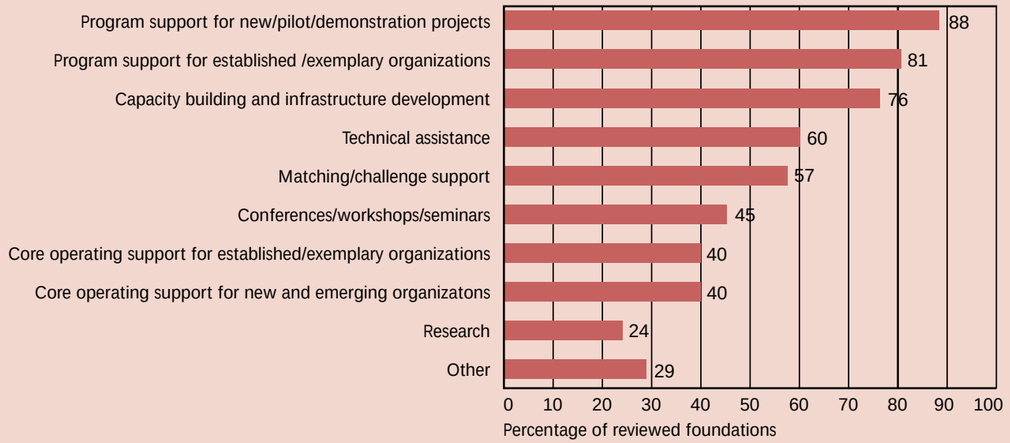
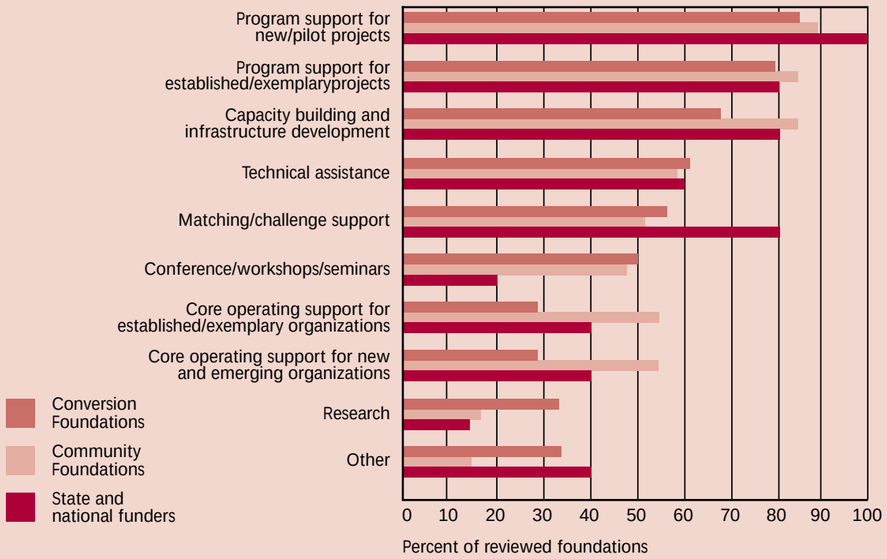


Figure 5. Grantmaking strategies, by foundation type.



THE REACH OF HEALTH PHILANTHROPY

The grantmakers reviewed in this study vary in their geographic area of interest within the state of California. They range from covering the entire state to targeting their grantmaking to specific zip codes within a local area. Private state and national foundations have typically focused on larger geographic service areas, targeting multi-county regions (30 percent) or the entire state (70 percent). Conversely, community foundations, by definition, have focused on smaller geographic areas, and have given primarily at the county level (60 percent), although some span several counties (30 percent) and a few (10 percent) focus on specific sub-county areas. California's health conversion foundations are relatively evenly divided among all geographic levels (32 percent concentrate on city/sub-county service areas, 26 percent focus on single counties, 21 percent give to multi-county regions, and 21 percent make grants statewide).

Consequently, the reach of California health philanthropy varies widely across the state. In this section, the spatial dimensions of healthcare philanthropy are examined, beginning with an overview of health philanthropy within the state, followed by a disaggregated analysis of health conversion and community foundation grantmaking, and then an analysis of their combined impact. Subsequently, the sharp variations within Los Angeles County are examined.

The mapping of health philanthropy is based on the strong assumption that grantmaking is evenly distributed across each foundation's geographic area of focus. The maps represent the potential for grantmaking, rather than actual grantmaking, across the state's regions, counties, and communities.[4] Also, national foundations are not included in this analysis because, given their national focus, we cannot assume that their behavior in 1999 is indicative of future grantmaking behavior within California. For these reasons, caution is urged in interpreting this spatial analysis.

[4] Information on the actual grants of the full set of foundations included in this analysis is not readily available and the collection of such data is beyond the scope of this study.

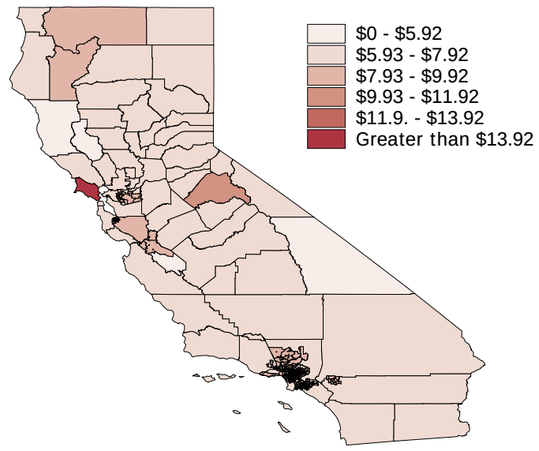
Health Philanthropy Across California. The potential dollars available from California philanthropy for health-related activities across the state's communities, standardized for population, is illustrated in Figure 6. This map presents the 1999 health grants made by 40 foundations, based on the geographic focus of the foundation. Included are the 16 health conversion foundations, 19 community foundations, and five state-based private foundations that made significant health-related grants in 1999.[5] Of these, nine foundations have a statewide focus for all or part of their grantmaking behavior. Their grants totaled $201.3 million and provide the base of potential dollars available to the entire state. Two of these foundations have a sub-state focus for part of their activities and these, coupled with the remaining 31 foundations, form the differentiated geographic foci presented in the map.

[5] Desert Health Care Foundation, The Healthcare Foundation for Orange County, Lucile Packard Foundation for Children's Health, and Pajaro Valley Community Health Trust made no health grants in 1999.

The base of statewide resources represents $5.92 per person. The highest levels of per capita grant dollars are in Marin county ($62.64 per person) and parts of Los Angeles county ($13.02 per person). The lowest levels are in counties with no targeted resources (Inyo, Lake, Mendocino, and parts of San Benito), or few (Fresno, Kings, Madera, Mariposa, Merced, Napa, parts of Solano, and Tulare average only pennies over the base in per capita terms). However, caution in drawing conclusions is warranted since foundations do not, in fact, distribute grants on a per capita basis. Nevertheless, the map is suggestive. It indicates that there may be substantial unevenness in the distribution of philanthropic health resources across the state, whether viewed in terms of community or per capita access to these resources.

Most of the interstate variation in health grantmaking is due to either health conversion or community foundations. Therefore, the geographic scope of the grantmaking of these two types of foundations is considered separately.

Figure 6. California healthcare philanthropy, grant dollars per capita.



Assumes grant dollars are distributed on a per capita basis across the geographic focus of the foundation

Health Conversion Foundations.

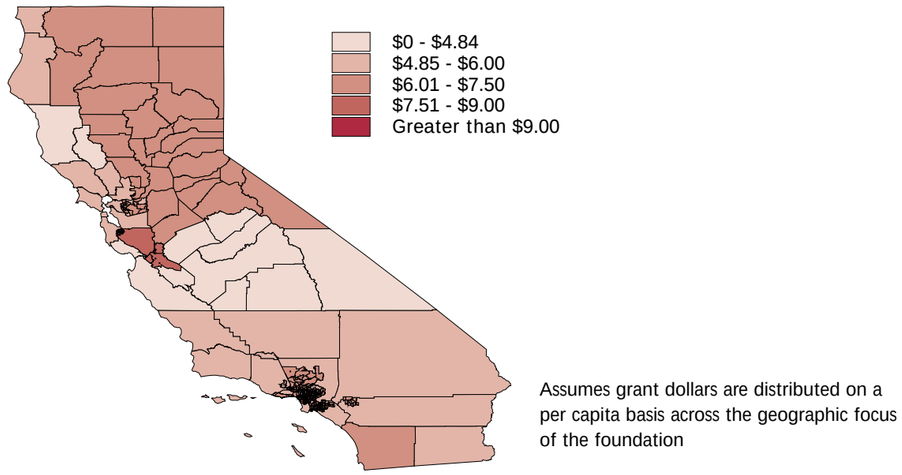
Conversions of healthcare organizations from nonprofit to for-profit ownership and the associated new foundations have not occurred uniformly throughout the state. Moreover, these foundations vary substantially in size and geographic focus. The associated geographic variation is revealed in Figure 7, which presents per capita grantmaking by health conversion foundations in 1999.

This map excludes three foundations that made no grants in 1999[6]. The remaining 16 foundations made health grants in the state totaling $197.3 million. Of this, $164.7 million were grants without a geographic restriction. These form the base level for these maps. The geographic variability introduced by the $32.6 million in restricted grantmaking represents only 17 percent of the grant dollars of health conversion foundations, and the range of variation in available grant dollars across the state is only $12.8 million.

Available grant dollars per capita range from the base of $4.84 (the base level in the map) to a high of $10.68. All areas with grant dollars per capita above $8.00, including the high of $10.68, are in Los Angeles County. In addition to the 12 areas noted above with access to only the unrestricted $4.84 per capita in potential grants, 13 areas have access to less than $5.00 per capita (Alameda, Imperial, Marin, Napa, San Francisco, San Mateo, Santa Barbara, Sonoma counties, and parts of Contra Costa, Kern, Riverside, Solano, and Ventura counties). The map highlights the absence of health conversion foundations with a geographic focus on the central part of the state.

[6] Desert Health Care Foundation, The Healthcare Foundation for Orange County, and Pajaro Valley Community Health Trust.

Figure 7. Health conversion foundations, health grant dollars per capita.



Assumes grant dollars are distributed on a per capita basis across the geographic focus of the foundation

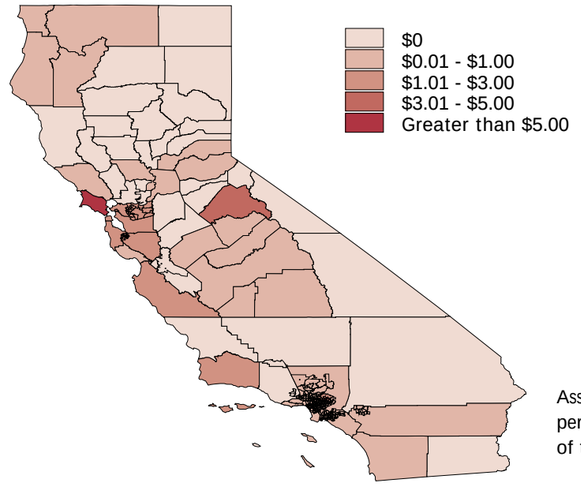
Community Foundations.

Community foundations are by definition geographically focused. Neither communities with such foundations nor the subset with an interest in health grantmaking are uniformly distributed throughout the state. Figure 8 summarizes 1999 geographic patterns in health grantmaking in per capita terms.

Community foundations have a larger range of variability in their health grantmaking than their geographically-restricted health conversion counterparts. Their health grant dollars ranged from 0 to $18.4 million. Marin County is the focus of the largest amount of health grants from community foundations. Los Angeles County receives the next largest amount, where community foundations target between $8.7 and $9.5 million. Twenty-nine counties, however, have no health grantmaking by community foundation, and an additional 22 counties receive less than $1 million in health resources from community foundations. Thus only seven counties have community foundations making health grants in excess of $1million.

Health grantmaking by community foundations ranged from 0 to $56.67 per capita. Marin County's $56.67 per capita is substantially greater than any other part of the state. The second highest coverage continues to be portions of Los Angeles County, but that county's highest level is only $4.66 per capita. Most of Los Angeles County and most of the state receives less than $1 per capita in health-related grants from community foundations. The other exceptions are Tuolumne county ($3.97) and Alameda, Contra Costa, Monterey, San Francisco, San Mateo, Santa Barbara, Santa Clara counties (which range between $1and $3).

Figure 8. Community foundations, health grant dollars per capita.



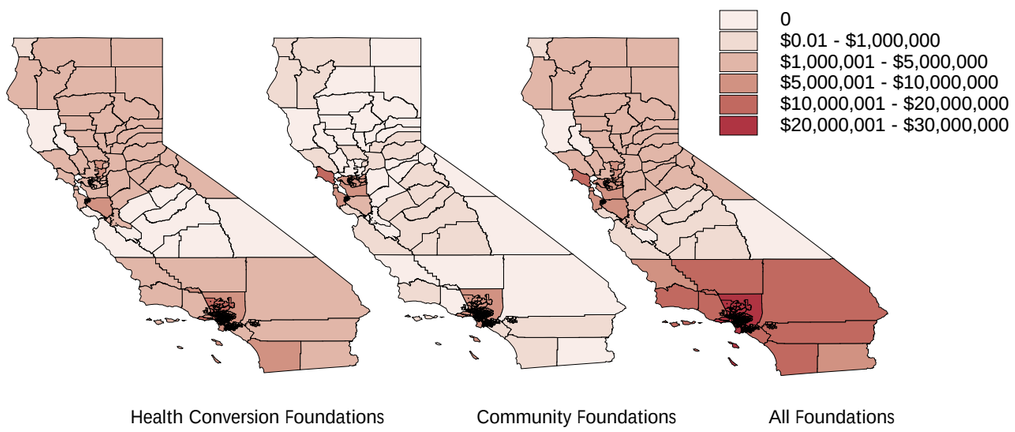
Assumes grant dollars are distributed on a per capita basis across the geographic focus of the foundation

Combined Impact. As the previous analysis reveals, the patterns of geographic restrictions differ across health conversion and community foundations. In addition, these two types of foundations differ substantially in the size of their grantmaking. Therefore, to understand their combined impact, it is useful to examine the spatial impact in the same units. Three views of health grants by foundations with sub-state restrictions – health conversion foundations, community foundations, and together with private foundations – are arrayed in Figure 9 to demonstrate their combined impact.

The combination of health conversion and community foundations leaves only four areas without access to geographically restricted health grant dollars – the counties of Inyo, Lake, and Mendocino, and parts of San Benito County. However, 16 additional areas have access that amounts to less than $1.00 per capita (Fresno, Imperial, Kings, Madera, Mariposa, Merced, Napa, San Bernardino, San Luis Obispo, Santa Cruz, Sonoma, and Tulare counties, and parts of Kern, Riverside, Solano, and Ventura counties).

Finally, the net impact of restrictions on the geographic focus of grantmaking has left some counties with very different access within their borders. Eleven counties have zip code-specific variable access to geographically restricted assets. Contra Costa, Kern, Los Angeles, Orange, Riverside, San Benito, Solano, and Ventura counties have differential access to restricted conversion foundation grantmaking. Los Angeles and Santa Clara counties have differential access to community foundation grantmaking. In addition, Monterey and Santa Cruz counties share differentiated access to the assets of the Pajaro Valley Community Health Foundation, which will manifest in different grantmaking access once this foundation begins to make grants.

Figure 9. Health grant dollars, sub-state geographic restrictions

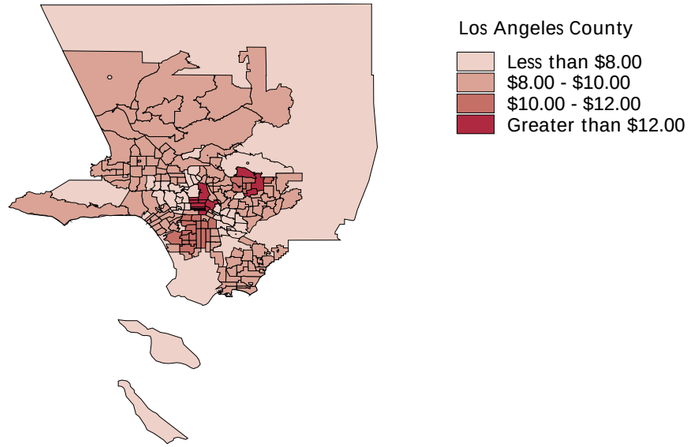


Los Angeles County. Nowhere are the consequences of the combined impact of geographic restrictions more evident than in Los Angeles County. Los Angeles is the only county that faces differential within-county access to both health conversion and community foundation funds. Three health conversion foundations (Centinela, QueensCare, and UniHealth) and two community foundations (Glendale and Pasadena) have within-county geographic restrictions on access to their grantmaking. The result for Los Angeles County is a patchwork of 20 different coverage levels.

The net impact of these different levels in per capita terms is shown in Figure 10. The base level of per capita access is $7.57, which includes both the county's access to unrestricted statewide health grantmaking ($5.92 per capita) and restricted grantmaking with a full-county focus ($1.65 per capita). Within-county restricted resources range from an additional $.11 to $5.45 per capita. The highest levels (zip codes that exceed $12 per capita) include combinations of the area foci of the QueensCare, UniHealth, and Pasadena foundations. Levels almost as high, $11.76, are achieved by combinations of area foci by the Centinela fund and the QueensCare and UniHealth foundations.

What is striking is the apparent disparity between the health grants that are available to adjacent zip codes. For example, 90027 and 90068 are adjacent zip codes at the base of the Hollywood Hills. The former, which is closer to downtown Los Angeles, has access to the highest ($13.02) per capita level of grants, while the latter has access to only $7.68 per capita. Again, we do not know exactly how grants have been distributed across these zip codes. Nevertheless, this analysis raises concerns, and suggests the need for additional information on the actual grantmaking patterns and the extent to which they match community needs.

Figure 10: Health grant dollars per capita, Los Angeles County.



THE POLICY CONTEXT OF HEALTH PHILANTHROPY

The conversion phenomenon has unleashed substantial resources for health philanthropy. This infusion of funds, along with the growth in the number and assets of other grantmakers with health interests, has greatly expanded the capacity for meeting the health-related needs of Californians. Yet to fully understand health philanthropy's impact and to contemplate its future contributions, it is necessary to consider the larger policy context. Two dimensions of the policy context are particularly important for an appreciation of the significance of health philanthropy: 1) the legal and regulatory framework that governs the conversion process and establishes the parameters of foundations, and 2) the scale and scope of public funding that are directed to the health needs of Californians.

Regulatory Impact. As the mapping analysis shows, the reach of health philanthropy has been uneven. The wide variation in geographic coverage across the state and within counties is heavily influenced by many disaggregated decisions, such as the conversion decisions of health organizations and efforts by the state to protect the public's interest in the assets of nonprofit organizations. The laws and regulations that define the interests of the public are critical to understanding the scope and reach of health philanthropy today and the future philanthropic missions of the new health foundations.

In California, healthcare organizations are overseen by two state-level governmental entities. The Department of Corporations (DOC) oversees HMOs and health insurance plans (technically "Knox-Keene licensees"),[7] while the Attorney General oversees all other nonprofit corporations, including nonprofit hospitals and other healthcare facilities. Early oversight of conversions was relatively lax. The DOC, which has had sole regulatory control over health plans since 1983,[8] was unaccustomed to enforcing the charitable trust law. As such, its oversight of conversions in the 1980s was widely viewed as allowing an undervaluing and loss of public assets. The Attorney General faced constraints as well. Since 1980, any California nonprofit hospital making a substantial disposition of its assets to a for-profit organization was required to provide written notice to the Attorney General.[9] Nevertheless, that office's only recourse for stopping a conversion was the breach of a charitable trust. The law of charitable trusts requires that the assets associated with charitable corporations be used for the stated charitable purpose. A conversion from a nonprofit to a for-profit entity changes the purpose of the corporation. The nonprofit assets must thus be transferred to another nonprofit entity that will carry on the original purpose *cy pres* (as nearly as possible). Since there was no requirement for the Attorney General to approve the conversion, enforcement options were limited.

The Blue Cross conversion triggered a change in California law. In 1994, a new Commissioner of Corporations, encouraged by some members of the Legislature, decided to reform the earlier departmental practice of undervaluing public assets in HMO conversions. The proposal to convert Blue Cross of California to a for-profit corporation generated a protracted negotiation process that involved the Department of Corporations, the state legislature, the Internal Revenue Service, the national Blue Cross trademark licensing organization, and consumer and professional interest groups. In 1996, after the Blue Cross transaction was completed, the legislature passed AB 3101, which codified the DOC standards used to review the Blue Cross conversion and enacted similar requirements for the conversion of nonprofit hospitals.[10]

The 1996 legislation requires Attorney General approval of any conversion of a nonprofit health facility to for-profit ownership.[11] More precisely, it is the Attorney General's responsibility to ensure that proceeds from the sale of charitable trust assets be used for a purpose consistent with the charitable trust in which the assets are held. Where there are concerns that the specific charitable purposes may be lost or diminished by the sale of assets, the Attorney General will place restrictions on the sale proceeds to ensure the original mission is protected. Moreover the Attorney General must now assess the impact of the proposed conversion on the availability and accessibility of health care in the affected community.

This evolution of the regulatory context is reflected in relatively distinct patterns of restrictiveness in the geographic service area and the programmatic foci of the succeeding charity, based on the date of formation. There are three identifiable periods (pre-1990, 1990 to the 1996 passage of AB 3101, post-AB 3101). Only three conversion foundations were created before 1990, two from HMOs and one from a hospital.[12] All operate without legally-defined geographic or programmatic restrictions. Between 1990 and the passage of AB 3101, five health conversion foundations were created, four from HMOs and health plans and one from a hospital. All contain both geographic and programmatic restrictions. The restrictions are, however, relatively general. For example, The California Endowment, the largest of the health conversion foundations, is required under its Articles of Incorporation to "promote the availability of and access to quality and affordable health care and related services to the people of the State of California."

Since AB 3101, all the health conversion foundations reviewed in this report have been created from hospitals and health systems. Of these 12 foundations, 10 operate under legal geographic restrictions, and nine operate under some type of programmatic restriction defined in their articles of incorporation.[13] In this set, we find more specific geographic regions and programmatic requirements. Geographic areas as specific as zip codes are relatively common. Programmatic restrictions can also be quite specific. For example, the Restated Articles of Incorporation of the Pacific Hospital of Long Beach Charitable Trust specify the following proportion for aggregate distributions: at least 46.5 percent for inpatient medical care, no more than 43.5 percent for outpatient medical care, and no more than 10 percent for medical education grants.[14]

It is important to note that all California HMO or health plan conversions have thus far occurred prior to AB 3101. Their resultant foundations account for the vast majority of conversion foundation assets (83 percent of 1999 assets), and the use of these assets is

[7] See the Knox-Keene Health Care Service Plan Act of 1975.

[8] California Corporations Code, Section 10821, and see Van De Kamp v Gumbiner (1990) 221 CA3d 1260, 270 Cal Rptr 907.

[9] California Corporations Code, Section 5913.

[10] California Corporations Code, Sections 5914-5919.

[11] Healthcare plans remain under the oversight of DOC (California Corporations Code, Section 10820).

[12] Sierra Health and Archstone (HMO conversions in 1984 and 1985) and Irvine Health (a 1985 hospital conversion).

[13] The M Health Foundation and the John Muir/Mt. Diablo Community Foundation have neither geographic nor programmatic restrictions, but the latter also has no assets. The Union Labor Health Foundation has no programmatic restrictions, but only $5 million in assets.

[14] In most cases, legal restrictions that specify the ratio of inpatient and outpatient medical care also incorporate an adjustment mechanism to correct for changes in these patterns over time, usually tied to an OSHPD Index.

governed by the less specific restrictions. In summary, 75 percent of the health conversion foundations reviewed in this report operate under some type of legal geographic restriction defined in their articles of incorporation, and 70 percent of the health conversion foundations had some programmatic restriction defined in their articles of incorporation. The pre-1990 foundations, which operate without restrictions, represent less than five percent of the 1999 assets of California health conversion foundations. In contrast, foundations with the most specific restrictions (those formed in the post AB 3101 period) have assets representing almost 16 percent of 1999 California conversion foundation assets. The remaining foundations, most of which were formed under DOC supervision, hold almost 80 percent of 1999 assets and face less constraining restrictions.

Obviously, both programmatic and geographic restrictions limit the scope and reach of health conversion foundations. Even though these restrictions reflect efforts to protect the public's interest in charitable assets, the combined impact of the restrictions on the communities involved are difficult to predict. The result may be unintended, uneven access to healthcare philanthropy across communities, as has already been discussed, or distorted allocations of specific healthcare services within communities.

Public Spending. The growth in resources devoted to health philanthropy is profound. Yet, the size of these resources must be considered against the scale and scope of public funding for healthcare – both established public programs and new funds available for health spending. In California, there are currently three important sources of public healthcare funding: funding from federal, state, and county governments; Proposition 10; and the Tobacco Settlement.

Public expenditures for health-related activities dwarf private funding. A precise measure of public expenditures for health in California is difficult to obtain, given the myriad programs. Data are available on county revenues used for the health function and for hospital enterprises during the 1997-98 fiscal year (the latest year for which these data have been reported). These total $6.2 billion, or $182 per person. This amount is an underestimate of public funding, as it does not capture state and federal funds that went to private parties (including Medi-Cal expenditures to private hospitals). Nevertheless, it provides a low-end estimate of public expenditures from established programs.

Another significant funding stream for health was established when California voters approved Proposition 10 in 1998. This initiative created the California Children and Families First Program to fund early childhood development. The program is supported by increased excise taxes on tobacco products, and is expected to generate revenues of about $690 million in 1999-2000, or approximately $20 per person in California. Twenty percent of these revenues is allocated to the State Children and Families First Commission; 80 percent is allocated to county commissions. Allocation among the counties is based on the percentage of live births.

The State Commission, constrained by the proposition, is limited to spending on mass media campaigns, educational activities, support for childcare providers, research, and administration. County commissions, however, have broad discretion over how to spend their funds. Although they must submit a strategic plan for the use of these resources, the proposition only requires that the expenditures be consistent with the goal of improved early childhood development. All expenditures must supplement, rather than supplant, existing levels of service, and conversations with commissions' staff make it clear that most of the expenditures will be health related. These monies thus represent a large new source of earmarked public dollars targeted towards health.

In addition, the tobacco settlement represents another new funding source for health-related needs. The state of California has claim to funds from the Master Settlement Agreement reached in 1998 to settle claims against tobacco manufacturers. The settlement requires that participating manufacturers fund a charitable foundation and make specified payments to states. The American Legacy Foundation will receive $25 million for each of ten years beginning in 1999 to support studies and educational programs to reduce youth tobacco use and to prevent tobacco-related diseases. The foundation does not yet have a set of grantmaking guidelines. Its national scope, however, makes it impossible to predict California's share of these resources.

California's share of the specified payments to the states is more predictable. It will receive 12.8 percent of the total state money from the settlement. This is expected to be $818 million in 2000, and to total $25 billion by the year 2025. This money will be split between the state, 58 counties, and four cities. The Attorney General's Memorandum of Understanding with the local governments states that these monies will be split 50-50 between the state and the counties. The county portion will then be split 90-10 between counties and the four cities (San Jose, Los Angeles, San Diego, and San Francisco) that had brought their own lawsuits against the tobacco manufacturers.

The Master Settlement places no restrictions on how this money can be spent. There are, however, several bills being considered in the Legislature that would specify allocation formula and restrict use. Thus far, none has passed. Initiatives have also been proposed that would restrict the use of county monies. Although we cannot predict how these settlement monies will be allocated, the amounts are substantial, representing about $24 per capita in 2000, and a substantial proportion is likely to be allocated to health-related activities. These expenditures may, however, supplant (rather than supplement) existing public expenditures and thus their net impact is difficult to predict.

These three sources of public healthcare funding exceed $200 per person in California. California health philanthropy totals less than $10 per person. The total 1999 restricted and unrestricted philanthropic health grantmaking identified in this report represents $9.56 per person. This suggests that philanthropic spending is no more than five percent of public spending for health services. In fact, it is likely to be considerably less. This percentage is a reminder of the relative roles of the sectors in health-related spending. It underscores the importance of health philanthropy playing a differentiated role in the health arena, and highlights the potential usefulness of public-private partnerships in effectively leveraging philanthropic resources.

SUMMARY AND CONCLUSIONS

The landscape of healthcare philanthropy has fundamentally changed over the past decade and a half. The philanthropic assets available for meeting the healthcare needs of Californians have grown substantially during this period. Although there has been a general expansion in the philanthropic sector, the growth of assets targeted to health grantmaking has been even greater, fueled by the emergence of a group of new foundations born from the conversion phenomenon in healthcare.

The sheer size of the assets and grantmaking of these new health foundations have had a tremendous impact on the support available for health-related activities in California. They account for nearly two-thirds of the total philanthropic health grant dollars made in California by the foundations included in this study, with The California Endowment and The California Wellness Foundation responsible for nearly 50 percent of total health grantmaking in the state. The private state and national foundations with major health funding commitments account for 28 percent, and the state's community foundations account for 11 percent.

However, the scope of the grantmaking by the health conversion foundations is virtually indistinguishable from the other health funders in this study. The health funding priorities, grantmaking strategies, and funding methods of health conversion foundations are not substantially different from other foundations in this study. For example, over 50 percent of all three types of foundations place priority on broad-based health programs such as health promotion and education, healthy families and communities, healthcare access, and service delivery. Within these funding priority areas, there is an emphasis on program support, as opposed to core operating support, for pilot or established exemplary programs, and for capacity building and technical assistance.

Although the means remain much the same, the reach of health philanthropy has been dramatically affected as the landscape has changed. The emergence of health conversion foundations and the expansion of community foundations have created substantial variations in the potential access to health philanthropy. While the three largest health conversion foundations have a statewide focus, the geographic restrictions under which most of the other health conversion foundations operate have created considerable variation in potential capacity for health grantmaking across California. These restrictions, coupled with the different location foci of other health funders, have created a patchwork quilt of potential access to philanthropic grantmaking. This is best illustrated by Los Angeles County, which has 20 different levels of potential access.

These differences in access to health philanthropy raise concerns. But to address them, more information is needed. First, where do actual grants land? A mapping of grants may generate considerably different patterns than the one generated here based solely on geographic scope. Second, how do grantmaking patterns relate to health needs? Areas with little coverage may in fact have fewer needs. For example, areas within Los Angeles County that appear to have less access to philanthropic dollars may in fact be wealthier, or have fewer uninsured, and thus have less need than other areas within the county. Only after we have this information can we assess the impact of regulatory restrictions on access to health philanthropic dollars and on the health of Californians.

Finally, this work has implications for the behavior of health foundations. Although a variety of philanthropic trends have shaped the current landscape of California health philanthropy, the new health foundations have been the driving force. And it is important to remember that these foundations are young. Eleven of the 20 reviewed here were created after 1995. The time may be ripe for them to take stock, and consider how they want to change and develop.

But the small size of health philanthropy relative to public healthcare expenditures has implications for the nature of that impact. It suggests the potential, but limited, benefits of targeting private resources to activities under-funded by the public sector. And it indicates that the effectiveness of health philanthropy is likely to be enhanced by partnerships, either within the sector or with the public sector, that leverage limited resources to increase the impact of philanthropic dollars. Finally, the relative size of public and philanthropic spending indicates that the public needs to have realistic expectations about the role that philanthropy can play in meeting the health needs of Californians.

APPENDICES

APPENDIX 1: STUDY SAMPLE AND METHODOLOGY

The 50 foundations listed here were contacted, and basic profiles were developed for 49 of these organizations (a response rate of 98 percent).[15] Information in these profiles was collected through a variety of sources, including foundation annual reports and Web sites, articles of incorporation, 990 returns, telephone inquiries, and other informational Web sites such as the Foundation Center online and the Council on Foundations site. In addition, a follow-up questionnaire to community foundations was used to obtain information on funding sources for healthcare.[16]

The information on community foundations included in this analysis relates to the health grantmaking from discretionary and donor-advised funds, as distinct from pass-through grants.

The information contained in these profiles is the basis for this analysis of the size, scope, and reach of health grantmaking within California. Some foundations could not provide answers to all questions, so the sample size for some analyses may vary slightly.

Table A1. Foundations included in the study

Health conversion foundations	California community foundations	Private national and California foundations with significant health grantmaking programs
Alliance Healthcare Foundation (San Diego, CA)	California Community Foundation (Los Angeles, CA)	The Commonwealth Fund (New York, NY)
Archstone Foundation (Long Beach, CA)	Community Foundation for Monterey County (Monterey, CA)	The David and Lucile Packard Foundation (Los Altos, CA)
The California Endowment (Woodland Hills, CA)	Community Foundation of Riverside County (Riverside, CA)	The James Irvine Foundation (San Francisco, CA)
California HealthCare Foundation (Oakland, CA)	Community Foundation of Santa Cruz County (Soquel, CA)	The Henry J. Kaiser Family Foundation (Menlo Park, CA)
The California Wellness Foundation (Woodland Hills, CA)	Community Foundation Silicon Valley (San Jose, CA)	Lucile Packard Foundation for Children's Health (Palo Alto, CA)
Centinela Medical Funds (Los Angeles, CA)	East Bay Community Foundation (Oakland, CA)	The Pew Charitable Trusts (Philadelphia, PA)
Desert Health Foundation (Palm Springs, CA)	Fresno Regional Foundation (Fresno, CA)	The Robert Wood Johnson Foundation (Princeton, NJ)
The HealthCare Foundation for Orange County (Santa Ana, CA)	Glendale Community Foundation (Glendale, CA)	W. K. Kellogg Foundation (Battle Creek, MI)
The Health Trust of Santa Clara County (San Jose, CA)	Humboldt Area Foundation (Bayside, CA)	W. M. Keck Foundation (Los Angeles, CA)
Irvine Health Foundation (Irvine, CA)	Marin County Foundation (Larkspur, CA)	Weingart Foundation (Los Angeles, CA)
The M Health Foundation (Walnut Creek, CA)	Orange County Community Foundation (Irvine, CA)	
John Muir/Mt. Diablo Community Health Benefit Corporation (Walnut Creek, CA)	Pasadena Foundation (Pasadena, CA)	
Pacific Hospital Charitable Trust (Long Beach, CA)	Peninsula Community Foundation (San Mateo, CA)	
Pajaro Valley Community Health Foundation (Watsonville, CA)	Sacramento Regional Foundation (Sacramento, CA	
QueensCare (Los Angeles, CA)	The San Diego Foundation (San Diego, CA)	
Sierra Health Foundation (Sacramento, CA)	The San Francisco Foundation (San Francisco, CA)	
Sisters of St. Joseph Healthcare Foundation (Orange, CA)	Santa Barbara Foundation (Santa Barbara, CA)	
UniHealth Foundation (Burbank, CA)	Sonoma County Community Foundation (Santa Rosa, CA)	
Union Labor Health Foundation (Bayside, CA)	Sonora Area Foundation (Sonora, CA)	
	Ventura County Community Foundation (Camarillo, CA)	

[15] Literature/Internet review and direct follow-up calls to the foundation did not yield significant information on the Pacific Hospital Charitable Trust. In addition, for five nationally-focused foundations--The Commonwealth Fund, the David and Lucile Packard Foundation, The Pew Charitable Trusts, the Henry J. Kaiser Family Foundation, and the W.K. Kellogg Foundation--data on health grantmaking specifically targeted to California was obtained only for 1998. In these cases, the 1998 data were used as the best available proxy for 1999 data in the analysis.

[16] The survey was conducted with the assistance of the League of California Community Foundations.

APPENDIX 2 OVERVIEW OF CALIFORNIA HEALTH GRANTMAKERS

Foundation Name and Location	Foundation Type	Date Created	Foundation Assets	Health Grants	Health Grantmaking Priorities	Primary California Service Area
Alliance HealthCare Foundation (SanDiego, CA)	Conversion	1988	105,716,723	4,845,033	Health promotion, disease prevention, and HealthCare health education; access to care; substance abuse/mental health; healthy families/ healthy communities; research; diseases and disabilities; environmental health	San Diego County
Archstone Foundation (Long Beach, CA)	Conversion	1985	131,009,654	2,259,050	Delivery of services; improving systems of care; aging	Southern California
California Community Foundation (Los Angeles, CA) Excludes Centinela Medical Funds	Community	1915	392,163,014	8,703,897	Health promotion, disease prevention, and health education; access to care; delivery of services, improving systems of care; healthyfamilies/healthy communities; diseases and disabilities	Los Angeles County
The California Endowment (Woodland Hills, CA)	Conversion	1996	3,500,000,000	103,295,139	Health promotion, disease prevention, and health education; access to care; improving systems of care; healthy families/healthy communities; diseases and disabilities	Statewide
California HealthCare Foundation (Oakland, CA)	Conversion	1996	813,666,049	12,350,640	Access to care; improving systems of care; healthy families/healthy communities; aging; health professions education; research; other	Statewide
TheCalifornia Wellness Foundation (Woodland Hills, CA)	Conversion	1991	1,108,027,501	46,061,006	Health promotion, disease prevention, and health education; maternal and child health; improving systems of care; healthy families/healthy communities; research	Statewide
Centinela Medical Funds(Los Angeles, CA)	Conversion	1999	50,000,000	3,000,000	Health promotion, disease prevention, and health education; access to care; delivery of services, improving systems of car; healthy families/healthy communities; diseases and disabilities	Los Angeles County
The Commonwealth Fund (New York, NY)	National	1918	*	539,884	Health promotion, disease prevention, and health education; access to care; maternal and child health; improving systems of care; aging; research	Statewide
Community Foundation of Santa Cruz County (Soquel, CA)	Community	1982	18,000,000	197,202	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/ healthy communities; aging; diseases and disabilities	Santa Cruz County
Community Foundation for Monterey County (Monterey, CA)	Community	1945	65,000,000	610,000	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/healthy communities; aging; diseases and disabilities; environmental health	Monterey County
Community Foundation of Riverside County (Riverside, CA)	Community	1941	29,700,000	115,890	Healthy families/healthy communities; diseases and disabilities	Riverside County
Community Foundation Silicon Valley (San Jose, CA)	Community	1954	290,030,52	1,750,000	Health promotion, disease prevention, and health education; access to care; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/healthy communities; aging; health professions education; diseases and disabilities; environmental health	Santa Clara County
Community Health Corporation (Riverside, CA)	Conversio	1985	45,567,000	895,550	Access to care; delivery of services; health professions education	Riverside County

Foundation Name and Location	Foundation Type	Date Created	Foundation Assets	Health Grants	Health Grantmaking Priorities	Primary California Service Area
The David and Lucile Packard Foundation (Los Altos, CA)	Nat/Cal	1964	13,000,000,000	32,382,307	*	Statewide, with a focus on San Mateo, Santa Clara, Santa Cruz, and Monterey Counties
Desert Health Care Foundation (Palm Springs, CA)	Conversion	1997	6,500,000	0	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; healthy families/healthy communities; aging; diseases and disabilities	Coachella Valley (Palm Springs area)
East Bay Community Foundation (Oakland, CA)	Community	1928	120,000,000	910,000	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; healthy families/healthy communities	Alameda and Contra Costa Counties
Fresno Regional Foundation (Fresno, CA)	Community	1966	8,900,000	166,495	Health promotion, disease prevention, and health education; access to care	San Joaquin Valley, including Fresno, Madera, Mariposa, Merced, Tulare, and Kings Counties
Glendale Community Foundation (Glendale, CA)	Community	1956	4,996,008	75,099	No specific health priorities identified	Glendale area
The Health Trust of Santa Clara Valley (San Jose, CA)	Conversion	1996	130,274,685	4,897,125	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; substance abuse/mental health; healthy families/healthy communities; aging; diseases and disabilities	Santa Clara and northern San Benito Counties
The HealthCare Foundation for Orange County (Santa Ana, CA)	Conversion	1999	20,855,185	0	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; healthy families/healthy communities	Anaheim, Orange, Santa Ana, and Tustin
The Henry J. Kaiser Family Foundation (Menlo Park, CA)	Nat/Cal	1948	630,000,000	1,065,019	Health promotion, disease prevention, and health education; research; other	National and statewide
Humboldt Area Foundation (Bayside, CA) Excludes Union Labor Health Foundation	Community	1972	42,540,333	156,500	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; substance abuse/mental health; healthy families/healthy communities	Humboldt County and Trinity, Del Norte, and Siskiyou Counties
Irvine Health Foundation (Irvine, CA)	Conversion	1985	28,905,109	851,533	Health promotion, disease prevention, and health education; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/healthy communities; aging; research	Orange County
The James Irvine Foundation (San Francisco, CA)	California	1937	1,605,121,505	3,105,000	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; healthy families/healthy communities; other	Statewide
John Muir/Mt. Diablo Community Health Benefit Corporation (Walnut Creek, CA)	Conversion	1997	0	1,039,100	Health promotion, disease prevention, and health education; maternal and child health; healthy families/healthy communities; aging	Central and East Contra Costa County
Lucile Packard Foundation for Children's Health (Palo Alto, CA)	California	1996	76,000,000	0	Health promotion, disease prevention, and health education; delivery of services; maternal and child health; healthy families/healthy communities	San Mateo and Santa Clara Counties

Foundation Name and Location	Foundation Type	Date Created	Foundation Assets	Health Grants	Health Grantmaking Priorities	Primary California Service Area
The M Health Foundation (Walnut Creek, CA)	Conversion	1986	43,623,295	1,600,000	*	Statewide
Marin Community Foundation (Larkspur, CA)	Community	1986	1,136,092,000	13,700,000	Health promotion, disease prevention, and health education; access to care; improving systems of care; healthy families/healthy communities; diseases and disabilities	Marin County and the San Francisco Bay Area
Orange County Community Foundation (Irvine, CA)	Community	1989	39,019,197	606,000	Health promotion, disease prevention, and health education; access to care; maternal and child health; substance abuse/mental health; diseases and disabilities; environmental health	Orange County
Pacific Hospital Charitable Trust (Long Beach, CA)	Conversion	*	*	*	*	*
Pajaro Valley Community Health Trust (Watsonville, CA)	Conversion	1998	14,216,130	0	Health promotion, disease prevention, and health education; delivery of services; maternal and child health; healthy families/healthy communities; diseases and disabilities	Watsonville, Freedom, Pajaro, and Aromas
Pasadena Foundation (Pasadena, CA)	Community	1953	20,000,000	826,243	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/healthy communities; aging; research; diseases and disabilities	Pasadena area
Peninsula Community Foundation (San Mateo, CA)	Community	1964	300,000,000	573,000	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/ healthy communities; diseases and disabilities	San Mateo and northern Santa Clara Counties
The Pew Charitable Trusts (Philadelphia, PA)	National	1948	4,894,417,637	14,618,000	*	Statewide
QueensCare (Los Angeles, CA)	Conversion	1998	357,544,000	4,615,000	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; healthy families/healthy communities; aging; health professions education; research; diseases and disabilities	Los Angeles County
The Robert Wood Johnson Foundation (Princeton, NJ)	National	1972	8,640,408,000	29,183,610	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/healthy communities; aging; health professions education; diseases and disabilities	Statewide
Sacramento Regional Foundation (Sacramento, CA)	Community	1983	21,000,000	98,852	Health promotion, disease prevention, and health education; access to care; maternal and child health; substance abuse/mental health; healthy families/healthy communities; aging; diseases and disabilities; other	Sacramento, Yolo, Placer, and El Dorado Counties
The San Diego Foundation (San Diego, CA)	Community	1975	285,000,000	252,415	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; substance abuse/mental health; healthy families/healthy communities; aging; health professions education; research; diseases and disabilities; environmental health; other	San Diego County

Foundation Name and Location	Foundation Type	Date Created	Foundation Assets	Health Grants	Health Grantmaking Priorities	Primary California Service Area
The San Francisco Foundation (San Francisco, CA)	Community	1948	683,902,603	4,726,773	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/healthy communities; aging; diseases and disabilities; environmental health	Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties
Santa Barbara Foundation (Santa Barbara, CA)	Community	1928	135,000,000	578,258	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/healthy communities; aging; health professions education; diseases and disabilities; environmental health	Santa Barbara County
Sierra Health Foundation (Sacramento, CA)	Conversion	1984	155,063,838	4,559,200	Access to care; delivery of services; maternal and child health; improving systems of care; healthy families/healthy communities	26 primarily inland rural counties of northern California
Sisters of St. Joseph Healthcare Foundation (Orange, CA)	Conversion	1992	42,000,000	1,383,216	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; improving systems of care; substance abuse/mental health; healthy families/healthy communities; aging; diseases and disabilities	Southern California, San Francisco Bay Area, and Humboldt County
Sonoma County Community Foundation (Santa Rosa, CA)	Community	1983	65,000,000	270,602	No specific health priorities identified	Sonoma County
Sonora Area Foundation (Sonora, CA)	Community	1989	8,200,000	209,526	No specific health priorities identified	Tuolumne County
UniHealth Foundation (Burbank, CA)	Conversion	1998	500,000,000	5,500,000	Health promotion, disease prevention, and health education; access to care; delivery of services	San Fernando and Santa Clarita Valley, west side of downtown LA, San Gabriel Valley, Long Beach, and Orange County
Union Labor Health Foundation (Bayside, CA)	Conversion	1997	4,966,071	191,000	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; substance abuse/mental health; healthy families/healthy communities; aging; diseases and disabilities	Humboldt County
Ventura County Community Foundation (Camarillo, CA)	Community	1987	24,900,000	*	*	Ventura County
W. M. Keck Foundation (Los Angeles, CA)	California	1954	1,789,949,000	6,125,000	Health promotion, disease prevention, and health education; access to care; delivery of services; maternal and child health; substance abuse/mental health; healthy families/healthy communities; research; diseases and disabilities; other	Southern California
W. K. Kellogg Foundation (Battle Creek, MI)	National	1930	6,387,840,996	5,063,401	*	Statewide
Weingart Foundation (Los Angeles, CA)	California	1951	853,011,148	1,400,000	Other	Southern California, except San Diego and Imperial Counties

* Indicates information that was not obtained about the foundation

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