

The Center on Philanthropy & Public Policy

THE ROLE OF FOUNDATIONS IN SHAPING HEALTH POLICY

Lessons from Efforts to Expand and Preserve Health Insurance Coverage

**Thomas R. Oliver
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**Research Paper - 15
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Thomas R. Oliver: Associate Professor and Director, MHS in Health Policy Program, Bloomberg School of Public Health, Johns Hopkins University; 624 N. Broadway, Room 403; Baltimore, MD 21205-1999

Jason Gerson: Doctoral Candidate, Bloomberg School of Public Health, Johns Hopkins University; 624 N. Broadway, Room 403; Baltimore, MD 21205-1999

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The Center on Philanthropy and Public Policy
School of Policy, Planning, and Development
University of Southern California
Lewis Hall, Room 210
Los Angeles, California 90089-0626

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ABOUT THE AUTHORS

Tom Oliver is Associate Professor of Health Policy and Management in the Bloomberg School of Public Health at Johns Hopkins University. Professor Oliver received his bachelor's degree in Human Biology from Stanford University. He received a master's degree in health administration from Duke University and master's and doctoral degrees in political science from the University of North Carolina at Chapel Hill.

Jason Gerson is a doctoral student in health and public policy at the Bloomberg School of Public Health at Johns Hopkins University. He received his bachelor's degree from Brown University and is concentrating his doctoral work in bioethics and public policy.

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Executive Summary

This study seeks to highlight the commonalities as well as the distinct interests, resources, and strategies of foundations in the area of health policy. It reviews and compares the activities of twelve foundations, including a select number of national foundations, a new breed of state health foundations, and some local foundations that consciously participate in health policy matters. Since the field of health policy is extraordinarily broad, this paper focuses its analysis on foundation activities aimed at expanding or protecting health insurance coverage. The issue is serious, persistent, and provides valuable insight into the connections between philanthropy and public policy.

A key problem facing the policy community, including foundations concerned with gaps in insurance coverage, is that many individuals do not take coverage offered to them in private or public programs. Thus, foundations are faced with two basic challenges. First, they must support strategies to improve take-up rates for existing programs. Second, they must also help develop initiatives to provide insurance coverage for individuals who do not currently qualify for employer-sponsored or public programs.

Most foundations invest in a very broad set of activities to achieve their policy goals. These diverse activities fit into three basic strategies for shaping public policy:

- 1) *Educate the public and members of the policy community*
- 2) *Invest in the development and demonstration of new institutions and policy options*
- 3) *Support capacity-building and advocacy efforts*

Building on twelve individual profiles of foundation activities, the study presents an overview of these foundations' choice of issues, audiences and partners, jurisdictions, and stages of involvement in the policy process. It identifies some clear patterns in the allocation of resources and examines what those patterns suggest about foundation preferences and capabilities for improving health insurance coverage.

Due to the nature of health care financing and delivery in this country, all of the foundations have devoted resources to improving private insurance coverage as well as protecting and expanding public sources of coverage. All of the foundations, however, accept the premise that governmental action is critical to solving the problems of more than 40 million uninsured Americans and they view public policy as a way to leverage the relatively limited resources they can devote to this issue. In the end, most foundations find themselves funding a combination of activities—public and private, and at different levels of the system. Some grants support policy or program development aimed at long term systemic change, while other grants support the delivery of discrete, short term services. While this study focuses on foundation efforts to change public policy, it is important to recognize that support for direct services may at times be a logical complement and not a competitor to systemic solutions.

The study also draws several lessons from these foundations' efforts:

Lesson 1

Foundations are not strictly leaders or followers on the issue of health insurance coverage.

Lesson 2

While foundations can adopt different strategies in the public policy arena, those strategies become less differentiated for foundations with greater resources and for foundations focused on state or local initiatives.

Lesson 3

It is necessary but not sufficient for foundations to develop expertise in health policy.

Lesson 4

Foundations must clarify whether they can best meet their goals as investors or as entrepreneurs in the policy process.

Lesson 5

The test of foundations' capacity to solve critical social problems lies in their collective contributions, not their individual roles in the policy process.

The limited progress toward universal coverage can hardly be attributed to foundation boards and staff wary of political controversy. As a number of foundation leaders point out, a few billion dollars of philanthropy does not go far in a \$1.5 trillion health care system. Nonetheless, the potential impact of foundations might be more highly leveraged through stronger, more selective advocacy and also through stronger collaboration among foundations.

The process of policy innovation requires the collaboration of different types of leaders—inventors of policy ideas, investors, promoters, and managers. But it also typically requires “policy entrepreneurs” who take the lead in that collaboration—entrepreneurs recombine intellectual, political, and organizational resources into new products and courses of action for government. The most distinguishing trait of policy entrepreneurs is their singular focus on a specific idea for new governmental procedures, organizations, or programs, and the significant professional and often financial stakes they place in those ideas. Policy entrepreneurs can and often do come from outside of government, even though their success depends on recruiting government insiders who have key positions and the political capital to move their proposals forward.

Foundations are clearly capable of becoming entrepreneurs in the policy process. Alternatively, foundations may choose the role of investor, providing financial support, technical assistance, access to decision makers, and prestige to one or more groups promoting their own ideas for improving public policy and public health.

There is a fundamental difference in these two roles and important implications for the allocation of foundation resources. In general, the national foundations in this study have consciously avoided endorsing particular solutions to the problems of the uninsured. In contrast, nearly all of the state and local foundations have selected—indeed, sometimes created—particular policies or administrative arrangements that they want government to adopt. Due to their more limited resources, local foundations appear to focus their health policy efforts on one principal initiative at a time.

There are many possible reasons why foundations would shy away from the role of policy entrepreneur and prefer that of investor. The choice involves practical issues of the amount of resources available to address an issue and the proximity of the foundation to key actors in the policy community. The choice also depends on whether the foundation's board and staff are willing to commit themselves to a specific initiative for a lengthy period of time.

Nonetheless, at whatever scale and in whatever manner foundations pursue an expansion of health insurance, they must confront the question of whether they might increase their effectiveness by not only helping develop products for policymakers but also engaging in more selective, forceful advocacy of their preferred products. The evidence from this study suggests that focused advocacy efforts might well be put to greater use in foundation efforts to protect and expand health insurance across the nation.

If there is a lesson that smaller, more local foundations can teach larger foundations, it is the importance of establishing and sustaining a specific policy design and marshalling resources to support it through close public-private partnerships. One approach is to pool resources into a single, foundation-sponsored initiative. Another approach is to establish informal collaboration in support of a government or community-based initiative.

Collaboration is primarily a means to an end, not an end in itself. There are two key issues regarding collaboration among funders and their operational partners in any initiative. First, are resources sufficient to meet the agreed-upon goals of the participants? Second, is the combination of activities comprehensive, incorporating each of the three strategies needed to maximize the likelihood of reshaping public policy?

Even in a best-case scenario of collaboration, foundations can rapidly approach boundaries to further progress on the issue of health insurance coverage. Without a single, well-endowed source of responsibility or success in persuading governmental officials to adopt the program, even the most skilled policy entrepreneurs within the world of philanthropy cannot sustain expansions of coverage—even modest ones—because of their extraordinary financial costs. At all levels of the political system, the financial and political costs require collaboration among foundations. Significant commitment and communication will be required, however, to work out the most effective configuration of roles and resources for protecting and expanding health insurance coverage across the nation.

The Role of Foundations in Shaping Health Policy: Lessons from Efforts to Expand and Preserve Health Insurance Coverage

INTRODUCTION

More than any other societal institution, foundations are positioned to promote and foster innovation in improving the health and well-being of individuals, families, and communities. The remarkable independence they enjoy as a result of their legal status and endowments makes it possible for them to set aside considerations of popularity or profitability and move beyond pre-existing agendas to promote social progress as they define it (Prager 1999, 1).

Foundations, according to their proponents, are not just another form of charity (Rogers 1987). Instead, foundations are vital institutions that exercise private power for the public good (Lagemann 1989; Knott and Weissert 1995). Terrance Keenan of the Robert Wood Johnson Foundation asserts that foundations are dedicated to “underwriting the quest for solutions to basic problems affecting the common good” (1998, 1). In theory, then, there is a strong connection between the responsibilities and activities of foundations and those of government. The real test of their effectiveness is not solely what gets done with their grant money, but what they persuade others to do—especially government (Keenan 1998, 2; Beatrice 1993, 187).

Lauren LeRoy and Anne Schwartz of Grantmakers in Health argue that any foundation can play a role in policy development. Yet philanthropic involvement with public policy is inconsistent and often tentative. A few foundations make public policy an integral part of their work; in many others, it is tangential to what boards and staff see as their core mission (LeRoy and Schwartz 1998, 230). There are many reasons for this state of affairs: First, foundations generally believe that they should not relieve government of its responsibility to finance and implement social policy (Keenan 1998, 2). Second, for many foundations the intrinsic conflict and controversy in public policy is uncomfortable. Third, foundations often interpret rules against lobbying on pending legislation to prohibit their involvement in many other forms of advocacy. Dennis Beatrice, a former vice president of the Kaiser Family Foundation, suggests that “foundations need to realize that advocating for attention to reform, filling information gaps, and educating policymakers and the public are perfectly acceptable foundation activities in the eyes of the Internal Revenue Service” (1993, 186).

Beatrice also argues that foundations tend to stay away from public policy because of their organizational history, habits, and staffing. Working with government is not their traditional mission and they are more used to working with health care institutions, community groups, or program demonstrations. Foundation officers without experience in government can be frustrated by unpredictable shifts in the policy process and lack of measurable progress toward their grantmaking goals. Most fundamentally, foundations have a different relationship with government than with grantees. To the degree that foundations can shape governmental

agendas—a basic issue for this study—they must do so through persuasion since they have no formal authority (Beatrice 1993, 186).

Foundations do bring important resources to the policy process. Although their funds amount to only 0.1 percent of all governmental health spending, their legitimacy and access to policymakers greatly extend the potential influence of their activities (Knott and Weissert 1995, 150). They also develop significant expertise and information on the issues of the day. Foundations have been key participants in the “politics of knowledge,” helping create new fields and institutions that influence policy decisions (Lagemann 1989; Smith 2002, 5).

Perhaps the most critical asset of foundations is their nearly complete freedom to select the issues they wish to address and the means of addressing them. According to David Rogers, the first president of the Robert Wood Johnson Foundation, it is this independence of choice that makes foundations “unique and precious institutions in our cultural and social order” (1987, 194). Unlike governmental officials who must confront a wide range of issues and typically take a conservative posture, foundations can focus quite narrowly on a problem and inquire into radical solutions without direct constraints. Foundations have no explicit constituency—no stockholders, customers, or voters they must answer to (Weissert and Knott 1985, 276). Compared to virtually any other institution in modern society, they are able to look beyond momentary conditions and take risks in their approach to social problems. If foundations have the appetite for risk and patience to fund projects in public policy, then regardless of the policy outcome a guaranteed benefit is an added vitality to the democratic process (David 2002).

This study seeks to highlight the commonalities as well as the distinct interests, resources, and strategies of foundations in the area of health policy. Grantmakers in Health is supported by more than 200 foundations and this analysis will not attempt to document the full range of their activities. It will instead review and compare the activities of a select number of national foundations, a new breed of state health foundations, and some local foundations that consciously participate in health policy matters.¹ Since the field of health policy is extraordinarily broad, this paper will focus its analysis on foundation activities aimed at expanding or protecting health insurance coverage. The issue is serious, persistent, and provides valuable insight into the connections between philanthropy and public policy.

¹ This study focuses on foundations that share the view that health insurance is a critical social good, and that the large and growing population of uninsured Americans is a serious problem that both warrants and requires governmental intervention. The study does not survey foundations or think tanks supported by philanthropy that approach the issue of health care coverage as, primarily, a question of the underlying values of our society and political system and that seek to minimize the responsibilities of government versus those of individuals and voluntary institutions. The allocation of philanthropic resources and strategies of actors on the more conservative side of this issue appear to differ significantly from those identified in this study.

FOUNDATION INVOLVEMENT IN HEALTH POLICY ISSUES

Health is a priority area for U.S. foundations. More than nine out of ten foundations award grants in the health field. The Foundation Center reports that, in its 1999 sample, foundations gave 11.8 percent of their grants and 17 percent of their grant funds to health. That made health-related grantmaking second only to education. Overall, foundations in the U.S. spent an estimated \$4.46 billion on health in 2000, more than double the amount in 1995. Adjusted for inflation, health-related grantmaking increased 15.3 percent annually between 1995 and 2000 (Lawrence 2001).

Foundations, nonetheless, account for only a tiny fraction of the more than \$1.5 trillion spent annually on health services and programs in this country. Historically, this was not always the case. In the 1920s, spending by newly organized foundations was about 90 percent of federal government spending on health; by 1973 it fell to 16 percent and by 1991 it amounted to only 0.4 percent of federal health spending (Weissert and Knott 1995, 277).

The disproportionate weight of government to foundation funding is evident even in California, which has large, prominent foundations dedicated to health grantmaking. Mark Smith, president of the California HealthCare Foundation, observes that the \$48 million the foundation spends in a year pursuing its mission to improve the health of Californians is less than the state's Medi-Cal program spends every hour (M. Smith 2001). So the main issue for foundations is how to leverage their comparatively limited resources in the health field (Grantmakers in Health 2000; Ferris and Graddy 2001).

As LeRoy and Schwartz (1998) observe, foundation support for health policy activities is only a small part of their overall interest in improving health and health services. The vast majority of health grantmaking goes directly to biomedical research, health care providers, and work on specific diseases (Beatrice 1993; Lawrence 2001). Interest and funding commitments for health policy are increasing, however.

Grantmaking for health policy, like other issues, is concentrated among a small number of foundations. The top twenty-five funders of health policy awarded 96.8 percent of the health policy grants recorded in 1995, up slightly from 94.7 percent in 1990. On its own, the Robert Wood Johnson Foundation (RWJF) awarded 44.6 percent of all giving in health policy in 1995, more than double its share in 1990. RWJF gave more than three times the policy-related funding provided by the second largest funder, The California Wellness Foundation (Renz and Lawrence 1998). As the profiles and analysis in later sections of this report suggest, however, the leverage of a foundation in the world of public policy depends on much more than its financial assets. The cumulative impact of a large number of small foundations dispersed across many communities, therefore, is likely greater than a few large foundations with equivalent funding capacity.

The establishment of The California Wellness Foundation in 1991 fueled the growth of support for health policy activities. It included health policy as a central programmatic focus and, in 1995, awarded nearly \$14.7 million—more than one-seventh of all the grant dollars for health policy recorded in the Foundation Center's sample. Since 1995, three major foundations—the

David and Lucile Packard Foundation, the Bill and Melinda Gates Foundation, and the California Endowment—added substantial resources to grantmaking in the health field (Lawrence 2001). The actual grants awarded underestimate foundation resources devoted to health policy, since several foundations have large, full-time professional staffs or program administrators active in health policy research, analysis, communications, and sometimes direct involvement in activities such as legislative testimony.

With increasing state responsibility for the design of the nation's health care programs, foundations have expanded health policy funding to state or local activities. In 1995, foundations directed \$39.1 million or 39 percent of health policy dollars to state or local programs, in contrast to only \$6.4 million or 21 percent of health policy awards in 1990. Two-fifths of health policy grant dollars in 1995 were targeted to certain population groups: Grants for children and youth comprised the highest share (17 percent) of health policy grant dollars among targeted groups, close to three times the share reported five years earlier. Grants explicitly referencing ethnic and racial minorities also gained dramatically, increasing from one percent of health policy grant dollars in 1990 to six percent in 1995 (Renz and Lawrence 1998a).

HEALTH INSURANCE COVERAGE: A PARAMOUNT CHALLENGE FOR PHILANTHROPY AND PUBLIC POLICY

This study focuses on the role of foundations in efforts to protect and expand health insurance coverage. Foundations that engage this issue are moving into a complex, controversial area that is far different from making charitable grants to health care providers. The amount of resources needed to provide all citizens with health insurance coverage is enormous, and the role of governmental policy in this area is a matter of considerable dispute. Because health care is provided through both private insurance markets and public programs, this study examines foundation activities aimed at improving employer-sponsored coverage as well as activities aimed at bolstering public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP).²

The Importance of Health Insurance

Insurance, of course, is neither the beginning nor the end of the road to good health. Many factors other than health services determine individual and population health status, including economic inequality, stress, childhood development, work status, social support, nutrition, and environmental hazards (e.g., Amick et al. 1995; Wilkinson and Marmot 2000). Nonetheless, health insurance coverage is a significant private and public good. Insurance coverage, whether from a public or private source, is a critical step in assuring equitable access to health services (Schoen et al. 1997; Berk and Schur 1998; Institute of Medicine 2001). The uninsured make

² Although it is beyond the scope of this study, an emerging issue in health care coverage is how to protect prescription drug benefits or extend them to those without access to this critical component of modern medicine. In recent years, prescription drug costs have risen dramatically and become a major focus of reform efforts for private insurers, for state programs, and for the federal Medicare program. The issue has gained its own place on the policy agenda and, in some ways, has diverted attention and resources away from those without any form of health insurance (Lee, Oliver and Lipton 2003).

fewer visits to the doctor, use emergency room care more frequently, and are more often hospitalized for chronic conditions than their insured counterparts (Blumberg and Liska 1998). The uninsured are several times more likely than insured individuals to lack a usual source of care, delay or not receive needed care, or fail to fill a prescription due to the costs. Compared to insured individuals, fewer of the uninsured report that they are in excellent or very good health and more report that their health is only good, fair, or poor (Kaiser Commission 2002, 5-6).

The costs of going without health insurance manifest themselves in many ways. A review of the scientific literature finds that the uninsured have later intervention and poorer outcomes from cancer, cardiovascular disease, diabetes, and other specific diseases. Babies born to uninsured mothers have lower survival rates. Being uninsured reduces the use of medical care by as much as 50 percent and, if individuals are uninsured for long periods of time, they have a significantly higher risk of dying. Since individuals in poorer health suffer reduced productivity and earnings, health insurance coverage also has general economic benefits (Hadley 2002).

Health Insurance Coverage: The Policy Context

In the decade since President Clinton sought to secure health insurance for all Americans, coverage has generally moved in the opposite direction intended by the president and underlying public opinion (Jacobs and Shapiro 1995). In response to the continuing problems many Americans have in obtaining or maintaining health care coverage, politicians at all levels continue to feel pressure to address the issue. The scope and methods of health insurance reform are considerably different than in 1993, however. Incremental and largely bipartisan proposals and reforms with far lower expectations have replaced the comprehensive, often partisan initiatives seen from the late 1980s until the downfall of the Clinton plan.

Despite these incremental initiatives, the ranks of uninsured Americans grew for twelve consecutive years prior to 1999. Between 1994 and 1998, the number of uninsured rose from 39.8 million to 43.9 million before declining to 42.1 million in 1999 (Hoffmann and Pohl 2000, 5). A combination of tight labor markets, rising incomes, and expanding enrollment in SCHIP further reduced the number of uninsured to 39.8 million between 1998-2000. In that period, 2.6 million additional low-income Americans (below 200 percent of the poverty level)—including 1.6 million children—became insured (Holohan 2002). Then, as the economy slowed, the trend reversed itself and the uninsured population rose in 2001 to 41.2 million, or 14.6 percent of all Americans (because the overall population grew, the number of insured Americans actually rose as well) (Mills 2002, 2). Between 2000-01, an additional 100,000 children gained insurance coverage, but 1.5 million adults—almost all of them low-income—lost their coverage (Holohan 2002).

Certain populations are especially at risk of being uninsured. An estimated 28.1 percent of young adults (age 18-24), 30.7 percent of the poor, 33.2 percent of Hispanics, 19 percent of Blacks, and 18.2 percent of Asian and Pacific Islanders were uninsured in 2001. In contrast, 11.7 percent of children (age 0-18), 10 percent of Non-Hispanic Whites, and only 0.8 percent of older adults (age 65 and older) were uninsured (Mills 2002, 2-3). More than 50 percent of the uninsured are adults without dependent children (Rowland 2002).

There is also considerable variation in insurance coverage across states. In 2001, the percentage of residents who were uninsured ranged from about seven percent in Rhode Island and Minnesota to about 23 percent in Texas and New Mexico (Mills 2002, 22). Some observers of state health policy have concluded that only a small number of states have the necessary combination of economic capacity and political will to make significant steps toward universal health insurance without major financial support from the federal government (Oliver and Paul-Shaheen 1997; Holohan and Pohl 2002). Even if a large number of states were able and willing to provide insurance for the “gap” population—those who depend on Medicaid, SCHIP or state-subsidized coverage—it would have to include the right states to “move the needle” on overall coverage (Colby 2002). Over 40 percent of uninsured Americans live in just four large states—California, Texas, New York, and Florida (Dubay et al. 2003).

Where there are low numbers of uninsured individuals, there is almost certainly a strong base of employer-sponsored coverage. But over time, there has been relative erosion in private sector coverage. During the late 1990s, marginal gains in private insurance coverage occurred in the midst of the strongest economy and tightest labor market in over three decades. The national unemployment rate fell to 4.1 percent in late 1999, less than half the rate of a decade earlier. Yet, the *proportion* of the nonelderly population insured through employer-sponsored health plans decreased overall in the 1990s (Fronstin 2000, 1).

There are several explanations why the economic gains in employment did not translate into substantial reductions in the number of uninsured. First, even workers who maintain employer-sponsored coverage were forced to shoulder a larger proportion of health insurance costs (Schroeder 1999, 10; Fronstin 1998; Levitt et al. 1999, 4). Second, the increasing gap in the wages of skilled and unskilled workers corresponds to a parallel gap in health insurance coverage (Kilborn 1999; Kaiser Commission 2002). A third factor is that, after considerable increases in public health insurance coverage during the early 1990s, such coverage slipped dramatically in the late 1990s. Much of the disenrollment in public programs was due to improved economic conditions; however, some disenrollment was attributed to unintended effects of the 1996 federal welfare reform legislation, which separated eligibility for Medicaid and food stamps from eligibility for welfare cash benefits. Many individuals leaving welfare were not informed of their continuing eligibility for Medicaid, or they were not able to negotiate the “maze” without concerted efforts by welfare caseworkers, health agencies, and community organizations (Ellwood and Ku 1998). Only in the last couple of years has the number of SCHIP enrollees begun to approach what was expected when the program was created in 1997.

Foundations and Solutions for the Uninsured

A key problem facing the policy community, including foundations concerned with gaps in insurance coverage, is that many individuals do not take coverage offered to them in private or public programs. *Thus, foundations are faced with two basic challenges: First, they must support strategies to improve take-up rates for existing programs. Second, they must also help develop initiatives to provide insurance coverage for individuals who do not currently qualify for employer-sponsored or public programs.*

As veteran health policy entrepreneur Paul Ellwood has noted, there is no single button to push to change the American health care system (Oliver 2003). The vast majority of health care organizations and clinicians are in the private sector, not in government. In 2001, 177 million Americans had employer-sponsored insurance while fewer than half as many, 71 million, had coverage through Medicare, Medicaid, and other public programs (Mills 2002). Even though initiatives that encourage small employers to offer and contribute to their workers' insurance coverage repeatedly have disappointing results, most Americans' faith in employer-sponsored coverage remains unshaken (Gusmano et al. 2002; National Public Radio 2002).

In addition, within the public sector the policy environment is fragmented with some major programs at the federal level (Medicare, veterans, military, Indian Health Service) and others shared between the federal government and the states (Medicaid, SCHIP). There is clearly an expectation that states will continue to have significant authority in the design and implementation of health insurance programs (Thompson 2001; Dubay et al. 2003). *A major focus of the paper, therefore, will be to understand how foundations decide to allocate their resources to private or public initiatives, and whether they give priority to policies and programs at the national, state, or community level.*

Finally, when funders take on the issue of health insurance, they face the political challenges inherent in economic redistribution and governmental regulation. On the face of it, health insurance is an important and popular issue: In October 2002, when asked which was the most important health issue for the President and the Congress to deal with, 35 percent of poll respondents answered "increasing the number of Americans covered by health insurance" (Kaiser Health Poll 2002). The issue received considerably more support than helping seniors pay for prescription drugs (23 percent), financially bolstering Medicare (21 percent), or protecting patients' rights in HMOs (10 percent).

Expanding health insurance, however, requires that the healthier and wealthier members of society subsidize less fortunate members; and programs to accomplish that are inevitably accompanied by a host of rules regarding eligibility for the subsidies, methods of holding down the costs of services for the newly insured, financial accountability for the transfer payments, and so forth. Because redistributive and regulatory policies are highly contentious (Lowi 1964; Wilson 1973; Wilson 1980), foundations and others advocating for policy change must be prepared for organized resistance, controversy, and long term commitment if they wish to deliver solutions for the persistent problems of the uninsured. In addition, they must accept the loss of control that comes with entering a bigger arena with more uncertainty (Schwartz 2003).

In the end, most foundations find themselves funding a combination of activities—public and private, and at different levels of the system. Some grants support policy or program development aimed at long term systemic change, while other grants support the delivery of discrete, short term services (California Endowment 1997; Schacht 1998; Schwartz 2002). While this study focuses on foundation efforts to change public policy, it is important to recognize that support for direct services may at times be a logical complement and not a competitor to systemic solutions.

ALLOCATION OF FOUNDATION RESOURCES

Foundation resources include money, knowledge, personal connections, leadership skills, and prestige. In other words, the capacity of foundations to influence public policy extends well beyond their financial assets. Yet in their written reflections or in direct conversations, foundation leaders demonstrate an acute awareness of the limits of their own organization's resources. They recognize quite clearly that the strategic choices of board members and staff can multiply or diminish the impact of foundation programs on social problems. The term they invoke most often is "leverage." For foundations that monitor public policies and programs, what are the strategies that can leverage their modest resources into new courses of action and better system performance? James Ferris and Michael Mintrom (2002) and Grantmakers in Health (2000) suggest a number of activities that foundations can engage in:

- Generate and disseminate data and policy analysis
- Improve public understanding of health issues
- Educate current and future policymakers and issue experts
- Support development, implementation, and evaluation of demonstration programs
- Serve as a builder of policy networks and convener of participants
- Provide a voice for vulnerable groups
- Collaborate directly with governmental agencies
- Shape policy implementation
- Support direct services

These diverse activities fit into three basic strategies for shaping public policy:

1) Educate the public and members of the policy community

By definition, the issues that come before government have not been solved through private transactions or by voluntary collective efforts. They are complex and it is often the case that solving one part of a problem creates other, unintended problems (e.g., Oliver 1999).

Information is critical, therefore, for the purposes of what Lawrence Brown (1991) calls "documentation," "analysis," and "prescription." It is needed to accurately define the full scope and magnitude of a problem—for example, how insurance coverage varies by family income, the size of firms, or type of industry. It is also important in analyzing the likely outcomes of policy proposals—for example, are subsidies adequate or will people who are eligible for public coverage still not enroll due to stigma. Finally, in the political marketplace where preferences are not fixed but instead depend on the available "products" (Riker 1986; Jones 1989), policy proposals themselves are an important form of information and education.

Foundations are influential, some argue, if they supply accurate and balanced information for health care purchasers, governmental officials, and ordinary citizens in a market that is dominated by large, commercial interests (Altman 1998). Their research and analysis can validate or invalidate the claims of self-interested parties and encourage debate to rely more on facts and experience than on ideology. Foundations must earn credibility through well-designed

work, but they have the advantage of being viewed as “a broker of objective information . . . with no axe to grind, no turf to defend” (Van Dusen and Nash 2000).

2) Invest in the development and demonstration of new institutions and policy options

Students of the policy process have long observed that the prospects for governmental action increase dramatically when there is an available, worked-out solution to the problem as it is defined (Walker 1977; 1981; Eyestone 1978). Many foundations see a primary role for themselves in “product development” for government, especially on politically-charged issues where public officials are reluctant to take the first steps (Beatrice 1993). Since foundations are viewed as being more nonpartisan than other prominent sources of policy proposals such as interest groups or think tanks, their ideas may have more face validity to wary policymakers.

A proposed solution must adequately meet the tests of technical feasibility, economic feasibility, and political feasibility (Kingdon 1984). Policymakers are far more likely to support a given proposal if they see there is substantial consensus among experts on its technical feasibility. Since there is usually considerable disagreement among experts on complex issues in health policy (Walker 1981; Brown 1991), real-world demonstrations can help push an innovation forward.

Foundations are often able to develop an idea and put it to the test long before government is ready to sponsor a demonstration of its own. As “venture capitalists,” foundations “run interference” or “prime the pump” for future policy development (Weissert and Knott 1995; Keenan 1998; Davis 1999). RWJF, for example, supported the creation of several state health care commissions in the late 1980s and early 1990s, which provided elected officials with carefully developed proposals that combined major expansions of insurance coverage, cost controls, revenue sources, and regulatory oversight into packages that had a realistic chance of enactment under the right political conditions (Schoen 2002; Oliver and Paul-Shaheen 1997, 739-40).

Demonstrations are typically the most expensive form of product development for public policy; they are also the most difficult to organize, operate, and evaluate. But a 1993 survey of congressional, federal agency, and interest group staff found that all participants valued the results of demonstrations more highly than those of commissions or other policy reports (Weissert and Knott 1995, 282).

3) Support capacity-building and advocacy efforts

As noted earlier, foundations are prohibited from lobbying on pending legislation. This is a relatively narrow restriction on their activities, however, and many leaders have expressly committed themselves to other forms of advocacy work. Typically, they provide funds and technical assistance to enable other organizations to build coalitions, coordinate strategy, and pressure public officials for changes in policy and program budgets (Holton 2002).

Foundation staff may also work directly with governmental agencies charged with program implementation, or support groups monitoring governmental performance and even mounting

legal challenges to policies and program decisions. Most commonly, foundations act as patrons of individual advocacy groups (Walker 1991; Knott and Weissert 1995) or help convene different groups to build networks and coordinate resources devoted to their priority issues (Prager 1999, 13; Ferris and Mintrom 2002, 21).

The three basic strategies are not mutually exclusive, and foundations often use all three when they mount major initiatives to address problems as daunting as improving health insurance coverage. What strategy or mix of strategies will yield the greatest return on foundation investments is not self-evident in many cases (Schroeder 1998, 212).

PROFILES OF NATIONAL FOUNDATIONS AND THEIR PROGRAMS ON HEALTH INSURANCE COVERAGE

The following section presents profiles of some prominent national foundations involved in health policy and characterizes their distinctive philosophies, adoption of different strategies for shaping health policy, and selected initiatives to protect or expand health care coverage. There is tremendous variation among foundations in terms of their resources, board composition, staff size, substantive focus, organizational structure, management style, and grantmaking approach (Prager 1999, 2). Due largely to the ideas and interests of its leaders, the priority issues, objectives, and strategies of a given foundation will differ from those of other foundations and other participants in the policy community.

Robert Wood Johnson Foundation (RWJF)

The Robert Wood Johnson Foundation (RWJF) is one of the largest grantmaking foundations and the only one of its size to focus exclusively on health and health care. Its mission is to improve the health and health care of all Americans. RWJF became prominent in size and national focus in 1971, after the settlement of General Robert Wood Johnson's estate. The foundation funds grantees through both multi-site national programs and single-site projects. In the past decade, RWJF's assets grew from around \$2 billion to about \$8 billion. During 2001, RWJF made 1,023 grants and 115 contracts totaling over \$561 million. As of 2002, RWJF targeted its grantmaking to four issues: access to health care, chronic health conditions, substance abuse, and healthy communities and lifestyles. There are two teams devoted to work on access to care. The first team manages projects on health insurance coverage and the second team manages projects on the health care "safety net," emphasizing not particular institutions but rather care for priority populations with demonstrated health care needs (Colby 2002).

Since the mid-1970s, the RWJF approach to grantmaking has been distinctive for large multi-site programs managed by outside institutions. This structure was suggested in a 1949 Ford Foundation report and it was "one of our best decisions," according to RWJF's founding president, David Rogers (1987, 81). Under this decentralized model of operations, says Robert Hughes, vice president at RWJF, "We very much rely on experts in the field to make substantive decisions about the proposals and to provide programmatic leadership that is acknowledged and recognized in the field."

In its grantmaking, RWJF traditionally emphasized development of products for public and private decision makers. The foundation is most noted for its national demonstration programs. In its first fifteen years, RWJF launched 46 competitive programs to establish specially targeted medical care demonstrations in five to fifty sites (Rogers 1987, 78). In addition, thousands of men and women participated in RWJF training programs. Rogers describes the strategy: “I came to view [RWJF] as an unusual kind of well-disciplined, focused research laboratory, busily at work not only spawning new programs but also training creative young people to examine and evaluate the strengths and weaknesses in our American system of health care” (1987, 83).

If the goal of service demonstrations is for government to adopt successful ones, then RWJF has had numerous successes. Steven Schroeder, the immediate past president of RWJF, points to several examples where the foundation’s demonstrations helped fuel new governmental policies, including areas such as emergency medical response systems, integration of AIDS health care services, school-based health clinics, and health care services for homeless persons (Schroeder 1998). Still, when Schroeder arrived to head RWJF in 1990, he encouraged a more “multi-faceted approach to getting work done” (Hughes 2002). To this day, RWJF still makes a heavy investment in “product development”: as of 1998, service demonstration projects accounted for 44 percent of the currently authorized grant support. Under Schroeder, however, RWJF adopted a three-pronged strategy to address its priority issues: policy analysis, service demonstration, and research and evaluation. Involvement in the public policy arena remains an essential element. According to Schroeder, “Any philanthropy interested in improving health and health care must be cognizant of the roles of government and sensitive to opportunities to inform public decisionmakers” (1998, 214).

RWJF Strategies for Improving Health Insurance Coverage

Access to care has been a priority issue for RWJF since its creation in the 1970s. In the specific area of health insurance coverage, Knott and Weissert (1995) referred to RWJF as a “pioneer” because its interest in the issue preceded widespread government attention in the 1980s and early 1990s. Prina (1992, 200) noted that Schroeder emphatically restated RWJF’s access goal—the assurance of basic health care for all Americans—when he became president in 1990. The key shift in the foundation’s strategy was away from specific groups to a more systemic view of the problem.

When asked how successful RWJF has been in expanding health insurance coverage—there are 10 million more uninsured Americans than a decade ago—Schroeder articulated the rationale for its continuing involvement: “What could be more central to the values and moral character of a country than the fact that tens of millions of its citizens don’t have access to basic health care because they don’t have insurance? And what would it mean if the nation’s largest health philanthropy threw up its hands and abandoned this quest? RWJ [realizes] that it is probably the most uphill of any of the things that we’ve been working on” (Iglehart 2002, 246).

RWJF has authorized \$160 million into health care coverage initiatives in the past three years alone. The goal of the foundation’s coverage team is to reduce the number of uninsured. Most of the initiatives are very clearly aimed at influencing public policy. According to Colby, RWJF

pursued three basic strategies: 1) increase awareness of the issue; 2) “max-out” currently available coverage; and 3) put new options on the political agenda. The RWJF role can involve communications, technical assistance, demonstrations, or policy development (Colby 2002).

A prominent initiative to raise awareness is what RWJF calls its “strange bedfellows effort.” It involves a bipartisan group of established health care organizations, many of which were antagonists in the 1993-94 reform debate. The sponsoring organizations included Families USA, Health Insurance Association of America, American Hospital Association, American Medical Association, American Nurses Association, Catholic Health Association, Service Employees International Union, and U.S. Chamber of Commerce. According to Colby, it started with a joint press conference; then, with RWJF support, the organizations convened a national meeting in January 2000 and subsequently backed a variety of strategies to expand both private and public health insurance coverage (e.g., see Kahn and Pollack 2001).

Over the past two years, this effort “morphed” into a \$10 million campaign on Covering the Uninsured. The initiative included an advertising campaign in newspapers and on television, a series of regional conferences, and satellite “town hall meetings” in more than 300 hospitals across the U.S. with a moderated debate among members of Congress and on-site discussions. It morphed again into Cover the Uninsured Week in March 2003, characterized as “an unprecedented weeklong series of national and local activities [to] sensitize the public and opinion leaders to the plight of the more than 41 million Americans who lack health insurance” (CoverTheUninsuredWeek.org 2003).

Another effort to educate the public and policymakers is a three-year series of six reports by the Institute of Medicine (IOM) on the uninsured, commissioned and funded exclusively by RWJF. The reports, to be issued between September 2001 and September 2003, have two overarching objectives: “to assess and consolidate evidence about the health, economic, and social consequences for persons without health insurance and their families, health care systems and institutions, and communities; and to raise awareness and improve understanding by both the general public and policymakers of the magnitude and nature of the consequences of lacking health insurance” (Institute of Medicine 2001; 2002). Colby notes that RWJF structured it as six separate reports to get more media exposure for the issue. Usually, the IOM does one study that gets a lot of attention but then others have to keep moving the issue forward.

The second strategy in health care coverage—to get people eligible for coverage to take it— involves a very different set of organizational partners for RWJF. Most of that effort is focused on two successive national programs. Covering Kids was established in 1997 to reduce the number of uninsured children. The initiative, which preceded the federal enactment of SCHIP later that year, aimed to help states and local communities increase the number of eligible children who benefit from health insurance coverage programs. What began as a \$13 million initiative planned for up to 15 states grew into a \$47 million initiative with programs in all 50 states and 170 local pilot communities. The Covering Kids initiative had three goals: 1) to design and conduct outreach programs that identify and enroll eligible uninsured children into Medicaid and other health coverage programs; 2) to simplify enrollment processes; and 3) to coordinate existing coverage programs for low-income children. RWJF funding helped organize

coalitions in every state to carry out the goals of the program, and supported technical assistance to the coalition and its members.

The second national program, Covering Kids and Families, builds on the Covering Kids program. Just authorized in 2002, it is a \$55 million initiative intended to increase the number of eligible children and adults in federal and state insurance programs such as Medicaid, SCHIP, and new programs designed for working adults with modest incomes. Working through broad statewide and local coalitions, the program facilitates state and local efforts to find, enroll and re-enroll eligible children and families into existing coverage programs.

The third RWJF strategy is to develop new policy options for both the federal government and states. In 1999, RWJF launched a national program on State Coverage Initiatives to help states adopt and implement options developed through planning grants from the U.S. Health Resources and Services Administration. The three-year, \$6 million program includes grants, technical assistance, workshops, and written products. Its basic objectives are to: 1) create and sustain approaches to expand coverage to working families and other uninsured individuals through public programs such as Medicaid and SCHIP; 2) implement strategies that build on employer-based health insurance; and 3) foster collaboration among stakeholders to build political will for health care expansions. To help states develop their plans and monitor efforts to expand coverage, in September 2000 RWJF also funded a State Health Access Data Assistance Center at the University of Minnesota. The purpose of the center is to assist states with collection of better data on the uninsured, use existing data more effectively, and evaluate initiatives designed to increase access to health insurance coverage.

This past year, RWJF commissioned the Economic and Social Research Institute to solicit, review and assemble ten different proposals to move the country toward universal health coverage. The proposals come from what RWJF calls a “philosophically diverse group of widely respected health care analysts and scholars.” The proposals include a number that are broad in scope and go beyond incremental reform. Included are new approaches to using federal income tax credits, expanding Medicaid and SCHIP, implementing Medicare buy-ins, and organizing insurance purchasing.

In its state and national programs to develop new policy options, RWJF takes great pains to avoid partisan positions. Colby acknowledges, “We have been very careful to be sure that we are not identified with a solution. We don’t have a solution we’re pushing; we don’t have a sector we’re pushing. . . . I get proposals all the time from organizations identified with one solution. A lot of them do great work. But no matter how great a job they are doing, we don’t fund them” (Colby 2002).

At this point, what has been accomplished by the myriad initiatives mounted by RWJF? Colby says that in the current atmosphere of a weak economy, state and federal budget deficits, and concerns over terrorism, it is difficult to advance health insurance coverage. Indeed, RWJF is rethinking how its programs can be more defensive, to keep policymakers from making major cuts to existing coverage. But he suggests two accomplishments that indicate the importance of process as well as objective outcomes. According to polling experts, the foundation has been instrumental in keeping health insurance coverage much higher in public opinion than would

have been expected. Also, “we have people talking to each other who haven’t talked to each other in a long time (insurers, unions, consumer advocates, business leaders, etc.). By building trust, they may be able to move together without us after we’re out of the picture” (Colby 2002).

W. K. Kellogg Foundation

The W. K. Kellogg Foundation was created in 1930, at the onset of the Great Depression. With \$5.5 billion in assets as of 2002, it is one of the largest foundations in the U.S. and it has large ambitions. William Richardson, its president, says that “We think of ourselves as a midwestern foundation with an international reach.” Throughout its history, the foundation’s main priorities have been agriculture, health, and education. Currently, Kellogg awards grants in four programmatic areas—youth and education, health, food systems and rural development, and philanthropy and volunteerism—in the U.S., Latin America and the Caribbean, and six southern African countries. Eighty percent of grants are targeted for domestic programs. In FY 2002, Kellogg paid out \$223 million to 961 grantees and made \$221,522,283 in new commitments to 760 projects. Over \$36 million, or 16 percent, was allocated for health, second only to youth and education (Kellogg 2002c, 40).

In Kellogg’s view, its programs should be catalytic, not categorical. Its approach involves capacity building at the local level, without prior commitment to specific program design or policy outputs. This differs from the large-scale demonstration initiatives of RWJF, for example, which seek to test a relatively well-specified program of action for community leaders and organizations in different communities. Instead of focusing on product development for replication across jurisdictions, Richardson notes that all Kellogg grantmaking incorporates crosscutting objectives of strengthening community leadership, improving information systems and access to technology; capitalizing on diversity; and supporting families, neighborhoods, and communities (Iglehart 1997, 191). All of the initiatives have “brought together partners from disparate sectors who might not otherwise be working together on health issues for the purpose of leveraging change in the health system” (Kellogg 2003a).

John Iglehart (1997) refers to Kellogg as the “quiet giant” of foundations, because of the foundation’s “meticulous” avoidance of partisan politics. Historically, in fact, Kellogg refrained from funding projects that directly affect public policy. It did not fund advocacy projects or provide general operating support to advocacy groups. It did provide limited funding for policy-related projects, including dissemination of its comprehensive evaluations of community-based health services projects to policymakers. Under Richardson’s leadership, Kellogg has become more involved with policy issues and the implications of its initiatives for replication and policy development.

Kellogg Strategies for Improving Health Insurance Coverage

Kellogg’s concern for the uninsured dates back over two decades. It was an early sponsor of programs focused on the uninsured, and gave growing amounts of support in that area in the late 1980s and early 1990s (Knott and Weissert 1995).

In its recent activities in the area of health insurance coverage, Kellogg has tried several basic strategies and targeted all jurisdictions—national, state, and local. One strategy is to support information and analysis of state health insurance programs. In the late 1990s, Kellogg took interest in the devolution of policymaking from the federal government to the states. Along with many other foundations, it supported the establishment of the multi-year Assessing the New Federalism project at the Urban Institute. The intent was to enable members of the policy community to monitor the social and health indicators associated with devolution and the accompanying changes in welfare programs, Medicaid, and children's health insurance (Iglehart 1997, 193).

A second strategy is to support efforts to educate the public, community leaders, and policymakers about the importance of health care coverage and access to services. At the national level, Kellogg made a grant to the National Leadership Coalition on Health Care in Washington, D.C. to design and implement a social marketing campaign focusing on the importance of establishing a national policy to assure access to appropriate, affordable, high-quality health care. The foundation also has provided several years of support to an advocacy group, Families USA, to provide the public and state officials with information about negotiating managed care systems, opportunities to expand Medicaid coverage to uninsured parents, and problems of health care access for particular community groups in their states. Most recently, Kellogg joined as a co-sponsor of RWJF's Cover the Uninsured Week in March 2003.

In 2002, Kellogg gave a three-year grant to establish a new Health Policy Institute at the Joint Center for Political and Economic Studies in Washington, D.C. The institute will focus on health policy issues affecting African Americans and other minorities. The grant will support public opinion polls, public forums, and technical support to community-based organizations. Eddie Williams, president of the center, noted that census data has shown increasing numbers of poor and uninsured persons and promised that the institute "will give many neglected Americans a meaningful voice in the health policy debates that affect them" (Washington Post 2002).

Kellogg supports a third strategy intended to support the populations most affected by the erosion of health insurance coverage. Much of the foundation's work centers around a six-year initiative, Community Voices: Health Care for the Underserved, which was initiated in 1998 and became operational in August 1999. The problem, in the foundation's view, is what to do until everyone has adequate health insurance. In the aftermath of the failed attempt by the Clinton administration to secure universal health insurance,

... 'the market' was battering public hospitals, public health, academic health centers, clinics, and other safety net providers and threatening the few remaining health care resources for the most vulnerable populations. ... What most Americans consider essential to maintain health—eye glasses, dental care, prescription drugs to treat illness—were far beyond the basic services provided to low-income working people, homeless, and others in emergency rooms and clinics. Health improvement within existing systems was an impossible dream for people outside of 'the market' (Kellogg 2002b, vi).

Through Community Voices, Kellogg is combining civic governance, development of concrete solutions based on direct services as well as insurance coverage, and interest in broader policymaking. Thirteen communities across the U.S.—viewed by Kellogg as “learning laboratories”—are participating in the initiative. The initiative is designed to strengthen community support services and to help ensure the survival of safety net providers. Each community is piloting a different approach, but the foundation regards it as a “collective journey.” By building connections with other grantees and developing models that can speak to state and national issues, the hope is that the initiative will generate “local solutions with national relevance” (Kellogg 2002b, vi).

The policy component of Community Voices is prominently featured in a report on the program prepared by the Economic and Social Research Institute (Silow-Carroll et al. 2001). In the report, the authors discuss early lessons for program planners and policymakers. They strongly encourage community sponsors of programs to expand health insurance coverage to work closely with governmental officials to establish stable funding sources and keep health insurance a high budget priority. They also suggest several specific state and federal policies that could improve the sustainability of the local programs.

In addition to the national Community Voices program, Kellogg has for several years funded another program to assist communities in its home state of Michigan. Known as the Comprehensive Community Health Models of Michigan, the initiative is a partnership between the Kellogg Foundation and community foundations in three counties in Michigan. The purpose of the initiative is to expand the capacity of communities to reshape the health systems that serve them. It provides a framework for providers, consumers, and purchasers in three Michigan counties to assess health status and resources, identify priorities, and initiate health system changes at the local level. Through this partnership, the Kellogg Foundation provides information, technical assistance, and training to the three counties.

In 2003, the Kellogg board adopted a new strategic plan that places even more emphasis on shoring up the health care system for a variety of vulnerable populations. It will employ three strategies: 1) promote a strong health care safety net; 2) promote improvements in the quality of health care services provided to vulnerable people and communities; and 3) build health leadership with an emphasis on diversity.

Henry J. Kaiser Family Foundation

The Henry J. Kaiser Family Foundation focuses on the major health care issues facing the nation. Although Kaiser is technically a grantmaking foundation, it functions like an operating foundation. It has a sizable professional staff, conducts its own in-house research and communications programs, and carries out other work through contracts with outside individuals and organizations. Although it spends about \$60 million annually, only a tiny fraction of it is in the form of grants for unsolicited proposals. When Drew Altman became president of Kaiser in the early 1990s, he recalls,

I asked one strategic planning question which I regard as very simple-minded: how you play a special role in a trillion-dollar mess which is totally dominated by organized commercial, political and ideological interests? With about \$35 million to spend a year at the time, it's no money. And the equally simple-minded answer that I arrived at was: not by making grants. We could support good work, but that that wasn't a recipe for playing a special role, and that was our aspiration. Instead, we saw an opportunity for there to be an independent voice and source of trusted data, analysis and information on these hotly contested national health care issues in the sea of organized interests. Not for a second because I thought these were technical issues or research questions but because—absolutely without delusions of grandeur—I believed we could be a counterweight to health care's big commercial interests and try to help put the focus more on people rather than money and politics (Altman 2002).

The Kaiser strategy involves four basic elements, according to Altman (1998). The first is producing information—from the most sophisticated research to basic facts and numbers. Most of the research is organized by foundation staff in partnership with outside groups and individuals. Kaiser staff participate throughout the process, from conceptualization through design, analysis, and dissemination.

In addition, through its new KaiserNetwork.org, the foundation is establishing a clearinghouse of health policy information from all sources, including other foundations. The network provides daily written summaries of events, media reports, and research on federal and state health policy issues. It also provides free access to web-based videos of events such as policy briefings, legislative hearings, and conference presentations. Kaiser has built a new building in Washington that is able to host conferences and press briefings, and provide media access to groups that cannot afford access to other facilities. Larry Levitt, the editor in chief of KaiserNetwork.org, suggests that Kaiser's electronic news reports and webcasts enable state and local groups to pay closer attention to national news and events. But he says it works the other way as well: local stories can now be read by a national audience (Levitt 2002).

The second part of the Kaiser strategy is targeting three distinct audiences: policymakers, the media, and the general public. Altman says the foundation's most important contribution is to serve as a translator for the research community and an information broker for the public and policymakers. Surprisingly, what often has the biggest impact is not sophisticated analysis at all, but basic facts about problems, policies, and programs. Kaiser's big sellers are its fact sheets, chart books, and budget analyses: "The ability to assemble the basic information for the staffer or the congressperson who doesn't live and breathe this stuff—or for the journalist—is fundamentally important. We have invested hugely in that" (Altman 2002). To succeed in this role, Kaiser has put a great emphasis on communications for all of its professional staff—facts and analysis without communication is a waste of time. Drafting a press release, answering a reporter's question, or designing a public service ad is everybody's job, not something to be handed off to a communications officer.

In part, Kaiser focuses on the media in order to improve reporting of health policy issues. Levitt notes that for reporters on deadline it is difficult to separate good information from bad, so Kaiser's role as a "filtering mechanism" is important. Also, the foundation recognizes that the media can maintain interest in an issue when policymakers are not focused on it. News stories are often not aimed at the general public, but opinion makers (Levitt 2002).

The third part of Kaiser's strategy is to establish a higher profile than other foundations: "It is a fact of life that if policymakers and persons in the media don't know who you are, they are not likely to pay much attention to what you do or say. A clear identity was also especially important in the beginning to distinguish ourselves from Kaiser Permanente" (Altman 1998, 203).

A fourth element of Kaiser's strategy is its unusual operating style. It is set up largely as a policy institute with significant professional expertise on its own staff. Thus, it serves as a resource center and on a daily basis much effort is put into fact finding, identifying experts, or explaining issues to journalists or policymakers (Altman 1998, 204). The foundation directly operates its major programs—for example, the Kaiser Commission on Medicaid and the Uninsured and its fellowship programs—or develops joint ventures with steady partners like the Harvard School of Public Health (for public opinion polling) and a wide range of media organizations, including the Washington Post, Viacom, NBC, MTV, Black Entertainment Television, and National Public Radio.

Given its national policy role, Kaiser cannot select only one or two issues to work on at a time. "We don't decide—we don't control our agenda. Our agenda is the nation's agenda. So that means you have to be there on Medicare, on health care costs, on Medicaid, on patients' rights and managed care. . . . We have to be there on the big issues that decide elections and budgets or we can't play the role we're trying to play. So we had to organize in the beginning to have capacity in those areas" (Altman 2002).

Kaiser Strategies for Improving Health Insurance Coverage

In its programs, Kaiser emphasizes public health insurance programs such as Medicare, Medicaid, and SCHIP but also has projects to examine private health insurance coverage.

To maintain awareness of critical issues such as health care coverage, Kaiser partners with National Public Radio and Harvard University's Kennedy School of Government to do periodic polling of public opinion on those issues. As noted earlier, the October 2002 Kaiser Health Poll found that "increasing the number of Americans with health care coverage" was rated a higher priority than any other health issue, including providing prescription drug coverage for Medicare beneficiaries (Kaiser Health Poll 2002).

The Kaiser Commission on Medicaid and the Uninsured is the foundation's largest operating program. The commission was created in 1991, under the leadership of Diane Rowland, to bring increased public awareness and stronger analysis to the policy debate over health coverage and access. In the past few years, the commission has expanded its purview beyond Medicaid to

SCHIP and other programs to cover the uninsured. It conducts research of its own and commissions outside research. The commission is based in Washington, D.C. Altman observes,

We set up the Medicaid Commission because at the time no one cared about Medicaid or programs for poor people. So there weren't any numbers about it. All of a sudden it became a really hot issue [as states moved to managed care and also used waivers to expand eligibility for Medicaid coverage]. . . . We had a particular strategy in mind in forming a bipartisan commission—it's not an independent commission that makes recommendations. . . . Our view was that once you do that—even if the recommendation is right—you become just another combatant in the war. So the commission's role is to provide data and analysis and let the numbers speak for themselves (Altman 2002).

Although Kaiser has greater expertise and professional connections on federal policy issues, it recognizes there is a great unmet need for health policy information at the state level. Kaiser's State Health Facts Online is a new source for a wide range of information on state-specific data on demographics, the economy, health status, insurance coverage, health care spending, and other specialized topics. According to Altman, the reason for developing this and other sources of information is to "shine a bright light" on what states are doing with the flexibility they have been given in social policy. Some will do good things and others will not. "So we hope that we are helpful to both journalists and the national policy community in understanding what is actually happening at the state level—and also to states in understanding what other states are doing. The single scarcest piece of information that I always needed the most when I was working at the state level was what other states were doing" (Altman 2002).

Kaiser has also focused some of its efforts on private health insurance coverage. Together with the Health Research and Educational Trust, it has conducted an annual Employer Health Benefits Survey since 1999. (The survey was previously conducted by KPMG Peat Marwick from 1991-1998 and the Health Insurance Association from 1987-1991.) The survey tracks trends in employer health insurance coverage, the cost of that coverage, and other topical health insurance issues. Findings are based on a nationally representative survey of public and private employers that range in size from three to more than 300,000 employees.

The Commonwealth Fund

The Commonwealth Fund, established by Anna Harkness in 1918, is the fourth-oldest foundation in the U.S. Its founder set forth a broad mission to "do something for the welfare of mankind." Throughout its history, the foundation has focused its resources on child development, women's health, and the accessibility and quality of health services (Davis 1999, 219). Commonwealth plans to spend about \$25 million per year over its current five-year planning cycle from 2002-2006, with one-fifth of it devoted to improving health insurance coverage and access to care (Commonwealth 2001, 19). Commonwealth's president, Karen Davis, articulates its chosen role:

Today our niche is to generate information—useful to both public officials and leaders in the health care sector—on changes that can be made to improve the lives of those who are at greatest risk: the poor, frail elders, young children, and minority Americans. We try to make a difference by bridging the worlds of health services research and health policy—encouraging research that is relevant to timely policy issues and making sure that information reaches those who can effect change” (1999: 219).

Like many other foundations, Commonwealth has adopted a strategic approach to grantmaking, organizing its activities around specific programs rather than funding isolated, unrelated projects. The strategic planning process is very much connected to public policy. Cathy Schoen, vice president for health policy, says that within the foundation’s health care coverage program, “We try to identify what are the issues that are likely to be debated at the federal or state level, what is the timing, and what will be the likely impact of policy options on those populations” (Schoen 2002). The foundation officers and staff then develop a set of related projects that “build toward a body of results over a sustained period of time—typically a minimum of five to six years” (Davis 1999, 222). Commonwealth’s board has set a goal that at least a quarter of all funding be for co-funded projects. Davis says this goal “provides motivation to reach out to others, keep abreast of priorities throughout the philanthropic community, and forge partnerships” (1999, 222).

With its orientation as a provider of information, Commonwealth puts a good deal of effort into communications. It publishes a variety of products—a quarterly journal, research reports, issue briefs, policy briefs, and fact sheets. It disseminates its work through reports it mails to targeted organizations within the policy community, including the mass media; forums it convenes for public officials, experts, and health care organizations; congressional testimony by its officers and grantees; and presentations to scholarly groups. Davis considers the key audiences to be policy officials—primarily at the national level—and private sector health care leaders. The foundation sponsors briefings on fund-supported work for congressional staff and other policy experts through the Alliance for Health Reform in Washington, D.C. (Davis 1999).

Commonwealth Strategies for Improving Health Insurance Coverage

The largest program at Commonwealth to address problems of the uninsured is the Task Force on the Future of Health Insurance. It was established in 1999 and is now being reauthorized by the board for another five years. The mission of the task force is to “help build a health insurance system that meets the needs of the 21st century workforce” (Commonwealth 2001, 25).

Organized much like Kaiser’s Commission on Medicaid and the Uninsured, the Commonwealth task force was established as an independent, nonpartisan body to oversee work on policy options to expand and improve health insurance coverage—especially through employer-sponsored insurance—and also to keep debate on coverage and the uninsured high on the national agenda. It has representatives from business, labor, state leaders and national experts.

Its chairman is James Mongan, the president of Massachusetts General Hospital who has long experience working inside and outside of government. The work of the task force is aimed at national and state policymakers, the media, private-sector health care organizations and scholars. It involves nearly all stages of the policy process and all jurisdictions.

Through the task force, Commonwealth supports activities to:

- identify emerging trends and consequences of those trends, focusing on populations lacking coverage or at risk of losing coverage
- identify different options for expanding or improving insurance coverage and model their impacts
- look for promising approaches in states and communities and also analyze apparent failures
- mobilize populations that are affected by policies

Schoen explains why the foundation devotes substantial resources to policy modeling: “One of the things that has happened in the national debate is, people put out their proposal and it looks good [on its own]; but it is much fairer running different proposals through the same model. Let’s not let the models look different [in terms of cost] because of different assumptions [about the number of people covered or benefits package]” (Schoen 2002).

Despite its longstanding interest in public insurance programs, Commonwealth has consciously made private insurance the priority of its task force. The decision is a pragmatic one:

We are looking at what is already out there: Kaiser has a terrific Medicaid commission, so we’re looking at the working population. About two-thirds of the working population gets their coverage through employer-sponsored coverage; and from what we can tell, they pretty much like it. . . . It is less from a philosophy that employer-sponsored coverage is better. It is more a judgment that people don’t overthrow systems until they are not working [for a majority of people]. The other problem with public insurance expansions is that you are throwing away \$330 billion in revenues [federal tax expenditures due to deductibility of employee fringe benefits]. Until someone figures out how to finance the system without losing that money, you have a real problem (Schoen 2002).

This pragmatic perspective is the guiding force behind a new “consensus framework” that Commonwealth developed in early 2003. According to Davis and Schoen (2003, 199-200), the purpose of the framework is to “help bridge differences between those who would expand coverage using private insurance and those who prefer public insurance, as well as differences between those supporting an incremental approach and those seeking more fundamental changes.” Schoen explains, “We have always had an emphasis on developing options. But we seem to be back into an environment like we had in the early 1990s, with people who have had health insurance losing it. There is an emerging interest in doing something in the states, but at the national level there seems to be gridlock.” She concludes, “There was no vision for working through the differences. We felt, you could take a lot of these little pieces and if you thought about how they fit together, you could cover a lot of people” (Schoen 2003).

The Commonwealth framework combines an individual mandate with tax credits, an employer mandate, and expanded public insurance programs. With the employer “pay or play” mandate, they estimate that more than 31 million people, about three-quarters of all uninsured Americans, would be covered. With both the individual and employer mandates, 39 million of the estimated 41 million uninsured would gain insurance coverage. The framework is not an actual proposal: “We are not saying, here is the idea everyone could rally around.” Instead, Davis and Schoen (2003, 200) argue that the framework “constitutes a beginning point for discussions around which parties with differing views could begin to identify areas of common agreement and feasible near-term steps. The framework also illustrates how incremental steps, if structured as part of a longer-term strategic plan, could move toward more universal coverage.”

Commonwealth also focuses considerable attention on incremental community and state initiatives. While it does not have sufficient funding to undertake multi-site demonstrations on its own, like RWJF, Commonwealth does evaluate the performance of different approaches with the goal of improving program design and learning from experience. Although organizations like the National Conference of State Legislatures, the National Governors’ Association, and the National Academy of State Health Policy all provide forums on health policy issues, relatively few policymakers and even fewer program managers are able to attend those meetings. Thus, dissemination of knowledge about policy innovation must occur through other methods: reports, the internet, and technical assistance conducted on a state-by-state basis.

David and Lucile Packard Foundation

The Packard Foundation was established in 1964 and provides grants for national and international activities while maintaining a special focus on four counties in northern California. In the years after David Packard’s death in 1995, the assets, staff, and grantmaking of the foundation grew rapidly. By 2000, the foundation awarded \$616 million in grants and operated programs in conservation; population; science; children, families and communities; arts; and organizational effectiveness and philanthropy.

Since the end of 2000, however, Packard’s endowment, tied to its ownership of Hewlett-Packard stock, has declined by 60 percent. Its total grants declined to \$451 million in 2001 and approximately \$250 million in 2002, and it expects the total to fall further to \$200 million in 2003. The fluctuations in the endowment led the board to consolidate its grantmaking into three programs in late 2002: conservation and science; population; and children, families, and communities. In addition, the foundation was planning to lay off up to half of its staff (Boudreau 2002; Packard 2002).

Until the major infusion of assets from the Packard estate, the foundation relied heavily on the work of its internal professional staff—more like the Kaiser and California HealthCare Foundation models (Lewit 2002). Through its Center on the Future of Children, for example, staff were directly involved in applied research and development, policy research and evaluation, and in initiating projects with grantees (Behrman 1990, 196). As the annual spending

requirements for the foundation increased several times over, the grantmaking outgrew the internal research and policy analysis functions.

Packard does not explicitly make public policy part of its strategy for social change. Eugene Lewit, senior program officer for the Children, Families, and Communities initiatives, says that the role for policy depends on the issue and desired impact: depending on what you want to accomplish, there is an “openness to recognize that policy is the way to do that. . . .” “If you look at health insurance and the objectives, the reality is that we’re not going to pay for it on our own, so it’s a policy goal. . . . That policy focus can be local, national or state, depending on the issue” (Lewit 2002).

Packard Strategies for Improving Health Insurance Coverage

Packard made the issue of health insurance coverage for children a growing priority throughout the last decade. One project in particular set a precedent for foundation investments over the next several years. Packard, RWJF, and the Atlas Foundation underwrote a campaign by Children Now, a nonprofit advocacy group, to seek non-legislative options to expand health insurance coverage for children in California. The premise was that, with the demise of the Clinton health reform initiative, federal action was highly unlikely. Thus, the project sought to encourage private sector organizations—insurers, hospitals, and companies—to voluntarily provide resources to cover uninsured children. In addition, it would pressure state health agencies to take administrative and regulatory measures where possible to expand coverage. Finally, the project would help elevate the problems of the uninsured in the public’s mind and help build a constituency capable of working toward public policy change and universal coverage in California (Children Now 1996).

When the federal government unexpectedly enacted the State Children’s Health Insurance Program (SCHIP) as part of the Balanced Budget Act in 1997, Packard saw it as an opportunity to greatly expand its work on health and since then it has “invested fairly heavily” in the program. By 2001, the issue of children’s health insurance was a significant priority for the foundation. Within the Children, Families and Communities program area, the foundation established a Child Health program. The stated goal of Packard’s grantmaking in this area is to “ensure [children’s] access to high-quality health care through health insurance.” It funded projects to implement and improve subsidized health insurance programs, develop sustainable outreach and enrollment systems, assure children continuous health insurance coverage, and improve the quality of care delivered to children (Packard 2001).

Lewit says that it was natural for Packard to get very involved with SCHIP. First, it focused on kids, an explicit objective of Packard’s programming. While other funders focus on Medicaid, it is not a “kids-only” program. Second, it was important to see SCHIP succeed if there was to be continued growth in insurance coverage. Third, because SCHIP was a block grant “it provided enormous opportunity to do innovative stuff. I think the hallmark of [SCHIP] is how innovative it is relative to the other public programs.” Fourth, with SCHIP—unlike other programs—enrollment became the metric of success:

Medicaid was always a welfare program and the idea was to keep people off, because it was tied to welfare and welfare was bad. CHIP was the first program where the metric was how many kids have you enrolled and why aren't you reaching your targets. The block grant is a very important part of that, because the block grants established targets for the states. It said this is how much money you have to spend on this program. . . . The dynamic is so different—the incentives are to spend the money, whereas in Medicaid the incentive is to not to spend the money, even though Medicaid is an entitlement (Lewit 2002).

Packard's involvement with SCHIP implementation and evaluation spans a wide range of activities and partners. Lewit says that Packard's approach differs from the RWJF Covering Kids program, which set up a coalition in every state. Because "our pockets are not that deep . . . what we've done at the national level is primarily fund the major national organizations that work in the area—advocacy groups, research groups, and TA [technical assistance] groups that work with either advocates or state program leaders" (Lewit 2002). For example, Packard worked with the National Governors' Association and the National Academy of State Health Policy to provide technical assistance to state governors and executive branch officials to implement and improve their SCHIP programs. At NGA, it provided core support for the Alliance for SCHIP Program Directors. Through NASHP, Packard supported the development of a center with regular staff, a website, regular meetings, newsletters and a password-protected bulletin board. The idea was to enhance program learning and improvement by encouraging states to measure outcomes and share—in a confidential environment—their problems and solutions in SCHIP implementation. Through this work, Lewit says "I personally know every CHIP director in the country, and know what their problems and issues are." In addition, Packard has funded advocacy groups like Families USA, the Center on Budget and Policy Priorities, Consumer's Union, and the National Immigration Law Center. Lewit points out that, "if we're serious about insuring all kids, then the problems of immigrants have to be addressed and at least enable those kids that are eligible for programs to be enrolled."

Looking beyond policy implementation, Packard has been a leader in organizing formal evaluation of SCHIP, both nationally and in California. The foundation established a multi-year Child Health Insurance Research Initiative collaborative in partnership with the federal Agency for Healthcare Research and Quality (AHRQ) and Health Resources and Services Administration (HRSA). The foundation made a considerable effort to develop the collaborative when other funders were focused on implementation issues. Most of the work is done through university-based researchers but they have regular meetings, support staff, and websites to discuss their projects. At the state level, Packard has worked with the California Managed Risk Medical Insurance Board, which administers the Healthy Families Program, to assess outcomes of its enrolled children. It also funded work at the University of California, San Francisco to improve county systems for health insurance enrollment and retention throughout the state.

Packard takes an even more comprehensive approach to improving health insurance coverage through its participation in the Santa Clara Children's Health Initiative. The goal of the initiative is to achieve universal coverage for all children in the county, regardless of immigration status.

It started as a coalition of health, labor, and faith-based organizations. Its activities include efforts to enroll children in existing public programs. In addition, it is developing a county-funded health insurance product for children in families with incomes under 200 percent of poverty who do not qualify for Medi-Cal or Healthy Families. The initiative has support from several public and private funders, including the California Endowment, The California Wellness Foundation, Santa Clara Family Health Foundation, County of Santa Clara, City of San Jose, and the Santa Clara Proposition 10 Commission.

Lewit says that, “Santa Clara is the only time we’ve funded insurance programs since I’ve been here. I think we’re hoping Santa Clara will be a model to encourage the adoption of more comprehensive approaches to insuring kids and extending insurance to other segments of the population. The fact that it’s in our own backyard is a plus.” Packard is also helping to launch a similar program in neighboring San Mateo County.

In Santa Clara, Packard first helped establish a development office because it was clear the coalition was going to have to raise money to sustain the program. It helped bring in an experienced organization to provide technical assistance, on the theory that the coalition would need an actual insurance product before it could attract several million dollars in funding. The foundation is also providing grants to directly subsidize the costs for those who purchase coverage through the county insurance plan. Finally, it has taken the lead in setting up an evaluation plan for the program. He says the initiative has also relied on significant collaboration among state and local funders.

Despite the confined size of the jurisdiction and target population of 71,000 uninsured children, the Santa Clara initiative has attracted statewide and national attention. This is due in part to the coalition’s aggressive promotion of the program, given its need for funding. Packard helped put the initiative on the map by getting the widely-respected National Health Policy Forum to do a series of 2-3 day site visits with health congressional staffers, the General Accounting Office, and Congressional Research Service; and by getting a group based in Washington, D.C.—the Institute for Health Policy Solutions—to provide technical assistance for the coalition to set up its program. Finally, Packard has established a group of people who are involved in health care policy at the state and national level to advise the evaluation. The group includes advocacy groups in California, the governor’s health advisor, and other foundation staff.

PROFILES OF CALIFORNIA’S NEW HEALTH FOUNDATIONS AND THEIR PROGRAMS ON HEALTH INSURANCE COVERAGE

In the past decade, a new breed of foundations has emerged out of the nation’s health care system. They are often referred to as “conversion foundations” because they are created with a portion of the assets of nonprofit health insurers or hospitals that become for-profit corporations. These new health foundations often have assets, staff, and capacity for programming that rival or exceed prominent national foundations. But they are often by law or charter focused on making an impact within their state or community.

In a 2003 study, Grantmakers in Health identified 165 conversion foundations nationally, with total assets exceeding \$16.4 billion (Grantmakers in Health 2003). The devolution of responsibility for health care from the federal government to states and localities increases the potential for these new foundations to effect change. They are often the largest source of non-governmental health funding in a community or state (Williams and Brelvi 2000, 258). Though California conversion foundations make up less than 10 percent of such foundations, they hold nearly half of all these assets (Ferris and Graddy 2001); thus, the experience of the California foundations provides early and important information about the general conversion phenomenon (Aspen Institute 2000).

The growth in resources for health philanthropy has been profound. Yet these resources must be considered against the scale and scope of public funding for health care. In California, there are currently three important sources of public health care funding: funding from federal, state, and county governments; Proposition 10; and the Tobacco Settlement.³ These three sources of funding exceed \$200 per person in California. By comparison, California health philanthropy totals less than \$10 per person. This underscores the importance of health philanthropy taking on a different role than government, and highlights the potential value of public-private partnerships for leveraging philanthropic resources (Ferris and Graddy 2001).

The following section presents profiles of the three largest new health foundations in California and examines both their general strategies for influencing public policy and their specific initiatives to expand health care coverage.

The California Wellness Foundation (TCWF)

The California Wellness Foundation (TCWF) is an independent, private foundation that was created in 1992 when a large HMO, Health Net, converted from a nonprofit to a for-profit company. The foundation's mission is to improve the health of Californians by making grants for health promotion, wellness education and disease prevention. The foundation subscribes to the World Health Organization's definition of health: a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Since its first year of operation, TCWF has awarded 3,008 grants totaling more than \$387 million. It currently has assets close to \$800 billion and makes an average of \$40 million in grants each year. With its statewide focus, it has program staff in both southern and northern California. Throughout its early years, the foundation emphasized initiative-driven grantmaking, setting priorities and working on them for five years. Most grants fell under the initiatives and there was little funding of unsolicited proposals.

Beginning in 2001, the foundation shifted its approach and vastly expanded its "responsive grantmaking." In particular, it began to put much of its resources into providing core operating

³ Proposition 10 established the California Children and Families Commission to create a comprehensive and integrated system of information and services to promote early childhood development and school readiness. The initiative, approved by voters in November 1998, added a 50 cents per pack tax to cigarettes and a comparable tax to other tobacco products. Proposition 10 is expected to generate approximately \$700 million annually.

support for California nonprofit organizations (Wellness 2001, 3). The foundation's charter requires that, to the extent practicable, at least half of its annual grants be for direct health services. The remainder are used to support public education, community organizing, advocacy and research (Brousseau and Peña 2002, 274).

Part of TCWF's mission is to inform the development of public policies. Ruth Holton, the foundation's director of public policy, says "We strongly believe we have the potential to improve the health of far more Californians through the work of our public policy grantees than we could ever hope to reach through funding direct service alone" (Holton 2002a, 2). She argues, "You can support direct service until you're blue in the face, support premium subsidies until you're blue in the face. In the end, the amount of money that foundations have is miniscule, and one of the most effective way of leveraging those dollars is through public policy" (Holton 2002b).

The foundation recently established public policy as one of five cross-cutting themes in all of its priority issues (2002, 1). Public policy grantmaking at TCWF generally follows one of the following strategies: 1) public education campaigns, 2) policy research and analysis, and 3) advocacy. An overarching purpose in all three areas is to improve the quality and representativeness of information in the policy process.

TCWF supports some policy-related research, but it stands out from other foundations in its broad-based approach to advocacy. Tom David, then executive vice president of TCWF, explained the rationale for supporting advocacy organizations: "Clear and compelling data are important but rarely decisive absent concerted efforts to directly educate decision makers" (David 2002, 1). Holton says that TCWF is probably the premier funder of advocacy in California—not just among health funders but all philanthropies (Holton 2002a, 11).

TCWF, like the Kellogg Foundation, has a very strong grassroots philosophy of action, preferring to work primarily through its grantees rather than establishing a high profile for itself. It believes that some of the most effective public policy work is done by those directly affected by the problem—by service providers who know what the problems are and have solutions; and individuals who don't have access to basic health services because of eligibility barriers or lack of funding (Holton 2002a, 3).

Through this strategy, the foundation officers and staff fund other public policy actors but do not consider themselves to be actors themselves. For example, Holton says she will meet with the staff of the health committees in the California Legislature to find out what they perceive the major issues are going to be. But she will not testify herself in legislative hearings. If legislators are seeking information themselves, TCWF will connect them with grantees that do the work in the area of interest. Similarly, the foundation wants reporters calling grantees rather than its own staff. Holton says that is one of the big differences between their strategy and that of the California HealthCare Foundation, which specializes in developing and brokering policy research and analysis.

TCWF believes that support of grass-roots advocacy, in particular, has long-term benefits that extend beyond the issue of the moment: “Changing public policy can be an empowering experience. Once community members have experienced a public policy success, they are more likely to stay engaged in efforts to improve their communities and hold policymakers accountable” (Holton 2002a, 15).

TCWF Strategies for Improving Health Insurance Coverage

The foundation’s work on health insurance coverage began under its Work and Health Initiative, first established in 1995. The initiative was broadly conceived and based on a growing body of research on the relationships between work and health: “The employed have better health status than the unemployed and at every income level health status improves. Therefore, the higher the salary and benefits, the more likely workers are to enjoy good health” (TCWF 2001, 3).

The Health Insurance Policy Program includes a focus on both employer-sponsored insurance and public insurance programs. One strategy of the program is to develop and disseminate information for educating the public and policymakers. The program provided a \$1.7 million grant to the University of California, Berkeley and its subcontractor, UCLA, to produce an annual report on *The State of Health Insurance in California*. Holton says that the report helped raise the level of the public’s attention to the issue of the uninsured. In addition, it provided a “common vocabulary and numbers”:

[It] has become the reference guide for all sides of the debate on the problem of the uninsured. Even though the statistics do not change dramatically from year to year, producing an annual report has kept the issue of the uninsured in front of the media by providing the ‘hook’ needed to discuss the issue. Advocates at the local level are also able to take advantage of the coverage to give the issue a local spin (Holton 2002a, 8).

Foundations can often disseminate information and focus policy debates by convening issue-oriented forums (Prager 1999; LeRoy and Schwartz 2000; Ferris and Mintrom 2002). TCWF has funded an annual conference which, according to Holton, “has become *the* conference on the uninsured. Everybody (advocates and policymakers) engaged in the issue comes once a year to discuss what needs to be done. So that’s become a really valuable forum” (Holton 2002b). The foundation has also made grants for health insurance education and outreach at the local level, including the California Small Business Education Foundation and the Los Angeles Alliance for a New Economy (Grantmakers in Health 2002).

Another strategy for TCWF is to support policy research and analysis. A core support grant to the Children’s Partnership helped fund the research and development of a proposal for “Express Lane Eligibility” to expedite enrollment in Medi-Cal and Healthy Families of those who are already in the school lunch or food stamp program. The proposal served as the basis for legislation enacted by the California Legislature in 2001 (Holton 2002a, 9). The new program will enable parents to authorize schools to share their applications for free lunches with county

social service agencies; if the children qualify for Medi-Cal or Healthy Families (under SCHIP), they will automatically be enrolled without having to fill out separate applications. About 70 percent of the children in California's school lunch program are uninsured, and the Children's Partnership said that the "Express Lane Eligibility" will be especially useful for enrolling Latinos, teenagers, and other hard-to-reach groups. When the governor delayed implementation of the program due to the severe state budget crisis, the California Endowment and the Packard Foundation stepped in with grants to get the program started and help nearly 700,000 low-income families in Los Angeles, San Diego, Fresno and Santa Clara counties enroll their children in the state's health insurance programs (Kaiser Daily Health Policy Report 2002).

The foundation has funded a wide range of projects to help advocacy groups push the issue of health insurance coverage at all levels of the political system—federal, state, and county government—and in community civic and business organizations. A major part of TCWF strategy is to fund technical assistance to grass-roots organizations, who in turn become powerful advocates for policy change. The foundation made a core support grant to establish a Sacramento office for the interfaith Pacific Institute for Community Organizations (PICO). PICO has 13 local advocacy groups throughout the state that have worked on after-school programs and are now working on health insurance and access to care. "So they are the face of the working poor. They go in and testify before Board of Supervisors meetings, they bring them and the press out to meetings. They're trained to be extraordinarily articulate about the issue—they don't bash policymakers over the head. The local groups also work together on statewide issues to expand access to care" (Holton 2002b).

Another example of TCWF's support of advocacy in policy formulation came after the state of California submitted a waiver proposal to the federal government to use SCHIP funds to cover parents of eligible children. A few states have had similar proposals approved, although the U.S. General Accounting Office issued a report in 2002 questioning the legality of such a policy (GAO 2002). Close to the anniversary of the waiver request, PICO members sent 50,000 handwritten letters to the office of Tommy Thompson, Secretary of the U.S. Department of Health and Human Services, who had the final authority over waiver approval. In its first year after establishing an office in Sacramento, PICO brought 3,000 members to talk to lawmakers and the governor. Along with the expansion of the Healthy Families insurance program, the advocates lobbied successfully for a \$50 million allocation to community-based clinics so they could expand services. Holton says that contacts in the governor's office and legislature tell her that PICO was the single most effective advocacy force for winning those increases (Holton 2002b).

TCWF developed a specialized role in the Santa Clara Children's Health Initiative. It funded the labor and PICO group that was part of the original coalition-building effort. It also gave a core support grant to the Santa Clara Foundation to help it engage a public relations firm and develop a campaign for corporate donations needed subsidize the costs of the insurance plan. While Packard and the California Endowment contributed millions of dollars in premium subsidies, TCWF felt it needed to focus on a less expensive, more highly leveraged role of capacity building (Holton 2002b).

The foundation also supports administrative advocacy and oversight of program implementation. According to Holton, one of the "huge successes" has been its support of the Western Center of

Law and Poverty to monitor the implementation of various new Medi-Cal entitlements [1931b extension to ensure continued eligibility of low-wage workers]. The state is now sending the center drafts of letters to county agencies to get their comments in advance. “This is a group that’s really working on the inside, making sure that the laws that are on the books are in fact being executed so that access does increase. And that’s administrative advocacy, which you can fund. Frankly, I think people focus too much on the legislative advocacy when that’s not really where the real stuff happens. You’ve got to get the framework for the policy passed, but it’s really in the regulation—the devil’s in the details” (Holton 2002b).

Finally, the foundation has made grants to local associations of community health clinics to build their infrastructure and assure their successful participation in public health insurance programs. It is important that patients who are used to seeking care at community clinics continue to have access to them even if they enroll in insurance programs; and it is equally important to underwrite services for low-income patients who have no insurance or financial means to pay for their care. For this reason, Schact (1998, 251) argues that foundations should provide funding for direct services even to protect the “safety net” for the uninsured even while working toward coverage for that population in the future.

Two patterns are notable in TCWF’s diverse advocacy efforts. First, many grantees are not specifically organized around health issues. This suggests that general advocacy skills and political resources, as well as issue-specific knowledge, are important for protecting and advancing the health interests of underserved groups and communities. Second, the foundation funds a combination of local and statewide organizations throughout all of California. Holton believes that it is necessary to touch as many of the entry points to the policy process as possible:

In the era of term limits, policymakers are less likely to have knowledge of the issues, so it is particularly important that policymakers hear from their constituents. Constituents put a face on the issues, and their solutions are seen as grounded in reality. Many state policy groups, however, do not have a grassroots capacity and need to learn how to seek out and work with grassroots organizations. Grassroots organizations, in turn, rarely have the resources to get engaged in state policy issues. It is important to provide resources to both types of groups so that they can work effectively with each other (Holton 2002a, 16).

The California Endowment

The California Endowment was established in 1996 when the state’s largest insurer, Blue Cross of California, created its for-profit WellPoint Health Network. The Endowment is a private, statewide health foundation with over \$3 billion in assets. Since its inception, the Endowment has awarded more than 3,300 grants totaling over \$1 billion to public and private organizations throughout California. It is one of the top health funders in the U.S., with outlays of \$191 million in 2000-01.

The mission of the Endowment, like that of its sister foundation, the California HealthCare Foundation (CHCF), is “to expand access to affordable, quality health care for underserved individuals and communities and to promote fundamental improvements in the health status of the people of California.” The Endowment has a significantly different strategy than CHCF, however; it seeks to position itself as a “partner for healthy communities.” The main office of the Endowment is in the southern California suburb of Woodland Hills, but the foundation divides the state up into eleven regions and has program staff located in Fresno, Los Angeles, San Francisco, Sacramento and San Diego.

The foundation’s first chairman of the board, J. Kendall Anderson, argued that the Endowment would “balance short- and long-term efforts, helping to fill acute, immediate gaps in California’s health infrastructure while working for lasting change in health policies and systems. . . . We also resolved not to fall back on the top-down approach to philanthropy, which tends to rely on a handful of experts and statistics for direction” (Endowment 1997, 3). Half of the foundation’s annual funding is devoted to “responsive grantmaking,” which directs support to communities’ self-identified concerns. With resources split roughly 50-50 between responsive and strategic grantmaking, the Endowment hopes to foster linkages between the two sets of grantees and create greater synergy in the work (Masters 2003).

The Endowment is still developing a focus on public policy as a means of fulfilling its mission. Its director of public policy, Barbara Masters, was recruited in 2001. Like TCWF, the Endowment has come to view advocacy as an essential element of its strategy. There is more willingness for the Endowment’s staff to take an active role in advocacy, however. “Foundations tend to be very concerned about being neutral. Clearly we don’t lobby, but I don’t think TCE sees itself as neutral. We do have a point of view and we don’t shy away from [it]. . . . We don’t believe that public policy work has to be done exclusively through the grantees” (Masters 2002). This is a considerable contrast with the position of most of the national foundations involved in health policy issues. Even in adopting a more aggressive stance toward advocacy, the Endowment is aware of the need for independence. Masters argues that it cannot play the important role of facilitator if it aligns itself too closely with a particular organization’s agenda and can’t back up its positions with credible research.

The ability of the Endowment to shape public policy rests in its resources and agenda-setting capacity. According to Masters,

When advocacy groups do their work, it’s about their particular agenda. We need to think about things in a less piecemeal approach. I think that’s a real asset we bring to the table. . . our ability to bring people together across sectors and disciplines, bringing together research, communications, policy and advocacy so that there is a real strategy with all these parts sewn together. The message and goals have to be reinforced across all parts of your work (Masters 2002).

The Endowment is conscious about representing and involving all parts of the state. Masters says that the foundation created a Local Opportunities Fund for this purpose, trying to reach

communities where they don't have as much capacity to write grants. The fund accepts two-page applications and even though it provides smaller amounts of money, it is more approachable for organizations without grantwriting experience.

Endowment Strategies for Improving Health Insurance Coverage

The Endowment sponsors both public and private sector initiatives to expand health care coverage in California:

We believe that to advance health access you have to bring business to the table. We have a point of view—everybody ought to have coverage—how you achieve that is not where we will stake out our ground. So we support different kinds of models . . . we support a lot of traditional advocacy work, on Medi-Cal and Healthy Families expansions. But we're not going to land a particular solution—that's for the political process to work out. We just want to make sure that there is a political process that wants to take that agenda on. We see that as our role—to increase the political will and visibility of the issue (Masters 2002).

A significant part of the Endowment's strategy is public education and advocacy on behalf of the estimated 4-6 million Californians without continuous health insurance coverage (State of California 2002, 6). Like TCWF, the Endowment has funded the Pacific Institute for Community Organizations to build the capacity of its local groups to advocate for expanding access to care for uninsured people. In FY 2001 alone, it gave more than \$1.6 million in separate grants to the California Primary Care Association and the Community Clinic Association of Los Angeles County to support advocacy, media support, and leadership training on the issue of access to care for low-income, uninsured residents (California Endowment 2001).

In 2000, the Endowment helped create the 100% Campaign. The campaign's goal is to provide all of California's children with affordable health coverage. California has two million uninsured children, by far the most of any state in the nation. Most of them are in low-income, working families and many are eligible for health benefits but not enrolled in any insurance program. Three nonprofit organizations—Children Now, the Children's Defense Fund, and The Children's Partnership—coordinate the campaign. The Endowment is the primary funder, providing more than \$3 million in support over three years starting in 2001. The campaign involves policy research, state-level advocacy, and outreach to uninsured families through a network of county and community-based organizations. These activities are intended to increase enrollment in public insurance programs and develop new approaches to increase health coverage for children and families throughout the state (California Endowment 2001, 35)

The Endowment commissioned a study to closely examine Latino, African American, Asian American and Pacific Islander, and American Indian communities in California to better understand why so many minority children—an estimated 1.3 million of the state's uninsured children—remain uninsured even though they are generally eligible for public insurance programs (Tomàs Rivera Policy Institute 2002). Given this situation, some of the advocacy in

the 100% Campaign is aimed at what David Colby of RWJF calls “maxing out” existing sources of coverage. Along with the Packard Foundation, the Endowment has supported implementation of the state’s “Express Lane Eligibility” initiative that allows school lunch applications to be used to enroll children in either Medi-Cal or Healthy Families. Masters describes the challenge for foundations trying to work simultaneously with state and local agencies, advocates, and other philanthropies on a seemingly straightforward task:

At the local level, it’s a pretty tough thing to get two huge bureaucracies—schools and counties—that have not traditionally worked with one another to change their systems. We also met with the state and developed a partnership with the state Departments of Education and Health Services to develop the financing and implementation strategy. We also support a policy group to work with the four communities where we are funding pilot projects. Everything was working well and when the budget deficit hit and the governor [anticipating the costs of covering more kids] decided that he wanted to delay the program that was scheduled to go live in July 2002. . . . Our policy grantee and our pilot sites now have a stake in the program, so they were very active in educating the legislature that delaying it until 2005 would be detrimental. The final disposition of the budget allowed a delay until July 2003, which was OK, because there’s still some planning in the pilot sites that needs to happen (Masters 2002).

The Endowment is also engaged in major local initiatives to expand health insurance, especially to low-income working families. In Ventura County, it supported creation of a Health Coverage Task Force, a 19-member group representing employers, labor, health insurance and legal professionals, community-based organizations, physicians, and university researchers. The work of the task force included analysis of existing health coverage projects around the state, an employer survey, focus groups with low-wage workers, a public education campaign, and a long-term plan to increase coverage in Ventura County. A new project supported by the Endowment now seeks to follow up the planning of the task force by funding community leaders to expand employer and employee participation in health insurance options (Grantmakers in Health 2002).

The Endowment supports several strategies to expand access to care in Santa Clara County. It funded PICO to participate in the coalition that created the Santa Clara Children’s Health Initiative and then gave over \$1 million to help subsidize premiums (Holton 2002; Lewit 2002). It recently provided a \$525,000 grant to the Community Health Partnership of Santa Clara County to expand advocacy, technical assistance and media support services to increase health care access to low-income, underserved residents in Santa Clara County. The foundation also has tried to ensure access to care in other ways. It gave the Community Health Partnership a separate small grant to develop a strategic plan for sustaining community clinics. In addition, the Endowment gave \$1.2 million to The Health Trust in Santa Clara County to establish a countywide, coordinated system of dental care for “at-risk children and youth” (California Endowment 2001).

In San Diego County, the Endowment has supported the effort of the Alliance Healthcare Foundation and other local groups to develop a model public-private health insurance initiative. It provided \$400,000 to subsidize the “affordable product” offered by Sharp Health Plan to small employers in order to boost enrollment in the demonstration. The Endowment has also developed relationships with other organizations. It gave \$300,000 to the San Diego Organizing Project to create a faith-based campaign to increase access to health care for uninsured and underinsured families. A new grant of \$800,000 to the nonprofit Business Healthcare Connection will create a resource center where small employers and their low-wage employees will be provided information, education, assistance and coordinated enrollment for both public and private health care options (Business Healthcare Connection 2002).

In 2003, the Endowment joined with RWJF as the principal co-sponsor of Cover the Uninsured Week. The foundation’s support of the RWJF initiative indicates both that lack of insurance coverage among Californians is a national problem, and that addressing that problem will likely require financial and legal commitments from both the state and the federal government.

Along with TCWF, the Endowment takes responsibility for improving short term access to services while pursuing expansion of public and private insurance coverage. For the past five years, it has provided \$14 million to support the Health Consumer Alliance, a partnership of legal services programs dedicated to providing local and statewide advocacy as well as assistance in securing health care coverage and access to services for low-income Californians. An evaluation found that the alliance had helped 46,000 Californians with insurance program enrollment and retention, and access to care between 1997-2001; 21 percent were able to obtain insurance coverage with the assistance of the centers (Cousineau and Nascimento 2003). Based on the positive findings, the Endowment awarded the Health Consumer Alliance a new \$7.2 million grant in 2003.

In FY 2001, the Endowment made a \$2 million grant to the CaliforniaKids Healthcare Foundation for health care coverage for uninsured, undocumented children. The funds supported outpatient preventive and primary health care coverage for 6,000 undocumented children, development of a sustainability plan, and participation of the group in public policy formation (Endowment 2001, 34).

Since “safety net providers” are essential sources of both primary and emergency care for the uninsured, the Endowment has made major contributions to both direct services and infrastructure to keep these public health resources financially viable. In FY 2001, it gave \$12 million to the Tides Foundation to expand and strengthen information systems and management capacity of clinic consortia, community clinics and clinic networks. This follows a one year, \$12.5 million grant two years earlier as part of the same initiative. Through the Tides Foundation, funds from the first Endowment grant made their way to nearly 100 consortia and individual clinics throughout the state (California Endowment 2001, 59, 69). In theory, this support enables community clinics to function not only as a last resort for the uninsured but also as a first resort for insured individuals in special populations who value the comprehensiveness and cultural sensitivity of care in community clinics.

California HealthCare Foundation

The California HealthCare Foundation (CHCF), based in Oakland, is a public foundation committed to improving California's health care delivery and financing systems. It was formed in 1996 with the proceeds of the conversion of Blue Cross of California to for-profit status. CHCF is about one-quarter the size of its sister foundation, the California Endowment. In FY 2001, it had \$783 million in assets and spent \$43 million—down from \$60 million in FY 2000. It shares the same mission as the Endowment: “to expand access to affordable, quality health care for underserved individuals and communities and to promote fundamental improvements in the health status of the people of California.”

From the start, the smaller size of CHCF and the activities of other foundations encouraged its leadership to develop a distinctive niche and allocation of its resources. CHCF chose to focus on “system issues—improving health care delivery, advancing effective business practices, and contributing to effective health policy development” (CHCF 2001, 6; M. Smith 2002). The approach at CHCF is linked closely with Mark Smith, who was an executive vice president at the Kaiser Family Foundation before he was recruited to head up the new foundation:

I think with any foundation, if it's doing its job right, you start by saying what's my mission and what assets do I have to spend on that mission. Then your strategy has to be derived in part from an assessment of those things, along with an assessment of the strengths and weaknesses of your board, your staff and who else is around in the environment. For instance, when we got started Wellness had already been in the public health business for years. It would have been silly for us to do violence prevention or teen pregnancy prevention. I did lots of reproductive health and teen pregnancy prevention work at Kaiser, so that was a personal interest of mine. But the notion that we were going to stumble upon something that Wellness forgot to do was not credible. This is less about my own personal interests and more about our judgments about who else is in the environment and what they're doing and what the opportunities are (M. Smith 2002).

The CHCF focus on the health care market was a source of consternation to consumer and health care advocates in the state, who wanted control over the Blue Cross conversion money for their work on access to care for low-income populations. Because of the Blue Cross connection, “the immediate assumption was that we were here to do the bidding of industry” (Laws 2002). But the CHCF leadership saw it differently—its job would be to recognize market failures and try to play a role in plugging them (M. Smith 1999, 4).

[T]he fact of the matter is, if you look at the top six or seven public policy problems facing service delivery of care for poor people today, they are not problems in the clinical domain, or the ethical domain or the political domain. They're problems of what is the right rate to pay a Medicare health plan. How do you assure the

solvency of a physician group? What kind of benefit design in terms of co-pays and deductibles balances out the need to reduce costs without presenting undue barriers to access? So our sense is not that we've tried to play a role here because we ideologically like one orientation as opposed to another (M. Smith 2002).

While the issues he pursues at CHCF are different, Smith has adopted the same kinds of operational structure and strategies that he helped Drew Altman implement during his five and one half years at Kaiser. One of the foundation's goals in the area of public policy is to promote "evidence-based policy." CHCF has initiated several projects to improve the availability and quality of "independent, objective, accurate, and timely information on health policy issues." The target audience is not so much the general public as key public and private decision makers. CHCF has invested a substantial proportion of its resources "to develop channels to respond to the information needs of legislative members and staff, executive branch regulators, industry leaders, and others making health policy decisions" (CHCF 2001, 7).

At the national level, there is always interest in California's trend-setting health care system. Because the state has over one-seventh of the U.S. population and an even greater share of the economy, there is also interest in the development and performance of California health policies. CHCF has established a partnership with the National Health Policy Forum to produce and disseminate issue briefs and convene periodic briefings for health policy staff from the Congress and executive agencies. It also provides support to Project Hope for roundtables on California-specific topics and publication of research and analysis in the journal *Health Affairs* (CHCF 2001).

The role of information is even more crucial at the state level. Smith believes that this is a time of declining expertise in government. Due to term limits in particular, he argues that

decisions that used to be made in Sacramento and Albany by career professional politicians are now being made by amateurs. I don't mean amateurs in a disparaging way. What I mean is that Medicaid is an incredibly arcane, complex program. The people who *run* it don't fully understand it. The people who have been making policy for it for *years* have difficulty understanding it. . . . Paradoxically, this actually puts more power in the hands of trade associations, lobbyists, and others with financial interests because they're the people who know Medicaid for a living. . . . [S]omething happens when market forces meet inexperience in the government sector, given the complexity of these programs. And I think that what happens is a policy opportunity for foundations to help play a role in supplying unbiased, objective information (M. Smith 1999, 7).

Much of CHCF's state-level work is carried on through the Medi-Cal Policy Institute, which is an operating part of the foundation that functions like Kaiser's Commission on Medicaid and the Uninsured or Commonwealth's Task Force on the Future of Health Insurance. CHCF also has

developed, underwritten, and produced *California Healthline*, a free, daily online summary of health policy and industry news from more than 300 sources. It is the state's counterpart to RWJF's decade-old online newsletter *Healthline* and the Kaiser Foundation's new Kaisernetwork.org.

CHCF has also put special emphasis on cultivating relationships with state policymakers. Primarily through Smith, the foundation has access to members of the legislature and the heads of state agencies. Margaret Laws, director of public policy at CHCF, says the most critical communication is with the staff of the major legislative committees that work on health. Once CHCF was known and trusted, relationships "moved to a stage where they started asking us specifically for things." More recently, the foundation staff started thinking about work that might become useful in the future—"not because one member of the legislature asked for it, but because we've understood and anticipated that that was an issue that was going to become hot and that we had some stuff in the can ready to go" (Laws 2002).

More than Kaiser, CHCF finds itself pushing the boundary between providing information and advocacy. Laws says that inside California policy circles,

I think we've been trying to take positions on things where we really do feel that there's pretty good consensus; where everybody agrees that this is a problem that needs to be resolved and there are going to be relative winners and losers but industry hasn't been able to figure it out by itself and regulators haven't either. So if we get in there and assert a little bit of a point of view about something—in some ways people are starting to ask for that. I think a question for us is when do we feel comfortable doing that and when by doing that we cross the line and become a "conservative" foundation or a "liberal" foundation or in the pocket of industry or in the pocket of a particular lawmaker (Laws 2002).

Ultimately, Smith argues that influence in the policy process comes back to credibility: "You see people in different settings, on different issues, repeatedly. And if they're right and objective and call them like they see them, over time you come to respect them. That's happened with us. We're among the few people who, if you go to industry sources and consumer advocacy sources and government sources, they'll know us and respect us and not quite agree with us on everything. And that's probably where we want to be" (M. Smith 2002).

CHCF Strategies for Improving Health Insurance Coverage

Two of CHCF's six program areas focus on health insurance coverage. The first, Health Insurance Markets and the Uninsured, is aimed at expanding employer-sponsored coverage among small firms. The second, Medi-Cal/Healthy Families, supports efforts to expand enrollment and access to care through California's public health insurance programs. Both programs employ a three-part strategy: 1) conducting or commissioning research to understand characteristics of different uninsured groups and the markets that serve them; 2) developing new

models of insurance targeted towards groups, markets, and systems; and 3) assessing the effectiveness of these models.

CHCF has sponsored research on the sources of low insurance coverage rates in the temporary services industry and, perhaps surprisingly, the health care industry. Given its goal to improve the performance of the private health care market, another area that is natural for CHCF to promote is insurance coverage among small employers and self-employed individuals. The foundation commissioned William M. Mercer to conduct a survey of individuals in small firms who made decisions about insurance coverage. It found that large numbers of small employers did not know they were guaranteed access to coverage under state and federal law or that health benefits were a tax-deductible business expense (and tax-free to employees as well). Some small employers overestimate the costs of insurance coverage, although most estimate accurately or underestimate the costs (Mulkey and Yegian 2001, 40).

Based on meetings with insurers, brokers, small businesses, and consumer advocates, CHCF also commissioned a literature review on the link between offering health insurance and financial performance. The findings neither supported nor rejected the argument that coverage improved outcomes such as worker productivity, absenteeism, turnover, or outlays for workers' compensation. So the multi-million dollar media and grassroots campaign that the foundation planned was unable to deliver the message it wanted to deliver—that offering health insurance is a good business decision (Mulkey and Yegian 2001, 41).

The foundation also met with the Chamber of Commerce, National Federation of Independent Business, and other organizations that serve small businesses. While CHCF hoped those groups would help educate their members on the issue, they did not offer to provide the leadership role that foundation staff sought. In the face of that lukewarm response and with additional focus-group research, CHCF concluded that its money would be better spent developing better information for employers who do look into insurance options rather than to conduct a broad-based education campaign. It helped establish a new online Small Business Health Insurance Resource Center to provide information to small businesses on their rights and regulations governing access to health insurance, tax deductibility of premiums, and resources for health insurance such as purchasing alliances, brokers, and online sites with information about health insurance options in the small group market (CHCF 2001, 23; Mulkey and Yegian 2001, 42).

In search of alternative models, CHCF invested in a body of research and analysis on the potential of purchasing alliances to enhance the buying power of small businesses. Here too, it found somewhat disappointing results: pooled purchasing most commonly led to greater choices of insurance plans, not more affordable coverage across the small-group market (Mulkey and Yegian 2001, 39).

Finally, the foundation has collaborated with the Alliance Healthcare Foundation in developing and evaluating the Sharp Health Plan's FOCUS program (Financially Obtainable Coverage for Uninsured San Diegans). This demonstration program offers coverage at below-market rates to low-wage workers in small businesses in San Diego. CHCF made an initial grant of \$1 million to subsidize premiums in the FOCUS program, which also received subsidy support from the California Endowment. In 2003, it made a followup grant of \$400,000 to continue subsidized

coverage in the short term and ease the transition of enrollees from FOCUS to commercial coverage (CHCF 2003). CHCF is taking the lead on evaluation of the program and expects to connect it to research on other local initiatives around the country (CHCF 2001, 54).

The foundation also deviated somewhat from its usual strategy when it recently made two additional grants of \$400,000 to safety net health care programs. One was to expand access to the local Family Care program, which provides subsidized health and dental insurance to low-income Alameda County residents who are ineligible for public insurance programs. The other was to expand access to the CaliforniaKids program—also supported by the California Endowment—and provide preventive and primary care services to uninsured children (CHCF 2003).

Outside of the private insurance market, CHCF has kept a fairly narrow focus. Smith argues, “I don’t think it’s credible to think that the problem of universal coverage is going to be solved on a state-by-state basis. So we don’t do a lot about beating the drum for universal coverage. Not because we don’t think that’s important but because we think that’s a national issue” (M. Smith 2002). Nonetheless, the role CHCF has adopted requires it to be responsive to changes in the political environment. As it became clear in early 2003 that California legislators were seriously considering new proposals to cover all or most of the state’s six million uninsured, CHCF developed a project to summarize lessons from past failures and to closely analyze the proposals pending in the state legislature so that all stakeholders would have a better understanding of the implications of the policy options.

Laws notes that the Medi-Cal Policy Institute—part of the initial portfolio of projects—was the first visible policy work at CHCF. It was not to be an advocacy organization; it would instead fill information gaps and try to promote more effective policymaking in the area of Medi-Cal. She says the institute “put a stake in the ground that wasn’t primarily about working with industry. It was really about helping the Medi-Cal program work better. So there were wide relationships formed with [state agency] officials and with the parts of the legislature that work on Medi-Cal issues, with counties and organizations around the state that work on Medi-Cal issues” (Laws 2002).

Medi-Cal and Healthy Families are massive insurance programs, covering a combined six million California residents. There are millions more eligible but not enrolled in the two programs, however—two of three uninsured children and one in seven uninsured adults (CHCF 2001, 25). One of CHCF’s initiatives has developed county-by-county data and analysis of the Medi-Cal program, in order for program officials, advocates, and policymakers to compare performance across California’s 58 counties. In its First Things First program, CHCF spent \$2.1 million to support the development or expansion of community coalitions to connect with hard-to-reach families and populations. In addition, the project includes evaluation of strategies and dissemination of the most promising practices through statewide meetings of grantees and other interested parties.

Perhaps the most distinctive initiative is Health-e-App, which uses web-based technology for streamlined enrollment in Medi-Cal and Healthy Families. It evolved from a 1998 report by the Medi-Cal Policy Institute on simplifying the program application and enrollment process. CHCF

spent more than \$1 million on software development, a panel of eligibility experts, and testing by state departments and community-based organizations.

Health-e-App allows an assistant to use any web-enabled device to collect information through a series of interview questions. Automatic error-checking software ensures all the needed information is collected, and applicants receive a preliminary eligibility determination instantly. Health-e-App also can provide real-time selection of health plans and providers by geographic area, specialty, gender and language preference. A demonstration project planned to train 21,000 certified application assistants to help implement what the foundation calls “the nation’s first fully-automated application” (CHCF 2001, 13). It was scheduled for statewide adoption in 2001-02.

The Health-e-App initiative exploits CHCF’s interests in technology, expanding health insurance, and public policy. Smith calls it “one of our signature grants” and says it has been licensed in four other states. It illustrates the value of foundation independence and the challenge of overcoming the cultural and procedural divides across philanthropy, business, and government:

What we did was recognize that this is a good idea and we said ‘we will build it.’ . . . We built the thing, tested it, debugged it . . . And we said this is the way we think it will work—once we build it, people will see what a great thing it is and all the reasons they have for not wanting to do it now will disappear. And in fact [they have]. But if we had waited for everyone to agree—the state government, the county government, social services, the feds—we’d still be waiting (M. Smith 2002).

Health-e-App also illustrates the value of foundation collaboration, not only with governmental partners but other foundations as well. Barbara Masters of the California Endowment notes that Health-e-App is a central feature in the Express Lane Eligibility program for school-based enrollment of children in the Medi-Cal and Healthy Families programs and explains how it came about: “Health-e-App has been out for a couple of years so we all know about it. Mark Smith and Bob Ross have a very good relationship and they talk all the time. So as we were embarking on express lane, particularly on the technology, I called someone at CHCF, and they told me you really ought to think about this company. It was on their recommendation that we went forward with that company” (Masters 2002).

Thus, the distinctive focus of the “business-oriented” CHCF generated a new technology that now facilitates the goals of the more advocacy-oriented TCWF and Endowment as well as the child-oriented Packard Foundation. What melds the diverse organizations and their diverse interests together is the issue of health insurance coverage—its magnitude and social importance. Laws (2002) notes that the potential for collaboration in this area is growing.

PROFILES OF LOCAL FOUNDATIONS AND THEIR PROGRAMS ON HEALTH INSURANCE COVERAGE

As Leroy and Schwartz emphasize, health policy grantmaking is not carried out solely by national foundations; many state and local foundations eagerly support policy-related work. These organizations are uniquely situated to address locally defined issues: “Community foundations often work at the nexus between policy and service as they facilitate planning and program development” (Leroy and Schwartz 1998, 232). While these organizations may resemble larger foundations in some respects, it is important to be mindful of the implications of their being rooted in particular localities: “Unlike other . . . funders, they cannot distance themselves entirely from community opinion; their grants are never abstract experiments” (Noland 1989, 130).

In this section we turn our attention to local foundations and the strategies they adopt in seeking to influence health policy. Our intent is not to document the entire scope of activity of local foundations. Rather, it is to take a detailed look at the activities of a select number of foundations active in health policy and offer some analysis of the strategic choices they have made. Three of the four foundations we profile below were established with assets generated from the conversion of nonprofit health plans or institutions into for-profit entities. One, the Rhode Island Foundation, is a community foundation. We are mindful that foundations resulting from conversions may have missions, structures and governance distinct from community foundations. In particular, conversion foundations, like other private foundations, face legal restrictions on lobbying that do not apply to community foundations (Schwartz 2003).

Alliance Healthcare Foundation—San Diego, California

The Alliance Healthcare Foundation is a private foundation located in San Diego, California. It was established in 1988 by the San Diego Community Healthcare Alliance, a nonprofit group of local business and health care leaders who wished to contain health care costs and improve access. Grantmaking in the foundation was funded by excess revenues of one of the Alliance’s businesses, the Community Care Network, a nonprofit preferred provider organization. In 1994, the Community Care Network was sold to Value Health, a large for-profit managed care company. The sale created an \$83 million endowment for Alliance, which has enabled the foundation to significantly expand its grantmaking. The foundation’s current assets are approximately \$100 million. The mission of Alliance is to promote quality health care, with a special emphasis on the medically underserved in the San Diego region, through innovative and proactive grantmaking, fund raising, advocacy and community education.

Since 1988, Alliance has awarded \$31 million to nonprofit organizations that provide care for the poor and underserved, primarily in San Diego County. About 85 percent of Alliance grants stay in the San Diego region. Selected grants have been made to programs throughout California that addressed issues relevant to the San Diego region and the foundation's funding priorities. Alliance has brought an additional \$36 million in matching dollars to its grants through funding partners such as The California Wellness Foundation, California Endowment, California HealthCare Foundation, Robert Wood Johnson Foundation and public sector funders.

Alliance Strategies for Improving Health Insurance Coverage

In San Diego County, an estimated 365,000 people, or 15 percent of residents, are uninsured. Children account for 11.5 percent of the uninsured in this region. Approximately 85 percent of San Diego County's uninsured residents work or live in a family where at least one person works (Alliance 2002). In light of these data, coupled with the fact that San Diego has a large proportion of businesses with fewer than 20 employees, Alliance saw an opportunity to improve the situation of the working uninsured.

While Alliance has funded direct services through its grantmaking in the access program area—providing funds to build staff and technical capacity at numerous county and nonprofit health care facilities—its work concerning health insurance coverage has employed a number of strategies, most notably demonstration projects and efforts to educate policymakers and the public. The president of Alliance, Ruth Lyn Riedel, considers its strategies to be somewhat distinctive:

Regional foundations tend not to work in advocacy and policy development. Many foundation staff and trustees seem more comfortable with grantmaking in selected areas, a job they can do very well. Some of the Alliance's grantmaking is more traditional, but also we're willing to take risks that others are not willing to take in our region of California (Riedel 2002).

The most prominent of Alliance's efforts in demonstration projects has been made through the Financially Obtainable Coverage for San Diegans (FOCUS) program. Created in partnership with Sharp Health Plan, FOCUS is a premium assistance program intended "to increase the rate of health insurance coverage for workers in San Diego County by providing coverage to small businesses and low- to moderate-income employees at affordable rates" (Silow-Carroll et al. 2001, 43). FOCUS is modeled as a "3-share" program in which the cost of coverage is shared by the employer, the employee, and a third party. In the case of FOCUS, third-party funding has been provided primarily by Alliance, which invested \$1.2 million to subsidize operational costs and premiums.

FOCUS was designed as a two-year demonstration project, and began enrolling employees and their dependents in 1999. The program's features included a sliding scale depending on income and family size, no deductibles, no lifetime maximums, low co-payments and the inclusion of some mental health and substance abuse services. Premiums were kept low largely as a result of lower provider rates, the absence of broker commissions, and lower administrative fees from Sharp Health Plan. As a result, the program has enrolled approximately 1,700 individuals from over 200 small businesses.

The project has also fostered partnerships with two other California foundations. The California Endowment has provided \$400,000 to cover additional enrollees while the California HealthCare Foundation has provided \$1.4 million in premium subsidies as well as grants to support the

evaluation of FOCUS. Given Alliance's limited resources, establishing partnerships with the big California foundations has been invaluable in carrying out some of their larger initiatives.

A major challenge in funding demonstration projects, particularly those like FOCUS that rely exclusively on private funding, has been to secure long-term financing to ensure the sustainability of the program. As foundation funding of premium support recently ended, Alliance, business and other sectors of the community sought out public sector funding for continuation of the premium assistance program (in 2003, FOCUS received an additional \$400,000 from CHCF to ease the transition). However, given the current budget crisis facing California state and local governments, public dollars are not forthcoming. Though 90 percent of employers who purchased FOCUS coverage have chosen to maintain coverage for the first year post-subsidy assistance, the substantial increase in rates employers are likely to face may result in their dropping coverage (Riedel 2002). As such, Alliance sees FOCUS as only a qualified success:

FOCUS was a successful product as viewed by participating employers and employees but there are no public dollars for continuation. Without continuation funds, we did not reach our first goal. We will have invested \$1.2 million, a sizeable grant for AHF, to demonstrate that "3-share" models are viable in this community, answering some local elected officials who believed FOCUS would be ineffective. From the evaluation of the first phase of enrollment, we learned that that the majority of employees who enrolled in FOCUS were eligible for Medi-Cal or Healthy Families. They preferred paying a modest monthly premium to the burdensome process of enrolling and maintaining participation in public sector programs. In addition, enrollees preferred that the whole family receive care from the same health care delivery system (Riedel 2002).

Though local funding for the FOCUS program has ended, Alliance continues to push for the adoption of "3-share" models around the country. It participates in an informal network of 10-15 such programs across the country in order to exchange ideas, successes and lessons learned, and to broaden support and advocacy for such models.

Regarding the objectives of funding demonstration projects, Riedel is emphatic in her belief that is *not* the role of foundations to replace government funding and programs:

Obviously, we cannot fill gaps in public or private sector programs. We only wish to demonstrate to local elected officials and the public at large that the needs for health coverage and a regular source of care are legitimate needs of our hard-working residents, and that these needs deserve support (Riedel 2002).

Alliance continues to support demonstration projects that seek to develop affordable health coverage options for employers and workers. The foundation has joined in an effort led by the

California Endowment to provide funding to the Business Healthcare Connection (BHC), a local resource center on health insurance for small employers. The California Endowment provided \$874,000 to establish the resource center. Alliance awarded a \$142,582 grant to the University of Southern California to evaluate the effectiveness of the BHC's goals.

Another strategy for Alliance is to educate policymakers and raise public awareness about health insurance coverage issues affecting the San Diego region. The San Diegans for Health Coverage project includes message development, letter-writing campaigns, establishing a speakers' bureau, placement of ads in major newspapers and magazines, and education of opinion leaders in business and policy positions. Part of this education effort also includes the San Diego County Healthcare Survey of Voter Attitudes and Perceptions on Healthcare, conducted initially in 2000 and again in 2002. The results of the 2002 poll indicate that San Diego County voters continue to rate access to health care as one of the highest-priority issues for local government to address. Voters' support for increased public spending to expand health insurance coverage for the working uninsured and underinsured in San Diego may help keep issues of insurance coverage on the political agenda.

Alliance has also sponsored local media to provide coverage of health care issues. For example, it funds a health care reporter for the local public radio station as a way to ensure that attention is continuously paid relevant public health issues. The foundation also awarded a small grant to produce a documentary on the uninsured that won national awards and recognition.

Rose Community Foundation—Denver, Colorado

The Rose Community Foundation was established with proceeds from the sale of Rose Medical Center in April 1995. Rose targets its work and resources towards enhancing the health and well being of the Greater Denver community. Rose has assets of approximately \$240 million and provides resources and support to nonprofit organizations serving the Greater Denver community. Its annual payout is \$13-15 million, with approximately twenty percent of that amount allocated to the health program area.

According to Annie Van Dusen, Rose's Senior Program Officer for Health, the foundation takes on programs in part based on a theory of social change expressed as follows: Good information plus committed leaders plus an engaged public equals better health policy, which ultimately leads to better health and health care (Van Dusen 2002). This theory has given rise to a number of key strategic choices made by the foundation in carrying out its health-related activities.

Though the foundation is quite young, there was recognition at an early stage that dollars spent on direct services are not nearly as well leveraged as dollars spent on informing public policies (Van Dusen 2002). The foundation's approach to grantmaking is varied, and includes operating grants, capital grants, research and planning grants, seeding new programs. While Rose also funds direct services, greater consideration goes to projects seeking to make longer-term improvements in access and coordination of the health care system. Accordingly, their chief health-related activities are aimed at influencing public policy at the state and local level.

Rose Strategies for Improving Health insurance Coverage

Rose's initial foray into the public policy arena involved a public-private collaboration with Colorado state government officials to identify, provide outreach to and enroll children in the state's version of SCHIP, Child Health Plan Plus. The foundation had the sense "that having a significant impact on access to care would require getting involved with government, the largest payer of health care services. Clearly grants for direct services—even grants for insurance subsidies—won't make access and navigation of the health care system any easier for low-income people" (Van Dusen and Nash 2000). The legislation required the program to be administered by a private-sector entity that could essentially market the program as a commercial insurance product to be purchased by low-income families for their children. Given the lack of interest among for-profit firms in bidding on the state contract, Rose saw an opportunity. As Van Dusen states, "We viewed the fact that there was no one out there who wanted to bid on this as a perfect opportunity for a foundation to respond to a public need in a way that is really innovative and can demonstrate the impact that the private sector can have on a publicly subsidized product" (Van Dusen 2002).

Rose established Child Health Advocates, a nonprofit organization designed to assume marketing, eligibility and enrollment, administrative and other programmatic functions of Child Health Plus. This effort has resulted in the enrollment of over 45,000 eligible children. In 2002, Rose sold Child Health Advocates to a for-profit entity for approximately \$2 million, representing a 300 percent return on its investment (Van Dusen 2002). It used these proceeds to establish a new organization at the foundation called the Colorado Child Health Foundation. This organization allows the foundation to expand its work in improving children's health throughout the state. Through its work in SCHIP enrollment and outreach, Rose "earned a reputation as a broker of objective information, capable of getting involved in public policy with no axe to grind, no turf to defend" (Van Dusen and Nash 2000).

Rose has also engaged in strategies to increase awareness around health insurance issues. Recognizing that Colorado state legislators have limited time and staffing to understand the complexities of various health care issues, the foundation established the "Hot Issues in Health Care" initiative following the November 2000 elections with the intention of providing legislators the tools needed to shape fiscally sound health policies. The initiative aims "to provide timely information to state legislators as they shape health policy, by bringing together health experts and decisionmakers" (Van Dusen 2002). Given the success of the first briefing session, Rose held a second session in 2002 and has recently hired a full-time staff person to run the program. This staffing capacity allows for one-on-one briefings with legislators as well as the ability to get out other written reports between election-year briefing sessions.

Another strategy involves raising public awareness and advocacy building activities. The Colorado Consumer Health Initiative was established in 1999 following a meeting of health advocates convened by Rose. Partnering with several other local foundations and the Public Welfare Foundation, the initiative works to educate the public about health care; build a strong, diverse coalition that strengthens the consumer voice in health policy discussions and decisions; develop and promote solutions that increase access to care, especially for the uninsured and those covered through public programs; and support efforts to decrease the number of uninsured

persons in Colorado. More than 50 local and statewide advocacy organizations have participated in the initiative, and it has been the only organization representing consumers in debates concerning the small group and individual health insurance markets. Moreover, it has played an important role in staving off efforts to undo regulations in these markets (Grantmakers In Health 2002a).

Rhode Island Foundation—Providence, Rhode Island

The Rhode Island Foundation (RIF) was established in 1916 in trust form with Rhode Island Hospital Trust National Bank as the sole trustee. The foundation pursues its mission of connecting private philanthropy to the public good throughout the state of Rhode Island. According to Foundation Center data (2001), RIF is the 21st largest community foundation in the U.S. in terms of assets. The foundation's current assets are approximately \$300 million. RIF's average annual payout is approximately \$15 million, about half of which is allocated to its strategic grantmaking programs.

RIF is a general-purpose community foundation, so a commitment to health and health care is not built explicitly into its mission. Prior to adopting a strategic grantmaking approach, the foundation typically awarded grants to organizations providing direct health services in Rhode Island (RIF 2001). According to Karen Voci, senior vice president of programs at RIF, the foundation leadership sought to gain more leverage from their limited grant dollars through policy-relevant activities. Their interest in public policy was partly in response to opportunities put forth by large national foundations such as RWJF and the Annie E. Casey Foundation:

We were a community foundation that was very much interested in reframing its work. From the board's perspective and the president of the foundation's perspective, we were trying to transition our role in Rhode Island to go beyond grantmaking and get to work on policy issues. And because we had these opportunities presented to us by national foundations; because we had leadership; because we had a number of other things in place; the board became excited about what the opportunities might be and is using health to launch itself into the policy game. We saw it as the stars aligning but at the same time it was the right time in Rhode Island: we had the right leadership in-house and we had the right leadership outside the foundation (Voci 2002).

RIF Strategies for Improving Health Insurance Coverage

The foundation's entrée into policy-related work came in 1994 through the Rhode Island Kids Count Project, initiated by the Casey Foundation and RIF. RIF's strategy in this project was to support information-based advocacy, producing independent, credible, and comprehensive information on Rhode Island's children that would be used to change or influence public policies and programs. Kids Count was a program of the Rhode Island Foundation from 1994 to 1997, and became an independent nonprofit organization in 1997. RIF continues to provide funding

support to Rhode Island Kids Count, and works in close partnership with the organization on a wide variety of issues.

The foundation has also supported grassroots advocacy groups. For over five years, RIF has provided funding to the Ocean State Action Fund's Health Care Organizing Project. The project seeks to represent consumers in the ongoing statewide discussion of the state's health care system. The Fund is a coalition of progressive community organizations and labor unions dedicated to promoting social justice through increasing consumer participation in public policymaking. Important elements of the Fund's work include increasing consumers' capacity to participate in policymaking, working with the legislature and through regulatory and policy vehicles to expand RItE Care, and to create a state-subsidized buy-in mechanism for the program. Explaining RIF's support for this strategy, Karen Voci states: "We see it as our role to fund, feed, provide technical assistance to credible organizations that can go up to the state house and can put a human face on what they're proposing to do. That's not us, but we see it as our role to ensure that there are other organizations in the state that are credible to do that" (Voci 2002).

A second strategy for the foundation has been to act as a neutral facilitator, providing a "safe space" for convening public sector, private sector and consumer representatives to address an issue of mutual concern: the working uninsured. The Rhode Island Foundation, in conjunction with Kids Count and RWJF provided a place for various players to come together and confront what was becoming a growing crisis in the state.⁴ The foundation arranged the Leadership Roundtable on the Uninsured in 1998, bringing together the top leadership in the state to address the issue of the uninsured, and facilitated the governor's working groups, all of which led to Health Reform Rhode Island 2000 legislation. Karen Voci recounts the sequence of events that led to the legislation:

We had commissioned a paper with the [state] health department and they went out and interviewed employers about the costs of insuring their employees and about what was needed to keep them providing coverage. That was the first piece of research on the employer-based market, which we commissioned with money from [Robert Wood] Johnson. It was amazing how that study became very important because there wasn't any other data. So we were the place where the administration came to say, 'We've got a crisis here, we need some better legislation and what can you do to help us?' So we not only turned our space over to them. We hired facilitators, we brought consultants in to help them do some number crunching, we put on information programs for the legislators, small businesses, consumers and advocates. We allowed the people who were working on the legislation—this huge bipartisan commission that the governor had appointed—to use our building and provided some staff support for that.

⁴ The crisis, precipitated by rapid eligibility expansions of RItE Care (the state's Medicaid managed care program) and instability in the commercial insurance market, came to a head with the departure of two of the state's five health plans, leaving over 150,000 individuals without coverage. For a more detailed description, see Silow-Carroll et al. (2002, 32-33).

As Silow-Carroll et al. (2002) report, the legislation—intended to make the private insurance market a more viable option for low-income people—resulted in several products. These include: 1) creating RItE Share, a combined Medicaid/CHIP premium assistance program for RItE Care-eligible people who had access to employer-sponsored health coverage; 2) introducing cost-sharing for RItE Care and RItE Share enrollees with incomes above 150 percent of the FPL; and 3) reforming the small-group insurance market, including rate stabilization.

Developed as a method of joining employer-sponsored coverage with publicly sponsored coverage, RItE Share was implemented in February 2001, but early enrollment was very slow. As a result, state officials are currently involved in a project to design an effective and comprehensive plan that builds on aspects of the RItE Care and RItE Share programs to further expand access to health care coverage for Rhode Islanders. This initiative, funded by grants from the RIF and RWJF's State Coverage Initiatives, provides state officials with flexibility to think creatively about possible ways to reach the remaining uninsured Rhode Islanders. The major obstacle to achieving this goal, as well as the primary challenge to Rhode Island's progress in expansion of access to date, is maintaining funding during an economic slowdown (Silow-Carroll et al., 2002).

The experience with the Leadership Roundtable and the Health Reform legislation has been instructive for RIF's staff and board. It demonstrates the potential reach the foundation can have in impacting public policy issues. Karen Voci observes:

In a small state it's easy to get to the top for what you need or what you want to do or to become the top. So I'm not taking anything away from what we've been able to accomplish, but it's probably much more difficult for some community foundation tucked away in the corner of Texas. . . . What we do is make ourselves available in a bipartisan way to any legislator or member of the administration or agencies who would like to work with us on an issue that we agree is important. . . . Then when we want to do something they usually help us as much as they can. . . . We are not health policy experts here. We are a general community foundation that just happened be in the right place at the right time with the right people. We were able to be smart enough to jump on the opportunity (Voci 2002).

RIF has also funded a project that represents an innovative form of model testing. In 2000, the foundation, exercising a program-related investment (wherein a foundation uses principal rather than interest from its endowment to support an initiative fitting its overall goals), spent \$2 million to essentially convert the Neighborhood Health Plan of Rhode Island (NHPRI) from a for-profit HMO into a nonprofit HMO with a permanent mission to continue serving lower-income Rhode Islanders. NHPRI, formed by the state's Community Health Centers in 1994, was already serving a majority of the state's RItE Care enrollees. RIF's purchase of NHPRI from a Massachusetts for-profit entity (which converts RIF's ownership into a long-term, low-interest loan to the plan) ensures continuity of coverage and care to a large number of low-income

families throughout the state. RIF worked closely with Rhode Island state officials to obtain needed subsidies and legal clearance for the purchase. The acquisition of a health plan by a foundation is believed to be the first of its kind in the U.S.

A second demonstration project undertaken by RIF is Providence Smiles, a school-based dental program that sends dental care professionals into the public schools to provide treatment and education to children. The project, funded by RIF and a three-year grant from RWJF, emerged out of a public-private partnership between the foundation, the state departments of health and human services, the public school system and a coalition of colleges and hospitals. Providence Smiles serves approximately 6,000 children a year, regardless of insurance coverage or ability to pay. According to a Grantmakers in Health report (2002a), the project initially focused on service delivery and has since broadened to address policy changes needed to ensure the sustainability beyond the original grant period. The options include increasing Medicaid reimbursement rates for dental services; developing public-private partnerships between providers and government agencies to deliver school-based services to low-income children; and using professional loan repayment programs as an incentive for dentists to provide services to underserved populations.

Yet another strategy that RIF has adopted is to identify and assist people eligible for coverage enrolled in existing public programs. The foundation has partnered with RWJF on the Covering Kids initiative to enroll all children in health insurance in Rhode Island. The grants provide funding to Rhode Island Kids Count to create a coalition of state and local organizations to design and implement a campaign to find and enroll all eligible families in RItE Care. In turn this group trained a bilingual staff to do outreach in multiple community settings, including schools, health centers, day care programs and hospitals. Covering Kids has proved highly successful, enrolling over two-thirds of the 20,000 children that had not previously signed up for RItE Care.

A final strategy of the foundation is to educate the public about health care issues. Partnering with the Benton Foundation and RWJF, RIF funded local public radio station WRNI to create “Insuring Our Health,” a five-program series of comprehensive health care stories that culminated in a live town meeting on health care policy.

As of November 2002, RIF introduced a new approach to its strategic grantmaking. The foundation will no longer require that applications be restricted to one of the four program areas described above. Instead, applicants will be encouraged to utilize one or more of the following strategies: Policy, Advocacy, and Systems Reform; Organizational and Leadership Development; and Innovative Models and Proven Programs. This “strategic refinement” was undertaken with the hope that RIF will both raise its profile and be more efficient in its grantmaking work (Voci 2002). This does not represent a sea change in the substance of the activities that RIF funds; rather, it renders more explicit the foundation’s commitment to engage in more policy-relevant work in those program areas. As Voci puts it, “[W]e feel keenly our responsibility to contribute our effort towards that vision, as a convener, a funder, an advocate, or all three. The Rhode Island Foundation will never be the largest funder in health care, but we like to believe that we can be a strategic partner in most phases of problem solving (Voci 2002).

Consumer Health Foundation—Washington, D.C.

The Consumer Health Foundation was established in 1994 as a result of the sale of the Group Health Association HMO to Humana, Inc. Consumer Health was the first health philanthropy in the Washington, D.C. area to emerge as a result of the conversion of a nonprofit entity. It is the only private grantmaking foundation in the Washington, D.C. area “solely dedicated to improving the health status of local communities... enhancing the consumer role in health and health care, and to closing the racial, ethnic, and socio-economic health disparities that exist in the region” (CHF 2002). The foundation’s current assets are approximately \$28 million, with an annual payout of approximately \$1.5 million.

Consumer Health employs numerous strategies in conducting its work: “Though grantmaking will always be our primary activity, we are also committed to serving as a catalyst, a convener, a risk-taker, and source of reliable information. Above all, we strive to be active participants in the communities we serve” (CHF 2000).

Consumer Health Strategies for Improving Health Insurance Coverage

In carrying out its Improving Access to Care initiative, the foundation supports: (1) consumer education and empowerment, which targets potential “users” of health care and includes education and training programs often developed by and for consumers; (2) provider education and training, which targets providers and seeks to make them more responsive to the needs of consumers, especially in terms of cultural competencies, special needs, and substance abuse; and (3) health system change, which focuses on obtaining coverage for the uninsured and underinsured by improving public and private policies and programs through advocacy and coalition building. Specific grants typically range from \$25,000 to \$50,000 and may embody a number of these approaches.

A core strategy for Consumer Health is to fund grassroots advocacy. Like Kellogg and TCWF, Consumer Health has a strong community-based orientation. It chooses to work largely through its grantees rather than establishing a high profile for itself. It believes that some of the most effective public policy work is done by those directly affected by the problem—by consumers, advocates, and health care providers who know what the problems are and have solutions.

Margaret O’Byron, president of Consumer Health, explains,

Within the grantmaking arena we fund advocacy groups that are in the fray, getting consumers’ voices heard in terms of health care—particularly those who traditionally have not been heard, who have been shut out of our health care system, or those whom the system has failed. . . . If you ever thought about us, it would be through the lens of the consumer. Ultimately, we are trying to build a movement of consumers and others committed to the vision of 100 percent access to health care and zero percent disparities in health outcomes. We also try to be advocates ourselves in this arena, when and where appropriate (O’Byron 2002).

Consumer Health has funded AFFIRM (Alliance for Fairness in Reforms to Medicaid) to develop and implement the Managed Care Quality and Access Project, which seeks to improve access to and quality of health care received by families enrolled in Medicaid managed care, and support ongoing monitoring and advocacy for families. The foundation also supports the Use Your Power! Project, a D.C. citywide parent council that trains and supports parents to be consumer health educators and advocates in the Medicaid managed care arena; creates health advocacy materials for consumers; and undertakes neighborhood-based health promotion and prevention activities led by parents. In addition, it solicited help from Families USA to help establish an independent consumer assistance (ombudsman) program to serve health care consumers in the District of Columbia and the Medicaid Community Assistance and Public Awareness Project.

In projects more directly involving advocacy, Consumer Health supported the Medicaid Community Assistance and Public Awareness Project that provides consumer-oriented policy expertise to organizations impacted by the District's Medicaid program. Finally, the foundation provided support to Health Care Now, a citywide coalition of consumers, community groups and others advocating for health care reform and educating low-income consumers in health and community organizing, in conjunction with the Center for Community Change.

In adopting an advocacy-centered strategy, Consumer Health understands that its impact may not be immediate or easy to measure. O'Bryon observes:

We do want to make a difference and we work hard to measure that. But we're also realistic. We're working with grassroots, community-based organizations. I think this is long-term work. We've only been giving grants for four years. I am not a person who says you can do this in a year. It doesn't work that way. You look at the effectiveness of the leadership, whether other funders have joined, what kinds of collaborations have occurred, what kinds of changes have occurred on the other end. It's a whole host of factors in the policy arena. In our town there's just a handful of organizations doing this kind of work. We're funding every group that's engaged in public policy in terms of the work around our mission. They've all been very effective in their own venues (O'Bryon 2002).

Another strategy of Consumer Health is to ensure that people eligible for public health insurance coverage programs enroll in these programs. The foundation provides funding to the D.C. Action for Children to support the D.C. Covering Kids and Families Initiative to identify and enroll children into health coverage programs, particularly Medicaid and other government-run programs that are currently underutilized. Consumer Health has also funded the Asian and Pacific Islander Partnership for Health to launch the Access Project, which will, through outreach and coalition building, help low-income and immigrant Chinese families in D.C. obtain health insurance.

Like TCWF, Consumer Health has supported local associations and consortia of primary care clinics and providers to build their infrastructure and support their participation in public health insurance programs. The foundation has made grants to the D.C. Primary Care Association, the Nonprofit Clinic Consortium, the Health Action Forum in Prince George's County, and the Primary Care Coalition of Montgomery County. Consumer Health is also working with these grantees and other regional health care activists and funders in an effort to establish a regionally-based Federally Qualified Health Center (FQHC) whose service area would encompass multiple jurisdictions (D.C., and parts of Maryland and Northern Virginia).

A final Consumer Health strategy is to act as a convener and a catalyst in the community and the region. "Foundations have the resources and connections to help make bigger things happen, to forge new community partnerships, and to attract additional funds" (CHF 2000). It helped to create the Health Working Group of the Washington Regional Association of Grantmakers. The Health Working Group is a group of funders working to support strategies toward achieving "100 percent access and zero percent disparity" in health care and health outcomes throughout the region. Through its community convening and advocacy role, the Health Working Group was pivotal in the early stages of policy development in the District of Columbia leading to health insurance coverage of ineligible children. Funders who participate in the Health Working Group also seek to meet on a regular basis with key local public health officials and policymakers. Consumer Health's key role in establishing the Health Working Group and its continued leadership reflect its desire to actively foster partnerships with a broad array of funders and other organizations:

We're always out there trying to figure out who we should be working with to help advance our mission on behalf of the community. My view is this: it's not one shot or one strategy. You have to look at it as a campaign. There are the organizers and the researchers, the providers and consumers, there are the guerillas and the advocates. You fund and build the capacity of all the legs of this stool and then you're building a campaign for systems reform reflective of what will promote a healthy community. Any foundation that thinks they can do this alone, there's just no way (O'Bryon 2002).

FOUNDATIONS' STRATEGIES FOR SHAPING PUBLIC POLICY ON HEALTH INSURANCE COVERAGE

Taken together, the twelve profiles of foundation activities establish a fairly comprehensive range of strategies for influencing public policy. The following sections examine more closely what patterns emerge from the allocation of foundation resources and what those patterns suggest about foundation preferences and capabilities for improving health insurance coverage. They present an overview of these foundations' choice of issues, audiences and partners, jurisdictions, and stages of involvement in the policy process. Table 1 provides a summary of foundation strategies and priorities in the policy arena.

Choice of Issues

A fundamental element of foundation strategy is the selection of issues to address. Jack Knott and Carol Weissert (1995) suggest that allocating resources among issues is the most troublesome part of decision making for foundations and other participants in the policy process. They highlight two important dimensions to this selection process: 1) timing of entry into an area; and 2) consistency of funding in that area once selected as a foundation priority. They characterize foundations as “pioneers,” “explorers,” “ranchers,” or “itinerants” based on the issues they focus on and the timing and duration of their funding.

Based on the current activities of the foundations included in this study, it is clear that most if not all of them have become “ranchers” and put down stakes on this issue for the long run. They are doing so because, as Steven Schroeder of RWJF argued, universal health insurance coverage is “central to the values and moral character of a country” (Iglehart 2002, 246). They are also doing so because the scope and magnitude of the uninsured population and the spillover effects on health status and economic well-being make it “a problem you can’t ignore” (Laws 2002). Among the major national foundations with a historical commitment to health policy and problems of the uninsured in particular, the Pew Charitable Trusts is the only one that has left the issue to others and moved on to a new strategic agenda (Rimel 1999; Byrnes 2000).

All but one of the national and state foundations in this study have decided to take a leadership role in keeping the issue of health care coverage alive. Packard, with its focus on children, is the lone exception. The RWJF campaign for covering the uninsured, the Commonwealth Task Force on the Uninsured, the Kaiser Commission on Medicaid and the Uninsured and its public opinion polling, and TCWF’s annual report on insurance coverage in California are examples of long term commitment to substantial reductions in the uninsured. Ruth Riedel of the Alliance Healthcare Foundation in San Diego argues that it has chosen to focus on the uninsured specifically because of a lack of political leadership on the issue. Every foundation is involved in different activities aimed at improving coverage in existing insurance programs—the “maxing out” strategy described by David Colby of RWJF.

All of the foundations have also committed themselves to working through both the private and public sectors. This, too, is pragmatic: Cathy Schoen of Commonwealth points out that their grantmaking priorities do not necessarily reflect a philosophy that employer-sponsored coverage is better, but that the system still works reasonably well for the majority of Americans and shifting large numbers of people into public insurance programs would require explicit new revenue sources to replace the existing tax expenditures for employee health benefits (Schoen 2002). Some of the “strange bedfellows” in the RWJF campaign hold the premise that success in expanding coverage would require both larger enrollment in public programs and tax credits or other inducements for individuals and employers. The initiatives funded by national, state, and local foundations such as those in Rhode Island, San Diego, Ventura, and Denver all sought to increase the number of employers who offered coverage and the number of their employees who took up the offer of coverage for themselves and their families.

Even if foundations are sometimes reactive in their issue priorities—for example, their nearly universal efforts to facilitate enrollment in SCHIP—their grantmaking style is often highly

proactive. All of the foundations included in this study are engaged to a considerable degree in strategic grantmaking, creating initiatives with dedicated funding and carefully chosen partners rather than primarily responding to unsolicited proposals. Kaiser, Commonwealth, and the California HealthCare Foundation provide insignificant amounts for projects outside their established initiatives.

It is not necessarily the case, however, that all foundations become more directive as their assets, expertise, and experience grow. TCWF is in fact pulling back somewhat from strategic grantmaking and funding projects initiated by community and advocacy groups. Along with the California Endowment, TCWF now devotes half of its annual funding to “responsive grantmaking.”

Choice of Audiences and Partners in the Policy Process

Lucy Bernholz observes that foundations are “infamous individualists” in their grantmaking priorities and strategies (2002, 1). James Ferris and Michael Mintrom argue that individualism is a liability for foundations who want to find points of leverage in public policy (2002). To accomplish their objectives, they must cultivate relationships and establish their credibility and reliability with a wide range of audiences and partners. These can include the general public; trade associations, advocacy groups, and community leaders; governmental agencies and officials; mass media; and other foundations.

General Public

Of the national foundations, RWJF, Kellogg, and Kaiser most clearly consider the general public as an audience for their initiatives. RWJF intentionally structured the series of six reports it commissioned from the Institute of Medicine to increase the amount and scope of coverage of the IOM’s findings in the mass media. It also sponsored ad campaigns and in 2003 mounted a Cover the Uninsured week to increase public awareness. The Kaiser Health Polls and general coverage of health insurance issues through Kaisernetwork.org will, in theory, reach the general public when health beat reporters around the country pick up information and pass it on to their local readers and listeners. Kellogg’s work with the National Leadership Coalition on Health Care uses social marketing techniques to raise awareness about the uninsured in general; and the institute it is establishing at the Joint Center for Political and Economic Studies will use opinion polls, public forums, and other means to focus attention on insurance coverage for African Americans and other minorities. TCWF uses its annual report on *The State of Health Insurance in California* as a “hook” to gain media coverage across the state; advocates at the local level then take advantage of the coverage to give the issue a local spin (Holton 2002).

All four of the local foundations see the general public as an audience for their initiatives. The Alliance Healthcare Foundation’s San Diegans for Health Coverage is explicitly committed to informing and educating the public about health insurance issues using opinion polls and media campaigns. The Rose Community Foundation’s Colorado Consumer Health Initiative, the Rhode Island Foundation’s support of the Ocean State Action Fund and much of the Consumer

Health Foundation's grantmaking involve consumer-oriented projects that make educating the public a key goal.

Observers and advocates for the uninsured might question why foundations are spending significant amounts of their resources on general public education, when the debate over health insurance tends to fall apart in the politics of policy formulation. When foundations have the ability to throw their weight around with tens or even hundreds of millions of dollars to help move the issue forward, public education appears to be an indirect and timid use of those resources.

Advocacy Groups

Trade associations and other advocacy groups are a primary audience for all of the national foundations. The reports of the Commonwealth Task Force on the Future of Insurance are aimed at these groups as well as at researchers, legislative staff, and program specialists in government agencies. They are an important constituency for the Kaiser Commission's reports and KaiserNetwork.org news summaries, poll findings, and webcasts of health policy events. The California HealthCare Foundation's Small Business Health Insurance Resource Center and its daily online *California Healthline* newsletter are targeted primarily at the business community, health care organizations, and advocacy groups.

Public policy scholars have noted how foundations are important "patrons" of interest groups (Kingdon 1984; Walker 1991). The activities of foundations in the area of health insurance coverage indicate that there is often a much stronger relationship, with foundations and advocates joining forces as strategic partners on specific initiatives. In its work on children's health insurance, Packard has established a number of such relationships, including national organizations such as Families USA and the Center for Budget and Policy Priorities as well as state organizations such as Consumers' Union and Children Now. Kellogg has also engaged Families USA to provide technical assistance in many states and alert policymakers to options for expanding Medicaid coverage to uninsured parents. Kellogg's major partnerships, however, are with community-based institutions and organizations in its Community Voices program. The RWJF Covering the Uninsured campaign has established ongoing partnerships with the Health Insurance Association of America, Families USA, the U.S. Chamber of Commerce, labor unions, and other major interest groups.

The California Endowment and TCWF have, far more than the national foundations, conducted their efforts on health insurance through advocacy organizations. TCWF has strong partnerships with statewide groups such as the Western Center on Law and Poverty and the Children's Partnership on monitoring public health insurance expansions and developing the "express lane eligibility" program for Medicaid and SCHIP. The Endowment's 100% campaign for universal coverage of children in California is led by three nonprofit advocacy groups. TCWF, like Kellogg, puts far more emphasis on true grassroots activity than the average foundation. It has exerted influence on national, state and local policies through its support of the interfaith Pacific Institute of Community Organizations (PICO) and its 13 local chapters. The California HealthCare Foundation brought together representatives from state business groups but ultimately did not get much assistance from them in its campaign to expand insurance coverage

for small firms and self-employed individuals. Ruth Holton of TCWF argues that, in California at least, the most effective strategy for advocacy is to link the technical expertise and professional connections of statewide organizations with community-based, grassroots organizations who can “put a face on the issue” for state legislators or county boards of supervisors (Holton 2002a, 16).

Establishing partnerships with advocacy groups is a primary strategy for all four local foundations. The Consumer Health Foundation, like TCWF and Kellogg, carries out most of its work on health insurance through advocacy organizations. It supports virtually all of the advocacy groups working on health care issues in the D.C. region as a way of improving access and coverage in the area. The Rhode Island Foundation’s Leadership Roundtable on the Uninsured and its support for the Ocean State Action Fund involve partnerships with consumer, provider and health advocacy groups, as well as union and business leaders. The Rose Community Foundation supports the Colorado Consumer Health Initiative, a diverse coalition of more than fifty local and statewide consumer-based organizations aimed at strengthening the consumer voice in health policy discussions and decisions.

The relationships that foundations develop with advocacy groups are sometimes quite complex. Successful relationships take time to develop and run two ways. Grantmaking, therefore, must be viewed as building up political capital, not a series of independent, one-time expenditures. Eugene Lewit of the Packard Foundation observes that, “the advocacy groups have to be there when you need them. . . . You have to have relationships with them because nobody wants to feel used. So you can’t just fund them when you need them.” The fact is, however, that a given organization may be right for one initiative but not another. Foundations are also aware that long-term partnerships may be perceived as unfair to groups that did not receive funding the first time around. TCWF is sensitive to the shaky finances of most nonprofit advocacy groups and requires that a group can be funded for only two consecutive grant cycles, then it must let others compete for scarce dollars (Holton 2002b).

Another challenge is that advocacy groups—like other grantees—have their own way of doing things and resist hands-on direction from a foundation. Lewit says that Packard, for example, recognizes the importance of creating a vibrant advocacy community: “There’s a strong sense that advocacy groups are important for keeping these issues alive.” At the same time, its board is very focused on concrete results like insuring every child in Santa Clara County. So it is natural to want to steer grantees in a direction that foundation staff think will most quickly turn a promising process into real results. Margaret O’Byron of Consumer Health Foundation also acknowledges that working with grassroots community-based organizations is long-term work. In some situations, advocates can be dogmatic and, through their inflexibility, actually prevent progress in policy formulation or implementation. In many states, for example, advocates for children are unalterably opposed to scaling back Medicaid benefits to afford an expansion of coverage to adults or to children with higher family incomes.

Governmental Officials and Agencies

Governmental officials and agencies are both an audience and active partners for foundation initiatives to expand health insurance. In addition to funding reports and newsletters that

circulate throughout the health policy community, Commonwealth, Kaiser, RWJF, and the California HealthCare Foundation all sponsor briefings in Washington through the Alliance for Health Reform, National Health Policy Forum, National Conference of State Legislatures, and other nonpartisan organizations that specialize in educating issue experts on Capitol Hill and in the federal agencies. They underwrite study panels by the National Academy of Social Insurance and the Institute of Medicine that often generate explicit policy recommendations. The Urban Institute project on Assessing the New Federalism, which is funded by all of the national foundations included in this study except Kaiser, provides regular data and evaluation for federal and state officials on Medicaid, SCHIP, and welfare reform. Through the National Health Policy Forum, Packard has supported site visits for congressional staff to acquaint them personally with the Santa Clara Children's Health Initiative. In Sacramento, the National Conference of State Legislatures established a support center for legislators and staff with a grant from the California HealthCare Foundation.

Several foundations have worked directly with governmental officials or agencies as partners in their health insurance initiatives. Packard provided funds to the National Governors' Association and the National Academy of State Health Policy to provide technical assistance to state SCHIP directors, for example. Packard also invested heavily in a partnership with the federal Agency for Healthcare Research and Quality to evaluate the outcomes of SCHIP. The RWJF State Coverage Initiative builds on planning grants from the federal Health Resources and Services Administration to state health agencies. The purpose of the RWJF grants is to push state coalitions and officials to move past the planning phase into actual expansions of health insurance coverage. Kaiser and Commonwealth, because they see themselves as information sources and not promoters of specific policy initiatives, do not have formal partnerships with government agencies. Their presidents are both former governmental officials, though, and they and other foundation staff regularly communicate with legislative and executive officials and are called upon to provide formal testimony to congressional committees.

Among the California health foundations, TCWF established a collaborative of nonprofit organizations to work with the state health department on implementation of Medicaid managed care reforms. More recently, TCWF, Packard, and the California Endowment have started working with health, education, and social services agencies at the state and local levels to develop and implement "express lane eligibility" for enrollment of school lunch recipients in Medicaid and SCHIP. The Health-e-App technology developed by the California HealthCare Foundation in collaboration with Medi-Cal will help streamline enrollment not only for children but all applicants for the state's health insurance programs.

To varying degrees, all four of the local foundations see government as an audience for their health insurance initiatives. The Rose Community Foundation's Hot Issues in Healthcare is the most explicit example, its primary goal being to directly educate state legislators through briefing sessions and other activities. Alliance's San Diegans for Health Coverage also aims to educate policymakers, though its activities are somewhat more diffuse. Two of the local foundations have worked directly with government as partners in health insurance initiatives. The Rose Community Foundation worked with Colorado state officials to establish Child Health Advocates in order to take on administration of the state's SCHIP. The Rhode Island Foundation has worked with state officials and agencies on a number of projects, most notably through its

support for the Providence Smiles dental program and its purchase of the Neighborhood Health Plan of Rhode Island. Interestingly, the two foundations that have partnered with government have also tried to establish themselves as neutral, credible actors who are not pushing particular solutions or approaches.

Mass Media

All of the national and state foundations in this study recognize the need to use the media to communicate messages about their priority issues to the public, industry, policymakers, or specialists in the field. The fundamental purpose of KaiserNetwork.org is to greatly expand the dissemination of policy-relevant information through a variety of media channels. According to Larry Levitt, the mass media improve the flow of information not only to the public and interest groups but also to governmental officials—who might miss another data-laden foundation study but must react to news coverage of policy issues in their home districts. RWJF is relying heavily on the mass media in its Covering the Uninsured campaign, especially the week of saturation coverage in 2003. RWJF and the California Endowment, for example, also allocate resources to “coach” their grantees to be media-savvy and effective in policy advocacy. Ruth Holton says that TCWF staff attempt to avoid the media spotlight and routinely refers the media to its grantees rather than comment on policy issues themselves.

Kaiser is the only national health foundation that has developed explicit partnerships with mainstream media organizations. It conducts opinion polls in collaboration with the Washington Post and National Public Radio, for example. It has set up health programming on the major television networks, as well as Black Entertainment Television and MTV. Finally, it has established programs to improve the quality of health policy reporting on health policy and increase the number of minority journalists covering health issues.

Among the local foundations, two have made modest but important investments in partnering with media organizations. Alliance provides ongoing support for a health reporter at the local public radio station, while the Rhode Island Foundation co-sponsored a local public radio station to create a five-day program examining health care issues.

Other Foundations

The foundations in this study have a mixed record of collaboration with each other on health insurance initiatives. In general, Kaiser and Kellogg do not put a lot of effort into joint projects. Other foundations, including RWJF, claim to be more commonly involved and enthusiastic about joint initiatives. David Rogers argued that, throughout its history, RWJF has valued collaboration with other foundations: “we were frequently most successful and our programs most durable if we collaborated with other partners in developing and following many of our major grantmaking efforts. . . . Our programs have often gained strength, legitimacy, and visibility through such collaborations” (1987, 82-3).

Collaboration among funders increases the complexity of planning and decision making, but according to Marcia Sharp it also has a number of advantages. An increase in financial support obviously increases the potential scale of the enterprise. Another advantage is that joint

sponsorship provides a “safe haven” for the individual foundations who reduce their financial risk and increase their political cover by bringing on partners (Sharp 2002; Hughes 2002).

RWJF did not collaborate with other funders in planning its Cover the Uninsured Week, but it actively sought contributions to expand the impact of the initiative. As the lead organizer as well as funder, it even developed procedures to accept donations from other organizations—not something it is accustomed to doing (Colby 2002). RWJF did team up with Packard and the Atlas Foundation to develop administrative options to expand children’s health insurance coverage in California. Other initiatives in California are noteworthy for the involvement of several foundations. TCWF, California Endowment, and Packard all had important roles in the “express lane eligibility” program—first in its development, then in funding partial implementation during the state’s budget crisis. The Endowment is now underwriting the broader use of the online Health-e-App developed for Medicaid enrollment by the California HealthCare Foundation. While there is still competition among the California health foundations, collaboration is steadily increasing. The presidents meet quarterly and the policy directors meet informally on a monthly basis. In addition, TCWF and Endowment are now partnering to support regional policy and advocacy training for their grantees.

Perhaps the most significant collaboration among foundations has taken place on local initiatives. The Alliance-led FOCUS program in San Diego to provide subsidized health insurance to low-income workers has resulted in collaboration with the Endowment, the California HealthCare Foundation, and Commonwealth. Packard, the Endowment, TCWF and the local Santa Clara Family Foundation have worked together on the Santa Clara Children’s Health Initiative to achieve universal coverage of all children in the county, regardless of immigration status. Kaiser has supported case studies of the Santa Clara program’s development. The Consumer Health Foundation helped to establish the Health Working Group of the Washington Regional Associations of Grantmakers to pool the resources of local funders to promote programs leading to “100% access, 0% disparity” throughout the region.

Choice of Jurisdictions

As the section on foundation audiences and partners suggests, none of the national foundations included in this study have an exclusive preference for activities in only one level of jurisdiction. Even those foundations with systematic preferences—Kaiser at the national level and Kellogg at the local level—fund projects to generate information, policy development, or advocacy in other jurisdictions.

The Kaiser Commission and the Commonwealth task force focus their research and evaluation primarily on the national level, and the RWJF and Kellogg campaigns on covering the uninsured are national efforts as well. The work that RWJF sponsors at the Institute of Medicine and the Economic and Social Research Institute is intended to promote national models for expanding insurance coverage. Packard’s work on children’s health insurance includes involvement with federal agencies as well as state program directors.

David Colby of RWJF observes that the nature of the issue and the current policymaking environment determine where foundations think they can make the most difference. In recent years, both Foundation Center data on grants and comments by their leaders confirm that national foundations are devoting more resources to state and community level activities (LeRoy and Schwartz 1998, 230).

RWJF and Kellogg have created large national programs to support efforts by states and communities to expand insurance coverage. The RWJF Covering Kids program helped create advocacy coalitions in all 50 states; and its State Coverage Initiatives program supports state health agencies in implementing new proposals for insurance coverage. Kellogg's Community Voices program supports coalition building and demonstration programs in 13 local "learning laboratories" across the U.S. Commonwealth has sponsored evaluations of many state and local initiatives to expand employer-sponsored coverage. Kaiser created its State Health Facts Online database even though its leadership believes that universal coverage can come only through federal action. In addition to their strategic initiatives, all of the national foundations except Kaiser have a funding program focused on their home base—New York City for Commonwealth, New Jersey for RWJF, Michigan for Kellogg, and four Bay Area counties for Packard.

The California health foundations also are active in all three jurisdictions—national, state and local. They recognize that both private and especially public health insurance programs like Medicaid and SCHIP are creatures of federalism; thus, there are important policy levers in the nation's capital as well as in Sacramento and throughout the California business community. For example, the grassroots letter-writing campaign inspired by TCWF applied pressure on HHS Secretary Tommy Thompson to approve California's waiver application to use SCHIP funds to cover parents. The California HealthCare Foundation has featured California health issues, including insurance coverage, through its partnership with the National Health Policy Forum. All three foundations have supported state-level advocacy campaigns, like the California Endowment's 100% Campaign to cover all the state's children or the joint effort to develop and implement "express lane eligibility" for Medicaid and SCHIP. Much of the foundations' efforts, however, are devoted to capacity-building and coverage expansions at the community level. These include the insurance demonstrations in Santa Clara and San Diego, as well as support for community clinics throughout the state. TCWF and the Endowment, in particular, see community-based organizing as a critical complement to communications with political insiders.

The preponderance of local foundation activities occurs at the local and state level. The Rhode Island Foundation and the Rose Community Foundation are supporting statewide advocacy campaigns, like the latter's Colorado Consumer Health Initiative. The Rose Community Foundation initially had a rather tight focus on the greater Denver area and still requires that all funded projects have an impact on the Denver metropolitan area. Yet much of its health insurance coverage work (Child Health Advocates, Hot Issues in Health Care) is carried out at the state level. The Consumer Health Foundation's work is more regional in focus, with activities taking place across D.C., Virginia and Maryland. The Rhode Island Foundation has a statewide focus and, given the state's small size, the state-local distinction on matters of health insurance coverage is largely insignificant. Though the Alliance Healthcare Foundation's initiatives are carried out exclusively within the San Diego region, it participates in a national

network of foundations and other organizations to advocate for the proliferation of “3-share” insurance models like its FOCUS program.

There is ample evidence from this study that state and even local foundations are pushing their resources up the federal hierarchy. If most foundations—even those with very limited resources—are devoting attention and energy to policymaking outside their principal jurisdictions, they must believe that spreading their resources will have short or long-term payoffs. Further research could clarify when and where this particular form of diversification in foundation programming is most productive.

Stages of the Policy Process

As foundation leaders in this study clearly understand, the policy process is fraught with peril even for initiatives put forward by the most powerful participants. The constitutional design of the U.S. government and most state and local governments makes defending the status quo immensely easier than promoting policy innovation (Hayes 1992; Steinmo and Watts 1995). Nonetheless, many scholars recognize an important, proactive role for leadership; Bryan Jones refers to the stages model when he describes the tasks of leaders as “defining a policy problem, recommending a policy proposal, mobilizing supporters, and shepherding the proposal through a complex policy process characterized by uncertainty and ambiguity” (Jones 1989, 11). The following section examines whether foundation strategies for improving health insurance coverage target certain stages of the policy process more than others.

Problem Identification and Definition

Foundations now invest heavily in generating and disseminating information to the policy community. Brown (1991) argues that information generated by health services researchers—often supported by foundations—is most influential in providing “documentation” of problems for policymakers. Jack Walker (1974) noted that the identification of “performance gaps” was an important catalyst for governmental action. In a similar analysis, John Kingdon (1984) found that several factors—dramatic change in social indicators, “focusing events,” feedback on program performance, or conceptualizing an event or behavior in a new way—were all important in helping the public and their political representatives define problems and their significance.

Foundations have put a lot of effort into defining a very heterogeneous population of people without health insurance as “the uninsured” and then tracking trends in their absolute numbers and rates among selected target groups. Media reports on this issue tend to emphasize increases in the total number of uninsured, missing the point that due to overall population growth the total number of insured persons has also increased. They also raise awareness among the middle and upper classes that the vast majority of the uninsured are employed, which establishes them as a more sympathetic group than welfare recipients, for example. Kaiser’s primers, fact sheets and online data on insurance coverage, the IOM reports sponsored by RWJF and the foundation’s accompanying public relations campaign, and TCWF’s annual report on insurance coverage in California are all activities aimed at influencing problem definition. The literature review and survey conducted by the California HealthCare Foundation helped to better specify the weakest

parts of the small group insurance market; its work also concluded that evidence could not support claims that offering health insurance was a profitable business strategy for small employers. RWJF and TCWF also get involved in generating proposals and advocacy to lessen the problem.

Developing and categorizing information and statistics are seldom sufficient to produce quick, demonstrable results, but those activities may accelerate the process of agenda setting by building an evidence base, developing “causal stories” of responsibility for social problems (Stone 1997), and influencing legislative testimony. Like other participants in the policy community, foundations cannot generate focusing events, but they can be ready to respond to either “problem-driven opportunities” or “politics-driven” opportunities for policy innovation (Oliver and Paul-Shaheen 1997).

Among local foundations, the Rhode Island Foundation support for Kids Count has helped develop a rich set of data on child health indicators for state officials. The Alliance Healthcare Foundation has sponsored local studies on the lack of coverage among employees of small businesses as a way of establishing the importance of programmatic intervention.

Agenda Setting

John Kingdon (1984) found that governmental agenda setting is largely top-down, controlled by elected officials and their top political appointees. As such, it is not heavily influenced by foundations or other actors outside of government. James Smith (2002) observes, “a foundation’s policy opportunities are largely shaped by external circumstances and sometimes battered by unforeseen contingencies. There are no formulas to assure success.” Unexpected events, unpredictable interest and participation in policy debates, and leadership turnover are among the many factors that can open “windows of opportunity” in the policy process and alter what policy options receive serious consideration. According to prominent scholars, issues rise on the governmental policy agenda when a given problem can be coupled with a feasible policy alternative and favorable political conditions (Walker 1981; Kingdon 1984; Polsby 1984).

Foundations are active and at times influential in problem definition, as noted above, and in the generation of policy alternatives. Agenda setting depends on the availability of alternatives that policymakers judge to be technically and politically feasible—and in an era still dominated by budget concerns, alternatives must be affordable both now and as initiatives are “scaled up” in the future. So demonstrations and evaluations of existing programs in other jurisdictions feed the professional consensus that is critical, in Kingdon and Walker’s view, to policy innovation. Much of the work of the Commonwealth Fund task force and Kellogg’s Community Voices program is devoted to identifying workable programs that governmental officials could adopt today if there was political will to do so. In addition, Commonwealth’s efforts in policy modeling provide more consistent and sophisticated analysis of the likely impacts on coverage and costs of different approaches—information that policymakers place a high value on when they begin to formulate actual legislation.

The important trend identified in this study is the increasing effort of foundations to “keep the issue alive” in the political stream through activities such as regular opinion polling, media

campaigns, building interest group coalitions, and educational forums for policymakers. Kaisernetwork.org and its poll reports are helpful for tracking what Kingdon calls the “mood of the country” toward health issues. RWJF’s “strange bedfellows” campaign is primarily devoted to agenda setting; but just as what Kingdon calls “focusing events” and “windows of opportunity” can unexpectedly push the health insurance higher on the policy agenda, similar phenomena in other issue areas can create significant distraction for policymakers and the public. This was the unfortunate situation for the Cover the Uninsured Week in March 2003, which came just as the nation’s leaders were campaigning for public endorsement of a war against Iraq that began the following week. In contrast, the potential contribution of foundations in what Kingdon calls “softening up” the political stream is made clear by the work of TCWF on “express lane eligibility” for public health insurance and the Endowment’s 100% Campaign for universal children’s health insurance in California.

Fostering effective policy networks is also a crucial aspect of agenda setting. Mark Smith of the California HealthCare Foundation explains that,

Foundation business is the relationship business. People outside foundations see us as holders of money and givers of grants and that is fundamentally what we do. But the amount of money is really trivial compared to the federal government, the state government, even a good size hospital. So the key is knowing how to spend the money—on what issue, at what time, with what tactic, on whom—and that’s based on knowing people. . . . The question is always who’s interested in this, who cares about this . . . and what is their capacity to act on this information once it’s produced. So that’s a question of knowing our constituencies, knowing consumers of information well, and having enough of a sense of the political, economic, and social environment to know when an issue can move and what is likely to move it.

Tom David views TCWF’s advocacy work in the same light; it is essential not just for influencing pending decisions but for preparing for decisions to come: “There is also an ongoing need to keep the policy infrastructure staffed and active even in ‘fallow’ periods, because a breaking news event or election result can change the policy climate overnight. If advocates are not prepared to act when the timing is right, a critical opportunity may be missed” (Holton 2002a, 1).

Foundations are capable of playing a more active and comprehensive role in the policy process in their community-based initiatives. At the national or state level it is difficult if not impossible for participants outside of government to create “windows of opportunity,” but at the local level there are many examples of “entrepreneur-driven opportunities” for policy innovation. The capacity for innovation is greatest when leaders gain support for their ideas across government, business, and civic organizations (Oliver 1991; 1996). David Rogers argues that RWJF funding for demonstration projects “often served as a powerful catalyst to bring together the necessary actors in communities that would otherwise have been unknown to us. It also helped make the process more democratic by allowing many to compete for funds” (1987).

Local foundations have themselves contributed to putting the issue of health insurance coverage on the agenda, chiefly through coalition building and improving the packaging of information for policymakers. The Rhode Island Foundation's Leadership Roundtable on the Uninsured brought all the major public and private sector actors to the table to begin to explore coverage for the working uninsured. The Hot Issues in Health Care project created by the Rose Community Foundation and Alliance's San Diegans for Health Coverage project represent attempts to provide intelligible, usable information to government officials and opinion leaders. Both the San Diego FOCUS program and the Santa Clara Children's Health Initiative are examples of state and local foundations establishing the policy agenda with their financial resources and, more importantly, creative partnerships with a variety of public and private organizations.

Policy Formulation

Though policy formulation is usually the domain of elected officials, political appointees and staff, foundations can still exert some influence through issue briefs, testimony, and analysis of pending legislation and rule-making. In an earlier era, foundation-sponsored commissions closely collaborated with governmental officials and agencies in developing detailed programs of action to reform parts of the health care system (Feldman et al. 1992). The contemporary policy process has many watchdogs, however, and the relationship between foundations and policymakers is closely monitored—especially by their ideological opponents.

James Smith tells the cautionary tale of RWJF's involvement in the Clinton administration health care reform effort in 1994. RWJF president Steven Schroeder recalls that the attack on the foundation for hosting four community forums on behalf of President and Ms. Clinton made his board and staff "much more sensitive about politics and how to avoid getting caught in the middle of highly partisan issues" (Iglehart 2002, 247). In its current campaign on covering the uninsured, David Colby stresses that, "We have been very careful to be sure we are not identified with a *solution*." RWJF and Kellogg have focused on injecting different proposals for expanding coverage into the process, or publicizing existing state and community initiatives, instead of supporting any one model (Colby 2002; Kellogg 2002). Commonwealth has had the same approach, but in 2003 as it sensed growing anxiety about health insurance across the country, it came forward with its "consensus framework" of what it advertised as a politically-balanced set of incremental initiatives (Davis and Schoen 2003). The intent was not to advocate for a specific program, but to indicate common ground for people on different sides of the debate to move toward and thereby facilitate policy formulation (Schoen 2003).

Having a role in policy formulation is less discomfiting to the California foundations. While they are careful to avoid any direct lobbying on legislation, their strategy includes core support for groups that are intimately involved with the drafting of legislation and program implementation. Funding from TCWF enabled PICO's local chapters to mount a campaign that produced 50,000 hand-written letters to the U.S. Department of Health and Human Services urging approval of California's most recent SCHIP waiver. Thousands of PICO members traveled to Sacramento to lobby the governor and legislators for \$50 million in additional state support of health services for the uninsured. The California HealthCare Foundation distances itself from most forms of advocacy, but its development of Health-e-App combined technical

assistance and direct formulation of a simplified application process for the state Medi-Cal program.

Policy Implementation

Foundations are appropriately interested in policy implementation because the translation from legislative or judicial decisions is never easy. A substantial literature confirms that there are often profound gaps between the stated intentions of government and the actual performance of its policies and programs (e.g., Palumbo and Calista 1990; Ingram 1990). Problems in implementation occur for many reasons: flaws in the underlying theory of action, commitment of inadequate resources, breakdowns in coordination between different organizations and levels of government, noncompliant target populations, or a lack of strong leadership (Bardach 1977; Sabatier and Mazmanian 1981).

In the implementation stage of the policy process, foundations typically build partnerships among stakeholders, work in collaboration with governmental agencies or nonprofit organizations to address gaps or provide funds for technical assistance to implement reforms. The Packard Foundation, for example, gave core support to the National Academy for State Health Policy and the National Governors' Association to provide states with technical assistance in SCHIP implementation. The RWJF national program on Covering Kids created state and community coalitions to monitor and assist state governments with SCHIP implementation. In California, all three state health foundations supported implementation of children's health insurance in different ways. The state health foundations have also focused on Medicaid: California HealthCare Foundation produces data with county-by-county comparisons of Medi-Cal performance. Throughout the Health-e-App initiative, CHCF worked closely with state and county agencies to maneuver through research and development, pilot testing, and approval of statewide adoption of the new process. Several of the California foundations, as well as Packard, have supported administrative advocacy and oversight of program implementation to prevent excessive delays in the "express lane eligibility" initiative to combine enrollment in school lunch and state health insurance programs.

Three of the four local foundations support projects related to SCHIP implementation. The Rose Community Foundation took the boldest approach by creating Child Health Advocates, a nonprofit organization that was responsible for the marketing, eligibility and enrollment and administration of Colorado's SCHIP. Both the Consumer Health Foundation and the Rhode Island Foundation have worked with RWJF to bring the Covering Kids initiative to their respective geographic areas.

Policy Evaluation

This study confirms that most large foundations pay close attention to the performance of both ongoing governmental health programs and new initiatives at the national, state and even local level. They regularly support projects for evaluating public programs, which may be conducted by independent investigators or done in collaboration with governmental agencies. In addition, they may invest substantial resources in evaluation of their own efforts to develop viable models for new public programs.

The national foundations in this study have a long track record of conducting careful evaluation of public policies and their own demonstration projects. According to David Rogers, the first president of RWJF,

The decision to initiate independent objective evaluations as part of almost every one of our major national programs has been perhaps our most widely recognized contribution to modern philanthropy. . . . Through the difficult process of evaluating many programs, we have learned painfully how hard it is to make meaningful progress in human affairs no matter how well-intentioned we are, and how often unexpected results that run counter to conventional wisdom can occur. But by publishing the results of these evaluations of our grants, we fulfilled what staff and trustees viewed as a public responsibility—reporting on our successes and failures. We have had our share of both (Rogers 1987, 82).

The Packard Foundation went to great lengths to initiate and implement a national network for research and evaluation of SCHIP. In addition, it worked with state agencies to evaluate the expansion of SCHIP in California. Several of the foundations funded the Urban Institute's National Survey of America's Families and its evaluation of the impact of welfare and Medicaid reforms as well as SCHIP. The Commonwealth task force puts a great deal of resources into evaluating potential models for the expansion of private health insurance. Kellogg advertises the 13 local coalitions in its Community Voices program as "learning laboratories" both for its network of participants and for other efforts to expand and protect access to care for vulnerable populations (Kellogg 2002).

In California, foundations have taken the lead in supporting and managing the evaluation of the major local initiatives to expand health insurance. The California HealthCare Foundation devoted considerable resources to evaluation of the San Diego FOCUS program and Packard has done likewise in the Santa Clara Children's Health Initiative.

Not all foundations require elaborate evaluations of their own initiatives. Evaluations sponsored by the California HealthCare Foundation range from formal controlled studies by professional evaluators to grantees' own reporting of their activities and outcomes. The caliber of the evaluation depends on the level of interest and level of funding. Sometimes the project is important to the field: "In that case, you've got to show that it works. There are other times you [evaluate] based on the notion that it's a good thing to do, and you're not interested in spending a lot of money in order to prove what you think you already know" (Smith 2002).

The local foundations we studied do not devote a significant amount of their own financial and staff resources to evaluation of public policies or their own programs. Because many of their programs are of interest to other communities and national policymakers, several of the local foundations have participated in evaluations sponsored by Commonwealth, Kellogg, Packard, RWJF, or the California HealthCare Foundation.

Whether foundations invest too many or too few of their resources in policy evaluation is a difficult question to answer. Clearly, the policy process goes on with or without evaluations because policymakers tend to use research and analysis to support their positions, not to alter them (Weiss 1989; Brown 1991). Foundations, like other participants in the policy process, are driven by their values as well as empirical findings; as Mark Smith suggests, they will invest in some programs they think are worthwhile regardless of evaluation results. Finally, the impact of policy evaluation is further limited by common failure to produce definitive results. Reflecting on his years at RWJF, Steven Schroeder puts that organization's serious efforts at evaluation in the context of a greater struggle:

Despite our efforts, our quest for performance measurement remains incomplete. In part this is because it is so difficult to establish causality when we are working on complex social issues, often alongside many others. For example, during the past decade we have invested heavily in programs to reduce the number of Americans who lack health insurance. Despite our efforts, the number of uninsured has resumed its upward climb. Should we accept some blame for that lack of progress? Did our efforts prevent worse outcomes? How can we know? . . . We often feel more like Sisyphus than Sir Edmund Hillary. Still we remain enthusiastic and committed, because of our mission, our focus, our realism and our culture (Schroeder 2001).

CONCLUSION: ASSESSING THE OUTCOMES OF FOUNDATION STRATEGIES TO SHAPE HEALTH POLICY

This report has presented in some detail the basic strategies and types of activities employed by a dozen foundations in their efforts to improve health insurance coverage. Due to the nature of health care financing and delivery in this country, all of the foundations have devoted resources to improving private insurance coverage as well as protecting and expanding public sources of coverage. All of the foundations, however, accept the premise that governmental action is critical to solving the problems of more than 40 million uninsured Americans and they view public policy as a way to leverage the relatively limited resources they can devote to this issue.

Across all twelve foundations, what patterns can be identified and what lessons can be drawn from the wide range of their activities to shape health policy?

Lesson 1

Foundations are not strictly leaders or followers on the issue of health insurance coverage.

On a broad scale, foundations often react to the policy agenda. Nearly all of the foundations in this study committed substantial resources to improving enrollment in the new State Children's Health Insurance Program, even though its maximum target enrollment was 5 million and several million more children and adults are eligible but not enrolled in Medicaid. Nonetheless, RWJF,

Kellogg, TCWF, the Endowment, and several local foundations have been promoting major expansions of coverage at a time when few federal or state policymakers are receptive to those proposals. It would be difficult to reject the conclusion that foundations have helped keep the issue alive and make it attractive to Democratic presidential candidates and an increasing number of other policymakers.

Foundations are often innovative in their means rather than their ends. In some very practical areas such as enrollment of children and families in public insurance programs, foundations identified solutions and succeeded in having them adopted by government. The Health-e-App technology developed under the auspices of the California HealthCare Foundation and the Express Lane Eligibility program initiated by TCWF and then piloted with the assistance of the California Endowment and Packard Foundation are significant examples of foundation-inspired innovation. The Alliance Healthcare Foundation in San Diego and the Rhode Island Foundation have been instrumental in designing, attracting financial and organizational assistance, and implementing entirely new insurance programs for low-income individuals. Kaiser's efforts to build unconventional partnerships with media organizations and vastly expand online sources of information on federal and state health policies are innovative as well.

Lesson 2

While foundations can adopt different strategies in the public policy arena, those strategies become less differentiated for foundations with greater resources and for foundations focused on state or local initiatives.

There are several strategies foundations can employ to achieve their policy goals. Most foundations have invested in a very broad set of activities around all three basic strategies: 1) educate the public and members of the policy community; 2) invest in the development and demonstration of new institutions and policy options; and 3) support capacity-building and advocacy efforts. Only Kaiser, Commonwealth, and the California HealthCare Foundation have self-consciously adopted a niche role emphasizing one or both of the first two strategies. Their primary goal is to improve the quality and availability of information for policymaking. Kellogg is taking a greater interest in national and state policymaking but its main role is to facilitate community-based change. RWJF, with its substantially greater assets, is able to pursue all three basic strategies to expand insurance coverage and access to care. Except for the California HealthCare Foundation, all of the state and local foundations pursue each of the three strategies and place a heavy emphasis on capacity-building and advocacy work.

The pattern of activities identified in this study suggests that, relative to other participants operating at their level in the policy community, both state and local foundations have substantial resources and access to policymakers. As a result, they are able to expand their activities into more direct forms of influence in the policy process. In addition, state and local foundations have chosen to push their issues up the federal hierarchy, working with higher level governments and also foundations. The California Endowment, for example, became a principal sponsor of RWJF's national Cover the Uninsured Week. The Rose Community Foundation became a central actor in development of the Colorado SCHIP program, for example, and the California HealthCare Foundation has worked closely with the National Health Policy Forum to keep federal officials aware of developments and emerging issues in the California health care system.

The Alliance Healthcare Foundation has attracted significant support from both California's new health foundations and national foundations such as RWJF and Commonwealth. The Rhode Island Foundation has actively sought out partnerships with national foundations such as RWJF and the Annie E. Casey Foundation.

Finally, most of the state and local foundations have made a major commitment to expanding access to care by supporting direct services as well as insurance coverage. Denis Prager (1999) argues that one of the central tensions facing foundations is whether to deal with the root causes of problems or respond to the symptoms of those problems. The California Endowment and TCWF, in particular, have argued that there is a great need to do both short term and long term work and that supporting the health care safety net is complementary to their policy initiatives. The same philosophy guides Kellogg's Community Voices program, which addresses the needs of the uninsured by strengthening community-based services and promoting policies to expand insurance coverage.

Lesson 3

It is necessary but not sufficient for foundations to develop expertise in health policy.

Foundations that wish to shape public policy must develop both policy expertise and personal connections in the policy community. Influence is impossible without expertise; leaders at Kaiser, Commonwealth, and the California HealthCare Foundation all stress the importance of being an authoritative source of information. But influence depends even more on being a familiar and reliable source of assistance for policymakers and their staff, advocacy groups, and media organizations.

This requires foundations to hire individuals who know government and governmental programs and are able to bridge the two cultures of philanthropy and politics. Kaiser, Commonwealth and RWJF have done this to a considerable degree. Packard's work on children's health has evolved from emphasizing internal staff analysis to cultivating relationships with agencies and officials in all jurisdictions—federal, state and local. Even though the California Endowment and TCWF believe strongly in grass-roots action, they have each strengthened their capacity in the policy arena by bringing in staff who understand the levers of power and effective tactics in advocacy work. Ultimately, foundations gain influence by connecting knowledge with power through their relationships with leaders inside and outside of government.

Lesson 4

Foundations must clarify whether they can best meet their goals as investors or as entrepreneurs in the policy process.

The process of policy innovation requires the collaboration of different types of leaders—inventors of policy ideas, investors, promoters, and managers. But it also typically requires “policy entrepreneurs” who take the lead in that collaboration. Policy entrepreneurs “recombine intellectual, political, and organizational resources into new products and courses of action for government” (Oliver and Paul-Shaheen 1997, 744). The most distinguishing trait of these leaders is their singular focus on a specific idea for new governmental procedures, organizations, or programs, and the significant professional and often financial stakes they place in those ideas.

Policy entrepreneurs can and often do come from positions outside of government, even though their success depends on recruiting government insiders who have key positions and the political capital to move their proposals forward.

Foundations are clearly capable of becoming entrepreneurs in the policy process. Alternatively, foundations may choose the role of investor, providing financial support, technical assistance, access to decision makers, and prestige to one or more groups promoting their own ideas for improving public policy and public health. Or they may avoid taking specific policy positions at all and serve only as a generator and broker of policy-relevant information. The issue is whether information alone is sufficient to avoid “market failure” in politics of policymaking, or whether the inequality among interests is so great that additional voices need active representation. In other words, is advocacy in a fairly direct form and for a specific purpose necessary for foundations to achieve the maximum leverage for their initiatives in the public policy arena?

There is a fundamental difference in these roles and important implications for the allocation of foundation resources. In general, the national foundations in this study have consciously avoided endorsing particular solutions to the problems of the uninsured. Kaiser refrains from funding projects involving the development or advocacy of specific initiatives, although it supports dissemination and analysis of others’ proposals. RWJF and Commonwealth support the development of many model solutions and, even though Commonwealth recently announced its “consensus framework” to advance discussion of specific policy options, neither foundation has directly promoted any policy option in a selective way. The indirect support of advocacy by RWJF on the issue of health coverage is a sharp contrast with its creation and support of the Campaign for Tobacco-Free Kids, a leading source of advocacy in tobacco control, and the Partnership for Solutions, a program that promotes specific policies to improve health care for people with chronic health conditions. Similarly, Packard is a strong supporter of the overall SCHIP program but assists in the development and implementation of many different state models. Only in its involvement with the Santa Clara Children’s Health Initiative has Packard adopted a more comprehensive, entrepreneurial role. Kellogg treats the 13 sites in its Community Voices program as “learning laboratories” but does not suggest that the foundation itself will explicitly promote any of the alternative models that have emerged in the course of the program—the lessons and best practices are supposed to emerge from formal evaluation and informal dialogue among leaders in the different communities. Overall, these foundations have played a general investment role in highlighting problems of the uninsured and keeping the issue alive politically. They have initiated a diverse and complex set of activities, most of which are carefully conceived within the limited role they have chosen for themselves. None of the foundations, however, have moved beyond that role to invest heavily in a specific solution or take on the broad tasks of policy entrepreneurship.

In contrast, nearly all of the state and local foundations have selected—indeed, sometimes created—particular policies or administrative arrangements that they want government to adopt. From its inception, TCWF has viewed advocacy of policy change as a core part of its mission. More recently, the California Endowment has stepped up its advocacy efforts. While both foundations prefer that other groups provide leadership, political skills, and mobilization of constituencies, neither shy away from taking policy positions or recruiting groups for specific policy initiatives. The Express Lane Eligibility program to combine enrollment in school lunch

and state health insurance programs was created through work coordinated by TCWF. Even the California HealthCare Foundation, which sees its primary role as a source of information, has moved further into advocacy and even entrepreneurship on selected issues. Its Health-e-App initiative is an hallmark example of successful policy entrepreneurship.

Due to their more limited resources, local foundations appear to focus their health policy efforts on one principal initiative at a time. Regardless of whether a foundation actually initiates the local program or not, it becomes part of the entrepreneurial team and its leaders have critical responsibilities for organizing, funding, implementing, and sustaining the program. Alliance and the Rhode Island Foundation have unquestionably served as policy entrepreneurs in expanding health insurance in their communities, and the Rose Community Foundation has played a similar role in implementing and expanding the Colorado SCHIP program.

There are many possible reasons why foundations would shy away from the role of policy entrepreneur and prefer that of investor. The choice involves practical issues of the amount of resources available to address an issue and the proximity of the foundation to key actors in the policy community. The choice also depends on whether the foundation's board and staff are willing to commit themselves to a specific initiative for a lengthy period of time. Packard, for example, estimates that in Santa Clara County alone it will take 5-10 years to get 95 percent of children enrolled in a health insurance program. The likely collapse of the FOCUS program in San Diego shows that successful entrepreneurship in establishing a new program does not ensure its long term stability if state or federal governments are unable or unwilling to underwrite that model of coverage. Given the current political and fiscal conditions in Washington and in most states, foundations and others interested in improving health insurance coverage may believe it is fruitless to focus on a single solution when real progress toward universal coverage may be years away.

Nonetheless, at whatever scale and in whatever manner foundations pursue an expansion of health insurance, they must confront the question of whether they might increase their effectiveness by not only helping develop products for policymakers but engaging in more selective, forceful advocacy of their preferred products. The evidence from this study suggests that focused advocacy efforts might well be put to greater use in foundation efforts to protect and expand health insurance across the nation.

Lesson 5

The test of foundations' capacity to solve critical social problems lies in their collective contributions, not their individual roles in the policy process.

Many foundation leaders make the argument that pluralism in the world of philanthropy is a good thing. It is an appealing argument, since it confers nearly absolute freedom on any individual foundation in how it pursues its values and goals in public policy. As noted above, the twelve foundations included in this study share essentially the same values and goals regarding health insurance coverage but they currently emphasize different strategies in their efforts to expand coverage. A few foundations, particularly those operating at the national level, have adopted a highly specialized role in health policy. Kaiser, the California HealthCare

Foundation, Commonwealth and RWJF almost completely avoid funding projects that involve advocacy of specific solutions to the large-scale crisis in health care coverage.

It may be reasonable for foundations, both individually and collectively, to adopt highly specialized roles if that enables each organization to be more effective in its chosen role. But the impact of philanthropy on public policy will suffer if support for any of the three basic strategies highlighted in this study is insufficient. The overall ecology of foundations and public policy is what matters.

The limited progress toward universal coverage can hardly be attributed to foundation boards and staff wary of political controversy. As a number of foundation leaders point out, a few billion dollars of philanthropy does not go far in a \$1.5 trillion health care system. Nonetheless, the potential impact of foundations might be more highly leveraged through stronger, more selective advocacy and also through stronger collaboration among foundations.

If there is a lesson that smaller, more local foundations can teach larger foundations, it is the importance of establishing and sustaining a specific policy design and marshalling resources to support it through close public-private partnerships. Hypothetically, what would happen if, for a few years, RWJF, Kellogg, and other large foundations devoted hundreds of millions of dollars each year to a single cause—universal coverage—and perhaps a single proposal, and then put nearly all of the money into building a social movement instead of developing more proposals and small demonstration projects?

In health insurance initiatives large and small, there can be different forms of collaboration. One approach is to pool resources into a single, foundation-sponsored initiative. This is what RWJF, the California Endowment, and Kellogg did with Cover the Uninsured Week in March 2003. Another approach is to establish informal collaboration in support of a government or community-based initiative. The national evaluation of SCHIP, the development and implementation of Express Lane Eligibility in California, and the two local health insurance initiatives in Santa Clara and San Diego counties, are examples of this approach.

Collaboration is primarily a means to an end, not an end in itself. There are two key issues regarding collaboration among funders and their operational partners in any initiative. First, are resources sufficient to meet the agreed-upon goals of the participants? Second, is the combination of activities comprehensive, incorporating each of the three strategies needed to maximize the likelihood of reshaping public policy?

The experience from the FOCUS program in San Diego suggests that, even in a best-case scenario of collaboration, foundations can rapidly approach boundaries to further progress on the issue of health insurance coverage. Without a single, well-endowed source of responsibility or success in persuading governmental officials to adopt the program, even the most skilled policy entrepreneurs within the world of philanthropy cannot sustain expansions of coverage—and fairly modest ones at that—because of their extraordinary financial costs. Advancing toward universal health coverage appears to be more difficult than most other health policy issues, if only for this reason.

The main question regarding the RWJF-led Covering the Uninsured campaign is, can momentum in agenda-setting be sustained? With the problem now attracting the attention of policymakers, what is the strategy from this point on to move from superficial consensus to policy formulation, while maintaining solidarity among the “strange bedfellows”? At all levels of the political system, there will be many opportunities for collaboration among foundations, but significant commitment and communication will be required to work out the most effective configuration of roles and resources for protecting and expanding health insurance coverage across the nation.

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Table 1
FOUNDATION STRATEGIES FOR IMPROVING HEALTH INSURANCE COVERAGE

CHOICE OF STRATEGIES	RWJF	Common-wealth	Kaiser	Kellogg
Educate the public and members of the policy community				
Generate and disseminate data and policy analysis	3	3	3	2
Improve public understanding of health issues	3	2	3	2
Educate policy makers and issue experts	3	3	3	2
Invest in the development of new institutions and policy options				
Develop new models and demonstration projects	3	2	1	3
Shape policy implementation	3	3	2	2
Evaluation	3	3	3	2
Support capacity-building and advocacy efforts				
Serve as a builder of policy networks and convener of participants	3	3	3	2
Provide a voice for vulnerable groups	2	1	2	3
Support direct services	2	1	1	3
CHOICE OF AUDIENCES AND PARTNERS				
General public	3	2	3	2
Trade associations and advocacy groups	3	3	3	2
Governmental agencies and officials	3	3 (audience)	3 (audience)	2
Mass media	3	3	3	2
Community leaders and organizations	2	1	1	3
Other foundations	2	2	1	2
CHOICE OF JURISDICTIONS				
National	3	3	3	2
State	3	2	2	3
Local	2	1	1	3
STAGES OF POLICY PROCESS				
Problem identification and definition	2	3	3	1
Agenda setting	3	2	2	2
Policy formulation	3	2	2	3
Policy implementation and program management	3	2	1	3
Policy evaluation	3	3	2	2

Authors' rankings: 3=Substantial priority 2=Moderate priority 1=Little or no priority

CHOICE OF STRATEGIES	Packard	CHCF	Endowment	TCWF
Educate the public and members of the policy community				
Generate and disseminate data and policy analysis	3	3	2	2
Improve public understanding of health issues	2	2	3	3
Educate policy makers and issue experts	3	3	3	3
Invest in the development of new institutions and policy options				
Develop new models and demonstration projects	3	2	3	3
Shape policy implementation	3	2	3	3
Evaluation	3	3	2	2
Support capacity-building and advocacy efforts				
Serve as a builder of policy networks and convener of participants	3	3	3	3
Provide a voice for vulnerable groups	2	1	3	3
Support direct services	2	1	3	3
CHOICE OF AUDIENCES AND PARTNERS				
General public	2	2	3	3
Trade associations and advocacy groups	3	2	3	3
Governmental agencies and officials	3	2	2	2
Mass media	2	2	2	2
Community leaders and organizations	3	1	3	3
Other foundations	3	3	3	3
CHOICE OF JURISDICTIONS				
National	3	2	2	2
State	3	3	3	3
Local	3	2	3	3
STAGES OF POLICY PROCESS				
Problem identification and definition	2	3	2	2
Agenda setting	1	3	3	3
Policy formulation	2	3	3	3
Policy implementation and program management	3	2	2	3
Policy evaluation	3	2	1	2

Authors' rankings: 3=Substantial priority 2=Moderate priority 1=Little or no priority

CHOICE OF STRATEGIES	Alliance	Consumer Health	Rhode Island	Rose
Educate the public and members of the policy community				
Generate and disseminate data and policy analysis	2	1	2	2
Improve public understanding of health issues	3	2	3	3
Educate policy makers and issue experts	2	1	3	3
Invest in the development of new institutions and policy options				
Develop new models and demonstration projects	3	1	3	3
Shape policy implementation	1	2	3	3
Evaluation	1	1	1	1
Support capacity-building and advocacy efforts				
Serve as a builder of policy networks and convener of participants	2	3	3	3
Provide a voice for vulnerable groups	2	3	3	3
Support direct services	3	3	3	3
CHOICE OF AUDIENCES AND PARTNERS				
General public	3	2	3	3
Trade associations and advocacy groups	2	3	3	3
Governmental agencies and officials	2	1	3	3
Mass media	2	1	2	2
Community leaders and organizations	2	3	3	3
Other foundations	3	3	3	3
CHOICE OF JURISDICTIONS				
National	2	1	1	1
State	2	3	3	3
Local	3	3	3	3
STAGES OF POLICY PROCESS				
Problem identification and definition	2	1	2	2
Agenda setting	3	3	3	3
Policy formulation	2	1	3	2
Policy implementation and program management	2	2	3	3
Policy evaluation	1	1	1	1

Authors' rankings: 3=Substantial priority 2=Moderate priority 1=Little or no priority