The Transformation of the Henry J. Kaiser Family Foundation

“We saw a glaring need in this changing health care system for an independent, trusted, and credible source of information, analysis, and balanced discussion in a field otherwise dominated by large interests, and we have tried to be that source.”

—Drew E. Altman, President of the Kaiser Family Foundation

MENLO PARK, CALIFORNIA, MAY 2006

Drew E. Altman, president of the Kaiser Family Foundation, put the telephone down and paused to catch his breath. He’d just taken a call from an Associated Press reporter who was interested in learning more about the issues surrounding a pending Senate amendment to Medicare. Before taking that call, Altman had spoken to an editor from the New York Times who was running a story on global efforts to fight tuberculosis. A local television news producer wanted Altman’s help in putting together a piece on the health problems facing African-American women in San Francisco. He would meet with the producer in the afternoon.

A press release had just come across Altman’s desk. It was from Fairness and Accuracy in Reporting (FAIR), a left-leaning media watchdog group. FAIR conducted an annual survey of think tank citations in the mainstream media. This year FAIR had placed the Kaiser Family Foundation at number six nationally, behind the Brookings Institution, the Heritage Foundation, the American Enterprise Institute, the Cato Institute, and the Council on Foreign Relations. Altman read the press release with bemusement. As an independent national charitable foundation, Kaiser wasn’t actually a think tank, but if FAIR chose to include Kaiser in its survey, that was fine with Altman. Kaiser’s work was registering in the media, and that was what was important.

Altman pulled up Kaiser’s web page on his computer, clicked through to the KaiserNetworks.org page, and watched a few minutes of an exclusive live webcast of the High Level Meeting on AIDS at the United Nations in New York.


Teaching Case Writing Program Director Barry Varela prepared this teaching case under the supervision of Professor Joel Fleishman and Professor Kristin Goss as a basis for class discussion rather than to illustrate either the effective or ineffective handling of an administrative situation. In addition to footnoted sources, information was drawn from a descriptive case written by Scott Kohler for Joel Fleishman.

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The Transformation of the Henry J. Kaiser Family Foundation

The phone rang. It was a House aide, inquiring after data on projected growth in health care expenditures over the next decade. Altman promised to send her a copy of the report Kaiser had recently prepared on the topic.

One measure of whether Kaiser had achieved its goal of providing an independent, nonpartisan voice in the health care debate was how often policymakers, members of the media, and the public came to the Foundation for information. For Altman, any day the phone was ringing off the hook was a good day.

That night Altman would take the red-eye to Washington. In the morning he would meet with Mollyanne Brodie, Kaiser’s vice president in charge of public opinion and media research; Richard Morin, director of polls at the Washington Post; and Robert J. Blendon, of Harvard University’s School of Health and the Kennedy School of Government. Brodie, Morin, and Blendon administered the “Reality Check” series of surveys designed to measure the ways that information shapes how people think. The Post published the survey results and the paper’s accompanying analysis of the data in multipage spreads. Kaiser performed and published its own analysis of the same data. In the afternoon Altman would speak before a group of Kaiser Media Fellows—journalists participating in a Foundation-sponsored program designed to deepen their understanding of the health issues confronting the country. In the evening he’d attend a public forum on media use among children at the Barbara Jordan Conference Center in Kaiser’s Public Affairs Center office building in Washington. The next day he’d meet with staff from the Kaiser Commission on Medicaid and the Uninsured before flying back to California.

All this activity—the media partnerships, the commissions, the public relations efforts—was a far cry from the way the Henry J. Kaiser Family Foundation had operated before Altman joined the organization in 1990.

HENRY J. KAISER AND KAISER INDUSTRIES

American entrepreneur and industrialist Henry J. Kaiser was born in Sprout Brook, New York, in 1882. Leaving school at age 12 to work in a dry-goods store, Kaiser spent his young adulthood as an itinerant photographer and photography-supplies salesman. At age 22 he found employment in a Lake Placid photography studio; within a year he had tripled business and bought out the owner. Two years later Kaiser moved to the Spokane, Washington, where he worked as a hardware salesman and later as a building-supplies salesman. At age 32, while living in Vancouver, British Columbia, he founded Henry J. Kaiser Ltd., which pioneered the use of heavy equipment in road construction. Seven years later the firm won a $500,000 road-building contract with the state of California, and Kaiser moved the company’s headquarters to Oakland.3 In 1927 the company won a $20 million contract to build roads in Cuba, greatly expanding the company’s capacity.4 In the 1930s, Kaiser worked on large government-funded projects such as the construction of the Boulder (now Hoover), Bonneville, Grand Coulee, and Shasta dams.

Kaiser maintained a contentious relationship with organized labor during his company’s early years. Lax safety standards at Boulder Dam contributed to the deaths of 110 persons during its four years of construction, legal responsibility for which Kaiser and the other main contractors on the job fought aggressively, and successfully, to avoid.5 During the 1930s Kaiser, aware of President Franklin Roosevelt’s more conciliatory New Deal labor policy and desirous of winning large federal contracts, transformed himself into a leader in industrial labor relations,

4 Adams, op. cit., p. 32.
offering his employees generous wages and low-cost medical services. Organized under the umbrella of Kaiser Industries, Kaiser’s businesses in the 1930s included concrete and magnesium production in addition to road and dam construction.

As the United States prepared to enter World War II, Kaiser Industries built shipbuilding plants in Richmond, California, and other West Coast locations, eventually employing over 200,000 people and producing nearly 1,500 ships. Kaiser’s contributions to the war effort made him a popular hero; *Time* magazine took to calling him the “fabulous Henry J. Kaiser,” and in 1944 Franklin Roosevelt contemplated asking Kaiser to join him on the Democratic presidential ticket. After the war, Kaiser Industries invested, with mixed results, in aluminum and steel production, automobile and aircraft manufacture, real estate development, and television and radio broadcasting. The Kaiser prepaid medical plan, whose roots extended to the company’s 1933 work on a California aqueduct project, evolved into Kaiser Permanente, the nation’s largest health maintenance organization (HMO). At the time of Kaiser’s death in 1967, Kaiser Industries was valued at approximately $2.5 billion.

**THE HENRY J. KAISER FAMILY FOUNDATION: THE FIRST FOUR DECADES**

Whether Henry Kaiser’s attitude toward labor changed during the 1930s as a result of a calculated assessment of New Deal policy or due to a sincere change of heart is perhaps unknowable. Nevertheless, the fact remains that by the late 1930s Kaiser’s companies were known for their generosity toward their workers. In addition to the prepaid health plan, Kaiser offered union-level wages to all employees, unionized or not. By 1954, the man who just 20 years before had fired a thousand striking workers on the Boulder Dam project rather than improve brutal working conditions was quoted as saying, “A great deal of the troubles which in the past have been brought down upon enterprises and the people could have been averted simply by genuine recognition that the right of collective bargaining not only is the law of the land, but is sound, essential human relations.”

Kaiser established the Henry J. Kaiser Family Foundation in 1948 after being advised by his accountants that his estate was facing a position of tax vulnerability. Kaiser believed that his most lasting and important legacy—dams, ships, and factories notwithstanding—would be the creation of the not-for-profit health care system Kaiser Permanente, which included the Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and the Permanente Medical Groups.

Kaiser’s interest in medical care led the Kaiser Family Foundation to concentrate its initial efforts on researching health care issues facing the nation, with an emphasis on health care delivery. When Kaiser’s wife, Bess Fosburgh Kaiser, died in 1951, she left the bulk of her $10 billion estate to the foundation.

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6 Adams, op. cit., p. 43.
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In 1954, the Foundation received a large estate of $10 million, providing it with its first large infusion of funds. The Foundation eventually received a total of approximately $78.5 million from Kaiser estates and trusts, an amount that would grow to about $250 million by the mid 1980s.

For the first several decades of its existence, the Foundation was administered as a family foundation supervised by members of the Kaiser family and primarily funding projects related to health care delivery. With the 1972 hiring as president of Dr. Robert J. Glaser, a former professor of medicine at Stanford University and vice president of the Commonwealth Fund, the Kaiser Family Foundation acquired a professional staff. Under Glaser, the Foundation continued to focus its concentration on the study of health care delivery and HMOs.

Dr. Alvin Tarlov

In 1984 Glaser was succeeded as president of the Kaiser Family Foundation by Dr. Alvin Tarlov, former chair of the department of medicine at the University of Chicago. Tarlov was best known for his work on the influential 1980 report of the Graduate Medical Education National Advisory Committee (GMENAC), which concluded that the United States faced a surplus of physicians.

Under Tarlov, Kaiser carried out activities in four major areas: a health promotion/disease prevention program focusing on five leading health problems (cardiovascular disease, cancer, adolescent pregnancy, substance abuse, and injuries), a program that promoted research into methods by which medicine could improve functional outcomes and well-being; a program that sought to promote minorities in the health professions; and a program that aimed at strengthening health organizations, especially those serving minorities and the elderly, in the San Francisco Bay Area. The Foundation also supported a small (3 percent of annual funds) program to promote health care in South Africa.

In a 1988 interview in the journal Health Affairs, Tarlov outlined his belief that foundations like Kaiser were obliged to “identify opportunities for social improvement that would not occur without us” and to seek out “problems that appear unsolvable.” He continued:

[F]oundations are moving toward community activation. It stems from a perception among foundations that social change can be effectively fashioned, customized if you will, to local circumstances by community groups if those groups are empowered to assume responsibility for it. . . . Foundations are finding that direct involvement at the community level can be a more effective instrument for social restructuring than work at the institutional level, that is, within universities or research institutions or even centralized government. While the Kaiser Family Foundation is moving more toward community grant making, we become engaged more actively with the communities in the implementation process.

Tarlov’s belief that foundations would become more involved in local communities would not be played out at the Kaiser Family Foundation, however. A year after the Health Affairs interview, Kaiser announced that it would discontinue its minority health program in South Africa.

15 Foster, op. cit., p. 278.
19 Inglehart, op. cit., p. 151.
20 Inglehart, op. cit., p. 152.
Affairs interview was published, Tarlov was no longer at the Foundation and the Kaiser board of trustees was seeking an entirely new direction.

HEALTH CARE IN AMERICA

Organized health care in America is older than the nation itself. In 1756 Benjamin Franklin opened the continent’s first hospital, specializing in the care of the poor and mentally ill. From the colonial era through the 1920s, more than 7,000 hospitals were founded. But because hospitals were understood, correctly, to be dangerous reservoirs of infection, patients who could afford to pay were treated by nurses or doctors at home.21

With the rise of modern biomedical science in the 1920s—particularly in the areas of infection control, disease treatment, and anesthesia for surgery—clinical efficacy improved dramatically. By the 1960s hospitals had replaced the home as the locus of health care delivery. The 1965 creation of the federal Medicare and Medicaid programs as adjuncts to Social Security injected millions of new dollars into the American health care system. As scientific knowledge increased and medical subspecialties proliferated, health care technology became ever more complex. Hospitals grew larger and more sophisticated, requiring more support staff and costlier and more highly advanced facilities and equipment. From the 1960s through the mid 1980s, the portion of the nation’s gross domestic product spent on health care increased from five percent to ten percent, more than in any other industrialized nation.22

Health care financing

At the end of World War II, most individuals were still paying for health care out of pocket. Simply put, if you became ill, you went to the doctor or the doctor came to you on a house call, and you paid for the visit. Most people did not have health insurance. (Kaiser Permanente was a pioneer in offering prepaid medical plans.)

Over the next several decades, however, a booming economy and progressive tax policy led to substantial increases in real earnings for workers. Newly empowered unions sought to gain health care coverage from large corporations—sometimes in lieu of wage increases, because medical benefits were classified as untaxed income. In 1965, with the creation of Medicare and Medicaid, government also became a major purchaser of health care. By the mid 1980s, most health care was paid for by large organizations, whether state and local governments or corporations, on behalf of large groups of beneficiaries. The majority of Americans either participated in voluntary health plans paid for by individuals or their employers or retirees, or were covered by social insurance plans such as Medicare or public welfare plans such as Medicaid. In 1985, less than fifteen percent of Americans participated in no prepaid health plan at all (i.e., had no health insurance).23 That number was rising, however.

Attempts had been made as early as the Theodore Roosevelt administration to nationalize American health care. Franklin Roosevelt had tried to include medical benefits as part of Social Security but was unable to overcome the opposition of the physicians’ group the American Medical Association (AMA). Congressional efforts during World War II, as well as President Truman’s attempt in the late 1940s, to implement national health insurance were defeated by the AMA with help from pharmaceutical, insurance, and other business interests. John Kennedy campaigned for the presidency on a platform that included a Medicare-style program to provide government-sponsored health insurance for the elderly and disabled. President Lyndon Johnson

22 Pointer, op. cit., pp. 7, 41.
23 Pointer, op. cit., p. 51.
signed Medicare into law in 1965 with the expectation that it would expand eventually to cover all Americans, but the Vietnam War crippled Johnson’s presidency and precluded fulfillment of the Great Society. Jimmy Carter campaigned on a promise of universal health care coverage but was unable to deliver in office. Republican presidents Ronald Reagan and George H.W. Bush put health care reform on the back burner.

Voluntary health insurance can take a number of forms. Commercial plans can be run for profit or not. They may be mutual (i.e., beneficiary owned) or stockholder owned. Blue Cross/Blue Shield plans are usually not-for-profit and often operate under special state charters. Rates are often based on communitywide, rather than individual, characteristics. In the early 1970s, President Richard Nixon signed into law legislation facilitating the expansion of health maintenance organizations, which combine insurance and health care delivery, typically through an owned or contracted network of hospitals, doctors, and other providers. (HMOs, exemplified by Kaiser Permanente, were most common in the western United States.) Like other insurance plans, HMOs can be run for profit or not.

Medicare, a federally sponsored program funded by involuntary payroll deductions, provides medical coverage to those over age sixty-five; in 1973 Medicare began covering disabled persons eligible for Social Security benefits. With the gradual aging of the population and with the addition of the disabled, Medicare saw over its first two decades an increase in the percentage of the population it covered; by 1985 approximately 14 percent of Americans qualified, making Medicare by far the nation’s largest single purchaser of health care.

Medicaid is a federal- and state-funded welfare subsidy that provides medical coverage to the poor. With variation from year to year and state to state, less than 10 percent of the population typically qualifies for coverage.

American per capita health care expenditure rose from about $126 annually in 1960 to over $1,500 annually by 1985.24 (In constant 1985 dollars, that was an increase from $458 to $1,500.25) Feeling the strain of rising health care expenses, both government and business demanded that administrators of health plans (e.g., insurance companies) and providers (e.g., doctors) bear a greater portion of the cost. During the 1970s and 1980s, employers also tried to shift the burden of increasing costs to workers by, for example, requiring them to pay insurance deductibles. As costs continued to rise, this stopgap measure proved insufficient, and employers cut back costs elsewhere. Dental, psychiatric, and other “nonessential” coverage was dropped. Dependent coverage was scaled back or eliminated. Some large companies paid employee claims directly, eliminating the middleman and exempting firms from certain state taxes. Ultimately many companies stopped offering health insurance altogether, especially newer businesses and those in the growing retail sector.26

Workers who continued to be enrolled in voluntary health plans saw them change as well. Prior to the 1980s, hospitals and doctors were generally paid on the basis of services rendered or costs incurred. This practice gave way to a system whereby treatment rates were determined prospectively; increasingly, providers were paid a set amount for a given patient complaint. The amount of payment was established through the use of diagnosis related groups (DRGs), a taxonomy of 470 “disease categories.” DRG determined payment regardless of how much the actual treatment cost. Theoretically, providers would make money on some patients and lose money on others, averaging a fair profit over time. The predictable consequence was that hospitals and doctors were motivated to keep costs down by cutting back on services.

24 Pointer, op. cit., p. 46.
With both employers and health care providers seeking ways to keep costs down, "managed care" stepped into the breach. Under managed care, a network of providers (physician groups, hospitals, and so on) discounted fees to employees of companies that participated in the plan. To keep costs down, managed-care organizations such as HMOs instituted various measures such as the requirement that patients receive approval from the insurer before admission to a hospital. Because doctors were paid at predetermined rates for their services, cost containment suited them—to a point. Physicians objected bitterly to the increased paperwork and to insurers’ encroaching on their clinical judgment. Insurers often hired outside consultants to review physician protocols and decisions, further alienating doctors.

As a result of this confluence of interests, managed-care organizations such as HMOs grew rapidly in number and size. From 1980 to 1990, the number of Americans enrolled in HMOs rose from about four percent of the population (10 million individuals) to about 14 percent (32 million individuals). Similar to HMOs but more loosely organized, preferred provider organizations (PPOs) and point-of-service (POS) plans also proliferated. Managed care resulted in complexity and uncertainty all around. Doctors were confounded by paperwork and annoyed that their clinical judgments could be overruled by insurers or consultants, and patients were confused and upset by complicated payment schemes that sometimes resulted in having to choose between a doctor they trusted but who was outside a network and an unknown doctor inside a network. By 1990, 70 percent of all American workers were enrolled in some variety of managed-care plan, and the “big five” private medical insurers—Cigna Corporation, Aetna Life and Casualty, Metropolitan Life, Travelers Corporation, and Prudential Insurance—had all turned their energies toward expanding their respective shares of the HMO business.

Furthermore, the 1980s represented a period of consolidation among providers. Hospitals, physician practices, and nursing homes merged to form integrated systems, some organized horizontally (e.g., several hospitals forming an affiliation), some vertically (e.g., a physician practice, a hospital, and a nursing home forming an affiliation), and some organized both horizontally and vertically (e.g., networks of affiliated physician practices and hospitals).

Follow the Money

In addition to growing in size and complexity, the health care sector experienced another profound change after 1980. Where once health care had been dominated by largely nonprofit actors such as community hospitals, during the 1980s for-profit corporations took over much of the sector.

For centuries, from their roots in the almshouses of the eighteenth century, hospitals had stood outside the commercial, profit-making world. Until the 1980s, with very few exceptions, hospitals were community or university owned and were operated without a strict eye toward the bottom line. As Medicare provided the elderly and disabled with the means to pay for hospital stays, beds filled and the money flowed in. By the late 1970s, private investor groups had begun to perceive the money-making potential of hospitals. By the early 1990s, about 28 percent of the 5,000 hospitals in America were investor-owned for-profit operations. Because hospitals, whether for-profit or not, were paid on the basis of DRGs, administrators were motivated to contain costs by, for example, allowing fewer tests, discharging patients earlier, seeking out simpler cases, and specializing in certain highly profitable procedures (e.g., open-heart surgery) at the expense of other, less profitable procedures.

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27 Pointer, op. cit., p. 66.
30 Birenbaum, op. cit., p. 57.
By the early 1990s, the American health care sector comprised 2,200,000 nurses, 600,000 physicians, 54,000 pharmacies, 6,500 hospitals, thousands of nursing homes, outpatient clinics, and other facilities, and millions of other workers. If health care had been a separate nation, it would have constituted the sixth-largest economy in the world.

As the health care sector grew and the profit motive drove its every aspect, lobbying in Washington exploded, from just over $20 million in 1990 to more than $120 million in 2004. The multibillion-dollar pharmaceutical industry, represented by the Pharmaceutical Research and Manufacturers of America and other trade groups, spent millions of dollars annually in lobbying. The health insurance lobby, led by the Health Insurance Association of American and by an organization called America’s Health Insurance Plans, distributed tens of millions of dollars yearly. Health professionals groups such as the American Medical Association, the American Nurses Association, the American Academy of Physician Assistants, and the National Association of Emergency Medical Technicians also spent tens of millions of dollars to advance their interests. Serving more than 5 million veterans, the Veterans Health Administration, a component of the cabinet-level Department of Veteran Affairs, constituted the nation’s largest integrated health care system, operating 1,300 care sites nationwide and wielding considerable power in Washington. Corporations and corporate groups not directly involved in health care but with a vested interest in health financing policy, such as tobacco manufacturer Philip Morris (now the Altria Group, Inc.), the National Association of Manufacturers, and the U.S. Chambers of Commerce (the single largest lobby in Washington), also lobbied on health care issues, as did legal groups (e.g., the Association of Trial Lawyers of America) and numerous citizens groups on the right (e.g., Citizens for a Sound Economy, Americans for Tax Reform), in the center (e.g., the National Coalition on Health Care), and on the left (e.g., the Universal Health Care Action Network). Academic institutions, independent medical research centers, biotechnology firms, think tanks, and countless federal, state, and local agencies also all had interests in health care policy.

Health professionals, employees of the insurance and pharmaceutical industries, veterans, government employees, corporate employees, small business owners, the elderly, the poor, the sick or disabled, immigrants, mothers, fathers, children—in short, the way health care was delivered was a topic that concerned every man, woman, and child in America.

**CHANGES AT THE KAISER FAMILY FOUNDATION**

In the late 1980s, key members of the Kaiser Family Foundation board of trustees were becoming frustrated with the Foundation’s direction. They felt that some members of the Kaiser family exerted, through their possession of permanent seats on the board, too strong an influence

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32 Johnson, op. cit., p. 45.
on the operations of the Foundation. Other board members were happier with the achievements and direction of the Foundation and resisted efforts to reform the board and the organization.

Key board members who fought for change within the board and staff included:

**Barbara Jordan**

Born in Houston, Texas, in 1936, Barbara Jordan earned a law degree from Boston University in 1959 and ran unsuccessfully for the Texas House of Representatives in 1962 and 1964, where she helped in the struggle for civil rights. In 1966 she became the first African-American woman to win a seat in the Texas Senate. In 1972 she was elected to the U.S. House of Representatives, becoming one of the first two (with Andrew Young of Georgia) African-Americans from the South to serve in that body in the twentieth century. Her 1974 testimony in support of the impeachment of President Nixon before the House Judiciary Committee’s Watergate hearings, as well as her stirring keynote speech at the 1976 Democratic National Convention, gained her fame at the national level. In 1979 she retired from Congress to teach at the University of Texas.

During the last years of her life, Jordan suffered from multiple sclerosis and used a wheelchair much of the time. She served on the Kaiser Family Foundation board of trustees from 1985 to 1993. Barbara Jordan died in 1996.

**Joseph A. Califano Jr.**

Joe Califano was born in Brooklyn, New York, in 1931 and graduated from Harvard Law School in 1955. He worked in the Kennedy administration to reform the Pentagon, and served as Deputy Secretary of Defense and as a senior domestic policy aide to President Johnson. In between stints in government, Califano pursued a private law practice in Washington, D.C. In 1976 President Carter appointed Califano secretary of the Department of Health, Education, and Welfare (HEW), where his confrontational style cost him popularity among White House staff and contributed to his firing after three years. A prolific writer, Califano has published nearly a dozen books, ranging from studies of the media, law, and health care policy to personal memoirs, as well as numerous magazine and newspaper pieces.

**Hale Champion**

A graduate of Harvard University, Hale Champion worked the financial beat as a reporter for the *San Francisco Chronicle* in the 1950s before serving as chief of staff to Governor Edmund G. “Pat” Brown of California. After holding administrative positions at the University of Minnesota and at Harvard and directing the Boston Redevelopment Authority, Champion served as Undersecretary of Health, Education, and Welfare under Califano in the Carter Administration. In the 1980s Champion lectured at Harvard’s Kennedy School of Government while also serving as a Kaiser Family Foundation trustee.

After a period of negotiation, Jordan, Califano, and Champion successfully engineered changes in the governing rules of the board and in the executive leadership of the Foundation. In the fall of 1989 a deal was struck whereby the previous chairman of the board, who was sympathetic to the changes desired by Jordan, Califano, and Champion, resigned his position, as did Alvin Tarlov, president of the Foundation. Also as part of the deal, the board’s bylaws were amended in such a way that the Kaiser family would be limited to two seats on the board and all members would be subject to term limits.

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38 Interview with Larry Levitt, July 2006.
39 Interview with Drew E. Altman, October 2006.
40 Levitt interview, July 2006.
Jordan, Califano, and Champion, as well as another key Kaiser trustee, former Senator Daniel Evans of Washington state, all had experience in working at high levels of government. These trustees had come to believe that the way to improve health care delivery in America was by influencing the functioning of government. Looking at the landscape of American health care, the trustees felt that the Foundation’s assets were insufficient to achieve real impact in such a large system. Kaiser, with assets worth approximately $400 million, was too small to fund massive nationwide demonstration projects, of the kind that larger foundations have at times underwritten, aimed at proving some new program’s large-scale efficacy. For-profit interests on either side of any number of controversial health issues would always be better funded than the Foundation.

The trustees perceived a specific niche that was going unfilled in American health care. Despite the abundance of private and public interests opposing one another on a host of issues, there was no independent, nonpartisan voice representing the interests of the public as a whole. Kaiser’s leadership came to believe that, by providing high-quality nonpartisan research and analysis and by using effective communications strategies to disseminate information, the Foundation would be able to upgrade the quality of the many debates constantly unfolding across the health care system, and ultimately improve the system itself.

With changes in the structure of the board in place, and a vacancy in the presidency, Jordan, Califano, Champion, and Evans set about searching for a new person to lead the Foundation.

Drew E. Altman

Drew E. Altman was born in Boston, Massachusetts, in 1951 and earned a bachelor’s from Brandeis University, a master’s from Brown, and a doctorate from the Massachusetts Institute of Technology, all in political science. He conducted postdoctoral research at the Harvard School of Public Health and taught courses in public policy at MIT. In the late 1970s, Altman held a senior position the Carter administration’s Healthcare Financing Administration. A vice president of the Robert Wood Johnson Foundation from 1981 to 1986, he served as Commissioner of the New Jersey Department of Human Services from 1986 to 1989 under Republican Governor Tom Kean. Before his appointment as President and Chief Executive Officer of the Henry J. Kaiser Family Foundation in February 1990, Altman was Director of the Health and Human Services program at the Pew Charitable Trusts.

Of his hiring at Kaiser, Altman recalled, “The board had an intuition that health care was coming as a national issue, and they wanted the Foundation to play a role in the debate. I was hired for my general qualifications—for my ideas about foundations and health care.”

Altman was extremely skeptical about the ability of foundations, especially ones the size of Kaiser, to transform society:

The first thing to understand about foundations is their limits. My time in government and in big foundations had convinced me that some foundation leaders had delusions of grandeur. I’d spent years of my life funding little demonstration projects. I’m now more realistic about what foundations can do. I’m more impressed by their limits than by their impacts.

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41 Interview with Drew E. Altman, August 2006.
42 Altman interview, August 2006.
As the trustees had, Altman compared the size of the Kaiser Family Foundation to the health care sector and concluded that nothing the Foundation could accomplish through conventional grantmaking would achieve nationwide impact:

I asked one simple question: How does one play a special role in a trillion-dollar sector with almost no money? The answer: Not by making grants. Traditional grantmaking was not a recipe for playing a truly special role. 43

Like the key trustees, Altman had a background in politics and public policy rather than in medicine. Altman recalled how his background—both as an academic and as the head of a state agency—influenced his approach at Kaiser:

My approach derived from political analysis—what was really broken was the politics of health care. We set out to build an institution that could help fix the politics. First, we needed to build the capacity to produce data—that is, do policy research and analysis. Second, we needed to build the capacity to communicate—explain the data in real time. 44

The board gave Altman the freedom to embark upon the task of creating that new institution, with its mission of fixing the politics of health care through policy research and analysis and communication, however he saw fit. “I was given carte blanche by the board to craft an agenda,” he recalled. “There was no complicated strategic planning process.” 45 Still, Altman gave credit to the board, especially to Hale Champion. Altman said, “As Chairman of the Kaiser Family Foundation's board of trustees, Hale Champion was the guiding hand in the conceptualization and shaping of our communications strategy.” 46

Altman decided that Kaiser would undertake to design and operate its own programs internally, rather than make grants to outside nonprofits:

Really, we considered no other options. In order to make an impact, we needed to be nimble. There were no fundees out there that could do that. We needed to create something that didn’t exist. The Foundation would start over—move from what was still in some ways a family foundation to an independent national foundation. 47

Under Altman’s leadership, the Kaiser Family Foundation set about closing down the four main funding areas (health promotion/disease prevention; improving functional outcomes in medicine; promoting minorities in health professions; and strengthening Bay Area health organizations) that had been developed under Tarlov. (The Foundation continued to support the South African program.) Not surprisingly, Kaiser staff were unhappy with the Foundation’s new direction. “Within a year, we had almost 100 percent turnover,” Altman recalled. 48 An exception was Matt James, a public information specialist who would later coordinate KaiserNetwork.org, the Foundation’s web-based information service.

In early 1991 the newly reorganized Kaiser Family Foundation announced its first major initiative, a $100-million, five-year commitment “to determine which state and federal

43 Altman interview, August 2006, op. cit.
44 Altman interview, August 2006, op. cit.
45 Altman interview, August 2006, op. cit.
47 Altman interview, October 2006, op. cit.
48 Altman interview, August 2006, op. cit.
government health programs work, why others fail and what policies can reverse the
deterioration in health care for low-income people and minorities."49 That initiative evolved into
the Kaiser Commission on Medicaid and the Uninsured, a permanent 16-member, bipartisan
national panel established to serve as a source of information and analysis on the Medicaid
program and the health and long-term care coverage of low-income individuals.

Over the following decade and a half, the Kaiser Family Foundation would launch
numerous other major initiatives.

**KAISER FAMILY FOUNDATION ACTIVITIES**

“We do three things,” Drew Altman said in 2006:

> Half of what we do is policy research and analysis. We also provide news and
information to help level the playing field—we try to be a modest counterweight to health
care’s big interests, spin, nonsense. And we conduct health information campaigns with
other media organizations. In everything we do, our product is information.50

Unlike most national foundations, the Kaiser Family Foundation operates no grantmaking
programs (with one exception, the South Africa program). Though the Foundation conducts
programs run by program officers, it has no grantmakers in the sense that other foundations do
(again with the exception of the officer in charge of the South Africa program).

Altman described the internal management structure at Kaiser:

> We wanted to avoid the Balkanization syndrome, wherein program officers protect their
fiefdoms against threats inside and outside the Foundation. We don’t control our agenda.
Congress, the public, and the media do. They determine the national issues that come
before the country. Because we respond to changes in the health care debate, we need to
be nimble. No program or program officer has a set budget. Instead, we have one pot of
money that’s divvied up among the best ideas. This approach fosters an entrepreneurial
environment.51

In 2003, the Kaiser Family Foundation opened a new $42-million, 96-thousand-square-
foot52 Washington office building, the Public Affairs Center. Housing the Kaiser Broadcast
Studio, the Kaiser Interactive Health Exhibit Lobby, and the Barbara Jordan Conference Center,
the building is also home to the Kaiser Commission on Medicaid and the Uninsured and to
KaiserNetworks.org.

Kaiser divides its activities into two main categories: Health Policy, and Media and
Public Education. The Foundation also runs a South Africa program.

**Health Policy**

Kaiser’s Health Policy program consists of five programs:

> The Kaiser Commission on Medicaid and the Uninsured
> The Healthcare Marketplace Project

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50 Altman interview, August 2006, op. cit.
51 Altman interview, August 2006, op. cit.
The Medicare Policy Project
The Race/Ethnicity and Health Care Program
The Women’s Health Policy Program

The Kaiser Commission on Medicaid and the Uninsured produces and analyzes information on health care coverage and access among low-income populations.

The Health care Marketplace Project produces and analyzes information about health insurance and health care costs and services, focusing on trends in employer-sponsored and private health insurance, the prescription drug industry, malpractice insurance, and tax systems relating to health insurance costs.

The Medicare Policy Project, the Race/Ethnicity and Health Care Program, and the Women’s Health Policy Program conduct research and analysis on and produce fact sheets, books, and reports to inform policy debates about their respective areas.

Media and Public Education
The Media and Public Education program is divided into five units:

- Public Opinion and Media Research
- Entertainment and Media Partnerships
- Kaiser Media Fellowships and Internships Programs
- Program for the Study of Entertainment Media and Health
- Kaiser Family Foundation Websites

Public Opinion and Media Research
The Foundation operates the nation’s largest public opinion research program devoted to examining Americans’ knowledge of and beliefs about health policy issues. The Foundation conducts surveys independently and in partnership with media organizations and academic institutions.

One major partnership was formed in 1995 with Harvard University and the polling arm of the Washington Post. The Post described the partnership in a box accompanying the publication of the first survey’s results:

Representatives of the three sponsors worked closely to develop the survey questionnaire and analyze the results on which this series of articles is based. The Post and the Kaiser Family Foundation with Harvard University are publishing independent summaries of the survey findings; each organization bears sole responsibility for the work that appears under its name. The Kaiser Family Foundation and The Post paid for the survey and related expenses. The survey data will be sent later this year to the Roper Center for Public Opinion Research at the University of Connecticut, where computer tapes of the information will be available.53

Altman described what led Kaiser to enter into the partnership with Harvard and the Post:

We were interested in conducting an experiment in survey research and journalism—not it conducting simple public opinion polls. At the time, we were the only example of a major news organization taking on a non-news partner. For Kaiser, the partnership gave us a voice right in the backyard of our most important audience—congress and

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The inaugural Kaiser-Post survey gathered information on American beliefs about minority employment, education, and health. Altman explained:

We were in the business of providing information to the public. But no one knew what the public knew and what they didn’t know. So, we wanted to find out what the public’s perceptions and misconceptions were. Then we and the Post could use that information as a basis for better informing the public—to fill in the gaps.  

The initial survey project was deemed a success by all three partners. The partnership has since produced more than a dozen additional surveys, on topics ranging from sex roles to the assimilation of Latino immigrants to Social Security.

Kaiser’s partnership with the Washington Post led to further media partnerships, first with National Public Radio and then with commercial media conglomerates.

Entertainment Media Partnerships
In the United States, Kaiser conducts media projects with major media companies, focusing mainly on educating young people about HIV and other sexually transmitted diseases. “We do some conventional public service announcements, but mostly we stay away from the kinds of things produced by the Ad Council,” Altman said of Kaiser’s entertainment media partnerships. “We enter into contractual agreements to integrate our messages and information into shows—things like hotline numbers. We try to arrange it so that a young person just bumps into the message.”

Kaiser has partnered to produce such programs as KNOW HIV/AIDS (Viacom CBS); think:HIV and think:sexual health (MTV), Rap It Up (BET), and Pause (Fox). Kaiser has also produced Spanish-language programs in partnership with Univision.

“Talking With Kids About Tough Issues” is a public information campaign administered by Kaiser and the nonprofit organization Children Now. “Talking With Kids” produces public service announcements (PSAs) and has teamed with NBC’s “The More You Know” project to produce television spots.

Internationally, Kaiser has entered into partnerships with media companies in India and Russia, as well as partnered with a coalition of 40 media companies in 24 African countries. The African companies agreed to devote five percent of their air time to broadcasting public affairs programs focusing on issues surrounding HIV/AIDS. In Africa, Kaiser also coproduces PSAs and works to incorporate educational storylines into entertainment programs such as soap operas.

Kaiser’s partnership with MTV International has led to the broadcasting of PSAs about AIDS in 164 countries worldwide.

In 2004, Kaiser and the Joint United Nations Programme on HIV/AIDS (UNAIDS) convened a meeting of international media leaders at the UN headquarters in New York. UN Secretary General Kofi Annan announced the formation of the Global Media AIDS Initiative to promote media leadership on HIV/AIDS issues.

Kaiser Media Fellowships and Internships Program

54 Altman interview, October 2006, op. cit.
56 Altman interview, September 2006.
57 Altman interview, September 2006.
Founded in 1993, the Kaiser Media Fellowships in Health Program consists of three programs: Kaiser Media Internships, International Health Journalism Fellowship Project, and HIV/AIDS Resources for Journalists.

Kaiser Media Internships is a three-month summer internship program for young minority journalists aspiring to specialize in health reporting. News organizations such as the Baltimore Sun, KTVU/2-TV (San Francisco-Oakland), and the Orlando Sentinel/El Sentinel have participated in the Kaiser internship program.58 Funded by the Bill and Melinda Gates Foundation, Kaiser’s International Health Journalism Fellowship Project underwrites programs located in Africa, India, Russia, and Ukraine that support journalists with interest in reporting issues surrounding HIV/AIDS, tuberculosis, and malaria. Kaiser’s HIV/AIDS Resources for Journalists program provides mini-fellowships and other tools to help journalists report on HIV/AIDS and sponsors site visits, workshops, and other events.

Program for the Study of Entertainment Media and Health
To better inform policymakers, researchers, journalists, and the public, the Program for the Study of Entertainment Media and Health produces and analyzes data on the relationship between entertainment media and health, with an emphasis on children and media. Kaiser’s website summarized the program’s activities:

- Major research projects include such topics as how teens use the Internet for health information; the amount of time children of all ages spend watching TV, playing video games, using computers, and reading; sexual messages on television; how health policy issues are portrayed on TV’s medical dramas; what viewers learn from health information in entertainment shows; the role of media in childhood obesity; and the impact of media-based public health campaigns. The Foundation also studies public policies on related media topics, including public service advertising on television, TV ratings, the V-Chip, and the impact of Internet filtering.59

Kaiser Family Foundation Websites
In addition to the Foundation’s home website (www.kff.org), Kaiser maintains five other major sites:

- KaiserNetwork.org
- StateHealthFacts.org
- KaiserEDU.org
- GlobalHealthReporting.org
- GlobalHealthFacts.org

The largest and most important site in the Kaiser Internet family, KaiserNetwork.org was founded in 2000 to provide a free online service to policymakers, journalists, and the public. KaiserNetwork.org provides live webcasts of more than 200 major health policy events annually, publishes three daily health reports, and sends out to subscribers email alerts of events and developments of interest. KaiserNetwork.org also maintains a national calendar of events, an online library of health policy advertisements, a list of reference links, and an archive of webcasts, email alerts, and other material.

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Founded in 2001, StateHealthFacts.org provides detailed, updated individual state profiles and 50-state comparisons of 500 health topics, including demographics and the economy, health status, insurance status, health costs and budgets, minority and women’s health, Medicare, Medicaid, and provider and service use.

KaiserEDU.org was founded in 2003 to provide faculty, students, researchers, and the public with health care policy data, research, analysis, and news. The site maintains tutorials, a network of reference libraries, and modules centering on current topics and debates.

Funded with support from the Gates Foundation, GlobalHealthReporting.org provides journalists and the public with up-to-date information on HIV/AIDS, tuberculosis, and malaria.

Companion site to GlobalHealthReporting.org, GlobalHealthFacts.org provides country information on HIV/AIDS, tuberculosis, and malaria and other health and socio-economic data in the form of downloadable tables, charts, and maps.

Program for Health and Development in South Africa

Founded during the apartheid era, the Program for Health and Development in South Africa is the only Kaiser program that predates the Foundation’s transformation initiated by Drew Altman in 1990.

The mission of Kaiser’s South Africa program is “to develop the people, plans and programs to help establish a more equitable national health system and a successful democracy.”60 To that end, the program provides health information to South African government policymakers; helps train health officials; and establishes resources in reproductive health, child health, and health systems. The program helped develop a government-adopted patient bill of rights and establish a national initiative aimed at cutting in half the rate of HIV infection among young people. The initiative, called loveLife, brought together the government, media groups, private foundations, and more than 100 community-based organizations to support an HIV education and awareness campaign and a network of outreach and support programs.

OUTCOMES

Harris Wofford

A year after Drew Altman assumed the presidency of the Kaiser Family Foundation, Senator John Heinz, Republican of Pennsylvania, was killed in an airplane crash. The Democratic governor of Pennsylvania, Bob Casey, was charged with appointing someone to assume Heinz’s office for the few months until a special election could be held to determine a successor to Heinz. Richard Thornburgh, a former governor of Pennsylvania and Attorney General under the first President Bush, quickly declared his candidacy in the special election. A popular figure in Pennsylvania, Thornburgh was heavily favored to win, and Casey had difficulty finding a Democratic politician willing to face him. Casey turned to his Secretary of Labor and Industry, Harris Wofford, a former adviser to President Kennedy and president of Bryn Mawr University. Wofford had never held elective office, and the conventional wisdom stated that he would have no chance against Thornburgh in the special election. In July 1991, opinion polls showed Thornburgh leading Wofford by margin of 47 points, 67 to 20.61

Running a populist campaign that stressed working- and middle-class concerns, Wofford slowly began making up ground on Thornburgh. In September, Wofford appeared in an ad, stating, “If criminals have the right to a lawyer, I think working Americans should have the right

The message struck a chord with voters and Wofford’s poll numbers immediately rose. Emphasizing the issue of health care in the few weeks remaining in the race, Wofford won the November special election by 10 points. The turnaround shocked the punditocracy, and Democratic campaign consultants grasped the potential of health care reform as a winning issue in the national elections of 1992.

**The Clinton Health Security Plan**

Having campaigned on a vow to “take on the health care profiteers and make health care affordable for every family,” President Bill Clinton took office in 1993 with grand ambition but little appreciation for just how entrenched was the health care status quo. There were many reasons for Clinton’s failure to enact a plan to provide universal coverage under “managed competition”: the unpopularity of his wife, Hillary Rodham Clinton, whom he appointed to head up the President’s Task Force on National Health Reform; the secrecy of the Task Force’s operations; the delay in the release of the plan, giving opponents time to demonize it before it could even be evaluated; the effectiveness of the “Harry and Louise” television advertisements, which depicted a middle-class couple worrying over the plan and included the famous tagline “They choose, we lose”; unified Republican opposition; and division among Democratic senators and representatives. In any case, the crash and burn of Clinton’s plan represented the twentieth century’s last effort at major reform of the American health care system.

The Clinton reform fiasco occurred early in the transformation of the Kaiser Family Foundation. If the Foundation had had all of its research, analysis, and communications operations up and running, would the outcome have been different? No one can say. “At Kaiser we try to be neutral and objective,” Altman said, recalling the Clinton years. “We weren’t for or against the Clinton plan. Still, it was a historic opportunity blown.”

As of this writing (fall 2006), Clinton’s plan represents the last serious effort to reform the national health care system.

**Health Care Today**

The state of health care delivery in American today is as precarious as it ever was. In 2005, more than 46 million Americans were without health insurance, an increase of 1.3 million over the preceding year. Minorities including African-Americans, Hispanics, Asians, and Native Americans are more likely to be without health insurance than are whites. Those without insurance are three times more likely to report difficulty in obtaining medical treatment than those with insurance, and the uninsured are much more likely to be unable to follow recommended treatments due to cost. Uninsured children suffer delayed medical care, have more unmet medical and dental needs, and visit the doctor and the dentist far less frequently than do insured children. Uncompensated care (i.e., medical bills unpaid by patients) amounted to

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62 Skocpol, op. cit., p. 27.


64 Altman interview, September 2006.


66 Kaiser Commission on Medicaid and the Uninsured, The Uninsured: A Primer, p. 4, op. cit.

67 Kaiser Commission on Medicaid and the Uninsured, The Uninsured: A Primer, p. 6, op. cit.

$41 billion in 2004, of which the federal government (including Medicaid) paid $24 billion, the states $11 billion, and private sources $8 billion.69

While millions of American go uninsured, the costs for those who do buy health insurance continue to skyrocket. Average annual premium costs for employees receiving family insurance rose from $8,438 in 2000 to $11,480 in 2006—higher than the salary of a full-time minimum-wage worker.70

In 2002, the United States spent far more per capita on health care—$5,274—than any other country in the world. By way of contrast, the second-highest spender, Switzerland, laid out $3,446 per capita.71

For those who can afford it, the quality of American specialty medical care remains high. But basic care leaves a lot to be desired. In 2001, a group of visiting health experts from the United Kingdom, Australia, and New Zealand found that the American health care system was “hard to navigate, poorly coordinated, expensive, and lacking in attention to basic primary care services.”72 The experts declared that they “would strongly prefer to be cared for at home if they became ill.”73

By 1999, the Kaiser Family Foundation had wound down all but one (the South Africa program) of its outside grantmaking programs. The vast majority of the money Kaiser spent funded activities that were conducted within the Foundation—placing the organization in an unusual, if not unique, tax position. Altman recalled meeting with representatives of the Internal Revenue Service:

In 1999 I flew to Washington to meet with the people from the IRS. They’d been looking at our tax records and didn’t know how to categorize us. Most operating foundations are museums or symphonies—things of that nature. The IRS told me there was no foundation or nonprofit like Kaiser anywhere in America. I asked them, “Well, what are we most like?” They said, “An operating foundation.” So we checked that box on the form, and that’s what we are.74

Drew Altman set about transforming the Kaiser Family Foundation in order to influence health care policymaking at the national level by providing an independent nonpartisan source of reliable information and analysis. Altman summed up the reasoning behind the Kaiser transformation:

Foundations have to choose between funding little demonstration projects that directly affect a few people, and playing an indirect role in influencing policy but potentially helping millions. The choice is between being a big player in a little game or a little player in a big game.75

The question must be asked: Even if one grants that Altman was successful in creating the institution he intended to create, did that effort represent the wisest course of action?

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73 Davis, op. cit., p. 3.
74 Altman interview, August 2006, op. cit.
75 Altman interview, August 2006, op. cit.
Was it true that, in 1990, Kaiser had lost its ability to effect meaningful change? Was establishing of a nonpartisan voice the most powerful way for a foundation of Kaiser’s size to influence the national health care debate? Is there any evidence that Kaiser’s presence has improved the quality of the debate?

Might there have been other ways, besides converting to an operating foundation, for Kaiser to create a nonpartisan voice? For example, might Kaiser have been more effective had it founded a new, operationally separate institution?

Would the Foundation have done more good by pursuing Alvin Tarlov’s ideas about “community activation”? Should Kaiser have continued to fund demonstration projects that helped relatively small numbers of people in measurable ways? Or has the Foundation done more good by attempting to influence an enormous sector in ways that are extremely difficult to measure? Is it better to be a big fish in a small pond or a small fish in a big pond?