I. ESSAY
The Impact Of Foundation-Funded Commissions On Health Policy
by Penny Hollander Feldman, Susan Putnam, and Margaret Gerteis

National task forces, commissions, and other ad hoc advisory bodies-both public and private-have been a prominent feature of the American political landscape since the turn of the century. However, studies of their impact on public policy are relatively recent and have focused primarily on presidential commissions. Privately sponsored bodies have received considerably less attention. This essay reports on a study we conducted with the support of The Commonwealth Fund to learn more about the impact of foundation-funded commissions on national health policy decisions.

The study had two main objectives: (1) to assess the policy impact of one of Commonwealth’s own recent commissions (the Task Force on Academic Health Centers), and (2) to extrapolate from the specific experiences of the task force and a small comparison group of commissions some practical lessons about the composition, conduct, and impact of such bodies. Because the sponsorship and funding of commissions is but one way foundations seek to influence public policy, our study cannot settle broader arguments about the policy role of foundations. It can, however, provide useful information for foundations and other sponsors about the design and management of ad hoc advisory bodies.

**Study methods.** We defined foundation-funded commission as (1) an ad hoc, task-oriented advisory body, (2) sponsored (that is, established) by a foundation or other private institution or organization, and (3) funded by one or more foundations to deliberate and formulate recommendations on an issue of public policy. We excluded from this definition all governmental commissions (for example, all ad hoc advisory bodies established by executive or legislative mandate or regulation), even
though they may have received foundation funds. We also excluded any foundation-funded institute or center established with the expectation that its activities would be ongoing rather than ad hoc.

We prepared case studies of five major foundation-funded commissions that were established in the post-World War II period to address national health care concerns. This sample was selected to control roughly for content area (each commission focused on health facilities, medical education, and/or personnel) and target audience (each directed its reports and policy recommendations not just to its sponsors or funders but to a broader policy audience as well). Exhibit 1 lists the commissions, their tenure, their sponsorship, and then-pending national legislation relevant to their charge.

The Task Force on Academic Health Centers (AHCs) was chosen because it was of central interest to The Commonwealth Fund. The other four were selected from a list of seven additional foundation-funded commissions that were in the same general content area and had completed their work. (Three commissions were eliminated because their explicit primary purpose was to inform their sponsors rather than to influence government policy.) Of the five chosen for study, three were both sponsored and funded by foundations (the Carnegie Commission on Higher Education: Advisory Committee on Medical Education, the Macy Commission on Physicians for the Future, and the Commonwealth Task Force on Academic Health Centers). Two were foundation

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Exhibit 1
Selected Foundation-Funded Commissions

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Commission</th>
<th>Sponsor</th>
<th>Funding</th>
<th>Pending National Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1944-46</td>
<td>Commission on Hospital Care</td>
<td>American Hospital Association (AHA)</td>
<td>Commonwealth Kellogg Infantile Paralysis</td>
<td>Hill-Burton</td>
</tr>
<tr>
<td>1976-48</td>
<td>Commission on Public-General Hospitals</td>
<td>AHA (Hospital Research and Education Trust)</td>
<td>Robert Wood Johnson Cleveland Kellogg</td>
<td>None</td>
</tr>
<tr>
<td>1983-85</td>
<td>Task Force on Academic Health Centers</td>
<td>Commonwealth</td>
<td>Commonwealth</td>
<td>Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985</td>
</tr>
</tbody>
</table>

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funded but privately sponsored (the Commission on Hospital Care, initiated in 1944 by the Postwar Planning Committee of the American Hospital Association [AHA] and funded by the W.K. Kellogg Foundation, The Commonwealth Fund, and the Foundation for Infantile Paralysis; and the Commission on Public-General Hospitals, established by the AHA's Hospital Research and Education Trust, with funding from The Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, and The Cleveland Foundation).

Each case study addressed two main questions: (1) What was the commission’s impact on contemporaneous policy decisions; and (2) What factors appear to have accounted for its relative success or failure in influencing the policy process. We relied on three main data sources in addition to the commissions’ published reports, recommendations, and minority opinions: newspapers, magazines, industry newsletters, and professional journals from the time of the commissions’ activity; government documents, including congressional hearings and reports; and the scholarly literature on particular commissions and the policy issues they addressed. Unpublished archival documents made available by The Commonwealth Fund, as well as interviews with virtually all living members and staff, were used to prepare the Commonwealth task force case study. For both the Macy Commission and the Commission on Public-General Hospitals, we interviewed three or more key appointees and staff members to supplement the written record.

Typology Of Commission Purposes

The characterization of presidential commissions by origin and purpose offers some useful insights on the possible purposes of foundation-funded commissions. In a comprehensive study of ninety-nine presidential commissions from Truman to Nixon, Thomas Wolanin found that “the primary presidential purpose for the largest number of commissions [was] to formulate innovative domestic policies and to facilitate their adoption.” In addition to policy analysis, the literature identifies five implicit purposes that are relatively distinct but not mutually exclusive: (1) long-range education or agenda setting-defining a problem, giving it public visibility, and establishing a frame of reference for public debate; (2) legitimation-mobilizing support for an initiative to which one or more policymakers are already committed; (3) crisis response-investigating the causes of a crisis and providing symbolic reassurance; (4) “issue management” -providing a “cooling-off period” during which crisis-induced tension can be reduced and objective analysis injected into policy debate; and (5) “issue avoidance”-creating the appearance
Applying this typology to the commissions we studied, we found that policy analysis was indeed their explicit primary purpose but that they also embodied a variety of implicit objectives, ranging from relatively modest educational goals to more ambitious goals of policy legitimation and issue management.

**Education.** The most modest of public policy objectives were those of the Macy Commission on Physicians for the Future, established in 1974 as the foundation’s first experiment with a commission format. Although the Comprehensive Health Manpower Training Act of 1971 was up for renewal at that time and policymakers were once again preoccupied with the problems of physician supply and apparent maldistribution, John Bowers, president of the foundation, showed no particular desire to influence the pending renewal legislation. Rather, he envisioned the commission as a kind of extended conference designed to engage knowledgeable people with interesting perspectives in a series of intensive discussions intended to educate themselves and, subsequently, the American public about issues of physician demand and supply.

**Legitimation.** In contrast, the sponsors of both the Commission on Hospital Care and the Carnegie Commission had well-defined substantive policy goals and a clear intent to influence federal legislation. The Commission on Hospital Care “approached its assignment with objectivity and without a preconceived pattern or plan for the future development of hospital care.” Nevertheless, its agenda was driven by the staff of the AHA and the W.K. Kellogg Foundation in conjunction with allies at the U.S. Public Health Service (PHS) who were committed to protecting the country’s “large capital and human investment” in voluntary hospitals. Furthermore, long before the Commission on Hospital Care completed its work, George Bugbee of the AHA, U.S. Surgeon General Thomas Parran, and Vane Hoge, also of the PHS, had been drafting legislation and organizing a coalition in support of a postwar hospital construction program built upon the existing voluntary hospital system. Thus a major implicit purpose of the Commission on Hospital Care was to legitimate that proposal. Policy legitimation was also an implicit purpose of the Carnegie Commission, inasmuch as its reports were crafted to support the foundation’s underlying commitment to massive increases in federal aid for education while ensuring institutional independence and academic freedom.

**Issue management.** Issue management, as much as objective policy analysis, was a major purpose of both the Commission on Public-General Hospitals and the Task Force on AHCs. The Commission on Public-General Hospitals was established in 1976, at the height of the fiscal crisis that threatened the financial base of many of the nation’s
urban public hospitals. Its formal purpose was to examine the role of public hospitals in the U.S. health care system and “to work toward generating a national dialog that [would] enable health policy makers to address more effectively the problems and the options for the future of these hospitals.”

No less important, however, were two implicit purposes: the desire of AHA leaders to respond to a restive public hospital constituency who felt that their concerns were being slighted by the parent organization, and the desire of the AHA’s public hospital constituents to construct a reasoned defense of their beleaguered institutions.

The Task Force on AHCs was established in 1983, when rapidly rising health care costs, increased competition, federal budget cuts, and Medicare’s impending prospective payment system (PPS) appeared to threaten the financial viability of the nation’s large urban teaching hospitals. Its explicit analytic purposes were similar to those of the Commission on Public-General Hospitals: “to examine the status of [AHCs] at a time of change and transition” and to “help inform the public about . . . policy issues that [would] shape the field in the future.”

Its implicit purpose was also similar: to protect a set of seemingly vulnerable institutions from precipitous or ill-considered public action by injecting analysis and reasoned argument into the policy process.

Impact Of Foundation Funded Commissions

Because elected officials and bureaucrats alike are free to ignore advisory reports and sometimes do, it is not surprising that commissions have acquired a “do-nothing” reputation. Popular criticism notwithstanding, studies of presidential commissions have found that most have influenced the policy process. Our findings on foundation-funded commissions in the health policy arena are remarkably consonant with the findings on presidential commissions. All five commissions we studied produced a substantial body of “usable knowledge”—policy-relevant information and analysis that reached government decisionmakers, health care experts, and the attentive public.

Two had a relatively diffuse impact on the policy process, while three had a discernible impact on legislation. Almost certainly the laws they influenced would have passed even if the respective commissions had not existed. However, these three bodies left a clear imprint on the substance—and, in one case, the implementation—of public policy.

The commissions with the most diffuse policy impact were the Macy Commission and the Commission on Public-General Hospitals. Even judged against the standard of its own relatively modest aim of facilitating an exchange of ideas on a complex policy subject, the Macy Com-
mission's impact is difficult to document. Its members recalled the meetings as “interesting” but also somewhat frustrating because no one quite understood “what Macy wanted.” Its report was widely distributed and mentioned in the national media. However, the report's main finding—that the adequacy of the current physician supply was a “subject of wide debate”—did little to clarify, much less resolve, the issue and, in any case, could not easily be translated into a clear-cut policy dictum. The impact of the Commission on Public-General Hospitals is also difficult to pinpoint. Its report provided a cogent defense for the continued existence of public general hospitals in the nation's 100 largest cities at a time when their physical, financial, political, and ideological underpinnings seemed to be giving way. To what extent this defense may have contributed to increased support for those institutions cannot be determined. However, some of the themes this commission sounded—the need for special relief for hospitals that served disproportionate numbers of poor and uninsured patients, for example, or for federal reimbursement policies to recognize the contributions and special needs of urban teaching hospitals—would continue to be heard in public policy discussions over the next decade.

Of the three commissions whose recommendations could be linked to specific legislation, the most influential was the Commission on Hospital Care. Virtually all of its major recommendations were embodied in the Hill-Burton Hospital Survey and Construction Act of 1946, and virtually every critical feature of that legislation bore the stamp of the commission’s work. Moreover, the planning methods and the state health planning bodies developed as a result of the commission’s activities influenced the implementation of the program long after the commission had disbanded. These results should not be surprising, however, inasmuch as a major purpose of the Commission on Hospital Care was to provide the rationale and lay the technical groundwork for Hill-Burton, which was being steered through the political process by staff from the AHA, the Kellogg foundation, and the PHS. Furthermore, the commission was operating during a period when foundations had in essence become close partners of government, almost routinely providing senior government officials with advice and staff and, in turn, drawing their own ideas and staff in part from the senior levels of government service.

The Carnegie Commission on Higher Education also had a discernible and acknowledged influence on national health legislation. The commission’s health policy role was primarily to legitimate and help crystallize a set of programs and policies initiated several years earlier and already embodied, at least in part, in prior health manpower legislation. Higher Education and the Nation's Health, one of the best known of
the commission’s twenty-three official reports, was released in the fall of 1970 and timed specifically to influence the successor to the Health Manpower Act of 1968. It did so in large part by providing a compendium of shared ideas and policy refinements that served as a reference point for health policymakers in both the Nixon administration and Congress. The commission’s endorsement of “first-dollar” operating support for all medical schools willing to expand enrollment was evident in the “capitation grant” provisions of the resulting Comprehensive Health Manpower Training Act of 1971. Other Carnegie recommendations embodied in the 1971 law were provisions for extension and expansion of existing programs of medical school construction grants, student loans, scholarships, and loan forgiveness; and for establishment of satellite “area health education centers,” linking health facilities in remote areas to medical schools and university health science centers.

A less ambitious undertaking than either the Commission on Hospital Care or the Carnegie Commission, the Task Force on AHCs had a narrower legislative impact than its more famous predecessors. Prescription for Change, issued by the task force in October 1985, consisted of three reports focusing on graduate medical education programs and costs; the role of teaching hospitals in providing care for the poor and uninsured; and the future financing of teaching hospitals. Only two of nearly a dozen novel recommendations presented in the reports found their way into legislation, and those two provisions represented but a fraction of the many health care provisions embodied in the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. Nevertheless, the data and the analyses developed by the task force constituted the major information base used by COBRA decisionmakers in modifying federal graduate medical education payment policy. The COBRA provision limiting medical resident payments to five years or first eligibility for specialty certification was modeled on a key task force recommendation. Another recommendation—that teaching hospital payments incorporate special adjustments for “social severity”—was also included in COBRA, as the disproportionate share adjustment for hospitals serving a large proportion of low-income patients. However, the National Association of Public Hospitals, not the task force, was the leading proponent of the Medicare disproportionate share adjustment.

**Political Consensus, Policy Windows, And Policy Impact**

These case studies suggest that private commissions, like presidential commissions, are most likely to leave their imprint on policy decisions when they can take advantage of a “policy window”—a situation in
which the public perceives a problem, government officials believe
that government action is appropriate, and political activists and “policy
intellectuals” agree on the broad outlines of a solution.28 Both the
Commission on Hospital Care, in crystallizing public concern over
hospital bed shortages, and the Carnegie Commission, in addressing the
widely publicized physician shortage, seized such policy windows. In
both cases, organized interest groups as well as politicians agreed on the
preferred policy alternative—some form of government subsidy. Thus,
although these commissions provided independent policy analysis, their
recommendations served to reflect and document as well as to shape the
consensus of the political establishment.

To a significant extent, this was also the role played by the Task Force
on AHCs in its work on the funding of graduate medical education and
the financing of teaching hospitals. The issues surrounding AHCs
aroused much less popular interest than those surrounding perceived
national shortages of hospital beds or physicians. The political consensus
in favor of revising Medicare graduate medical education payment pol-
icy was much narrower than the earlier national consensus to subsidize
hospital construction or to expand the supply of practicing physicians.
But it was a consensus nonetheless, shared by the health policy estab-
ishment in Congress, on both sides of the aisle. The task force’s analysis
of graduate medical education costs and its proposal to limit direct
payments to medical residents impressed government officials because
they filled a policy void and addressed a problem high on the congres-
sional agenda. In contrast, the task force’s work on health care for the
poor, which fell on deaf ears, neither reflected a political consensus nor
responded to the practical needs of government decisionmakers.

Lack of consensus and failure to grasp a policy window can be blamed,
at least in part, for the imperceptible policy impact of the Macy Com-
mission. Deliberating at a time when the once-solid political support for
government subsidies to redress the physician shortage was openly dis-
solving, the commission members themselves could not bridge their
disagreement over the physician shortage issue. According to at least
one member, the problem lay not with the commission or its leadership
but with the times. Yet their contemporaries on the Carnegie Council
on Policy Studies in Higher Education, successor to the Carnegie Com-
mision, did forge an action agenda, which reportedly influenced the
content of the health manpower legislation of 1976.29

The diffuse impact of the Commission on Public-General Hospitals
can be attributed in part to the absence of a clear policy window at the
national level and in part to the complexity of the political environment
surrounding public hospitals. Although federal Medicare reimbursement
policy directly affected public hospitals and some of the commission’s recommendations were aimed at least obliquely at that policy, during the tenure of the commission there was no major federal legislation pending and no serious prospect for short- or intermediate-term action on public hospital reimbursement at the national level. Moreover, because of the heterogeneity among public hospitals, the multiplicity of state and local decisionmakers, and the variability in state and local fiscal and political conditions, the commission faced more potential policy targets at the state and local levels than it could monitor or manage effectively.

**Structural And Operational Factors Affecting Policy Impact**

Whether a commission can take advantage of a policy window depends not only on its political environment but also on six structural and operational factors identified through our case studies: (1) the sponsor’s commitment to actively influencing the policy process; (2) the members’ credibility and “connections;” (3) forceful leadership; (4) practical recommendations backed by usable knowledge; (5) a policy entrepreneur; and (6) sufficient scope, duration, and sensitivity to the time horizons of policymakers. The three commissions with the greatest immediate policy impact displayed all six features, while the two commissions with more diffuse impact were weak in all areas but membership (Exhibit 2). Although the case study method does not allow us to determine which of the factors are absolutely necessary for success, the cases suggest that the most important factors are the sponsor’s commitment to exerting policy influence, the exercise of forceful internal lead-

**Exhibit 2**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Commission on Hospital Care</th>
<th>Carnegie Commission</th>
<th>Task Force on Academic Health Centers</th>
<th>Macy Commission</th>
<th>Commission on Public-General Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activist sponsor</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
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<tr>
<td>Credible/connected membership</td>
<td>•</td>
<td>•</td>
<td>•</td>
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<tr>
<td>Forceful leadership</td>
<td>•</td>
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<tr>
<td>Practical recommendations</td>
<td>•</td>
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<tr>
<td>Policy entrepreneur</td>
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<tr>
<td>Sufficient scope, duration,</td>
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<tr>
<td>and timing</td>
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</tr>
<tr>
<td>Immediate legislative impact</td>
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</tr>
</tbody>
</table>
ership, and the aid of a policy entrepreneur to “market” a commission’s findings in the policy arena. These three conditions are likely, in turn, to foster credible membership, practical recommendations, and sensitive timing. Conversely, an inattentive or reluctant sponsor, an ineffective leader, or an entrepreneurial vacuum will more likely result in a commission’s overlooking the practical details required to reach policymakers. For the sake of brevity, we do not discuss each factor for each commission but rather provide illustrative examples.

Sponsor’s commitment to influencing the policy process. A commission sponsor, whether a foundation or another private organization, can significantly enhance the impact of a commission by making an explicit commitment to influencing the policy process and bolstering that commitment with sympathetic appointments and ample resources. If the sponsor communicates neither a sense of urgency nor a particular desire to shape public policy, the efforts of the commission to reach decisionmakers will depend largely on the predilections of members and staff, who may or may not take the initiative in the policy arena. For example, John Bowers of the Macy Foundation neither encouraged the members of the Macy Commission to take an active policy role nor provided the staff or resources to support such a role. The result was that the members were somewhat uncertain about the purpose of their enterprise and did not attempt to maximize its policy impact. Ambivalence also marked the leadership of the AHA, who were more concerned with balancing the interests of the AHA’s diverse constituencies than with exercising a major policy voice through the Commission on Public-General Hospitals. As a result, commission members and staff were left without a strong policy imperative or a clear strategy.

In contrast, Alan Pifer established the Carnegie Commission on Higher Education to help fulfill his vision of philanthropic foundations as key players in policy making and social reform. He then selected as chairman a prominent national figure-Clark Kerr, who had recently been dismissed as president of the University of California-who shared this activist vision and articulated an explicit reform strategy. Pifer and Kerr shaped the commission’s membership and operations to ensure continuous Carnegie support for the body’s undertakings.

A foundation’s control over the policy direction of a commission is arguably greater when it is both funder and sponsor (as was the case with Carnegie) than when it is simply funding a commission established by a separate sponsor with authority over appointments and operations (as was the case with the Commission on Public-General Hospitals). But the experience of the Commission on Hospital Care-in particular, the strong behind-the-scenes direction provided by Graham Davis, hospital
director of the Kellogg foundation and head of the AHA’s Committee on Postwar Planning suggests that a foundation can effectively influence the policy agenda of a separately established commission if a strong commonality of interest and a close working relationship exist between the foundation and the sponsoring organization. Furthermore, as the experience of the Macy Commission attests, the combination of foundation funding and sponsorship does not necessarily guarantee a strong policy direction.

**Knowledgeable, credible, and “connected” membership.** Sponsors generally place great importance on a commission’s membership, which affects the quality of its deliberations and recommendations, its credibility, and its direct access to authoritative government actors. Sponsors can raise the level of discussion, heighten members’ interest, and sustain their involvement by appointing a preponderance of individuals with relevant experience, immediate knowledge of the issues, and a stake in the outcome of policy decisions. They can also increase consensus by choosing individuals with generally similar values and policy preferences. Prospective members, in turn, often cite the “caliber” and congeniality of other appointees, along with the expected “level” of discussion, as important factors in their decision to participate.

Furthermore, the “connections” of commission members can significantly enhance impact. Without a public mandate, privately sponsored commissions have a more tenuous connection to the policy arena than government-sponsored bodies have. Along with their reputations and expertise, members may increase the leverage of a private commission by taking advantage of already established ties to authoritative government actors. For example, by virtue of their positions as heads of major teaching hospitals or medical schools, many members of the Task Force on AHCs had ties to health policymakers in Congress and/or the White House. In addition, three appointees were themselves former members of Congress or the administration. Altogether, at least six task force participants made use of these ties to meet with members of Congress or their staffs to discuss task force recommendations.

A problem for sponsors, however, is that commission members chosen primarily for their knowledge, interest, and connections may not be perceived by outsiders as sufficiently diverse to represent the public interest. Policymakers expect the positions of organized interest groups to be biased and one-sided, and they can usually judge “what kind of ‘correction factor’ they have to apply.”

They are much less certain about the positions of “independent” advisory groups that claim to be balanced and objective. If a commission’s membership appears lopsided, exclusive, or representative of a narrow constituent group, this may
undermine the perceived objectivity of its findings and recommendations. Thus the objectivity of the Task Force on AHCs was questioned by some on Capitol Hill because of its heavy representation of teaching hospital leaders. On balance, however, the benefits the task force derived from its members’ connections apparently outweighed any liability incurred from its somewhat narrow membership base.

However difficult it may be to balance competing concerns of congeniality, credibility, and “connectedness” in appointing commission members, every one of the commissions we studied seemed to do a relatively good job. Perhaps such careful attention is paid to appointments because they are the first and usually most visible decisions associated with a commission until its findings and reports are issued.

**Forceful leadership.** Strong internal leadership is necessary to focus the work of a commission and to guide its members toward consensus—viewed by some as the sine qua non of commission influence. The chairperson is the obvious source of such leadership. But if he or she cannot provide it, the sponsors of a successful commission will have to look to commission staff or perhaps to a steering committee comprising commission members. Both the Macy Commission and the Commission on Public-General Hospitals enjoyed dedicated, benign, but not particularly forceful leadership. In contrast, the three more influential commissions each benefited from strong and focused leadership. Kerr, who worked full time on Carnegie Commission matters, was a very strong chairman; he kept commission staff and technical advisory committees focused on practical products and steered commission meetings around contentious issues to achieve clear and solid consensus. Moreover, his leadership role was reinforced by his close association with the president of the foundation. Thomas Gates, president of the University of Pennsylvania while he also served as chairman of the Commission on Hospital Care, was not so vigorous a leader. However, many key leadership functions were performed by commission staff and by a strong and active technical advisory committee that included powerful members of the sponsoring body (AHA), as well as the foundations and the PHS. Robert Heyssel, chairman of the Task Force on AHCs, and Jerome Grossman, program director, devoted considerable time and energy and exerted a strong influence on that group’s operations despite their responsibilities as heads of major teaching hospitals. Together, Heyssel and Grossman formed a triumvirate with then Commonwealth Fund Vice-President Thomas Moloney, whose active involvement in task force activities provided additional leadership support. In each of these cases, the commission’s sponsor significantly contributed to the success of the body by identifying and nurturing strong internal leadership.
throughout the life of the commission.

**Practical recommendations backed by usable knowledge.** In the “policy primordial soup” from which government decisionmakers select proposals for serious consideration, those ideas that survive must pass the test of technical, fiscal, and political feasibility.\(^35\) Thus commissions can increase their chances of influencing the policy process by making specific recommendations based on credible information geared to the practical needs of policymakers. When the leaders of the Commission on Hospital Care saw that the proposed Hill-Burton hospital construction legislation was high on the congressional agenda, they quickly worked to produce national estimates of hospital bed needs for use by the PHS and congressional health subcommittees. They also sharpened their focus and decided to concentrate most of their resources on overseeing the development of the state hospital surveys that would be needed for successful implementation of the law. These data collection and planning activities served the practical needs of health policymakers to both “verify” the problem they were tackling and demonstrate the viability of the proposed solution. In overseeing the Carnegie Commission, Kerr took a similarly pragmatic approach. He directed the commission staff and technical advisory committees to produce succinct draft reports that could be used by policymakers as practical “blueprints for action.” Then he led the commission members in “carefully planned and highly focused talk” aimed to elicit a consensus that would guide subsequent drafts and recommendations.\(^36\) An emphasis on usable knowledge and specific recommendations geared to the immediate legislative concerns of Congress also marked Heyssel’s successful efforts to influence graduate medical education legislation with the findings of the Task Force on AHCs. According to congressional staff intimately involved in drafting graduate medical education legislation, the task force work was “very, very useful in [their] deliberations-the information was current, it was useful in the context of what [they] were doing, and it helped in getting the answers to fundamental questions.”\(^37\)

In contrast, the task force’s recommendations on health care for the poor and uninsured were so general and out of tune with the immediate concerns of Congress that they had no discernible impact. Similar vagueness was a problem for the Commission on Public-General Hospitals, whose draft report was sent back for a complete rewriting after senior staff at The Robert Wood Johnson Foundation criticized its lack of practical policy prescriptions. Even the revised report suffered from generality. Notably, the recommendations of the three most influential commissions were consensual and unanimous.

**Skilled policy entrepreneurs.** Even the most compelling and expedi-
ent policy proposals rarely find their way into government decisions without the aid of a “policy entrepreneur”—an advocate willing to invest time, energy, and reputation in capturing the attention of decisionmakers and persuading them of the merits of a particular approach.38 Neither the Macy Commission nor the Commission on Public-General Hospitals benefited from the work of a dedicated policy advocate committed to advancing its recommendations in the policy arena. Neither sponsor actively nurtured entrepreneurial activity. Neither commission spontaneously spawned a policy entrepreneur—the Macy Commission, no doubt, because of its internal disagreements, and the Commission on Public-General Hospitals because of its difficulty in targeting its recommendations to a clearly defined set of authoritative actors.

In contrast, each of the more influential commissions benefited from one or more dedicated policy entrepreneurs who built on their established political connections, spoke with authority based on both personal expertise and the weight of their commission’s findings, and used both formal and informal communications to educate policy experts, policymakers, and the attentive public. Formal communications—addition to circulation of commission documents—consisted of articles in professional journals, public speeches, press conferences, and testimony at legislative hearings; informal communications consisted of phone calls and meetings with key members of the policy community and affected constituencies. In some cases these entrepreneurial activities were funded by the commission’s budget and undertaken as part of a formal dissemination strategy, but frequently they were the result of individual initiative and were outside the formal aegis of the commission or its sponsor.

A commission’s chairman is often its chief policy entrepreneur, but this is not necessarily the case. The indefatigable entrepreneurs responsible for keeping the work of the Commission on Hospital Care in the forefront of policy developments at both the state and national levels were Graham Davis, hospital director of the Kellogg foundation; Vane Hoge, a prominent official of the PHS, who sat on the commission’s technical advisory committee and later became the first administrator of the Hill-Burton program; and Arthur Bachmeyer, former AHA president and staff director of the commission. These well-positioned men orchestrated a massive dissemination effort that not only involved their personal contacts with policymakers but also mobilized commission members, staff, and supporters in propounding the work of the commission. The chief entrepreneur for the Carnegie Commission was chairman Kerr, who personally undertook to keep the commission’s reports and recommendations before the eyes of Congress, cabinet officials, and
the press. Likewise, the chief entrepreneur for the Task Force on AHCs was chairman Heyssel, who personally met and/or testified before virtually all of the legislators actively engaged in the federal graduate medical education debates and who provided detailed input to those congressional leaders and staff most intimately involved in drafting graduate medical education legislation.

**Scope, duration, and timing.** The entrepreneurial activities of the successful commissions had two distinguishing characteristics: They were not “one-shot” efforts but reflected sustained efforts to “soften up” both the policy community and the attentive public; and they were responsive not just to the requirements of commission members and staff but to the needs and deadlines of policymakers. The Commission on Hospital Care and the Carnegie Commission were most successful in exercising continuing leverage on the policy process. The Commission on Hospital Care could do so because of its scope. In rallying hospital industry support at the state level and stimulating the development of numerous state planning bodies, it assured that its methods and models would extend beyond its immediate membership and would influence national hospital construction policy long after the panel had ceased to exist. The Carnegie Commission could exercise continuing leverage because of its duration: It had already been in existence for nearly five years and had already made a number of health policy recommendations before it issued Higher Education and the Nation’s Health in 1971. Thus, Kerr and other commission members had already had a long period for cultivating political activists and public officials. Moreover, the commission continued to operate for two more years and was succeeded by a similar body with overlapping leadership and interests.

Equally important in the quest for influence was the sensitivity of commission entrepreneurs to the time horizons of congressional policymakers. Realizing that their commissions’ fact-finding and deliberative processes might produce reports that appeared too late to influence key policy decisions, these entrepreneurs provided government decision-makers with preliminary information and recommendations whenever they could. As a result, the major impact of the Commission on Hospital Care stemmed not from its final report, which appeared long after the Hill-Burton bill had been drafted and introduced, but from the meetings, testimony, data collection, and planning activities that led up to the report and were geared to advise the key actors involved in the early stages of policy development. Similarly, the principal impact of the Task Force on AHCs came not from Prescription for Change but from preliminary meetings with congressional health policy leaders. Yet the formal issuance of these reports was important, inasmuch as policymakers...
needed authoritative published sources to justify and legitimate decisions made in the interim.

**Implications**

What are the implications of our findings for foundation sponsors? First, ad hoc commissions established to call attention to new policy problems or to propose radical new reforms are not likely to have an immediate impact on contemporaneous policy decisions. The commissions we studied were most successful when they addressed a problem that was already high on the political agenda and that elicited solid support for government intervention. Moreover, the proposals that made their way into legislation were generally consistent with, and in some cases intended to legitimate, the values and policy preferences of the political establishment. This does not mean that ad hoc advisory bodies have no role in fostering social change; rather, it means that commission sponsors whose primary objective is agenda setting, as distinct from policy legitimation or issue management, should not measure the success of their enterprise in terms of short-term legislative impact. Moreover, given the sustained period of “softening up” that usually precedes adoption of significant reform proposals, foundations should not expect ad hoc commissions, which by definition are of a limited duration, to be effective agents of fundamental change in the absence of other long-range educational efforts aimed at the policy community.  

Second, commissions likely will be most effective in the short run when, seizing an open policy window, they are able to provide credible information and practical recommendations to policymakers poised for action. Their credibility will depend partly on the reputations of their members and staff and partly on the quality of analysis provided. Although foundation sponsors need to give careful thought to the composition of membership, the case studies suggest that decisions about commission composition may be less important than those about leadership, content, and strategy. Commission sponsors will need to identify, enlist, and sustain forceful leaders who can focus the activities of commission staff and help members achieve consensus on concrete, workable proposals, and will need to provide sufficient material resources to produce and disseminate reports and recommendations.  

Third, to exercise effective leverage on the policy process, commissions will have to capture the attention of political activists, attentive publics, and, above all, government decisionmakers. Thus, sponsors, in conjunction with leaders, will have to involve skillful policy entrepreneurs willing to devote their time, energy, and personal reputation to
propounding the work of the commission. Moreover, given the short time horizons of policymakers, entrepreneurs must be identified early in the deliberative proceedings, must be skillful in scanning the policy environment for imminent government decisions, and must be prepared to ply the wares of the commission prior to publication of a final report.

Finally, to have maximum impact, commissions must go beyond “one-shot” efforts to reach the policy community. Thus, sponsors, leaders, and policy entrepreneurs should consider strategies for extending and “institutionalizing” their influence. One strategy, successfully employed by both the Commission on Hospital Care and the Carnegie Commission, would involve creating a corollary or successor organization with similar goals and overlapping membership. A second strategy would involve transferring selected functions to already existing, permanent organizations. (A variation on these themes is the development of the Institute of Medicine in the 1970s as a quasi-governmental, de facto standing commission established with major foundation input to overcome some of the limitations of ad hoc advisory bodies.)

In sum, a commission’s impact depends on both the political environment and the actions of its members. In the short term, foundation-funded commissions can do little to alter the political environment. If they are unfocused or unresponsive to that environment, their impact is likely to be diffuse. However, if by their leadership and conduct they are prepared to build on emergent political consensus and to meet the practical needs of authoritative government decisionmakers, there is much they can do to influence immediate policy decisions.

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NOTES


4. Sources included the Macy Commission’s 1976 overview of major studies on the need for physicians; E. Ginzberg, “The Politics of Physician Supply,” in E. Ginzberg, The Medical Triangle: Physicians, Politicians, and the Public (Cambridge, Mass.: Harvard University Press, 1990); and periodic reports of the Carnegie, Commonwealth, Kellogg, and Macy foundations. We chose not to study private commissions still in operation during the course of our study (for example, the Commonwealth Commission on Elderly People Living Alone or the National Leadership Commission on Health Care). Although such commissions would likely have afforded greater access to participants, staff, and unpublished records and might have contributed greater insight on process issues, we believe that judgments about their impact would have been premature.

5. We eliminated the Special Planning Committee of the Association of American Medical Colleges (1962-1965), the Citizens Commission on Graduate Medical Education (1966), and the Macy Commission for the Study of the Governance of the Academic Medical Center (1970).

6. The measures used to assess a commission’s impact were qualitative: (1) major media or professional coverage of its proceedings and recommendations; (2) perceived impact by key contemporary opinion leaders and/or policymakers; (3) perceived impact by historians, scholars, or other apparently objective observers; and (4) changes in government policy corresponding to the commission’s recommendations. This latter definition closely follows that used in Wolanin, Presidential Advisory Commissions, 131.

7. Ibid., 11-14.

8. Ibid., chapter 2; and Flitner, The Politics of Presidential Commissions, chapter 2. Additional purposes cited by Wolanin, Flitner, and others include satisfying demands of those inside or outside the administration who have personal or political ties to the White House, providing an independent check on the work of executive branch staff, and maintaining the presidency as a primary source of policy initiatives.


11. Commission on Hospital Care, Hospital Care in the United States (New York: The Commonwealth Fund, 1947), 4.


13. Gerteis, “Case Study of the Commission on Hospital Care.”


19. Wolanin, Presidential Advisory Commissions, 247; and Flitner, Politics of Presidential Commissions, 25-26. These authors cite numerous articles that express this view.

20. Tutchings, Rhetoric and Reality; and Wolanin, Presidential Advisory Commissions.


22. This account relies principally on interviews with Maxine Bleich, Macy Foundation; and Rosemary Stevens, University of Pennsylvania, cited above. Also, Eli Ginzberg, Columbia University, personal communication, 28 September 1989.


25. Karl and Katz, “The American Private Philanthropic Foundation and the Public Sphere.” The Commission on Hospital Care worked jointly with the U.S. Public Health Service in the collection and analysis of data. This close collaboration permitted the commission to claim a quasi-public status in its promotional literature.

26. Medical school capitation was reportedly invented in the US. Bureau of the Budget in 1967 by analysts who did not trust medical school deans or government bureaucrats to adopt major changes without additional legislative or financial incentives. Daniel M. Fox, president, Milbank Memorial Fund, personal communication, 31 May 1992.

27. The idea of a disproportionate share adjustment can be traced back to the 1977 recommendations of the Commission on Public-General Hospitals.


32. Lagemann, Private Power for the Public Good, 136.


36. Lagemann, Private Power for the Public Good, 139-140.


38. The term policy entrepreneur is from Kingdon, Agendas, Alternatives, and Public Policies.