Vision to Venture
FOUNDATION

A Multiplier Opportunity in Health Philanthropy

Connecting existing resources to the people who need them.

The resources exist. The barriers shouldn't.

VISION TO VENTURE FOUNDATION

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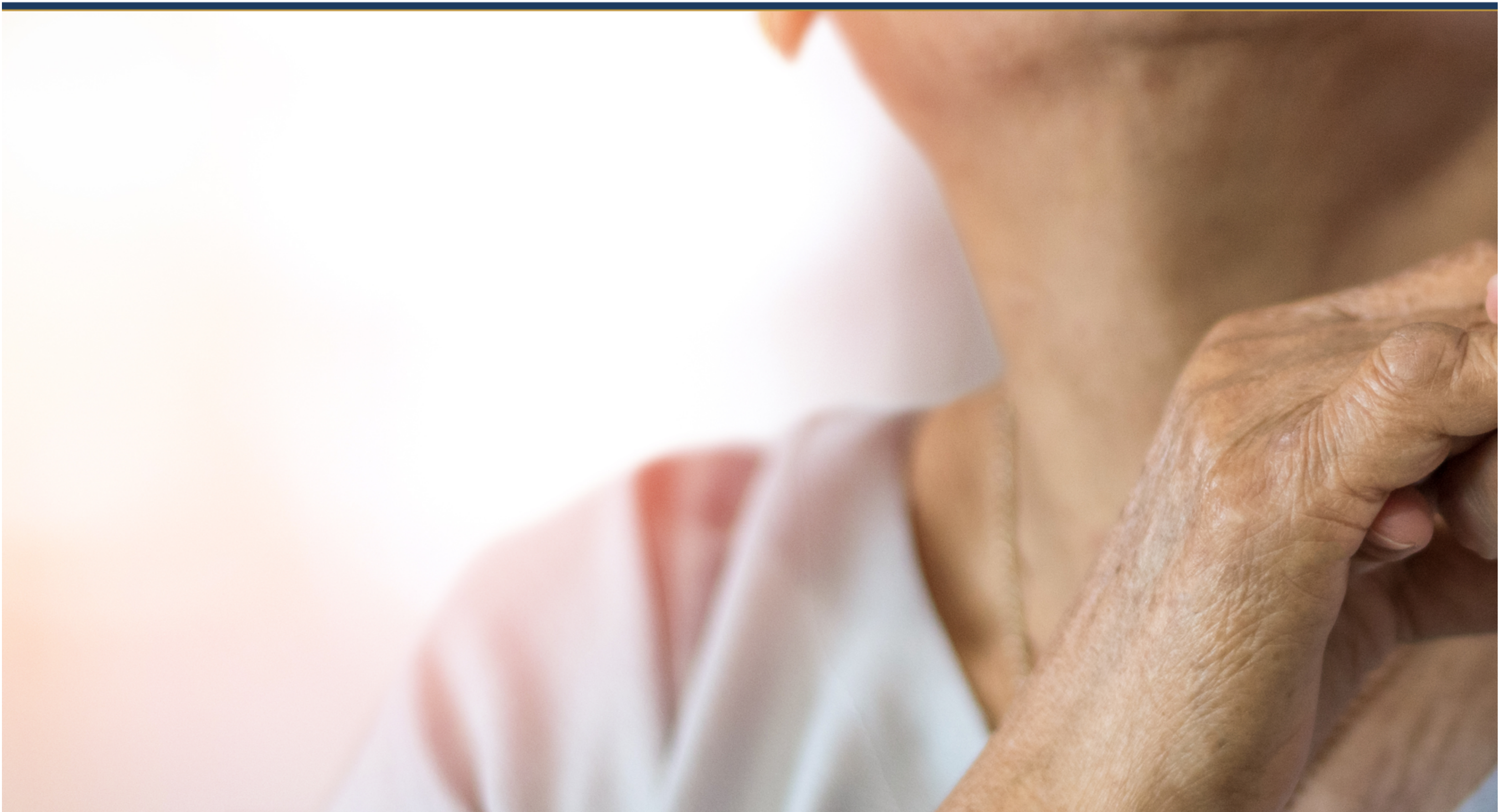

American philanthropy enters 2026 with extraordinary capacity. Charitable giving climbed to a record $592.50 billion in 2024. Foundation assets surpassed $1.6 trillion. Furthermore, Foundation grantmaking in 2024 topped $109 billion. A generation of donors and operators built durable institutions, funded research that saved lives, and lifted millions of families toward opportunity. That work matters.

It also opens a question worth taking seriously. With this much capital flowing, where can the next dollar do the most good?

One answer is hiding in plain sight. In healthcare, especially, the resources to help people often already exist. The infrastructure to connect those resources to the people who need them often does not. Closing that gap is a high-leverage opportunity for entrepreneurial philanthropy. It is the opportunity Vision to Venture Foundation is exploring.

Vision to Venture Foundation is built on a single conviction: the persistent failures of American social policy are not a failure of generosity. They are a failure of architecture. The capital exists. The programs exist. The clinical trials, patient assistance funds, social services, and care models exist. What is lacking is often the connective tissue that turns those resources into positive patient outcomes. Building that connective tissue is the work.

THE MULTIPLIER BEHIND THE MONEY

Health philanthropy has produced extraordinary breakthroughs. The Cystic Fibrosis Foundation's venture philanthropy model helped fund the discovery of CFTR modulators, turning a fatal childhood illness into a manageable condition. When the foundation sold its royalty rights in 2014, it received $3.3 billion to reinvest in research, followed by another $575 million from a second sale in 2020.

Drug discovery is one form of infrastructure. There are others.

Benefits Data Trust used data, technology, and a service center to help more than one million households access over $7.5 billion in public benefits like SNAP, Medicaid, and WIC. The benefits already existed. So did the eligibility. A clear path through the application maze did not. Benefits Data Trust built that path. Its closure in 2024 ended one of the most effective access engines in

American social policy and underscored how fragile delivery infrastructure remains when it depends on a narrow funding base.

The Robin Hood Foundation takes a similar approach to criminal justice in New York. Its grantee partners served, over a four year period, more than 4,200 New Yorkers and helped achieve an 8 percent recidivism rate among program participants, compared with a 50 percent baseline among comparable populations.

A pattern emerges across these examples. The most durable wins do not come from a single grant or a single program. They come from infrastructure that helps capital, knowledge, and care reach the people they were always meant to serve.

A FAILURE OF ARCHITECTURE, NOT GENEROSITY

Between the funders who deploy capital and the providers who serve communities sits a structural vacuum. This is where good intentions stop translating into outcomes. It is where proven programs cannot scale, where existing resources never reach the people who need them, and where the most committed practitioners burn out trying to compensate by hand for systems that were never built. Closing that vacuum is not adjacent to the work of philanthropy. In our view, it is the work.

Much of American philanthropy operates inside what we would call an operational orthodoxy. The legal architecture, anchored in the Tax Reform Act of 1969, established a 5 percent minimum payout requirement for private foundations. The intent was to ensure capital flowed. The unintended consequence is that the floor became a ceiling. Many foundations now treat 5 percent as the cap rather than the starting point, optimizing to preserve corpus rather than to maximize impact in the present.

That orthodoxy hardens into what analysts have called a compliance mindset. Program officers come to view their primary role as stewardship and protection of assets rather than venture partnership. The grants that result are restricted, time-bound, and stripped of the indirect costs that make programs actually work. The for-profit sector has long since accepted that overhead, defined as research and development, talent, and systems, is the engine of growth. The nonprofit sector still treats overhead as waste. The result is a sector that is structurally fragile and operationally hollow, even when it is well-funded.

THE STARVATION CYCLE

The most pernicious outcome of operational orthodoxy is the nonprofit starvation cycle, documented at length by The Bridgespan Group. The cycle is a self-reinforcing loop. Donors prefer organizations with optically low overhead, in the mistaken belief that an organization spending 90 percent on programs is inherently better than one spending 70 percent. Nonprofits compete for those dollars by under-reporting overhead, then deferring the technology, training, and financial systems that would let them deliver well. The under-investment shows up as turnover, fragile data, and missed milestones, which donors read as poor performance, which tightens the restrictions further. The cycle compounds.

Most foundations cap indirect costs at 15 percent. Bridgespan's research found that the actual indirect costs of effective, financially healthy nonprofits range from 21 to 89 percent. Their analysis of the 274 nonprofits most highly funded by the fifteen largest U.S. foundations is sobering: more than half experienced frequent or chronic budget deficits, and 40 percent had fewer than three months of cash reserves. These are the sector's most successful organizations.

"While most foundations cap indirect cost reimbursement at 15 percent, the actual indirect costs of effective, financially healthy nonprofits range from 21 to 89 percent."

It is not a financing problem alone. It is a measurement problem. The sector grades organizations on the wrong axis. The metric we believe matters is whether the people the organization exists to serve actually get connected to what they need.

WHY INFRASTRUCTURE MULTIPLIES IMPACT

Funders who back infrastructure tend to see what one practitioner calls big and broad results. They build the connective tissue that lets every other dollar work harder. Three examples make the case.

In India, the A.T.E. Chandra Foundation and partners invested roughly $3.6 million in the GiveIndia platform. Annual giving through the platform grew from approximately $3 million pre-pandemic to $120 million during COVID-19, and has settled at around $60 million per year. CEO Gayatri Nair Lobo describes returns of 28 to 300 rupees of nonprofit revenue for every rupee the foundation invested in fundraising infrastructure.

In the United States, the Raikes Foundation backed Giving Compass, which now reaches roughly 100,000 visitors per month and pushes curated giving guidance directly into the donor-advised fund providers where high-net-worth donors actually decide. Raikes Director Stephanie Gillis frames the work plainly: “If we can shift mindsets and behaviours among this base of donors, resources will flow more effectively to the things that work.”

Globally, the Bill and Melinda Gates Foundation has supported GivingTuesday, which on a single day in December 2024 helped facilitate $3.6 billion in giving, and GlobalGiving, which has channeled hundreds of millions of dollars to grassroots organizations in nearly every country in the world.

None of these investments simply funded programs. Each built rails on which other capital could flow. That is the multiplier hiding in infrastructure.

THE MESSY MIDDLE

There is a counterintuitive pattern in nonprofit balance sheets. Organizations with budgets under $1 million hold a median of 6.7 months of unrestricted reserves. Organizations with budgets between $1 million and $2 million hold 4.7 months. Organizations with budgets between $5 million and $10 million hold only 3.4 months. As nonprofits scale, they become more efficient at deploying capital and more financially fragile at the same time. The largest, most critical service providers in many communities operate within weeks of an air pocket.

Organizations with annual revenues between $500,000 and $5 million face a particularly acute version of this problem. Commercial lenders cannot underwrite them — there is no collateral and the perceived risk is high. Traditional grants do not cover working capital. The blended finance market has mobilized over $262 billion to date, but its median deal size of $64 million puts most organizations entirely out of reach. We call this the messy middle. It is where the operators most ready to scale are most starved of the capital that would let them.

Closing the messy middle is not a question of inventing new instruments. The instruments exist. Multi-year unrestricted operating support exists. Recoverable grants and program-related investments exist. Pooled philanthropic vehicles like Blue Meridian Partners, which has gathered more than $4.5 billion from 14+ partner philanthropists to make $100 to $200 million investments in nationally-scalable solutions, exist. The instruments are simply not being deployed at the scale the problem requires. That is a choice — and a choice that can be made differently.

THE HEALTH OPPORTUNITY

American healthcare is full of resources that do not reach the people they were meant to serve.

Patient assistance programs offer a vivid example. Pharmaceutical companies invested more than $22 billion in patient support programs in 2024, yet only 3 to 8 percent of eligible patients actually use them. The funds exist. The eligibility exists. The medications exist. The clear, reliable path from prescription to enrollment to refill often does not.

Maternal health offers another. Doulas and community health workers measurably improve outcomes, yet many models lack stable reimbursement and training pipelines. The Commonwealth Fund has documented multisector partnerships that bring infant mortality down toward national averages when the connective infrastructure is in place.

Technology offers a third. A Stanford HAI survey found that 76 percent of nonprofits believe their organization would benefit from greater use of artificial intelligence, particularly for mission-related work. Roughly half already use AI for back-office tasks. Most lack philanthropic support to build the platforms, data infrastructure, and training that would make AI safe and durable in clinical and community-facing settings.

The Bridgespan Group's Pay-What-It-Takes Philanthropy research reinforces the broader point. Across 20 nonprofits Bridgespan studied, real indirect costs ranged from 21 to 89 percent of direct costs, far above the 15 percent ceiling many foundations hold. When funders pay only the program line, they squeeze out the very systems and people that make programs work.

In each of these cases, the constraint is not a shortage of money or research or willing providers. The constraint is the absence of the connective infrastructure that converts existing resources into care delivered.

WHAT VISION TO VENTURE IS EXPLORING

Vision to Venture Foundation is just getting going. We do not claim to have solved the questions raised here. We are organizing around a thesis we find credible and want to test in the field.

The thesis is straightforward. In health, a meaningful share of the next generation of impact will come from organizations that build delivery infrastructure rather than fund discrete programs or substitute for direct service. That includes patient navigation platforms that automate enrollment and connect siloed databases. It includes the human infrastructure of community health workers, and benefits navigators that insurance reimbursement often does not cover. It includes the unglamorous data and interoperability work that lets agencies share information securely.

Our work is organized around four pillars, each chosen because the resources to solve the problem already exist and the missing element is structural. Each is small now. Each is meant to scale by being useful, not by being heroic.

Access to Clinical Trials Among Patients with Rare Forms of Cancer. Sarcoma represents about 1 percent of adult cancers but encompasses more than 70 distinct subtypes, each requiring specific diagnostic and therapeutic approaches. National clinical trial enrollment averages 7.1 percent, even though 70 to 80 percent of cancer patients say they are willing to participate. Patients often never learn about the trial that matches their tumor biology. We are building AI-powered trial matching designed specifically around what sarcoma trials actually require — subtype, genomic markers, HLA typing — and pairing it with claims-denial advocacy and a guided pathway from diagnosis through enrollment.

Navigating Specialty Medication Access Programs. Pharmaceutical manufacturers invested more than $22 billion in patient support programs in 2024. Only 3 to 10 percent of eligible patients, however, successfully enroll in these programs. Prescription abandonment reaches 60 percent when out-of-pocket costs exceed $500. The fastest-growing barriers in specialty pharmacy are the copay accumulators and the copay maximizers. — 46 percent of plan sponsors now use accumulators, 53 percent use maximizers, and patients in those plans face $4,000 to $4,200 in additional annual out-of-pocket costs when manufacturer assistance is exhausted without their knowledge. We are building a unified application hub across manufacturer programs and charitable foundations, with the proactive accumulator and maximizer detection that no other platform currently offers.

Connecting Persons in Need with Community-Based Programs. Clinical care accounts for only 10 to 20 percent of what determines health outcomes. The other 80 to 90 percent comes from social determinants — economic stability, education, housing, transportation, and social context. The current system forces a person in crisis to tell their story to five agencies and hands them phone numbers instead of providing pathways. Common Thread builds the coordination layer between healthcare systems and social services, with closed-loop referrals rather than handoffs.

Health Literacy Portal. Approximately 36 percent of U.S. adults — about 90 million people — have Basic or Below Basic health literacy. Only 12 percent reach Proficient. When measured by SMOG, the most accurate readability formula for healthcare materials, 99.3 percent of patient education content exceeds the recommended reading level. Patients with limited literacy spend $10,688 a year on healthcare versus $2,891 for those with adequate skills, a 3.7x cost multiplier, and Medicare alone could save an estimated $25.4 billion annually, and avoid roughly 993,000 hospital visits, with improved literacy. We are building a portal that translates patient-specific clinical information into plain language at the 5th-to-6th-grade reading level, with comprehension verification rather than simple delivery. If a patient cannot demonstrate understanding, we do not assume the message landed.

These pillars are not parallel programs. They share infrastructure on purpose. A sarcoma patient identified through Fight Sarcoma can be screened for medication assistance through MedSpan. A social barrier discovered during trial navigation triggers a Common Thread referral. A literacy challenge identified any routes to the portal. The integration is the architecture.

We are early. We will share what we learn.

THE CHOICE IN FRONT OF US

A useful thought experiment for funders considering this terrain: ask not only what your dollar funds, but what your dollar enables. A grant that helps one organization run a navigation pilot is good work. A grant that connects that pilot to the database, the reimbursement model, and the policy reform that lets ten more organizations run the same pilot is multiplier work. Both matter. The second is rarer and harder to find.

The opportunity in front of philanthropy is not to do less of what works. It is to invest in the infrastructure that makes everything else work better.

It is also a moment to retire some of the metrics that have held the sector back. Overhead ratios are a poor proxy for organizational health. Liquid reserves, grantee retention, the quality of the partnership between funder and operator, and the leverage ratio — how many additional public or private dollars each philanthropic dollar mobilizes — are far better signals. Foundations that adopt those metrics will find themselves backing different organizations than the ones that score well on the old ones.

The brand of philanthropy itself has to shift, in our view, from benevolent donor to risk partner. Risk partners say what they got wrong. They simplify their applications. They write multi-year unrestricted checks. They take board seats. They share the failure when something does not work, because the

alternative — quietly walking away from a portfolio company that needed help — is what produces the next round of starvation cycle.

The resources exist. The barriers shouldn't.

SOURCES

All statistics and quotations are drawn from the following primary sources. Hyperlinks throughout the document point to the same materials.

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› Draper Richards Kaplan Foundation. $300,000 of unrestricted capital over three years plus capacity-building support estimated at $500,000 per portfolio company; portfolio reach of 300 million+ lives.

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› UnitedHealth Group, "Improving Health Literacy Could Prevent Nearly 1 Million Hospital Visits and Save Over $25 Billion a Year," October 2020 (https://www.unitedhealthgroup.com/content/dam/UHG/PDF/About/Health-Literacy-Brief.pdf). Estimated $25.4 billion in annual Medicare savings and 993,000 fewer hospital visits per year if all U.S. counties achieved high health literacy levels.

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