GRANT MAKERS IN HEALTH

KNOWLEDGE TO ACTION:

Applying What We've Learned to Improve Health

JUNE 2007

KEYNOTE ADDRESSES FROM THE ANNUAL MEETING ON HEALTH PHILANTHROPY

MIAMI, FL

This publication is available on-line at www.gih.org.

FOREWORD

On February 14-16, 2007, Grantmakers In Health (GIH) held its annual meeting **Knowledge to Action: Applying What We've Learned to Improve Health** *in Miami, Florida. Since this meeting marked our 25th anniversary, we designed a program that offered the opportunity to reflect on the past with the goal of creating momentum for future. The agenda was structured to illuminate changes in health, health care, and the field of health philanthropy over the past quarter century. It also aimed to raise questions about the lessons learned from funded projects, the grantees with whom we have worked, the experiences of our peers and colleagues within the health sector and beyond, and how we could be most effective in translating what we have learned into action.*

This compilation includes remarks from each plenary session and the Terrance Keenan Leadership Award luncheon. Our plenary speakers offered a variety of perspectives on the trends since the early 1980s and the challenges that lie ahead. Whether it was sharing thoughts on how foundations have responded to the HIV/AIDS epidemic, discussing the twin epidemics of diabetes and obesity, or considering the potential of information technology to empower consumers and communities, these presenters provided inspiration and fresh ideas and challenged attendees to act on lessons learned from both successes and disappointments. We thank them for helping set the tone of a successful meeting and encouraging us to look thoughtfully and analytically at the work, strengths, and challenges in the field of health philanthropy.

Our thanks go, as well, to our many Funding Partners whose annual support helps underwrite a portion of everything GIH does, including the Annual Meeting on Health Philanthropy. We are particularly indebted to those Funding Partners that awarded GIH supplemental program grants, above and beyond their annual support, to help cover the substantial costs of this undertaking. Their additional generosity is instrumental in keeping registration fees affordable and the quality of the meeting high. They merit special recognition. Funders contributing to the annual meeting include: Archstone Foundation; The California Endowment; California HealthCare Foundation; The Annie E. Casey Foundation; The Colorado Health Foundation; Consumer Health Foundation; Health Foundation of South Florida; Jewish Healthcare Foundation; Robert Wood Johnson Foundation; Kaiser Permanente; W.K. Kellogg Foundation, Paso del Norte Health Foundation; Quantum Foundation; and the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

We would also like to thank those who helped make the 2007 annual meeting a success by designing and presenting breakout sessions during the meeting. This year's call for sessions produced an all-time high number of submissions, representing the wealth of challenging topics facing health grantmakers. Our great appreciation goes to the following individuals who rose to the challenge of reviewing and evaluating the many session proposals we received: Carol Breslau, The Colorado Trust; Bets Clever, Carlisle Area Health & Wellness Foundation; Ralph Fuccillo, Oral Health Foundation; Billie Hall, Sunflower Foundation: Health Care for Kansans; Sandra Martínez, The California Wellness Foundation; Robin Mockenhaupt, Robert Wood Johnson Foundation; Mary Vallier-Kaplan, Endowment for Health; and Nancy Zionts, Jewish Healthcare Foundation.

The Terrence Keenan Leadership Award selection committee also deserves special thanks for devoting considerable time to reviewing the nominations and discussing the merits of each nominee. These committee members, drawn from GIH's Funding Partners, are Sharon Dalton, Aetna Foundation, Inc.; Jewell Garrison, Columbus Medical Association Foundation; Roger Hughes, St. Luke's Health Initiatives; Helen Kim, Gordon and Betty Moore Foundation; Ed Meehan, The Dorothy Rider Pool Health Care Trust; and Stephen Schoenbaum, The Commonwealth Fund. GIH board member Kim Moore of the United Methodist Health Ministry Fund chaired the committee's deliberations but did not vote on the award's outcome.

For her work in editing the transcripts that form the basis of this report, GIH would also like to thank our editor Anita Seline.

Producing this volume gave us a chance to revisit the thoughts expressed and challenges posed to meeting participants. We hope you will value the opportunity to reflect on these remarks again and that you will share them with others who were unable to attend.

TABLE OF CONTENTS

LEARNING AND LEADERSHIP TO IMPROVE HEALTH

Lauren LeRoy

I want to welcome you to Grantmakers In Health's (GIH) annual meeting and to sunny Florida. We're in the very dynamic city of Miami. The population here has increased nearly 40 percent in the past 20 years, with substantial change in its racial and ethnic composition. In 1980 non-Hispanic whites made up 46 percent of the population. By 2000 they comprised 21 percent while the proportion of Hispanics had grown from 36 percent to 57 percent over those same 20 years. Miami is a city where 94 percent of Hispanics and three-quarters of the Asian population speak a language other than English at home. It faces major challenges in addressing both health disparities and the demands on the health system created by this ethnically and linguistically diverse population.

In the state public health rankings for 2006, Florida came in 41st. It could claim relatively low rates of cancer and obesity (that's good news), but it has high rates of uninsured, violent crime, and infectious disease. It has also seen recent increases in smoking and decreases in immunization rates.

While the specific numbers may be unique to Florida, the health issues they represent are not. They are familiar and longstanding, many having been with us for over 25 years, since Grantmakers In Health was established.

Looking Back Over 25 Years

Yes, GIH is 25 years old! We have built it together, and I celebrate you for being a part of it. When we thought about how to acknowledge this milestone, we decided it gave us the perfect opportunity to look back over the past 25 years and ask what we have learned about trying to produce social change and improve the health of all people. We will spend the next two days doing just that. We are also sending you home with a book of essays, fast facts, and resources prepared by GIH staff to supplement what you learn from your colleagues.

Twenty-five years. If this were our annual meeting 25 years ago, rather than asking you to turn off your cell phones and put away your Blackberries, we would have pointed out where the pay phones were. We might have been revolutionary (or presumptuous) enough to ask you not to smoke until the breaks. And, I wouldn't have dreamed of making any last-minute changes to my speech because the slides would have already been loaded into the projector's carousel.

SPEAKER PROFILE

Lauren LeRoy has served as president and chief executive officer of Grantmakers In Health since 1998. Previously, she was executive director of the Medicare Payment Advisory Commission (MedPAC), a nonpartisan congressional advisory body. Prior to MedPAC, she served as executive director of the Physician Payment Review Commission after coming from The Commonwealth Fund Commission on Elderly People Living Alone. Dr. LeRoy spent more than a decade at the Institute for Health Policy Studies at the University of California at San Francisco and began her career as a health policy analyst at the U.S. Department of Health, Education, and Welfare. Dr. LeRoy's work has focused on Medicare reform, the health workforce, health and aging, and health philanthropy. She has also chaired two study panels for the Institute of Medicine. Dr. LeRoy is a fellow of the UCLA School of Public Policy and Social Research Senior Fellows program. She received a doctorate from the University of California at Berkeley.

GIH wasn't the only new kid on the block in the early 1980s. We came along with the Sony Walkman, the first IBM PC on the market, and the first portable cell phone (which weighed nearly one pound and cost $3,500). How would we live without Post It notes, whose sales took off in the early 1980s? Barney Clark received the first permanent artificial heart in 1982, and we can thank Coppertone for introducing the first sunscreen to protect against the combined threats of UVA and UVB radiation.

We had our share of wars to deal with in 1982. Britain and Argentina went to war over the Malvinas (also known as the Falkland Islands), and we honored Americans lost in the Vietnam War with the dedication of Maya Lin's memorial on the Mall in Washington, DC. The Equal Rights Amendment faded away in 1982 when time ran out before garnering approval from the 38 states needed for ratification.

How many of you have read *One Hundred Years of Solitude*? Its author, Gabriel Garcia Márquez, won the Nobel Prize in Literature in 1982. The Academy Award for best picture (given that we're in that season) went to *Gandhi* (*E.T.* took the Golden Globe), and this year's pick for the Golden Globe's best actress, Meryl Streep in *The Devil Wears Prada*, received the same honor in 1982 for *Sophie's Choice*. When Kelly Clarkson, the first winner of *American Idol*, was born in 1982, who could have imagined how reality TV would dominate the airwaves today?

In the last 25 years, the world has gone wireless and digital. It has moved from video to DVD, from cassettes to

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CDs to iPods. If you had mentioned Yahoo or Google 25 years ago, people might have thought you were sneezing or drunk. Many of us have since become addicted to the Internet and e-mail, first at our computer terminals and then in our handheld PDAs. Using its criterion of "the greatest influence for good or evil," *TIME* magazine took the bold step 25 years ago of choosing the computer as its Man of the Year. It broke with tradition again 25 years later, by choosing "You" for its Person of the Year as shorthand for the impact of the World Wide Web in connecting people to information and creating cybercommunities.

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The Facts on Our Health and Health System

Each year I have given you the facts — the latest data on how our health system is performing. This year, my staff was kind enough to compile them in your resource book, so we don't have to review them in detail. I'm a little wistful about this change, I have to say. The numbers are often so striking. But, I recognize that this audience doesn't need the numbers to know that racial and ethnic disparities exist, that obesity is on the rise, that we face monumental demographic shifts, that the increase in uninsured is unabated, that large numbers of those with mental disorders don't get treatment, that the public health system remains vulnerable, and that both chronic and infectious disease take enormous tolls in terms of dollars, lives, and suffering.

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Since I can't resist using at least some data, let me try to capture the nation's health status with just a few vital statistics. Health spending in 2006 was nearly $2 trillion. That translates into over $6,000 per person and accounts for 16 percent of the gross domestic product (up from 9 percent 25 years ago).

We spend more than any country on health care, with health care costs rising at quadruple the rate for wages, while insurance coverage recedes. The chief global strategist of Starbucks recently noted that the prices of all those lattes and cappuccinos we drink went up last year for the sole purpose of keeping up with the cost of health insurance premiums for their employees, an example of cost shifting that gets a little too close to home!

Let's look at some admittedly crude-but-telling measures of what we are, or are not, getting for all that money. U.S. life expectancy at birth falls about one year below the average for all industrialized nations. The U.S. spends nearly three times as much per capita as Japan, and, yet, Japanese born in 2003 can expect to live on average more than four years longer than Americans born

that year. Think what you could do with those extra four years.

Don't you find it downright shameful that the U.S. leads industrialized nations in infant mortality? The U.S. also has the highest obesity rate among industrialized nations, so is it any surprise that 70 percent of deaths and health costs in this country are attributed to chronic disease? And we have a lot of ground to make up with the proportion of the population over age 15 that is obese being at least 20 percentage points higher than Canada, Poland, Sweden, Italy, France, Switzerland, and Japan, among others.

One change we have seen in the past 25 years is a growing interest, actually demand, for measuring performance in philanthropy and in the health sector. Let me pull from three reports issued this past year that together provide indicators of performance for our health care system, the public health system, and the nation's health.

The Commonwealth Fund, with guidance from its Commission on a High Performance Health System, developed a national scorecard that includes key indicators in five areas: health outcomes, quality, access, efficiency, and equity. Judging U.S. performance against benchmarks achieved by top performing groups (be they health organizations or countries), the fund concluded that "the overall picture that emerges is one of missed opportunities and room for improvement." And, that room is considerable: calling for improvements of 50 percent or more, relative to the benchmarks in many cases.

The Trust for America's Health again issued its assessment of the public health system's capacity to respond to and protect people from health emergencies (a proxy for the health of our public health system). Half the states could do no better than meeting 6 of 10 indicators of system capability. Twenty-five states would run out of hospital beds within two weeks of a modest pandemic flu outbreak. Forty states have nursing shortages. And 11 states, plus Washington, DC (the nation's capital and hot spot of vulnerability), lack sufficient capabilities to test for biological threats.

Even with these deficits, however, we do see a number of improvements when we look at the overall health of the population. America's Health Rankings has tracked nearly a 20 percent improvement in the nation's health over the past 17 years based on what it defines as the best available indicators of both health determinants and outcomes. That improvement has come from reductions in infant mortality, infectious disease, smoking, motor vehicle deaths, and a handful of other areas as well as increases in immunization rates and prenatal care.

There are two measures that have moved in a negative direction and hold back our progress, however. Not surprisingly, they are obesity and the number of uninsured.

Evolving Health Issues over 25 Years

It's not always easy to look back over a time as long as 25 years and remember what our concerns were then and how both conditions and people's thinking have evolved during that time. To try to gain some perspective, I turned to the journal *Health Affairs*. The journal's topics not only reflect editorial choices, they mirror what we in the health sector have defined as key issues at a particular point in time.

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Health Affairs' inaugural issue was published in the winter of 1981, just before GIH arrived on the scene. Let's take a look at the topics covered in that issue and the next three, which were published in 1982. We see concerns about health spending and debates about the most effective ways to improve the delivery system. Questions about the use of technology and incentives for its development are addressed. Ensuring an adequate health workforce and the financial and institutional requirements to support its training were clearly on people's minds 25 years ago. And the twin goals of promoting health while giving people insurance protection when they are sick were apparent in 1982 just as they are today.

It seems we're still grappling with most, if not all, of these issues today. At the same time, the years have surfaced other issues that either reflect change and innovation during this past quarter century or were there all the time but had not captured attention because of lack of appreciation of their importance or, perhaps, our inability or unwillingness to do something about them.

Added to the types of issues addressed in earlier years, we see a focus in 2005 on evidence-based practice and particular attention to health information technology. Racial and ethnic health disparities are explicitly addressed, and our attention expands beyond our borders to the broader world.

Last year, mental health received long-overdue attention, as did public health. Our concerns about the erosion of employer coverage were front and center. And, the promise of new therapies made possible by genomics and questions about how we will pay for them raised issues we're likely to be facing well into the future.

Looking across the years, we see change — sometimes for the better, and sometimes not. Despite our progress, The Commonwealth Fund reported last summer that "three-quarters of all adults believe that the U.S. health care system needs either fundamental change or complete rebuilding." Looking at such assessments, it's clear that we have our work cut out for us — and that we should be thinking boldly.

The good news is that we're here and we're energized. After the recent elections and looking forward to 2008, the buzz is that health care will be high on the agenda. One of the first tests may be the reauthorization of the State Children's Health Insurance

Program (SCHIP), something a number of you are focused on already.

The year 2007 may also go down in history as the year of the states. In a recent review of governors' state-of-the-state addresses by The Henry J. Kaiser Family Foundation, insuring all kids or going even further to cover the uninsured was a theme across the nation. Several states went even further, singling out long-term care and community-based services as areas ripe for improvement and experimentation. Real change there may be farther in the offing, but it will likely become irresistible over the next 20 years as baby boomers age.

So, let's ride the wave of momentum that seems to be building at both the state and national levels to strengthen our health system. Let's draw on the lessons from our past efforts and make the most from what we've learned about applying the assets that champions of philanthropy claim for us.

Philanthropy's Assets

Recently at the 50th anniversary celebration of the Foundation Center, Barry Gaberman, former senior vice president of the Ford Foundation, reviewed the often-noted comparative advantages of foundations. He included risk-taking, willingness to fail, capacity to stick with things, flexibility, fast response, piloting innovative ideas, and the ability to deal with politically sensitive issues. This is quite a dynamic set of attributes and a reminder of what our work is all about.

Between 1982 and 2004, the number of foundations grew from 23,770 to 67,736. Philanthropic assets have increased from over $58 billion to over $510 billion. In the health sector, much of that growth, outside of the Gates Foundation, has come from foundations created as the result of for-profit conversions of nonprofit hospitals or health plans. In 1982 many of the foundations represented in this room did not exist. Their emergence and the reaction to them, within and outside philanthropy, have had a profound influence on the field.

With all that money and Barry Gaberman's list of attributes, health funders should be well positioned to stimulate change. But, let's be candid. We know it's not quite that easy. Why is that?

In his new book, Joel Fleishman, a long-time observer and practitioner of philanthropy, suggests that "when a social problem is not discrete and well-bounded, when it permeates large segments of society, or when it is created in part by dug-in groups, a foundation can usually do little to solve the problem." Included in his examples of such problems is redressing inequities in our health care system. He notes the conclusion of some respected observers of philanthropy that the imbalance between foundation assets and these complex problems makes foundations "peripheral players," at best, in the pursuit of social change. And while Fleishman does not share that view, it is a humbling assessment.

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Douglas Nelson, president of The Annie E. Casey Foundation, recently described what he saw as a "sea change" during our lifetime in the way foundations view their role. He too acknowledges that foundation resources are only a fraction of what will be needed to fulfill funders' aspirations for social change and that they are dwarfed by the resources of government. But he doesn't let philanthropy off the hook. He notes that foundations "have an obligation to…have ideas that create change…advocate in a way that leads to change…and fund ideas and solutions we didn't have before."

Given the aspirations, assets, and advantages foundations can bring to the table, and the very real challenges they face in having a measurable impact on society, we need to think long and hard about how we get the most out of our organizations in this uphill climb for system transformation and social justice. Sometimes looking back down that hill and retracing our steps can give us guidance on how to move ahead and avoid the pitfalls of the past. That's where systematically building learning into our work becomes an asset.

Organizational Learning

The topic of organizational learning has captured considerable attention and interest among grantmakers in the past few years. Our desire to learn from our work and the work of our peers is widely shared. There are some very serious efforts underway that provide models for effective learning. Still, we have a long way to go to overcome philanthropy's learning disability. And, that begins with clarifying what learning actually entails and appreciating the value it brings to our work. In other words, we need to start by learning about learning.

We all know we have reams of material waiting to be read in our offices. In fact, a common occupational hazard among foundation staff is their being inundated with information. But, information isn't enough. Learning involves processes and tools that help us organize and integrate that information, assess what it means for our work, and apply our knowledge and insights to make smarter decisions.

It's interesting how important learning is to grantmakers whom we hold up as leaders or role models. While she was at The California Wellness Foundation, Ruth Brousseau interviewed 10 recipients of the Scrivner Award, given by the Council on Foundations to honor individuals considered exemplars of creativity and effectiveness in grantmaking. What emerged from those conversations were five common themes that shaped their work. These grantmakers viewed the ability to gather information, sift through it, see patterns, and change their thinking when the data warranted it as critical to their effectiveness. They shared the sense that their work was a journey, requiring flexibility to make mid-course corrections. And they benefited from their interpersonal skills and ability to

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cross boundaries, which allowed them to deepen their understanding of the social order and learn from grantees and others who ultimately would determine the outcomes of their work. Learning, in all its facets, was central to their success.

These leaders also made clear that learning doesn't stop with the individual grantmaker. It requires foundation support and exchange with peers in the field.

Ralph Hamilton and his Chapin Hall colleagues at the University of Chicago spelled out seven core components of learning foundations in their 2005 report *Learning for Community Change*. They included:

- a clear and concrete value proposition,
- an internal structure aligned to learn,
- providing leadership for learning,
- having a learning partnership with grantees and communities,
- creating a learning partnership among foundation peers,
- a commitment to share with the broader field, and
- investment in a broad and useable knowledge base.

This provides a tall order for those who want to fully embrace learning as a core value of their foundation. Some foundations have systematically taken incremental steps to incorporate specific components into their work. Many others have been more ad hoc. Foundations are also repackaging longstanding practices as part of their new learning strategy to respond to this trend in the field.

You can find many examples of foundation efforts to incorporate learning into their work. Foundations obviously expect their staff to do their homework up front. Many fund evaluations of their programs. Many of you build listening tours or community forums into your work. And, you come to meetings like this to share information with your colleagues.

In fact, I'm sure we all think we're learning every day. People who enter philanthropy are motivated, eager to learn, and want to be smart in what they do. Why, it almost seems insulting to suggest that grantmakers are not engaged in meaningful learning. So what's missing? Why is there so much emphasis on learning these days? Why are whole conferences devoted to it? First things first: we shouldn't take this personally. In some ways, it is recognition of the conditions that hinder us from learning as effectively as we could.

Systematically building learning into a foundation's work can profoundly change the organization. It takes two precious resources: time and money. Particularly now, when administrative costs are under the microscope, investing in learning may seem imprudent to the foundation's board and executives. Those costs go on the books, whereas the costs of repeating mistakes, while real, are less visible in the grants budget. It's also hard to squeeze in

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learning when staff and trustees are under constant pressure to get the money out the door.

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Foundations have also been known to make the mistake of thinking that putting a knowledge management system in place will transform an organization into a learning institution. Beware! Investing in tools to gather and organize information before understanding which information is worth preserving and how the information will be used does not enhance learning.

Integrating learning into our work will also be affected by who is assigned responsibility for the task. Like evaluation, knowledge management and organizational learning risk becoming silos within the foundation where they are viewed by staff as the job of a few people, not something that infuses everyone's work.

We know there are many sources we can turn to in order to enhance our learning (from the research literature to internal foundation grant reports). I want to mention just two that I think are particularly important and challenging: learning from grantees and sharing with peers.

In Ruth Brousseau's interviews, the Scrivner awardees emphasized the importance of learning from grantees — those on the foundation's front lines. They placed relationships with grantseekers at the heart of philanthropic work. And yet, we know that seeking honest feedback from grantees immediately bucks up against the imbalance of power created by the money funders have and grantees need. Brousseau describes the "a-ha" moment for many grantmakers when they realize they have "wandered into a wonderland where feedback had ceased to be real." That problem can be exacerbated by what Fleishman calls the sins of foundations: treating grantees condescendingly, not responding in a timely manner, being hard to contact, not giving clear signals about a proposal's prospects, and embracing chic or trendy ideas just because they're new.

We conduct our work without input from grantees at our own peril. How can we improve if we don't know when we've blown it? We also risk what philosopher Michael Hooker calls the "conspiracy of optimism" where grantees over-promise that they can leap tall buildings in a single bound and funders delude themselves that, like the children of Lake Wobegon, all their grantees are above average.

We have to be vigilant about not abusing the power inherent in those relationships. It's incumbent upon us to build trust and mutual respect through clear and realistic expectations, flexibility, openness, and accountability.

Building a Learning Community

I'm sure every one of you came to this meeting hoping to learn from your colleagues. We hear over and over from grantmakers: "I want to go home with ideas I can put into action;" "I want to hear about mistakes I should avoid;" "Don't just describe your grant. Tell me the real story behind the project description."

I'm struck by the irony that funders' appetite to get to the meat of grantmaking is so much greater than the priority they place on sharing what you all say you want and need. Nearly all the respondents to a FoundationWorks survey of leaders and observers of philanthropy noted a seeming unwillingness to share learning across foundations. In the Grantmakers for Effective Organization's 2005 member survey, the least common reason given for engaging in knowledge management was "to share learning with other grantmakers."

There are foundations that have made it a priority to share what they've learned, but that means overcoming a number of potential hurdles. The individualistic culture of philanthropy and the somewhat surprising competition among foundations can work against openness. Funders have different thresholds for candor and risk taking, as well as appetites for delving into issues. Deciding what, when, how, and to whom to share also consumes time and effort.

At the same time, there is something special in learning from your peers. You share a common experience, understand each other's constraints, and have probably grappled with many of the same problems. Grantmakers know it's hard to give away money or play a constructive role on issues that involve so many different stakeholders. They know the feeling of having done your homework but still holding your breath as you step into the unpredictable business of social change. And yet, conversations among funders (even at meetings like this) tend to shy away from reflections that might show vulnerability or "not having it all figured out" and focus instead on sharing successes, learning about current issues, and teachable skills.

So, let's turn to a touchy subject. Grantmakers are often accused of only showcasing their biggest successes, putting a positive spin on average projects, and sweeping missteps — or downright failures — under the rug. It's hard to be a risk taker in something as messy as social change without the expectation that failure is part of the process. Why are we afraid to share that part of the process? And, besides, success may not be all it's cracked up to be. Today's success can be ephemeral or sow the seeds of future problems. Let's recognize that success and failure are two sides of the same coin and turn each to our collective advantage.

Creating the culture for change in your organizations requires everyone's commitment, but it has to start at the top. It takes leadership that is supportive, inspiring, respectful, and flexible; that creates a culture where it is safe to make mistakes, learn from them, and move forward. That culture matters

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for everyone in the organization. It stretches from getting the board more actively engaged in program and strategy issues to creating a staff environment that rewards questioning and self-criticism.

It doesn't stop in our individual organizations. For us to truly create a learning community among foundations (among all of us), we also need a culture change that explicitly honors and respects open debate and provides a safe environment for seeking advice, admitting mistakes, and learning from them. We have the opportunity over the next two days to begin to shape that culture, and I challenge you to take advantage of it.

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Preparing for Foundation Leadership Change

Finding effective ways to institutionalize learning in our organizations takes on an added sense of urgency when we consider the leadership changes that will occur in foundations over the next decade as baby boomers decide to retire, scale back, or pursue other professional interests. Learning organizations are less vulnerable to the loss of institutional knowledge when a leadership transition occurs. Foundations are well aware of this impending challenge but have tended to direct their concerns to bracing nonprofits for the tidal wave of retirements rather than focusing on themselves. For that reason, data on foundation executive transitions are scarce. But, the message is pretty clear from what we can piece together.

An informal chat among GIH staff surfaced nearly 20 foundations we work with that recently had either changed leaders or announced their CEO's retirement plans.

Nearly a third of the respondents to our latest survey of foundations created through conversions anticipated an executive transition sometime within the next 5 years.

An earlier survey of community foundation CEOs suggested even greater change. After a decade of stability, 55 percent of CEOs in 2003 said they planned to leave their positions within five years. In addition, over 80 percent of CEOs who were under 50 also anticipated leaving their current jobs at some point, with half of these expecting to do so within five years. Regardless of whether foundation executives are retiring or moving on to new challenges, the face of leadership in philanthropy will be profoundly different in 10 years than it is today.

The picture is even more striking among nonprofits that both carry out foundations' work and are often training grounds for foundation leadership. The report *Daring to Lead* presents the sobering results of a 2005 survey of nonprofit executives — three-quarters planned to leave their current jobs within five years.

Both foundations and the nonprofit sector generally will face increasing competition for senior staff as the

baby boomers retire and the labor market tightens. The stark reality, according to Tom Tierney and his colleagues at the Bridgespan Group, is that the combination of baby boomer retirements and increased staffing demands of a growing nonprofit sector will create a leadership deficit that will force the sector to think and act in new ways. They estimate that, in the next ten years, 640,000 new senior managers will be needed.

With numbers this striking, you would think that foundations would be preparing for change. From what we know, there is a bit of the ostrich effect going on here. Only 15 percent of conversion foundations in our latest survey had written succession plans, slightly less than the 20 percent reported by community foundations. Ultimately, executive recruitment is the board's job, and it's obviously in its interest to avoid a poorly managed transition.

Diversity of Foundation Staff and Boards

As we think about succession, let's take a look at the foundation workforce today and how it's changed over the past 25 years. We've seen the greatest changes among professional staff, with women making up over two-thirds of the staff as compared with 55 percent in 1984. This may be good for women, but we need to ask ourselves where have all the men gone, and why. Minority gains in the professional ranks were helped particularly by their increases among program officers, where they now make up 35 percent as opposed to roughly 15 percent in 1982.

Women have made great strides in moving into foundation leadership positions. Only 26 percent held the position of CEO in 1982, whereas 55 percent do so today. The same can't be said for minorities, however, who fall well below their representation in the larger society. By 2006 minorities still made up only 6 percent of foundation CEOs.

Since boards are responsible for recruiting new leadership, let's take a look at their composition. Here, again, we see progress over two decades, but generally both women (who now make up 36 percent of trustees) and minorities (who comprise 12 percent of trustees) still have ground to make up.

We could assume that, with the demographic shifts taking place, we can sit back and the problem will take care of itself. Survey findings in *Daring to Lead,* however, would suggest otherwise: Younger nonprofit executives were just as likely to be white as their older colleagues, and newly hired executives were only slightly more likely to be minorities.

We cannot give lip service to the challenge of diversity. And, this is not something that should be left to chance. I would argue that we be more intentional, recognizing that we are not only addressing social injustice but are creating a work environment that enhances our ability to understand the issues we address and find effective ways to solve them.

The face of leadership in philanthropy will be profoundly different in 10 years.

The Next Generation

As if I haven't given you enough to tackle, there is a larger challenge than just getting our succession plans in order. And, that has to do with nurturing the promising leaders of tomorrow who are waiting in the wings (or perhaps, chomping at the bit). I daresay a number of you are in this room. The good news is that young professionals today should have tremendous career opportunities as the boomer generation leaves the labor market. The flip side of that story is greater competition among employers in all sectors.

The good news is that young professionals today should have tremendous career opportunities as the boomer generation leaves the labor market. The flip side of that story is greater competition among employers in all sectors.

Just to play the numbers game, it's obvious that, with relatively fewer people now rising through the ranks than we had when baby boomers were in their 30s and 40s, it becomes more important than ever for foundations to invest in staff development and create attractive conditions to retain staff. The good thing is that creating a culture that supports learning can also promote strong working relationships within a multigenerational staff: respect, candor, openness to new ideas, flexibility, and a commitment to professional development and opportunity. It demands that we older folk (the ones who said, "Never trust anyone over 30") have a healthy sense of humor about ourselves. Still, we also need to be mindful of some real generational issues that can strain staff morale and effectiveness.

First, I think many baby boomers in our circumstances are schizophrenic. I can say that because I am one of them. While we sometimes grouse about being overworked and dream about retirement, the thought of leaving our work is often daunting. We've always been accused of being self-indulgent, and maybe wanting to stay on the job is just the latest manifestation. Particularly with our ability to look and feel young, we may see no reason to stop working for social justice just because we turn 65. And, there are many of our generation, including some grantmakers, who may not have a choice other than to keep working because of inadequate retirement earnings. Large numbers of executives in their 60s say retirement is not their ideal next role. Their experience and continued engagement could help fill the projected leadership gap, but we need new models that pass the baton to the next generation of leaders while taking advantage of the experience and continued contributions more seasoned workers want to make.

We also need to be up front in acknowledging that generation gaps exist within our organizations, and it's up to us to determine whether they are disruptive or advantageous. Studies by the Pew Research Center for People and the Press have documented the differences in world views, lifestyles, prejudices, and priorities across generations. It's most recent report on Generation Next notes their greater comfort levels with living in a multiethnic/multicultural society, somewhat different attitudes toward work, and greater facility with and

acceptance of technology. This last point was brought home to me one night while listening to National Public Radio when the reporter made the distinction between my son's generation of digital natives and mine, which represented digital immigrants who could master the language but would always speak it with a heavy accent. In this digital divide is a lesson that I think we can apply more broadly in our work. Regardless of where we are in our careers, we each have things to learn from one another. It's not always easy, and we can all be pretty stubborn and opinionated — regardless of age. Learning from mentors and being challenged by new perspectives of younger colleagues are critical to our effectiveness in pursuing our shared commitment to social change.

With all the challenges I've presented you today, let's be happy that our work is not like the Rubik's Cube, which caught on across the globe 25 years ago as people scrambled to find the one (and only) correct answer out of 43 quintillion wrong ones. As we work to solve health problems, making headway and mistakes, we gain experience that we can learn from and share. That process can be as important as the actions we take. So let's make sure that we take the time to reflect and apply what we've learned so that we can make the most of our efforts to improve people's health.

LOOKING INTO THE CRYSTAL BALL

Georges Benjamin, Angela Glover Blackwell, Molly Coye, Marc Freedman, Xavier Leus, Mark McClellan, and Susan Dentzer (moderator)

Dr. Lauren LeRoy, *Grantmakers In Health*: The theme of this meeting is *Knowledge to Action: Applying What We've Learned to Improve Health*. Although this theme emphasizes reflection to improve our effectiveness going forward, it is difficult to think about how to apply those lessons if you do not have any vision for the future.

Peter Schwartz, chairman of the Global Business Network, has said, "The dominant intellectual strategy that people bring to the future is denial." That is not for us. We prefer to tackle this head on.

We have gathered a panel of experts on current and unsolved issues and new developments within and outside of the health sector who will discuss what they think defines or will define health and health care in the future. Each panelist brings different experiences and perspectives to the conversation. You will get to know each of them from their comments, so let me just introduce them briefly. They are: Georges Benjamin, executive director from the American Public Health Association; Angela Glover Blackwell, founder and chief executive officer of PolicyLink; Molly Coye, founder and chief executive officer of the Health Technology Center or HealthTech; Marc Freedman, president of Civic Ventures; Xavier Leus from the World Health Organization (WHO) and the director of the WHO office to the World Bank and the International Monetary Fund; and Mark McClellan, senior fellow at the AEI-Brookings Joint Center for Regulatory Studies, and until recently, the administrator of the Centers for Medicare and Medicaid Services (CMS). Susan Dentzer, health correspondent with *The NewsHour with Jim Lehrer,* will moderate the panel.

Susan Dentzer, *The NewsHour with Jim Lehrer*: We are going to talk, first of all, about how health and the health sector have changed over the last 25 years and identify some of the key issues that have propelled those changes forward. We will also discuss how they might change in the next 25 years. Finally, we will talk about the opportunities ahead in addressing some of the top issues in health, domestically and around the world, and the role for philanthropy.

Before we pull out that crystal ball and look forward, we are going to look back and learn from our panelists their perspectives on the most important change that influenced health care and the health sector over the last 25 years.

Mark McClellan, ***AEI-Brookings Joint Center for Regulatory Studies***: One of the big issues that I have struggled with over the last 25 years, both in my academic career in economics and in my policy work at the Food and Drug Administration and CMS, is medical technology and the advent of molecular medicine. The way that many diseases are treated has changed through an understanding of the molecular process that causes the disease. For example, in heart disease the death rates today are half of what they were 25 or 30 years ago, in good part because of an understanding of the mechanisms causing heart disease. New drugs are coming along such as beta blockers, ACE inhibitors, and other treatments. According to recent studies by my colleague and coauthor David Cutler, these new drugs have added literally trillions of dollars to the well-being of Americans and people around the world. If you look at medical conditions such as HIV/AIDS, the drugs that have been developed in response to the molecular understanding of the disease have transformed treatment. This is true for cancer and many other conditions.

This new understanding has had an impact not only on people's lives but on our regulatory and health care financing system as well. Many of the struggles we have faced in health care financing relate to changing what we pay for to reflect the trends in the way diseases are treated. There is now much more of an interest in prevention. Why? If we diagnose diseases early, we can actually do something about it, thanks to these molecular interventions.

With this explosion in medical capabilities has come real problems in paying for care and in making sure that the right patient gets the right treatment at the right time. I think the challenges of dealing with more personalized medical technologies are going to become even greater for our financing and delivery systems in the years ahead, and it is definitely something to pay attention to.

Health care is a dynamic industry. Medical technology is ultimately driving many of the changes that we are facing in health care financing and delivery. Health care should be a lot less about paying for things after complications occur and more about heading them off. But that is not the way our health care delivery system or our health care financing mechanisms have been designed. Many policy reforms, including Medicare Part D and other major changes in Medicare that I helped implement, are really driven by this change in medical technology.

Health care should be a lot less about paying for things after complications occur and more about heading them off.

Georges Benjamin, ***American Public Health Association***: AIDS. You think about AIDS from its original presentation on our shores. It starts with denial, discrimination, and fear. It exposes the core infrastructure of our public health system. It exposes the politics of medicine and public health in a way that no other disease has ever done. It has continued to advance around our world. It is the pandemic of our time. Now it is even a national security issue.

Think about it. A whole continent with the potential of being depopulated with all of its natural resources

SPEAKER PROFILE

Susan Dentzer is a health correspondent with *The NewsHour with Jim Lehrer* on the Public Broadcasting Service (PBS). She leads an award-winning unit dedicated to providing in-depth coverage of health care, health policy, and Social Security, including the acclaimed pieces "Wounded Soldier" and "Wounded Warrior," as well as an investigative piece on the importation of prescription drugs. Prior to joining *The NewsHour*, Ms. Dentzer was chief economics correspondent and economics columnist for *U.S. News & World Report* and a senior health writer for *Newsweek*. Ms. Dentzer's work in television has included appearances on *ABC's Nightline*, CNN, and *The McLaughlin Group*. Ms. Dentzer is a member of the Council on Foreign Relations and serves on the board of directors of the International Rescue Committee, the Global Health Council, and the Japan Society of New York. Ms. Dentzer is a graduate of Dartmouth College.

poses a phenomenal national security issue for the planet. HIV/AIDS is right in the middle of all of that.

AIDS truly has transformed the public health community. As we see the next great pandemic emerging, whether it is SARS or avian flu, we can just hope we do not repeat the same mistakes we did with the first one. AIDS has transformed the public health community as well as exposed its weaknesses. Think about how long it took us to identify the AIDS virus. In contrast, within weeks we had an understanding of the molecular biology of the SARS virus. Our aggressiveness now in dealing with pandemics has changed, but we still have a weak public health infrastructure, and we have not fixed that yet.

Our aggressiveness now in dealing with pandemics has changed, but we still have a weak public health infrastructure, and we have not fixed that yet.

Molly Coye, *HealthTech*: I am going to be an optimist because, ironically, Al Gore and President Bush both agree about the importance of the Internet. Al Gore invented it, and President Bush was the first president to have an executive order saying it should be the foundation of the health care system.

I think that what the Internet has already done is transform what it means to be a consumer, and access to information. It has equalized the role of consumers in many other sectors. It is really not used in health care nearly as much as it will be in the next 25 years. We can see how this will play out in a number of critical ways.

First, in addition to this shift in balance of power, is the diffusion of knowledge. Some of us assume this now, but 25 years ago, medical knowledge was still in books or in the heads of medical professionals. Now there is the idea that everyone can have access to medical knowledge and contribute to it.

Second, it is creating communities. We know from research that has nothing to do with the Internet, that communities of patients can be enormously powerful in creating prevention

approaches, the treatment of diseases, and the maintenance of good health in the face of chronic disease. On the Internet you see the birth of communities that cut across local geography and form bonds on the basis of many different elements.

The last one that I want to mention is the role technology has played in global awareness. The United States is atypical for most developed nations in being very isolationist. Most of the American population really do not have a lot of experience with other countries and other cultures. Now, through the Internet, bonds are being formed, communities created, and inquiries carried out that span national boundaries. I think it is going to have a very important effect both on health care in the United States and also on our consciousness as a country.

The Internet has transformed the experience of patients in health care enormously; a lot of elders go on the Internet to read about a disease before they go to see a doctor or after they have seen a doctor. It makes them feisty. I think this is very good; I think we are seeing a real transition. As an example, let me share with you an article that appeared on the front page of *USA Today* recently. A survey of national parks asked what age sector tended to bring Internet devices into the park most. It was 65-and-older segment. This is not just something in the future.

Angela Glover Blackwell, *PolicyLink*: Over the course of the last 25 years I think we have really come to understand as a nation that we do not thrive together if we do not thrive individually. We have come to understand that the disparities that we have been very aware of, in terms of income and education, also have had an impact on health and well-being.

The issue of disparities, disparities in health for people who are African American, who are Latino, who are Asian, those issues have come front and center. We have had real public discourse about them, and that has been very good. At the same time, though, we have seen that as we have gained knowledge about what really contributes to health and well-being, we have come to understand that lifestyle and environment play a big role, in fact larger than the issue of access to health care.

We recognize that where you live has really become a determinant of your access to opportunity, just as it determines whether or not your children get to go to a good school, or whether or not in an emergency you can pull resources out of your home to be able to respond. It also determines whether or not you are going to be healthy and, in many cases, how long you are going to live. We all saw it exposed in graphically humiliating details in the incidents that happened in the Gulf Coast 18 months ago.

This awareness that where you live can have an impact on health and well-being is leading to a different kind of strategy for promoting a higher quality of life. It includes being able to live free of asthma, being able to deal with issues that we worry about such as whether or not there are bus depots in your neighborhood, whether there are

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safe parks where you can get out and exercise, and whether there are places where you can purchase healthy foods, fresh fruits, and vegetables.

One, disparities exist in health as well as in the other areas. Two, a part of the greatest disparity of all in this country is the disparity that is associated with place.

Susan Dentzer: A recent study out of the Harvard School of Public Health identified eight different Americas in that respect; one America at the top where people live longer than even those who live longest in five countries in Asia. At the other extreme, there is the America where people live at the level of Third World countries in terms of their life expectancy.

Angela Glover Blackwell: We spend a lot of time looking at the issue of infant mortality in this country, but if you look at heart disease and diabetes and those kinds of things, you will see these same glaring differences. It is so easy to assume that you are just talking about people who should take better care of themselves, but it is not that simple. It is not just that resources and money put you in a position to have better health care. It is that some people live in places where nobody should really have to live. One of the things we failed to do as a nation (and we are starting to be hurt nationally because of it) is that we have not set a floor below which we do not let people fall.

Global public health has a history of many successes, but there also is a history of missed opportunities.

Xavier Leus, *World Health Organization*: From a point of view of global health, there is little doubt that HIV/AIDS has been the defining experience over the past 25 years. When I was in Suriname on the border with Guyana, a republic in the north of South America 25 years ago, I saw the first cases of this disease in Haitians working on banana plantations for the export trade.

That is when we started making those links. At that time, we had a different view of global health and where we were going. We have had to totally redefine and struggle for the past 25 years. In many ways, it is the return of infectious diseases, which we thought we had largely conquered.

The impact of AIDS is not just on people but also on the structures of how we deal with global health issues: the relationship between trade and health, intellectual property regimes, human rights in health, all issues that we touched upon in earlier days.

Global public health has a history of many successes, but there also is a history of missed opportunities. We have seen this coming. We have dealt with it in very limited ways. We did not link the HIV/AIDS agenda to our agenda on sexual and reproductive health; we didn't link our HIV/AIDS agenda to the oncoming or returning epidemic of tuberculosis nor to the other neglected tropical diseases.

So it is an age in which, in fact, we have learned many lessons. It is a time of great hope because there are major amounts of funding that have become available for global health.

But questions remain : Are we dealing with prevention? Are we looking at an

SPEAKER PROFILE

Mark McClellan is a visiting senior fellow at the AEI-Brookings Joint Center. Prior to joining the center, he served as administrator for the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services. Dr. McClellan previously served as commissioner for the Food and Drug Administration. He was an associate professor of economics at Stanford University, an associate professor of medicine at Stanford Medical School, and a practicing internist. Dr. McClellan was also a research associate at the National Bureau of Economic Research and a visiting scholar at the American Enterprise Institute. He has served as associate editor of the *Journal of Health Economics* and coprincipal investigator of the Health and Retirement Study, a longitudinal study of the health and economic well-being of older Americans. Dr. McClellan served in the White House for two years as a member of the President's Council of Economic Advisers and as a senior policy director for health care and related economic issues. He is a graduate of Harvard University and the Massachusetts Institute of Technology.

epidemic that will continue growing, that will continue to put increasing numbers of people in resource-constrained environments with treatments paid for by foundations such as yours, paid for by governments of the Organization for Economic Co-operation and Development? Will we have a class of citizens in the world who are actually dependent on good will for their continued treatment? We must deal with these issues of prevention and contain this, nip it in the bud, and deal with it from a holistic perspective.

Marc Freedman, *Civic Ventures*: As I tried to think about aging over the last 25 years and whether there was a resounding event, I ended up more with a whimper more than a bang. It was in 2005 when I read a little snippet from the Associated Press that the original Leisure World in Orange County, California had decided to change its name to Laguna Woods Village. I thought that, even though that garnered very little national attention, it was actually the confirmation and completion of a 50- to 75-year process that began with Social Security and led people to live much longer and healthier lives, much of it outside of the workforce. It was the same process in which Walter Reuther in 1949 had identified when he described older people in the country as "too old to work, too young to die." This gaping hole of people dangling at the end of the life span for years and years had opened up.

In the 1950s, first, the financial services industry, and then the retirement community developers, the Sun City folks and the Leisure World entrepreneurs, came in and answered that question. When Sun City opened

in 1960, it was around the banner of an active new way of life. During the 1960s, 1970s, and 1980s, it went well beyond these retirement enclaves to become a democratic, nationally distributed lifestyle, which contributed to yet further gains in life and health. By 2005 it was irrelevant to be called Leisure World because you did not have to go to a special place to live an active new way of life. If you were older, it was everywhere in every community.

The refrain you hear over and over again is: "Who can play golf for 30 years?" Even though people want to play golf, Leisure World itself actually has become an artist's colony, a creative place where people are doing lots more than the traditional pursuits. But we now know from studies like Robert Kahn and Jack Rowe's *Successful Aging* that lifestyle is such a critical ingredient in sustained physical and mental health. They talk about Freud's adage of love and work, the connection with other people, and also that sense of purpose, a reason to get up in the morning. These are so central to sustained health.

Susan Dentzer: I am struck by this combination of pessimism and optimism on the panel. Two of you basically have singled out the worst pandemic humankind has ever experienced, HIV/AIDS, and pointed to how long it took us to wake up to that, how poorly still we are addressing all of the needs that arise from that, how much of a challenge it remains for us. Ms. Blackwell pointed out the astounding fact that we confront many inequities in the richest country on earth, some due to actual outright disparities in the access to health care but also by virtue

SPEAKER PROFILE

Georges Benjamin currently serves as executive director of the American Public Health Association Dr. Benjamin also served as secretary of the Maryland Department of Health and Mental Hygiene, where he played a key role developing Maryland's bioterrorism plan. His career has included work as chief of the Acute Illness Clinic at Madigan Army Medical Center in Tacoma, Washington; chief of emergency medicine at Walter Reed Army Medical Center; and chairman of the Department of Community Health and Ambulatory Care at the District of Columbia General Hospital. Dr. Benjamin is well-known for his public health work on bioterrorism and emergency preparedness, the West Nile virus, and mental health care. He is board-certified in internal medicine and is a fellow of the American College of Physicians. He is a graduate of the Illinois Institute of Technology and the University of Illinois, College of Medicine.

of the fact of where people live and what we do with our lives. These are provocative issues that we confront, as you say, most directly when we see the aftermath of Hurricane Katrina.

But at the same time, others of you have identified these constructive, positive changes that have taken place. For instance, we now understand what causes so much disease and can move fully into attacking diseases at their molecular and genetic roots. That is a phenomenal breakthrough in our ability to deliver health care. We can communicate all of this so that we are empowered to go to our doctors and say we know almost as much because we can read all of the articles on *PubMed* on the Internet. We can understand the course of our disease. Then, of course, the final positive note, we are living longer than ever.

So with this combination of pessimism and optimism, particularly looking back over the last 25 years, do you think, each of you, that foundations and philanthropy have fully engaged in these challenges, on the one hand, that have been created by the events you have described but also these opportunities? Do you think that philanthropy has fully seized the opportunities in the past?

Xavier Leus: I would say yes, and there are tremendous examples. Studying the same time period of 25 years, the Center for Global Development in Washington had the working group looking at global public health and put out a little publication *Millions Saved*. This book documented a number of experiences across the world, such as the smallpox eradication program where the international community has actually achieved major success.

So there are huge opportunities in global health for grantmakers, for foundations, for civil society to be involved and to involve others. I think the key issue that we see is: Do we understand how health comes about? We should not address HIV as a disease. We should address HIV/AIDS and the challenge that we have in HIV/AIDS as part of a holistic approach to the health of the public. Health is created by where people live, where people play, where people work. That is how we need to understand health. That is where the contribution can be made by foundations, by civil society, in understanding and acting on these different issues. Obviously we are continuing to find new technologies that would be helpful to us, but we have a fair amount of technology already in our hands.

The key asset on which we need to work is people — people and communities. Only individuals and communities can take their own fate in their own hands. We need to give them the means so that they can do so, including dealing with the HIV/AIDS pandemic.

Angela Glover Blackwell: I absolutely agree. I think that many foundations have made important contributions even if they did not always have a deep understanding of the problem because they understood the role of community.

The key issue that we see is: Do we understand how health comes about? We should not address HIV as a disease. We should address HIV/AIDS and the challenge that we have in HIV/AIDS as part of a holistic approach to the health of the public. Health is created by where people live, where people play, where people work. That is how we need to understand health.

For example, in 1986 The Rockefeller Foundation began to fund projects around the country where communities were actually using data and community-building strategies to address the problems of building and strengthening community. The Annie E. Casey Foundation had a place-based initiative that, for many years, focused on building and strengthening community. The California Endowment has been extraordinary in terms of being able to take all that those foundations learned, fund the community building work, and combine it with a conscious focus on health and well-being.

We have seen foundations begin to define a new field and actually put that together with a health frame. I have been pleased with the leadership, though it has not been conscious or broad enough yet, but we are moving in the right direction.

Having foundations out there pointing the way to better ways to organize health care, better ways to finance health care, to promote quality and promote prevention has been important.

Susan Dentzer: Dr. McClellan, one of the issues that you identified was the inability of our current regulatory systems, including government, to deal with all of the opportunities that have come forward by virtue of our understanding of molecular medicine and personalized medicine. Philanthropic organizations can engage in advocacy of our need to step up to the plate and deal with some of these issues. Do you think that the advocacy voice has been there? Do you think that there is enough of a voice saying we need to move forward and actually look at new ways of seizing the opportunities available to us in health care?

Mark McClellan: There certainly are lots of examples of foundations trying to get the public and policymakers to understand the new technologies coming along, whether it is new kinds of medical treatments or health information technology. But I think it goes beyond advocacy. The community work that we were talking about a moment ago is very important to show how these new treatments can be better integrated into medical practice and can be used to address and improve health disparities and many other key public health issues. A broad range of foundations has been engaged in those kinds of activities.

There is just so much government involvement in many of these health care issues, particularly health care financing. On the one hand, that is good because it helps assure that everyone can have access to newer technologies in a way that would not happen if we did not have so much government involvement. On the other hand, the pace of change in policymaking often falls behind the pace of change in health care delivery and biomedical knowledge.

Having foundations out there pointing the way to better ways to organize health care, better ways to finance health care, to promote quality and promote prevention has been important. In the debate on Medicare over the last 20 or 30 years, foundation activities that point out and analyze the best ways to bring health care financing systems up to date were important.

SPEAKER PROFILE

Molly Coye is founder and chief executive officer of the Health Technology Center (HealthTech), a nonprofit education and research organization established in 2000 to advance the use of beneficial technologies in promoting healthier people and communities. Dr. Coye has extensive experience in both the public and private sectors, serving as commissioner of health for the state of New Jersey and director of the California Department of Health Services, in addition to heading the Public Health Division at The Johns Hopkins School of Hygiene and Public Health. She is a member of the Institute of Medicine and coauthored the reports *To Err is Human* and *Crossing the Quality Chasm*. Dr. Coye is on the board of trustees of the American Hospital Association and the Program for Appropriate Technology in Health. She was a founding board member of The California Endowment. Dr. Coye earned her medical and master's degrees from The Johns Hopkins University.

It is not just about advocacy; it is about helping to speed up what otherwise can be a slow and cumbersome process of making our health care financing and our health care regulation keep up and hopefully promote some of the most important changes in medical technology.

Molly Coye: I want to ask a question of Ms. Blackwell and Mr. Freedman because I think foundations have done a very good job in addressing the digital divide. There has been a lot of activity for 20 years to distribute access to the Internet, just as an example.

But I think that there is going to be a real crunch because the cost of the technologies is going to be so tremendous, and most of the use of the technology is going to be in the baby boomer and elderly population. David Hayes-Bautista was one of the earliest people to describe the risk we run of the informed elder electorate extracting huge transfers of income from the working population, which is increasingly more diverse than the elderly population in this country. We may face some very tough times.

I wonder what you think about civic education. What do you think about the risk to the communities that we are trying to help build? They are going to be the source of this income transfer to deal with the cost of technology if we do not manage to restructure the reimbursement system.

Marc Freedman: There is an issue that I wanted to raise that relates to what you were saying. You have framed things as pessimism and optimism. What is striking from where I sit is that what should be a source of optimism is generally seen as the worst thing that ever happened to us. Last year there was

an article in *The Atlantic Monthly* by Charles Mann called "The Coming Death Shortage." How can it be that all these extensions of longevity, health, well-being, and education are producing this calamitous event that is going to undermine posterity?

To the issue of philanthropy, I think that foundations are doing a great job, but they face an unbearable burden because the number of frail elders is growing so rapidly. It is the fastest growing part of this population, and the need for innovation is there. But at the same time, we are creating, in fact, a new stage of life between the end of first careers and true old age, and the needs of people in that stage are quite different. Aging programs are being forced to balance both of those. They are enormous developments in and of themselves.

Susan Dentzer: Let me ask where the slow accretion of 47 million uninsured Americans fits into your trend line of the last 25 years? Have foundations have adequately stepped up to the plate on that issue?

Georges Benjamin: While we have built a reasonable safety net for very low-income individuals, in some places single adults, we really did not care much about it. We did this collectively, the grantmakers and those of us in public policy jobs, but it was something the public really did not care about until it affected them. Now the fact that it is a middle-class deficit and a middle-class problem, our nation seems poised to do something about it.

The problem is that, while public policy and the debate around the uninsured exist, it is still an inside

SPEAKER PROFILE

Angela Glover Blackwell is founder and president of PolicyLink, a national nonprofit research, communications, capacity-building, and advocacy organization whose mission is to advance a new generation of policies to achieve economic and social equity. Ms. Blackwell founded PolicyLink after serving as senior vice president for The Rockefeller Foundation, directing its domestic and cultural divisions. In 1987, she founded the Urban Strategies Council in Oakland, California, and received national recognition for her work in pioneering community-building approaches to social change. Ms. Blackwell is a coauthor of *Searching for the Uncommon Common Ground: New Dimensions on Race in America*. Currently, she serves on boards for numerous organizations including the Children's Defense Fund, Levi Strauss & Co., the Corporation for Enterprise Development, and The Brookings Institution's Center on Urban and Metropolitan Policy. Ms. Blackwell earned a bachelor's degree from Howard University and a law degree from the University of California at Berkeley.

game. My mother, your mother, our cousins, they do not quite understand it. They know that there is a risk. They know they do not have insurance, but they do not quite understand the public policy implications of option A over option B. Quite frankly, even though it is going to be a huge policy debate around this during the election this year, I am not sure we have yet framed it in a way or brought the language down to where the average citizen can fully engage in a debate.

I would encourage grantmakers in these next six to eight months (and we do not have 18 months to do this) to develop materials to answer the questions around why costs are the way they are, who is uninsured, who is not, and to make it real to the average person.

Angela Glover Blackwell: I think there is an enormously important role to play in terms of public education about the uninsured issue. It is a leadership challenge for sure because the public understands that there is a problem. I am often struck by how what used to be a conversation only about people who were poor has become such a middle-class problem. When you have a child who turns 25 or so and is not quite in school and is not quite employed with health care benefits, what do you do? What do you do because the health insurance is so expensive? The middle class is worried about this. It is clear that people are holding on by their fingernails to their middle-class status. All it takes is a health incident to be able to kick people right out of being middle class. So when you have that level of visceral understanding, it is the moment for leadership to take it, frame it, offer solutions, and get the public behind it.

As to Dr. Coye's question, I think we do have this political problem in America, and we have to understand that no matter how we think about our work, ultimately, it is going to become a political issue. We have to be able to build the kind of political understanding and leadership.

On the upside, I think that whether this country wants to believe it or not, its future is inevitable; people of color and people who have less income will become the political driver as we go forward. As people who have been on the outside, dependent on those who have had traditional power to solve their problems, begin to step up to build their own political clout, their own agendas, and their own voices in the policy arena, I think we are going to see a lot more solving of problems than one might predict.

Looking forward over the next 25 years, I think the story is going to be about a new generation of leadership in America, taking America to a place it always longed to be and could never quite see how to get there.

Susan Dentzer: Ms. Blackwell has given us a terrific segue into the next phase of our discussion which is, indeed, the next 25 years. What are the opportunities? What are the challenges? Most particularly to all of you, what is the single biggest thing that could happen over the next 25

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years that will transform many of the issues we just talked about? What will transform health care, not just domestically but globally? What will transform the well-being of the citizenry around the world, whether inflicted by HIV/AIDS or deaths in childhood given that 10 million children around the world every year die by the age of five? What are the things, if they happened, that could make the biggest difference?

Xavier Leus: It is important for us to go back to the principles and values of public health. I do not mean a public health service but a public health approach. We do not deal with issues as single diseases. We should deal with them in context and deal with them in view of the determinants that are there, including issues that are outside health.

The reality is that when you look at the poverty line as determined by the World Bank, if you include out-of-pocket expenditures that people in the developing world spend for their health services, the poverty line doubles. There are almost 100 million people who fall into poverty because of health expenditures and out-of-pocket expenses.

The World Health Organization has articulated its global health agenda that deals with these different issues. The question that arises now is this: Is it possible that governments and civil society companies in the world will mobilize around this global health agenda? You realize that the budget of the World Health Organization, by itself, the Secretariat, is smaller than one public hospital in New York.

So the value of the World Health Organization is not just in its technical functions. It is truly in the advocacy role that it can play. Will the World Health Organization be able to articulate its agenda? As you know, we just elected a new director general, Dr. Margaret Chan. She has said that she wants to be judged in her term (which is a term of five years) on whether her new management of this global health community will yield results. The two outcomes that she wants to be judged for are the health of Africans because that is obviously the continent that is most challenged in terms of health outcomes. The second one is the health of women. She has also articulated that it is not just about targets of programs, but to make sure that Africans and women are seen as key assets in this fight against disease, in taking up this public health approach.

For the moment, we are in the challenge. It behooves all of us to be part of this movement that we need to carry forward.

Marc Freedman: The saying goes that "60 is the new 40." In fact, 60 is the new 60. There is truly something, this once-a-century process in this country, where we invent a new stage of life. You have tens of millions of aging boomers flooding into this time period. Work is going to displace other institutions of the second half of life, but the vision of work in that period of life is up for grabs. When you have so many people, such a long period of time, so much talent, an enormous amount is at stake. This is a

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SPEAKER PROFILE

Xavier Leus is the World Health Organization (WHO) representative and director of the WHO office at the World Bank and the International Monetary Fund. He began his career as a general practitioner and joined the Pan American Health Organization (PAHO) as an associate professional officer at the Caribbean Epidemiology Centre in Trinidad and Tobago. Dr. Leus then served as an epidemiologist and PAHO/WHO representative in Suriname. He was appointed PAHO/WHO representative to Haiti in 1988 and then joined WHO's Europe Office as regional advisor for external relations and coordination. In 1995 he became managing director at the EURO Health Group, an international health consultancy firm. Dr. Leus returned to PAHO as chief of the field office for the United States — Mexico border in El Paso, Texas before joining WHO once again, this time serving as director of emergency and humanitarian action and director of cooperation and communication. Dr. Leus earned his medical degree and master's degree in public health from the Catholic University of Leuven, Belgium. He was also a Sloan Fellow at the Massachusetts Institute of Technology where he obtained a master's degree in management.

potential workforce for health, given the labor shortages that are opening up in that segment of the economy. The old deal was if you agree not to work in this period, we will make it worth your while. We need to come up with a new deal where if people work, we will make it worth their while. We could not only create lives that make more sense with productivity balanced across the life span, but a society that makes more sense in general. So a small group of people in the middle are not asked to support the dependent as well as the not-nearly dependent. The band of productivity in society should be expanded to bring things back into equilibrium.

Molly Coye*:* What I want to address is what continues to be the scandalous disproportion between our expenditure in prevention and community and public health, and the rest of the health care system where I spend most of my time now. I am convinced that the only way we can do that in the United States is something which CMS was starting to work on, which was to try to align payment for the bulk of the money we spend in health care so that we are actually paying for people to be kept healthy. We must pay doctors, hospitals, and community systems to keep people healthy and return them to health as rapidly as possible.

Dr. McClellan made reference to the fact that we are still mostly paying for sick care. We have very good models in the Veterans' Administration and some of the things that have be done at Kaiser that tell us that, if you set the incentives in place, then you can achieve higher levels of quality and start to drive down the cost.

SPEAKER PROFILE

Marc Freedman is founder and chief executive officer of Civic Ventures. Mr. Freedman has also led efforts to create Experience Corps, the nation's leading, nonprofit, national service program engaging Americans 50 and older. He is the former vice president of Public/Private Ventures and was a Visiting Fellow of Kings College, University of London. A frequent commentator in the national media, Mr. Freedman has testified before numerous committees of the U.S. Congress and the British Parliament on topics including the aging of America, retirement, and volunteering. Mr. Freedman is author of the highly-praised books *Prime Time: How Baby Boomers Will Revolutionize Retirement and Transform America* and *The Kindness of Strangers*. He is a graduate of Swarthmore College and Yale University.

There is so much we can do to help people control their own health and improve their status, but we need a public health, population-based mentality. We have to align the incentives. If we can do that in the next 10 years, we can get the engine running that we need to continue improvement in a substantial way.

There is so much we can do to help people control their own health and improve their status, but we need a public health, population-based mentality.

Angela Glover Blackwell: Assuming that we solve the problem of not having universal access to health insurance, the big change will be people who have not thought of themselves as being in the health business understanding that they are. Take the city of Richmond, California where, in their general plan, they are thinking about and consciously working on how to bring health and public health into the planning. Working with PolicyLink, The California Endowment, and MIG, Inc., which is a planning group, they are bringing health into their city plan. They have people who are in education who are beginning to understand that they, too, are in the health business. They have planners and developers and people who are thinking about zoning and infrastructure and who understand that their decisionmaking has an impact on health and well-being.

At PolicyLink we started the PolicyLink Center for Health and Place where we are pulling together all of the work that we have done about the impact of place on health. We are helping community-based groups be advocates to ensure that the places where they live serve them well. This notion is people who live in community become their own advocates and join in a cross-disciplinary way with others.

Georges Benjamin: Yes, it is all about healthy communities. As we look at this reintegration of medicine to public health, which is going to happen, and begin to make data-

driven decisionmaking, we need partners that are architects and planners to understand how bus routes affect health. Take a community without grocery stores. Maybe micro grants could be used to transform liquor stores into grocery stores or rebuild playgrounds so they are safe and inviting. Take the power of philanthropy. I think it is wonderful the things that the Gates Foundation and the Clinton Foundation are doing in Africa, but suppose they had chosen southeast Washington or inner-city Detroit or downtown Los Angeles, or New Orleans. We would certainly transform lots of other places, but we clearly should transform ourselves. Place matters. So what it is really about is rebuilding our systems holistically.

I do have one concern. I think that technology is wonderful, but we do have two potential technology futures, one where we have the haves, and one where we have the have nots. There are still too many of our young people who do not have access to these technologies. We could develop a system where we have all of this wonderful technology, genomic medicine, and all these kinds of things, and then a whole population of people who does not have access. So as we build this community of love, wellness, and support, we have to make sure that we do it so that we do not have two Americas.

Mark McClellan: Let me just pick up on Dr. Benjamin's comments. I think where medical technology is headed is toward much more personalized medicine. So there are new sciences coming along like genomics and nanotechnology, but they have not yet had a real impact on the way that health care is delivered. When they do, I think you are going to see the barriers between what is regarded as traditional health care and what is regarded as all these other lifestyle and environmental influences on health break down more. What works best for each individual patient is increasingly going to depend on their personal characteristics, their genetic makeup, where they live, and how they like to live their lives.

Look at what some leading employers are doing in redesigning their health benefits by moving away from traditional benefit design only and toward ways to intervene early in the workplace, modifying the workplace, taking steps to help each of their individual employees be more productive and live a better life. This will transform the way that traditional health insurance works.

The problem is that if we keep our same old financing and regulatory systems in place, we are never going to be able to afford it. I can tell you about a couple of things that are not going to work. Just trying to extend the same old traditional health insurance to everyone else could cost a lot more money than what we are spending already. We are spending a lot in our health care system, and we are not spending it well.

Instead, we should focus on ways to link getting better health care

Technology is wonderful, but we do have two potential technology futures, one where we have the haves, and one where we have the have nots.

coverage to people, reforms in the delivery system, support for providing better quality care, and getting better results. Another thing I think is not going to work in the long term is a focus on health care quality from the standpoint of medical processes. It is very important that we use the evidence that we have on things such as beta blockers for someone who has a heart attack. It is going to get much more complex down the road in the next five, 10, or 20 years to try to determine whether medical technology is cost effective or not. It is going to depend a lot more on the characteristics of the individual patient. What works best in terms of drugs, genomic interventions, and lifestyle interventions is going to get increasingly personalized. The only way that we are going to be able to support that well, in the longer run, is doing a much better job of measuring what we really want in our health care system and in public health, which is better health for our population at the lowest possible overall cost, and paying for that.

One of the basic rules of economics is that you get what you pay for. Today we are paying for more services and more utilization and more complications. We are not going to get to an effective era of personalized medicine that we all can afford and make the next 25 years as promising as they should be, unless we really switch the focus to what we want. There is a huge role for communities to play in this and a huge role for foundations and grantmakers to help us identify what we can be aiming for and how we can actually achieve it in practice.

Susan Dentzer: There is a strikingly common theme among everything that you all have just said about the next 25 years, and it all gets back to broadening the definition of health and public health. Dr. Leus emphasized returning to the notion of a public health approach, as in not treating a single disease but attacking this across the board. Mr. Freedman, you said there must be the transformation of the nature of work and engagement of the 60-plus generation. But a question would be: Are those people healthy enough at the end of their lives to do all of that? Dr. Coye, you talked about the overall shift to prevention that has to happen to seize the opportunities of technology to lower costs across the board. Ms. Blackwell, you talked about extending this to people who are not in health and making the connection that they really are in health. Dr. Benjamin, you made similar points in terms of healthy communities.

All of that leads to the question of what the role of foundations is in achieving these goals over the next 25 years? If you had to write the mission statement for the next big mega-foundation, global or otherwise, or at the micro level the next community foundation, whether in Richmond, California or any place else you may be familiar with, what would the mission statement of that organization be? How would it be designed to seize the opportunities we have talked about?

Marc Freedman: The folks at Harvard did the *Better Together* study that had a wonderful phrase in it. They said that the health club of the 21st century was essentially social connectedness. That is something that cuts across all of us, not just connections among people you know but connections with people who are of different ages and from different classes and ethnic backgrounds. Try to create bridges among the community in ways that also build health. First of all, it creates a sense that a community is a whole, that everybody has a stake in the health of everybody else because they are going to end up paying for it if they do not.

But also, it picks up on Ms. Blackwell's point that all of these people who do not think they are in the health business actually are. So for example, people who are mentoring kids, building those kinds of connections, or giving care are in the health business. So in a community that is more connected, not only will individuals benefit (because there is all that research about how social connectedness benefits health), but there might well be the political will that goes beyond that.

Molly Coye: There are two kinds of energy we can deliberate in the next 25 years. One is at the community level to call on resources that are not involved in health care now so that everybody understands the role they can play. Two, we spend so much money in the traditional health care system. We need to reorganize the use of that. The work that The Commonwealth Fund and other foundations are doing to help us understand what the options are is critical. What are the possible ways we could reorganize the use of those resources? We have to do that because we are not going to be able to continue to waste at the level we are now.

To change that, there some pretty good proposals out there from Commonwealth and other places about what this might look like. We need to have larger scale trials of this. There are communities of hospitals and physicians that would step forward and work on this with community leaders. Testing out some of these models is going to be very important.

CMS can do some of this, and they have some demonstration projects that are very exciting. But it goes slowly, and it is often politically hamstrung from doing the things that are most bold. Either individual foundations or collaborations of foundations must come up with ways to test some of these bigger, new ways of reorganizing health systems. I believe that CMS and Congress would be willing to give them the running room if they came forward.

Georges Benjamin: I have always believed that health is a fundamental human right. I think we need to build, in effect, a civil rights movement around health and empower the American people to engage in that movement in effective ways. That

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means we need to better inform them. We need to teach them the policy aspects of what they do. We need to figure out ways to engage them.

If I could create the magic foundation, it would do several things. One, it would begin the information process of all of our population from grade school up and teach them about population health so that they understand that they are part of a collective.

I would build an effective public health system, which we still have not done, and fund and support it. I would create the linkages between core public health activities, governmental public health, and that whole range of nongovernmental public health activities out there. Finally, I would spend a fair amount of time engaging the media and policymakers collectively so that they understand this as important.

There is no success in global health without U.S. leadership. It is clear that the rest of the world thinks the United States cannot do it alone. It is also true that the rest of the world cannot do it without the United States being actively and massively involved.

But the pressure to do this only comes from the public and the grassroots community. If I were to appear before Congress, they know exactly what I am going to say, but they do not have any clue what the unanticipated messenger is going to say. Until the public stands up and demands it on a daily basis, until my mother can walk into a room and say, "I want you to support population health. I want you to pay some attention to data; I want you to deal with health costs this way or deal with health that way in an informed manner," then we will not get the job done.

Xavier Leus: I will give three different answers. One is that the key unresolved issue in the world is human resources for health. A 2006 World Health Organization report documented the deficit not just in health professionals but also community health workers, nurses, and public health leaders. We just do not have the people to execute the programs or work we have in our communities. Unless that is addressed in some kind of coalition, it is truly difficult to work around this.

In this aspect, of course, as many of you know, U.S. foundations, particularly The Rockefeller Foundation and W.K. Kellogg Foundation used to be instrumental in the development of public health schools all around the world and of the public health capacity that exists. It is not just about physicians and nurses. There just is not a human resource capacity in the sector to deal with all the challenges.

The second issue is that there is no success in global health without U.S. leadership. It is clear that the rest of the world thinks the United States cannot do it alone. It is also true that the rest of the world cannot do it without the United States being actively and massively involved. So if you truly want to move forward for success, we will need U.S. leadership on these different challenges that we have. We will need much more massive involvement. I think this is a key role of foundations and the community activists in this regard.

The third one is that we live in a global world, like it or not, although I know that many of the founda-

tions here are domestic foundations looking into their communities. I also know from my work, in regards to my friends on the U.S.-Mexico border when I was working at the U.S.-Mexico Border Health Association, that the second largest Mexican city in the world, after Mexico City itself, is Chicago. The second largest concentration of Ethiopians in the world, besides Addis Ababa, is Washington, DC.

I have just returned from the Liberia Partners' Forum, which is part of efforts of the Liberian government and partners to reconstruct that country after a long period of civil war, which left the country with a total of 50 physicians for their entire population. There is obviously a tremendous amount of linkage between Liberia and U.S. communities, between Ethiopia and U.S. communities, between Mexico and U.S. communities.

My plea would be, for the ones who are not already doing so, that even if your involvement is local, is domestic, make sure that you understand the challenges your people face in the worlds that they come from. From that we can truly build a global world.

Mark McClellan: Taking the 25-year perspective, I really would like to see a mega-foundation move toward thinking about a better model for health care financing. Think about how you would get to a health insurance system that focuses on paying more for better health. The ways to get there for each individual will be increasingly different. Each community is going to be increasingly different. We need to develop new ways to measure these results. We need to develop new ways to support the financing.

I say this with a couple of caveats. Number one, you cannot spend more money overall. We are already spending a tremendous amount of money in our health care system, and we really need to focus on doing it more effectively. Number two, we need to bring all major stakeholders in the health care system along. Our health care system in the United States and globally involves a lot of public-private components participating together. Foundations are already working on ways to develop these models collaboratively. I think much more can be done at the local level. There is already a tremendous amount going on in communities in terms of getting these different stakeholders together moving toward different financing mechanisms locally. This happens in Indianapolis and Minneapolis and other communities.

Angela Glover Blackwell: My foundation would be global and huge. It would not be a local foundation, though I could think of many wonderful things a local foundation could do. It would be global for the reasons that we have already heard. I do not think you can understand the challenges in your own community or even your own neighborhood today if you do not have a global perspective and that global perspective has to come from real interaction.

Think about how you would get to a health insurance system that focuses on paying more for better health.

The mission statement would build a world in which all can participate and prosper. It takes a lot to be able to participate. It takes a lot of education, resources, well-being, good health, connectedness, and civic voice. Prosperity is something that people all over the world want, defined in the appropriate terms. Prosperity is a legitimate aspiration.

While this huge global foundation would do many things, one of the things that it would do all over the world, from the smallest community to the largest, is make sure that the people who have the most difficulty participating can have their authentic voices frame the debate, begin to inform the policy, and drive the implementation. This means a real challenge for philanthropy.

So this large, global foundation is going to really shock the world as it invests huge amounts of money in the authentic voices at a level of detail that others could only dream about. One of the things that it would do is form partnerships with people who have an understanding of what is going on in their communities. Community foundations, local foundations, regional foundations can learn a lot from interacting with my big global foundation that is moving all over the world.

The other thing it would do is find those organizations that are getting it right, the ones that are leading, the ones that are framing questions in a new way, and make a big bet on those organizations. We are absolutely in this process, those who are funding with those who are receiving, where we are learning from each other. We are absolutely in an iterative process, but we do not put enough focus on letting those organizations start to run. Give them enough money so that they can really sprint, so that they can get out into the future, go down the road, and then come back and have conversations. So make big bets. Put endowments in some places. Give people 20 years of support so they do not have to keep coming back, begging for money, to be able to go the next step, and then that step is not even needed anymore by the time they get there.

Susan Dentzer: I understand that experience is America's only growing natural resource. I think what you just heard, distilled down, is a lot of experience and insight. I hope it will be of value to those of you forging ahead in the next 25 years of philanthropy and health.

REMARKS ON ACCEPTING THE 2007 TERRANCE KEENAN LEADERSHIP AWARD IN HEALTH PHILANTHROPY

Mario Gutierrez

Let me say that there is no greater honor than to be singled out by your peers and selected for such a distinguished and important award such as this. In this case, it is made even more special by the fact that this award is named in honor of Terrance Keenan, someone whose legacy in this field has been an inspiration to us all. So as we say here in Miami, *muchisimas gracias*.

In 1992 Robert Wood Johnson Foundation published a short booklet titled *The Promise at Hand*, which was based on a series of lectures given by Terrance Keenan on the occasion of the foundation's 20th anniversary. Keenan sought to answer the question: What makes a great foundation? He listed ten attributes. As I reread them recently, I was struck by how deeply his words have stuck with me over the years. They have been an inspiration and a moral guide. Given the theme of this year's annual conference, it is fitting that we reflect on and highlight his insights as we move forward together to chart a path for health philanthropy for the 21st century.

Before I do, however, I want to quote one of my friends, Rick Foster from W.K. Kellogg Foundation, who once said to me, "If you are walking down a country road and you see a frog on a fencepost, you know darn sure it didn't get there on its own." I know I wouldn't be standing here today without the support, the wisdom, and the guidance of some individuals whom I wish to acknowledge at this time.

First and foremost, I would like to thank my family, who has given me a lot of support through those long hours and days and weeks away from home, and especially to my wife, Debra, whose tireless support and encouragement have inspired me to reach higher than I ever thought possible. More than anyone else, she has taught me the true meaning of giving of oneself in service to others through her international surgical volunteer activities for Third World children, which I have been fortunate to share with her.

I also have been blessed with a loyal and highly skilled team who has been instrumental in my success and with whom I should share this award. Julie German, my program assistant, has been with me for the last 13 years, spanning two foundations. She has kept me always pointed in the right direction and has been a calming influence in an often chaotic and fast-moving world.

SPEAKER PROFILE

Mario Gutierrez is director of Rural and Agricultural Worker Health Programs at The California Endowment. In this capacity, Mr. Gutierrez leads the foundation's initiatives and programs to address one of the nation's greatest contradictions — the sickness and poverty of farm workers amid fields of abundance. He has also held positions at the Sierra Health Foundation; the California Rural Indian Health Boards, Inc.; the State of California, Department of Health Services, Indian Health Program; and the Toiyabe Indian Health Project. Mr. Gutierrez was also one of the visionaries who created the California-Mexico Health Initiative in partnership with the University of California Office of the President and the Ministry of Health of Mexico. He is a fellow of the American Leadership Forum and serves on the boards of the California State Rural Health Association and La Raza Galleria Posada Art and Cultural Center. He is a member of the California-Mexico Health Initiative Advisory Board and the National Rural Funders Collaborative Steering Committee. Mr. Gutierrez holds a master's degree in public health from the University of California, Berkeley.

Linda Garcia, more than just a program associate, has been a true partner and a friend, always challenging my assumptions with her quick logical mind and her detailed management skills. Her passion for our work together has provided me with the freedom to stay focused on the big picture.

To all my friends and colleagues at The California Endowment, many of whom are here today. I thank you for keeping me always humble and honest as we continually strive for excellence in our work together.

I also have been extremely fortunate to have worked at two great foundations with visionary leaders over the last 17 years. In 1990 Len McCandless offered me my first opportunity to work at one of the first major health conversion foundations in the country. The truth is that, at first, I really had no intentions of staying there very long. Having worked in community health for so long, I felt that I wanted to get inside the beast, learn it, and get out as quickly as possible. I am sure there are some of you who have written grant applications and waited for answers and then received a mysterious letter saying that you no longer meet the foundation's priorities. I felt it was important to see what it was all about. In Len McCandless and Dorothy Meehan, Sierra's program vice president, I found kindred spirits as they were both new to philanthropy themselves. They brought a fresh, open approach to grantmaking,

and Len's leadership and common sense approach to community health continue to be an important influence on how I approach my work today.

In 1996 my world completely changed when Acting Chief Executive Officer Ann Monroe and Program Director Mariano Diaz called me and said, "We're starting a new foundation. It's going to be $3 billion. We want a crew of people who know the state and know philanthropy and who have worked in nonprofits." Although I did not really want to leave Sierra — we were right in the middle of our initiative — I felt that this was an opportunity that we could not pass up.

So I went to The California Endowment. One of the quotes from Terry Keenan that really struck me is "the opportunity to create a rich and accessible resource for discovery and change." I think that is what The California Endowment has really been for the people of our state. It is rich, but it is accessible.

In 2000 after some growing pains at The California Endowment, we took a quantum leap forward when Dr. Bob Ross arrived at our doorstep, who not only brought us a new level of passion and vision as a leader, but he also reinforced what Terrance Keenan characterized as the moral purpose of philanthropy. Dr. Ross clearly understood the importance of race and culture as the critical pathway for understanding and reducing health disparities, particularly in California. In 2001 Bob Ross gave me my greatest challenge yet when he put me at the helm of our new $50 million initiative to improve the health, living, and working conditions of California's million-plus Mexican-born agricultural workers, work that I continue to do today.

As I reflect over these past 17 years and think about the emerging role of philanthropy as a force for creating social change in the 21st century, I believe there are two fundamental issues that we, as leaders in health, must recognize and confront if we are serious about improving the health of the underserved individuals and communities. These are both serious and challenging issues, and, quite frankly, they are issues that tend to be too easily dismissed because they are overwhelming or too difficult. As I have never been one to shy away from the seemingly impossible, I would like to share them with you today.

By now most of us recognize and accept the notion of our foundations' resources serving as investments in organizations and communities, not just charity. As Terrance Keenan put it, this is "a hand up, not a handout."

But if you believe, like I do, that the real power of philanthropy lies in its total net worth, not just the 5 percent we are required to distribute annually, then we must all conclude that we have not yet begun to scratch the surface of our true power.

The fact of the matter is that most foundations are content with practicing what is called the blind-eye

Most of us recognize and accept the notion of our foundations' resources serving as investments in organizations and communities, not just charity.

Let us all be the change we want to see in health philanthropy.

approach to managing our financial investments. That as long as we are making money and we are growing the endowment and protecting it, then all will be fine. After all, there will be more money for grantmaking. But at the end of the day, I believe we must ask ourselves: Are these investments consistent with the mission, values, and strategic focus of our respective foundations? Does it make sense that our sectorwide obsession with strategic planning and impact assessment is so narrowly focused on the use of 5 percent of our assets, while the remaining 95 percent stays outside the parameters and unaccountable to the mission and strategic goals of our foundations?

Dr. Ross has inspired us at The California Endowment with one of his favorite quotes from Gandhi, that is, "Be the change you want to see in the world." I have always tried to live my life that way. But imagine how powerful this philosophy could be if we applied it institutionwide and to the health foundation sector as a whole.

Recently the Bill and Melinda Gates Foundation was taken to task by the *Los Angeles Times* for creating a situation in which the gains from its vast financial holdings were directly undermining its grantmaking. Incredibly, after initially stating that they would conduct a thorough review of their policies in this regard, they concluded that, even if they were to revise their investment practices, the $60 billion under their control would have little influence over the companies of concern.

The Gates Foundation lost an opportunity to lead. I believe the time is right for us in health philanthropy to recognize, to act, and to counter unrestrained, destructive behaviors of private corporations in which we invest our billions, undermining our values and principles and effectively neutralizing our strategic grantmaking goals.

I say let us all be the change we want to see in health philanthropy. Now I realize that this is a challenging and complicated issue with no easy answers. You know that your investment managers, your chief financial officers, and your finance committees are going to resist — as they should — because their mission is to make the endowment grow. But if we think about who we are as institutions and what we are hoping to accomplish within our own foundations and collectively through GIH, then I believe we have no choice but to be thinking in terms of the triple bottom line; that is, yes, we want to be profitable but also socially just and environmentally sound.

So I call on GIH to take the leadership to undertake a comprehensive study of this issue and develop recommendations and voluntary guidelines to help those who choose this path. As a starting point, I suggest that GIH explore the development of a three-tiered rating system to assess current and potential investments for foundations. Level one would be the "do not support" list of specific corporations and sectors that behave irresponsibly and indiscriminately undermine the health of our children,

youth, and families, as is already the case with big tobacco. If we are sincere about reversing the childhood obesity and diabetes epidemics, then shouldn't we also single out the truly bad actors contributing to this problem and move our investments elsewhere? Otherwise we are investing counter to the work that we are doing with our grantmaking strategies.

The second tier would identify those corporations and funds that potentially could be influenced to improve their corporate practices through the power of our investments, much like the big CalPERS and CalTERS retirement funds create social and political change. So let us think about how we use those resources to influence those corporations that are willing and that can be rewarded for improving what they do.

Then the third tier would be reserved for those select few, what I would call the GIH five-star corporate leaders, who by their example of true progressive, socially responsible, and supportive health practice would earn the rating.

And while we are at it, why not go to the next step and incorporate our investment strategies in our communities? It is still amazing to me that so few foundations use the valuable tool that we have at our disposal of the program-related investment (PRI). We had a unique opportunity with the creation of the foundation in 1996 when we had an extreme payout obligation and were able to take advantage of that situation to create a $20 million program-related investment with a $10 million grantmaking program. To my knowledge it is still the largest PRI ever made.

That resulted in tremendous profits, not just profits for the nonprofit housing corporations, because they were able to leverage another $80 million in loans, but it also created $200 million in additional public funding through legislation and a bond measure supported by the voters. Most importantly, thousands of farmworkers are now living in safe, affordable housing, and our evaluations documented that they actually were living better and taking care of their families better. My point is that this was a win-win for both sides of the foundation house.

There are a number of foundations across the country that are leading the way in their creative and effective use of their capital resources. Two I would like to highlight are the F.B. Heron Foundation in New York, which has, to date, set aside 24 percent of its assets for program-related investments directly in support of their mission, and the groundbreaking efforts of the Jacobs Family Foundation in San Diego that has chosen to focus investments on the low-income, neglected Diamond Triangle neighborhood by committing to a 25-year investment strategy to revitalize businesses and local institutions, in a true partnership with the leaders of those neighborhoods.

My second message is a more personal one. Today I have come full circle to the city where I was raised by my working-class Cuban parents, actu-

It is still amazing to me that so few foundations use the valuable tool that we have at our disposal of the program-related investment.

ally not too far from here in Little Havana. As you can imagine, in those years of the 1950s and 1960s when I was growing, Miami was a very different place. Fidel was still a young lawyer dreaming of independence and revolution, and lest we forget, this was then the segregated South. Until the time I graduated from high school, we were still living under Jim Crow laws. That meant that all the beautiful beaches around here, schools, water fountains, restaurants, et cetera, all had signs that said "for whites only." Can you imagine?

Yet, although things may seem very different now in this glitzy city of Miami, the inconvenient truth of the matter is that Miami and south Florida are still places where race and poverty are still deeply linked. You may not realize this, but we are meeting in the third poorest city in America, where one in five kids (mostly black and Latino) live in poverty, and one in four households can't afford a place to live. And you don't have to go very far from before you're deep in the poverty-ridden, mostly black neighborhoods of Overtown and Liberty City where the riots were ten years ago. And not more than three years ago, down the Dixie Highway (as it is still called today) around the agricultural fields near Homestead, they discovered forced slavery of Mexican and Central American workers who were working in the fields and in prostitution.

For most of my professional career in California, I have dedicated myself to working for the alleviation of poverty and the improvement of the quality of life for low-income families, whether they live in the Logan Heights of San Diego, Tenderloin of San Francisco, are among the native tribes of California, or Mexican farmworkers. Throughout this time, there is one common denominator of race and poverty.

The point I seek to make here is that if we are sincerely committed as a sector to improving the health and well-being of the underserved and disadvantaged, primarily people of color, then we simply cannot ignore this fundamental issue. We must confront directly and forcefully this dual epidemic of poverty and structural racism.

We must confront directly and forcefully this dual epidemic of poverty and structural racism.

I realize as health foundations we tend to shy away from those less traditional health improvement strategies such as wealth creation and economic development that do not directly have a specific health outcome. But let's remember Terry Keenan's words that what makes a great foundation is our willingness to participate in funding coalitions with foundations that have different missions but a common goal, and that we work together around a common effort to change things in this world.

It is critical that we as a sector within philanthropy not be so insular. We must reach out to funders in other sectors and create comprehensive, collaborative strategies to not only improve the social and physical environments where people live, but also stimulate the economic drivers that impact poor communities of

color where we find the greatest health disparities.

Recently, Ralph Smith, vice president of The Annie E. Casey Foundation, called for the elimination of poverty to be the moon shot of this next generation. So I call on us here at GIH to make this our moon shot, working together, and urge all of our members individually and collectively to transform these unacceptable conditions of poverty and hopelessness in America. Make this one of our goals moving forward.

In closing, I would like to share a story about someone whose own transformation has had a profound influence on me and my passion for this work. Rich Atlas was one of the founding trustees of The California Endowment. Rich's professional background is in equity investments. Throughout his entire career as a true blue capitalist at Goldman Sachs, he lived to make money. He would get up in the morning and could not wait to read *The Wall Street Journal* and figure out ways to make more and more money. Eventually he became a managing partner at Goldman Sachs, and he came to Los Angeles, California where he became enlightened. In Los Angeles, he discovered something, which was very strange to him. It was called a nonprofit, and it just did not make any sense to him. But once he learned about what it is to be mission-driven, he really embraced that notion to the point that when he retired a very rich man from Goldman Sachs, he created his own family foundation and still practices what he preaches through his foundation.

He was an influential, insightful board member who brought not just the keen eye for finances, but also a real sense of mission, a real sense of purpose for The California Endowment and was one of the people who set us on the path that we are on now.

At his retirement, after seven years on the board, he gave an impassioned speech and talked about his transformation. At the end of his speech, he stood up and he held up a sign that he had just written out right there before he talked. The sign said, "Create a sense of outrage."

So Rich, I will continue to be outraged that childhood poverty is going up in America instead of down. It is the highest it has been in ten years. It is now at 17.6 percent, which translates to 13 million children.

I am still outraged that over 11 million hard-working immigrants from Mexico who strive to put the food on our tables, who construct our houses, who do all the work that nobody else will do, who come here with dignity, are treated as criminals, are considered non-persons without human rights. It is unconscionable that we do not have a humane immigration reform in place that acknowledges their contributions.

I am outraged that 136 million tons of pesticides in California alone, applied by agricultural interests, were exempt from basic environmental regulations,

We must reach out to funders in other sectors and create comprehensive, collaborative strategies.

without regard to the health impact of those in the fields or us, the consumers.

And we should all be outraged that the $336 billion that has been directed and diverted to this war in Iraq ($1,000 per individual), could produce health insurance for every underserved, underinsured, uninsured child in America for the next 30 years.

Can you imagine what we could do with $1 billion if it was directed toward social and human conditions that exist throughout our country?

But I do not want to end on a negative note so I decided to do my own sign of hope. So to each of you, join me in inspiring hope and, in the words of Terrance Keenan, "Seek greatness."So, again, to all of you, this has been an incredible experience, and to all of my friends and colleagues who have worked with me to help make the work that we do so successful, I thank you from the deepest part of my heart.

ENDING AN ERA OF DENIAL: PHILANTHROPY'S ROLE IN THE THIRD DECADE OF HIV/AIDS

Stuart Burden, Jennifer Kates, Terry McGovern, Sunita Mehta, Todd Summers, and Betty Wilson

Lauren LeRoy, ***Grantmakers In Health***: Twenty-five years ago, when Grantmakers In Health was created, we had only an inkling of the devastation that HIV/AIDS would cause in this country and around the world. We have seen great progress on many fronts since 1982. Our message today is a simple one: we cannot be complacent. This is a message that our colleague Sunita Mehta from Funders Concerned About AIDS (FCAA) knows well. I invite her now to frame the issues to be discussed today.

Sunita Mehta, ***Funders Concerned About AIDS***: A warm thank you to my colleagues at Grantmakers In Health for working with Funders Concerned About AIDS, not just in organizing this plenary session, but also for their work with us throughout the year on a number of programmatic activities. This plenary is the culmination of a year of collaboration to get out of our silos to talk to each other and work with each other.

FCAA is 20 this year. In the beginning, a new disease was ravaging our communities. We were facing immense personal loss right in our homes and in our immediate circles. Twenty years later, the face of the disease has changed. We have cut across populations, across gender, nation, race, and class. As part of a strategic planning process through the past year, our organization has reconfirmed that AIDS is decimating populations abroad. If two-thirds of Sub-Saharan Africa is HIV positive, there is no question that AIDS abroad is a priority, but AIDS is not over in the United States. Today we will hear from the panelists who have dedicated their lives to this work because there is an absolute imperative to keep the attention on AIDS domestically.

Every year there are 40,000 new cases of AIDS in the United States. Half of those living with HIV in this country are African American. An increasing number of them are women. Half the people who are HIV positive in this country, the richest country in the world, are not receiving regular care. One in four Americans who are HIV positive do not even know it. We have our work cut out for us.

Jennifer Kates of The Henry J. Kaiser Family Foundation will make an opening presentation and then moderate the panel. Ms. Kates is vice president and director of HIV policy at the Kaiser Family Foundation.

There is an absolute imperative to keep the attention on AIDS domestically.

She oversees all of the foundation's HIV/AIDS policy efforts, directing and conducting policy research and analysis focused on both the global HIV/AIDS epidemic and the epidemic within the United States. The other panelists are on the board of FCAA or close to our constituency. I know that you are going to be inspired and I hope that when we leave this plenary, we will all leave in a spirit of collaboration and recommitment to a problem that is not going away anytime soon and will not go away if we do not work on it together.

Jennifer Kates, *The Henry J. Kaiser Family Foundation*: Thank you to Grantmakers In Health for making this issue, HIV/AIDS, a priority of the conference. I also want to thank FCAA as the only affinity group of foundations devoted entirely to focusing on HIV, and that has kept the drumbeat going for a long, long time.

We in the United States are part of a global epidemic in which 40 million people are living with HIV, and we see the addition of 4 million new infections every year.

The focus of this panel, even though we will touch on the enormity of the epidemic globally, is on HIV in the United States. Where are we with the epidemic in the United States and where do we need to go? It is easy to forget the impact at home and to pit the domestic and global epidemics against each other. I do not think this is intentional, but that is often the way the discussion plays out.

So I will do three things today. First, I will provide a quick snapshot of where the epidemic has been, where it is going, and some key trends. Then I will reflect on the role of foundations. Then as I moderate this panel, we will hear from people whose work on HIV reflects different perspectives and grantmaking strategies. We will explore how they have navigated that field and kept the commitment going despite the challenges. We all face a similar challenge of keeping this on the radar screen (or getting there in the first place) with our boards, with our colleagues, and with others in the field. I am proud to be at a foundation where our president and board have made a strong commitment to HIV for a long time, and it just keeps growing. We also want to make sure we are playing our part nationally and internationally in the discussion to keep this front and center.

We in the United States are part of a global epidemic in which 40 million people are living with HIV, and we see the addition of 4 million new infections every year. Those are hard numbers to grasp. Access to antiretroviral treatment is still limited. It is growing, but it is still not at an acceptable level. Most of those infected in the world do not even know they are positive.

Turning to the United States, we find more than 1 million people living with HIV/AIDS and 40,000 new infections a year. As many as 50 percent of these individuals do not have access to care and one-quarter do not know they are infected. These are big challenges.

There are also successes we should not forget. The number of new infections has decreased from a high of 78,000 in 1992 to the number, 40,000, that I just mentioned. This decrease is largely

due to community response, including foundation response, but this rate has been at a plateau level for more than a decade. Most of us working in the field think it is more than that now.

What does that mean? It means that we have a growing epidemic here, and this growth in the number of people living with HIV/AIDS in the United States is both part of the success story — extending people's lives, people living longer — and the continuing challenge of new infections.

Among the key trends is the impact on minority Americans, particularly the black community. In the mid-1990s, there was a crossover from an epidemic that primarily was affecting whites to one affecting blacks. African Americans are 12 percent of the population but 50 percent of the new cases. Whatever measure you look at, people living with AIDS, deaths, new infections, et cetera, the impact is significantly disproportionate. Women represent a growing share of new AIDS cases as well.

Although there is not as much data as we would like, a recent study by the Centers for Disease Control and Prevention (CDC) illuminates the challenge. In a study of men who have sex with men in five cities, the rates of HIV infection were extremely high: 25 percent overall and 46 percent for blacks. These are big challenges. Finally, we need to take a closer look at what is going on in the South. The South should demand a lot of our attention, as it has an increasing share of new cases.

Now let me turn your attention to a different issue. We do a lot of polling at Kaiser, and one of the things we try to assess every couple of years is what the U.S. public thinks about AIDS. Where is AIDS on their radar screen? We are very concerned about AIDS fatigue. The success of foundations, communities, and many of the community organizations that you all fund, is keeping HIV on the radar screen of the U.S. public, which is very hard to do because there are a lot of competing priorities.

We have a growing epidemic here, and this growth in the number of people living with HIV/AIDS in the United States is both part of the success story — extending people's lives, people living longer — and the continuing challenge of new infections.

SPEAKER PROFILE

Sunita Mehta has been executive director of Funders Concerned About AIDS since 2005. Previously she was associate director of the Soros Reproductive Health and Rights Fellowship at Columbia University. Prior to this, she served as director of grants and programs at The Sister Fund. Ms. Mehta is the founder and a member of the board of directors of Women for Afghan Women, and she edited *Women for Afghan Women: Shattering Myths and Claiming the Future*. She serves on the board of directors for Women in Media and News. She also served on the founding board of directors of the Third Wave Foundation. Ms. Mehta has a bachelor's degree from Rutgers University and a master's degree from SNDT Women's University, Mumbai, India.

We put out this survey in the spring and asked the U.S public: What is the most urgent health problem facing the nation? We used an open-ended question. We did not prompt them. We did not say, "Is AIDS up there?" We just said, "What is it?" The answer was that the third most urgent health problem cited without any prompts was AIDS. Now I will say that a few years ago it was number one. So it is no longer number one, but it is pretty high given all of the other issues affecting people's lives.

Another finding was even more telling. We asked: Are we spending too little on this epidemic or too much? We know the American public does not really like to spend more tax dollars. In fact, most people say we spend too little, and the share of the U.S. public who say we spend too little on this epidemic has increased. All of us should be able to take some credit for that especially in the communities that we support.

We also focused on prevention, asking, "Do you think that spending more money on HIV prevention in the United States will make a difference?" Most people think it will, and the share is increasing over time. That to us is heartening because, despite the debate, despite the fact that people are still unclear about what prevention is, how to measure it, and how we should be focusing on it, most people think we should spend money on prevention and that it will make a difference to do so.

The U.S. public's view on the global epidemic is also where we think we have seen some good results. Just to give you some context, in general, the U.S. public does not think much of foreign aid. They think we spend way too much on foreign aid. In fact,

SPEAKER PROFILE

Jennifer Kates is vice president and director of HIV policy at The Henry J. Kaiser Family Foundation, a non-profit, private operating foundation. Ms. Kates oversees all of the foundation's HIV/AIDS policy efforts, directing and conducting policy research and analysis focused on the HIV/AIDS epidemic. Ms. Kates also works closely with the foundation's health journalism training programs and entertainment media partnerships on HIV/AIDS. Prior to joining the foundation, Ms. Kates was a senior associate with The Lewin Group, a health care consulting firm, where she focused on HIV/AIDS policy, strategic planning and health systems analysis, and health care for vulnerable populations. Ms. Kates was also the director of the Office of Lesbian, Gay, and Bisexual Concerns at Princeton University. Ms. Kates is currently pursuing a doctorate in public policy from The George Washington University. She completed her undergraduate studies at Dartmouth College and obtained master's degrees from the University of Massachusetts and Princeton University.

49 percent say it is the second largest spending area after defense. It is actually 2 percent of the federal budget. Sixty-two percent of people say we spend too much on foreign aid.

But when we ask people about HIV globally, they have a very different view. We see that the U.S. public is actually quite supportive of spending on HIV in the global context. That has jumped significantly from 2002 to 2006. Thirty-one percent said we were spending too little when we asked them several years ago. Now more than half say we are spending too little. That, again, is the result of increasing attention by foundations, by government, by others to this issue.

Now we get to the best part, which is our panel. First, we have Todd Summers, a senior program officer at the Bill and Melinda Gates Foundation working on global health. He plays a major role internationally on many critical global health issues facing the world, including vaccine research and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

We have Stuart Burden from the Levi Strauss Foundation and also an FCAA board member. He has worked in the field of HIV for years at several different foundations and brings an interesting perspective on the differences in the field.

We have Betty Wilson, who is the president and chief executive officer of The Health Foundation of Greater Indianapolis and a leader in bringing this issue to a smaller-scale local foundation to really take on HIV and keep that commitment alive for many years.

Finally, Terry McGovern has joined us, someone who was an inspiration to me when I was first got involved in HIV/AIDS activism. Terry took on the federal government, successfully suing to change the laws and policies of this country to better serve women and poor people living with HIV and those at risk.

My first question is for Ms. Wilson. In thinking about your foundation, you provide a great example to everyone here of how a foundation works in a defined area, Indianapolis. You convinced your foundation and the community to make HIV a priority focus, one of, I think, three or four. That was in the early 1990s, and it still is a priority today. How did you do that? Why did you do it? How do you keep that going now, this length of time, in a community?

Betty Wilson, ***The Health Foundation of Greater Indianapolis, Inc.***: HIV/AIDS is one of our three areas of grantmaking. To set the stage a little bit, the foundation is one of the early conversion foundations, only we did not know to call ourselves that in 1985. Today we are $29 million big; it is the size of many of the grants made by some of the country's larger foundations.

So putting that into perspective, we had to do a lot of the big C's — collaboration, cooperation, and coordination. We took the lead on this issue because no one else in our

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The criticism of our foundation for taking on HIV/AIDS has gone away. Now it is our accepted role in the community. The negative side to having that as the accepted role in the community is that other folks do not think they have to do it, too. That is why we talk so much about collaboration, coordination, and cooperation.

community was doing so. We knew that living in the shadow of the Lilly Endowment, we needed to have our own niche in the community. Because we had committed our funding to health issues and because we knew we would not have an impact on doing a broad-brush approach, our board had the courage to step up and say, "We want to do what no one else in our community will do, and we want to do the controversial stuff because we know people will pay attention."

And, by golly, in 1990, when we made our first grant, we sure got the community's attention. We had phone calls from people saying: "What in the world are you thinking? Why would you want to get involved in that kind of issue? Where do you get your money? I want to know who I need to call to keep this from happening again." When I reported all of the feedback to the board, they said, "Hooray! We got their attention. We're not in the shadow of the Lilly Endowment anymore."

So it was really about making an impact in the community around an issue that no one else was addressing. People were affected disproportionately. We had communities of young people, in particular, who were not paying attention to the issue. They were not scared enough. Our population of older gay men was dying, and so they were not able to help carry the message of the importance of this issue — that HIV does kill you.

So it was a courageous thing for the foundation board to do, and it was a lot of fun for the staff, all two of us, who often locked our office door because of security concerns.

We are still doing the same things in different communities for different reasons. Because we are a small foundation, it is important to hear how to do things from our colleagues at larger foundations who can do more of the broader thinking. We would like to bring that big-idea thinking to the grassroots.

The criticism of our foundation for taking on HIV/AIDS has gone away. Now it is our accepted role in the community. The negative side to having that as the accepted role in the community is that other folks do not think they have to do it, too. That is why we talk so much about collaboration, coordination, and cooperation. We know that if you are doing funding in education, you are addressing the same constituents that we are addressing through our funding in HIV.

So we still get some of that criticism. Remember, we are on the edge of the Bible Belt. It is a conservative community, and we still have issues about sex. You know, it is just hard to talk about sex in public, and those of us at the foundation use that issue in social settings just to break the ice.

Jennifer Kates: I want to segue to Todd Summers on one of the points that you made. Mr. Summers has worked for years in the domestic epidemic, both on the frontlines as an activist working in the Clinton Administration,

SPEAKER PROFILE

Betty Wilson is president and chief executive officer of The Health Foundation of Greater Indianapolis, Inc. A 20-year veteran of health foundation management, Ms. Wilson oversaw the organization's development as a conversion foundation, successfully focusing its grantmaking to be more effective in key funding areas. Prior to joining foundation, she was the director of community services for the Indiana State AFL-CIO. Ms. Wilson has been honored in her community with the Sagamore of the Wabash Award, bestowed by the governor of Indiana. She has served as a member of the advisory committee of the Robert Wood Johnson Foundation Local Initiative Funding Partners Program, the National AIDS Fund, the Joseph F. Miller Foundation, and the Indiana State Mental Health Board, a gubernatorial appointment. She was named one of Indianapolis' "Most Influential Women" by the *Indianapolis Business Journal*.

working with lots of foundations, including The Henry J. Kaiser Family Foundation, and now at the Bill and Melinda Gates Foundation. Do people believe that the Gates Foundation is already taking care of the problem?

Todd Summers, *Bill and Melinda Gates Foundation*: Yes, we get that quite a bit on a number of fronts. We fund a lot of biomedical research on HIV vaccines and microbicides that would protect women. Now we are hearing from members of Congress that we have that base covered so Congress can devote its attention to other things.

Similarly, because we are involved in a lot of international funding and because our grants tend to be large, there is a perception that somehow we have filled the gap — which could not be farther from the truth. I was thinking that foundations need to understand and exploit areas where they could complement each other's work. Gates can make large grants, but we cannot make small grants. We are not very good at it even though some of the best work happens with the smaller grants.

So I think one of the challenges that we have as grantmakers is how to, in a given space, figure out what we are all going to be particularly good at and how we work together, as opposed to assuming that because the Gates Foundation is working on this, that somehow the issue is solved.

The second thing I would say is that we have no monopoly on intelligence. These are challenging issues, and it requires a lot of thought to figure out how you are going to make progress against HIV, which is grounded in so many intransigent problems and recalcitrant cultural mores. So what

Foundations need to understand and exploit areas where they could complement each other's work…one of the challenges that we have as grantmakers is how to, in a given space, figure out what we are all going to be particularly good at and how we work together.

SPEAKER PROFILE

Todd Summers is a senior program officer for global health at the Bill and Melinda Gates Foundation and leads its advocacy efforts on HIV, including work on supporting the Global HIV Vaccine Enterprise and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Before joining the staff in 2005, Mr. Summers was founder and president of Progressive Health Partners, a public health policy consulting firm whose clients included the Gates Foundation, The Henry J. Kaiser Family Foundation, and the University of California, San Francisco. Mr. Summers was also the deputy director of the White House Office of National AIDS Policy. While there, he helped coordinate the nation's HIV/AIDS programs at numerous federal agencies, served as principal liaison to President Clinton's Advisory Council on HIV/AIDS, and worked to increase funding for HIV prevention and care. He has a bachelor's degree from Middlebury College in Middlebury, Vermont.

is it that we can do together to try to work at this?

It requires innovation. If we are going to try to fund innovation and work together, it requires a certain level of cooperation and coordination.

Jennifer Kates: One of the things I have watched the Gates Foundation do that I think is a great lesson for all of us, particularly working with domestic groups, is your emphasis and ownership of the word "advocacy." A lot of foundations step back from advocacy. Yet you not only say you do it, you are setting up networks globally that I think could teach us a lot about what we could be supporting here. What do you mean by advocacy? And how have you navigated that territory?

Todd Summers: Advocacy is one of those words that can be used in a lot of different ways. When I started working in HIV a few years ago, I was advocating for needle exchange for ACT UP in Boston. Now I fund larger institutional advocacy, the other end of the spectrum, perhaps.

Advocacy for us relates to our belief that we certainly cannot do it all. As many of you know, we have a fairly large endowment thanks to the generosity of Bill and Melinda Gates, and now Warren Buffett. If you compare it against the issues that we are standing against and the needs that are there, it is a drop in the bucket. We must leverage everything we do, and advocacy for us is the fulcrum for leveraging. So, yes, we can invest a lot in services, but we are never going to be able to provide prevention services to everybody at risk for HIV in the developing world. The only way we are going to get real traction is to push for the leadership at the community level, the national level, and the international level, to push for

donors to come up with the resources that are going to be needed to address the epidemic. So for us, advocacy is all about taking the investments that we are making in research and in program design and implementation and leveraging those out further.

Jennifer Kates: Terry McGovern, one of the things I think would be interesting for people to hear about is how you have taken your work in legal advocacy, particularly focused on women. How have you applied your experiences as legal advocate to the work you now do at The Ford Foundation?

Terry McGovern, *Ford Foundation*: For many years, I worked at the HIV Law Project, serving women for whom the system did not work. They needed lawyers. What you realize doing this work is that HIV is connected to everything. In other words, if your client cannot access benefits, they can't pay the rent, they can't work, and, therefore, they can lose their kids and end up in family court proceedings. When you work with women, you have to deal with drug treatment issues — are there placement slots for families and women with children? You have to deal with prison, with women who are incarcerated, who do not see their kids, who come out very ill.

So it became extremely clear to me that if we were going to address HIV, we needed to get all of these different systems — including the systems that deal with women who are experiencing violence — we needed them all to understand and begin to integrate HIV into their approaches.

As a funder, I realize that we have to work out of the HIV silo. Also, I have a real appreciation for how complex this work is. If you are really going to work with the numbers, the people who represent the numbers that we heard, there is no easy fix. We have to go back. We have to begin to get into the complexities of this because that was what all our case representation was about.

Todd Summers: I can dovetail on that. There are actually few differences between many of the issues that are being faced internationally and those that are being faced domestically. There are obviously some significant issues that should not be overlooked, but there are also a lot of similarities — stigma, prejudice, isolation, lack of a political support system that would allow you to even enjoin a lawsuit to make change. Those are substantial problems here and everywhere. You do not need to go to Sub-Saharan Africa to see HIV prevalence rates that are off the charts. You can go to New York City. You can go to Washington, DC, which actually has the highest HIV rate per person of any city in the United States. So I think that we have drawn a gulf between international funding and domestic funding as if the problems are completely different. In many cases they are not.

Jennifer Kates: Ms. McGovern, will you explain a little bit what you did with Social Security Administration and the Food and Drug Administration?

You do not need to go to Sub-Saharan Africa to see HIV prevalence rates that are off the charts. You can go to New York City. You can go to Washington, DC.

Terry McGovern: In 1988 I was a legal service lawyer for a civil poverty law program. A lot of low-income people, a lot of women, but also low-income gay men of color living in the housing projects were coming in, and they were unable to access benefits for HIV. In other words, they could not qualify for Medicaid. They did not have AIDS so therefore, they could not get housing that was available for people with AIDS.

So we did Social Security disability hearings for people (and I did a lot of them), and we kept losing because my clients were HIV positive, but did not have AIDS. The vast majority of these cases involved women. I began to talk to the activists, including some women in prison, who were saying the AIDS definition was not based on adequate studies. They contended that the studies were primarily of men, that there were not enough affected populations in those studies, and therefore, the epidemiological definition was inappropriate as a gateway for services.

In 1990 we brought a class action suit. Ultimately we proved that the definition was too restrictive and did not adequately address the needs of women and other populations. As you probably know, Social Security changed the criteria. It is not perfect, but it got better, and the CDC definition was expanded.

Jennifer Kates: We go now to Stuart Burden, who is a corporate foundation representative on our panel although not from a pharmaceutical company.

Stuart Burden, *Levi Strauss Foundation*: The question is: Why is a Levi's guy here at the Grantmakers In Health annual conference? Just a little bit of information. I have been at Levi's for five years. Before that I spent 11 years at The John D. and Catherine T. MacArthur Foundation in Chicago before they had an HIV/AIDS program. I also worked at the Ford Foundation before they had an HIV/AIDS program. In both of those instances, the organizations said, "Well, we are not a health care foundation, and we don't do single diseases." We had to go through the whole process of talking about how HIV connected with all the other issues that they were concerned about.

So the question I pose to you is: What could you do in your foundation's context that may not be obviously connected to HIV but is a natural connection given the role the pandemic plays? I could stand up here and talk about Levi's, but I want to talk about what some other colleagues in the field are doing. I want to celebrate their work because we are all in this together, and this is about collaboration.

Many of you are familiar with the Red campaign, Project Red, in which a group of corporations have come together including Motorola, Converse, American Express, Gap, using their brand strength to put into the marketing of special products. The funds from those products are used to support the Global Fund for HIV/

SPEAKER PROFILE

Terry McGovern is the HIV/AIDS Human Rights program officer at the Ford Foundation. Ms. McGovern founded the HIV Law Project in 1989 where she served as the executive director and successfully litigated numerous cases against the federal, state, and local governments including a case against the Social Security Administration to expand HIV-related disability criteria allowing women and low-income individuals to qualify for Medicaid and social security. As a member of the National Task Force on the Development of HIV/AIDS Drugs, she authored the 2001 federal regulation authorizing the government to halt any clinical trial for a life-threatening disease that excludes women. Ms. McGovern also initiated the Models of Resistance Project that identifies and develops victim-led models of resistance to fundamentalism, in response to her mother's death in the World Trade Center attacks. Ms. McGovern earned her law degree at Georgetown University.

AIDS, Tuberculosis, and Malaria. This is a beautiful campaign; it is a great effort and is to be applauded. Note that the organizations I am talking about, including Levi's, are not pharmaceutical companies. We are not health care services nor health care product companies.

There is another campaign run by Aldo. For those of you who do not know Aldo, they sell shoes, and they have launched a campaign called "Hear No Evil, See No Evil, Speak No Evil." This campaign is not quite two years old. When you go to buy your shoes, you can also buy an empowerment tag for $5. They also invite you to go to the Web site to learn more. To date, they have sold 700,000 of these tags and raised $2.7 million for YouthAIDS, an organization in Washington, to redistribute the money for HIV prevention focused on young people. The campaign is slick and beautifully done. This terrific marketing is from a shoe company, I will remind you.

Another example is VIVA GLAM, a lipstick from M.A.C. Cosmetics. Starting in 1994, with one lipstick and now today there are six, they take all the profit, every single cent, from the sale of this product and put it into their M.A.C. AIDS Fund. What is impressive about this, I might say, and which I did not really appreciate when I worked for MacArthur and Ford, is that M.A.C. sells its products through stores such as Macy's. They have convinced Macy's, which is entitled to take the profit from the sale of the lipstick, to donate that money into the M.A.C. AIDS Fund to be redistributed. That is a pretty impressive partnership. Since 1994 they have raised more than $86 million through this campaign.

So, to wrap up, the theme of the campaign is about getting out of silos. Question yourself. How can you extend the work that you are doing on elder care and health, and youth and health, and health and human rights, and access to health care and policy, minority health issues, and extend it to cover HIV/AIDS?

How can you extend the work that you are doing on elder care and health, and youth and health, and health and human rights, and access to health care and policy, minority health issues, and extend it to cover HIV/AIDS?

For those of you in research, let me just put in a plug for this. Both Mr. Summers and I sat on the President's Advisory Council for HIV/AIDS, and I cannot tell you the importance of evidence-based policymaking. In that setting, the policy recommendations that came from work funded by this foundation were extraordinarily important because we know these recommendations were not political. Those studies came in with private dollars and independent funding, and really helped shape some incredibly important public policies. This is another role you can play.

The second question to ask me is about Levi's, again, a clothing company, an apparel company working in this field. Why are we doing it, and what have we done that might resonate with this audience?

We are one of the world's oldest clothing brands, but we do recognize that we have a role to play in HIV prevention and care. We focus on three things at Levi Strauss, the company and the foundation. Both giving programs have identical funding priorities. We focus on economic empowerment through asset building. We focus on workers' rights. And the third thing is we focus on HIV/AIDS. Specifically, we want to confront stigma and discrimination, and we also want to increase access to clean syringes. That was a very interesting board meeting for me to walk in there and say, "Yes, I want you to become the first corporation to openly fund the distribution of

SPEAKER PROFILE

Stuart Burden is director for the Americas within the Worldwide Community Affairs Department of Levi Strauss & Co. and the Levi Strauss Foundation. In this role, he is responsible for the strategic direction of the philanthropic, employee community involvement, and external relationship-building activities in Canada, the U.S., Mexico, Latin America, and South America. Prior to joining Levi Strauss & Co., Mr. Burden worked for The John D. and Catherine T. MacArthur Foundation, the Ford Foundation, the New York Foundation, and Citibank. He served on the Presidential Advisory Council on HIV/AIDS during both the Clinton and Bush Administrations. Mr. Burden currently sits on the board of directors of the International Women's Health Coalition and is a member of the Northern California Committee of Human Rights Watch. He graduated from Stanford University.

clean needles around the country. All in favor?"

How did we get there? Why did we do it? We did it because if you look at a pie chart about HIV infections, you find that one-third are the result of the exchange of dirty needles. But for the sake of this panel today, I just want to point out we did not do this alone. We did it with several other organizations. We did it with the Elton John AIDS Foundation. We did it with Public Welfare Foundation, the Irene Diamond Fund, and the National AIDS Fund. Together we are working to build a new organization called the Syringe Access Fund. Sometimes there is safety in numbers.

If we are going to really get serious about this pandemic in the United States, we are going to have to address some very uncomfortable issues for some of our foundations, such as sex and needle exchange. But we are foundations. It is the role, I think, we are expected to play in our society. It is one of the few examples I can point to — 11 years at MacArthur, two years at Ford, five years at Levi's — where foundations have truly come together. We talk about collaboration all the time, but how often do we have examples really to show on a controversial issue?

I do want to talk about creativity. In South Africa, starting four years ago, we did a Red for Life campaign to reach the entire country, which is 24 percent HIV positive. Using the resources that we had, we used music, we used marketing, and then we got a partner with *Cosmopolitan* magazine. As part of the campaign, we created a Red for Life condom. In connection with World AIDS Day 2006, this condom was attached to every magazine, which every South African subscriber received that month. So every subscriber in South Africa got their magazine with the Levi's condom.

Terry McGovern: I want to encourage people to take a risk on advocacy. Actually, Len McNally is sitting in the audience, who is from The New York Community Trust. And in 1988 he gave me a $30,000 grant to do the HIV Law Project. He took a big risk; I would encourage that.

Jennifer Kates: I will pick up on the theme of collaboration because I have noticed in the last few years that there has been an increasing desire on the part of my foundation and others to work together. We need to figure out how to do it better and how to keep doing it. It used to be that we wanted to do it ourselves or label work as "our project," but that is changing. We are working with Ford, with the Gates Foundation and with the Elton John Foundation to try to figure out what we each do best and bring those together.

Todd Summers: The club needs to get a little bit bigger in size and there is room for those with a different focus. Somebody mentioned elder care, and I recall a recent *New York Times* article about a community education program among elders who have recently been widowed and are now sexually active, helping them understand what safe sex was, something they probably did not

If we are going to really get serious about this pandemic in the United States, we are going to have to address some very uncomfortable issues for some of our foundations.

pick up in the last 40 or 50 years. It struck me as one of those things people would not normally consider as an issue for elder care.

My partner runs an assisted living program. I recently asked him, "When are you going to do a program for your residents about safe sex?" He looked at me and said, "What are you talking about?" I said, "Well, do they have sex with each other?" And he said, "Well, yeah, but we don't like to talk about that." So there you are.

I think that it is too easy to say, "It's not really fitting in my strategy, my priority list, and what it is that our foundation does." That is a cop-out. There is a lot that you can do. You do not need to transform your foundation. Stuart said it brilliantly. I think that it is just a way to extend the work that you are doing, to pick this up. Because if you are not, chances are you are ignoring it.

Jennifer Kates: Let me add one other piece of information in case people have not looked at the Funders Concerned About AIDS reports on trends on philanthropy and commitments to HIV. What we have seen over several years is that the share of grantmaker commitments going to HIV in the United States is decreasing so we are going to be tracking that again. We will have a new report coming out in a few months, and we will be looking specifically at that.

STEERING FOR THE CURVE AHEAD: TAKING ACTION TO ADDRESS AMERICA'S HEALTH CRISIS

Mike Huckabee

Congratulations for 25 years of Grantmakers In Health and all that you are doing, especially around your theme of "Knowledge To Action." I think that this is a wonderful theme because sometimes organizations can come together, and they talk about knowledge, and they share knowledge. And then they go home without putting anything into practice. Well we are at a point now where we cannot afford to simply talk about the extraordinarily urgent sense of crisis in this country. We really do have to take the knowledge that we have and put it into action; otherwise, the meeting is a waste of time and money, other than everybody being able to have some good fellowship.

The urgency, the immediacy of the crisis that we are facing demands that we do something about it rather than just talk about it. When I think about this organization being 25 years old, I realize that when it got started we were much younger. Many of you are fellow baby boomers, who have lived a little time and have a few gray hairs. The amazing thing is I am 51 years old and I am doing things today that I could not do when I was 18, largely because I took control of my health. Four years ago when my doctor sat me down and told me I was digging my grave with a knife and fork, he predicted that I was in my last decade of life unless I changed my lifestyle. He then described what the decade was going to be. I must admit to you that as he gave this vivid description of what type 2 diabetes would do to my body and how I would exit, I realized it was time to plan a new exit strategy. So I changed the way I ate, and I changed the way that I lived, and I shifted away from a lifetime of fried foods, from which I pretty much got my nourishment, coming up from the Deep South as I did, and gave up things such as processed foods and sugar. I then started an exercise routine that began very mildly, with just a few minutes per day on a recumbent bike, and got to the point where I have now completed four marathons, having completed the New York City marathon last year. I am able to tell you that I am healthier today than I probably was in my 20s. I am healthier than I was 25 years ago.

Here is the great challenge we face: Because of the advent of chronic disease that is now creeping into preteens who are being diagnosed with type 2 diabetes, kids being born today will be the first generation of Americans, since the founding of this country, who are not expected

The urgency, the immediacy of the crisis that we are facing demands that we do something about it rather than just talk about it.

to live as long as their parents and their grandparents. Think about that. With all of our technology, with all of our medical advances, we ought to be seeing a group of kids who are living past the 100-year mark. But because of lifestyles and because of the incredible epidemic of chronic disease among children, particularly type 2 diabetes, due largely to obesity, we are seeing the first generation of children growing up who we will outlive in terms of our life span versus theirs.

The crisis is real. I know there are some people who think that this is the news story of the month or this is the flavor of the day. I do my best to try to say this one is real. This one is not going away. It is not going to cease being a crisis in a year or two just because we will decide to move on to something else. Here is why: Because today we are truly not only seeing the physical impact of poor health, but we also are seeing the economic impact in a way that is unsustainable.

Ask any governor in America, and he or she will tell you that they face two great challenges. Number one will be the state Medicaid budget, which grows at twice the rate of inflation in almost every one of the 50 states; the second is the cost of health care for the state employee pool. Now in most every state, the number of state employees makes that group the largest single employee pool in that state. There are only a few states that are the exception.

In my state alone, every employee of both Wal-Mart and Tyson Foods together would not quite equal the number of employees we have within the state system. So as governor, I not only oversaw the largest insurance program, Medicaid, for a population of nearly 1 million of our 2.7 million citizens, but I also oversaw a health care system for state employees, which was by far the largest pool of people anywhere in the state. The next largest pool was the entire Blue Cross system, which was half as many as we had in the state system.

Governors are uniquely sensitive to this reality. It also explains why we governors launched the Healthy America Initiative as mentioned in the introduction. The reason that it is happening at the state level, not at the federal level, is because the feds can always print or borrow money. Governors cannot; they have to balance budgets. This is an acute economic issue, but it is also an acute issue in terms of our very capacity to be competitive.

Today America spends almost 17 percent of its gross domestic product (GDP) on health care. I want you to stop and think about that compared to anybody else on Earth, because the Swiss spend about 10.5 percent of their GDP on health. They are the second highest-spending country. Most of the rest of Europe spends in the 9.5 percent range, and everybody else in the whole world spends less than that. But at 17 percent, we are so far above the cost of our gross domestic product on health care that it has a staggering impact upon our economy.

SPEAKER PROFILE

The Honorable Mike Huckabee was governor of Arkansas from 1996 to 2006 and recently announced plans to explore a presidential bid for 2008. Governor Huckabee, a national leader in education and health care reform, formerly served as chairman of the National Governors Association, tackling issues such as Medicaid and welfare reform. Governor Huckabee also served as chairman of the Education Commission of the States. Governor Huckabee's efforts to improve his own health have received national attention. Diagnosed with type 2 diabetes four years ago, he lost 110 pounds and completed a marathon. He has written several books including *Quit Digging Your Grave with a Knife and Fork* and *From Hope to Higher Ground: 12 Steps to Restoring America's Greatness*.

To put it in perspective, if we spent 11 percent (which still would be more than anybody else) instead of 17 percent, we could save $700 billion a year. Think about what $700 billion would do. You could give everybody their own personal physician and trainer for $700 billion a year. You could cut taxes, build roads, pay teachers more, give everybody a college scholarship, and still have money leftover. But the tragedy is that this figure of 17 percent is expected to increase to 20 percent by the year 2015 at the current trends, which means that the rate is simply unsustainable. From an economic standpoint, this is singularly the most urgent, important issue this country faces. If we do not get it under control, it will bury us.

Eighty percent of all health care costs in this country are related to chronic disease. I am telling you something that you probably already know and have discussed for several days while attending this conference. But if you stop and think about it, 80 percent of these incredible expenditures are the result of a preventable or a curable chronic disease that is largely the result of three behaviors: overeating, under-exercising, and smoking. Then to be sure, if we tackle those things that are the primary causes of the chronic disease, we would see an economic shift.

The truth is the American people resemble an NFL football game on Sunday afternoon. You have 22 people down on the field who desperately need rest and 70,000 people in the stands who desperately need exercise. Therein is your contrast. If we do not address it and do it soon, again, it is no longer just a financial cost. It means: Who is going to be the workforce tomorrow? It is pretty staggering when Harvard University comes out with a study that says one of our greatest threats to productivity is not absenteeism, which has been

Today America spends almost 17 percent of its gross domestic product on health care.

sort of the code word for people who are too sick to show up for work. There is a new word that Harvard has come up with called "presenteeism," defined as the people who show up for work but are operating at less than 60 percent of their capacity to actually do their jobs. While they are physically showing up, they are ill. They are sick with chronic disease, and, therefore, they are not able to perform to their full capacity and expectation. How are we going to compete in a global economy when our people, if they do show up, are showing up too sick to get their work done?

There is not a more urgent issue on the domestic scene today than dealing with the health of America. One of the things we are challenged by is that most people in public policy will say, "We have a health care crisis in this country." Let me correct that. It is not that we have a health care crisis in this country. We have a health crisis in this country. Our health is the reason that we have a health care crisis. If we were not so sick as a population, it would not be that difficult or expensive to cover most of our costs. The crisis is real. When people say, "What's the cause?," quite frankly, one of the problems we face is that too many people want the cause to be overly simple. So they think if we just changed a few little things and tweaked and tinkered that it would all go away, but it is much more complicated than that.

Eighty percent of all health care costs in this country are related to chronic disease.

We are the products of our own success in this country. We truly do eat too much. The quantities we eat are staggeringly larger than they used to be. For example, I remember when I was a kid, if someone gave me a muffin, it was about the size maybe of my fist, and that would have been a big muffin. Go to the typical bakery today and look at the muffins. They are bigger than my head. It is unbelievable. They are seven servings. When I was a child, I did not get birthday cakes as big as the muffins sitting in Starbucks. So part of it is that the portions are huge, and we are eating too much.

Then add to that the fact that our physical activity is dramatically different. For kids, this is especially acute because, as a child, most of us probably grew up where we did not have video games, and we did not have 150 television channels and DVDs and all the options. We were not worried about predators in our neighborhoods. So when we came in from school, from which we rode our bikes and walked, we played until well past dark. Our parents liked it that way. Today kids come in behind locked doors, and they sit with a bowl of chips in their laps, and they watch television and play video games or get on the computer and e-mail their friends and go to MySpace and Face Page and all the various Internet chat sites. As a result of the increased calories and the decreased activity level, we now see something we never saw before. Pediatric hospitals across the country, like Arkansas Children's in Little Rock, had never diagnosed a case of type 2 diabetes 15 years ago. It simply did not exist medically. We

had type 1 diabetes, which we called "juvenile." If you had type 2, that was called "adult onset." Nobody calls it adult diabetes or type 2 "adult onset" anymore because it no longer is an adult-onset disease. It used to be identified really by the maturity level of the person who received it. Fifteen years ago, you did not have teenagers getting type 2 diabetes. Today we have preteens getting type 2 diabetes. Several cases a week will be diagnosed at most any pediatric hospital in America, in children as young as seven years old. Now when preteens get type 2 diabetes, they are going to have vision problems in their 20s. These kids will have a heart attack before they are 30. They will have renal failure and be on full kidney dialysis before they are 40. They will be dead before they are 50. That is what we are up against.

The tragedy of this is that the cause is something that is curable, but only if we act with a sense of true urgency. In part we have to change the culture, and I would suggest that this organization can help set the pace. Grantmakers, who can help fund the projects out there that focus on changing the culture of health may be doing America the greatest single service that possibly could be done, because this is a cultural revolution. This is not a programmatic change. It must be a cultural change.

Now let me tell you, very candidly, why most people in politics are not going to talk about this issue in this way: because those of us in politics like to take on topics that we can change within an election cycle. This is going to require a generational change. It is not easy, but it is doable. Let me suggest to you that our country, even in my own lifetime, has seen cultural shifts of similar magnitudes, and why I am optimistic, not pessimistic, that we can get this job done. I want you to think back to the 1960s. As I go back 40 years ago, a full generation away, I want to take on four topics that had dramatically different cultural ramifications than they do today. One was litter. I can recall when people drove down the highways, and even sophisticated, well-educated people would finish whatever they had in their cars, roll the window down, and throw their trash on the side of the highway. Litter was a rampant problem. Lady Bird Johnson challenged us and said, "We need to beautify America." Litter is ugly and costly.

In the 1960s, seat belts were an after-market device for a car. Only Ralph Nader advocated them. People thought he was crazy for wanting to have people strapped in their automobiles. You could go buy a seatbelt and have it installed, but very few people did.

Smoking was so prevalent that I can remember as a child going to my doctor's office, and he would put his stethoscope up to me and listen to my heart while smoking a cigarette. I ask this question: How many of you 40 years ago or so had a doctor who smoked? If we had had this meeting of Grantmakers In Health 40 years ago,

It is not that we have a health care crisis in this country. We have a health crisis in this country.

ashtrays would have been on every table, and it would not have been the least bit odd for people to light up cigarettes after their meal and talk about health while smoking cigarettes at their table. If anyone had said to the smokers, "Excuse me. Would you put that out?," you would have considered the person incredibly rude to have dared ask someone to put out their cigarette. You remember when it was common to get on an airplane when people smoked. There were only maybe two rows of no smoking in the airplane. Now I am highly allergic to smoke so it is something I have never done and I have never understood. Why would you inhale something into your body that you naturally reject? The same toxic fumes that come out of a cigarette are the ones that come out of the back of a Greyhound bus. If you really want it, just go down to the bus station, get under the thing, and breathe deep, man. Have it for free.

Then there is drunk driving. Remember when Dean Martin and Foster Brooks made a good living as comedians telling us how funny it was to be falling down drunk?

Then something happened in each of those areas. I mentioned Lady Bird Johnson and the Indian with the tear coming down his cheek. Then there were the crash dummies, the Surgeon General's report on smoking, and the subsequent realities that it really was harming us. Mothers Against Drunk Driving told us that it really was not that funny for people to get behind the wheel of a car and drive while they were intoxicated. Today public attitudes and policies toward all of those areas are dramatically different. In my state, you could be fined up to $1,000 for litter. We have a toll-free number. If you see someone littering, you can call the toll-free number and report them, get their license plate, a letter will be sent to them. If it happens a third time, they get a fine. They have to go to court and fight it and prove they did not do it. We are serious about it. On smoking, a year ago I signed a statewide clean air act that banned smoking in every single workplace in the entire state, not just restaurants and bars. You cannot smoke indoors in Arkansas in a workplace anymore. That would not have happened a few years ago.

Now in these four areas where we have seen these cultural shifts, three things happened. First, there was an attitudinal change caused by awareness, education, and advertising, which all helped change people's attitudes toward the issues. Secondly, there was an atmospheric change. We started putting litter baskets out and "No Litter" signs. We took away the ashtrays, and we started putting up "No Smoking" signs and having no-smoking zones and no-smoking rooms. Now the entire Marriott and Westin Hotel chains are totally nonsmoking, and many places across the country are going to a completely smoke-free campus. A year before we did the smoking ban in Arkansas, every hospital in the state on the same day banned smoking not just inside the hospital but on the entire

campus, down to the parking lot. That was a bold move. The atmosphere changed. Finally, the third thing is the action phase. The action phase is when the government codifies what has become the new behavioral norm. Quite frankly, if the government had tried to start changing the behavioral norm with a law, it would never have worked and people would have rebelled and gotten angry. They would have hung the politicians who proposed it. But because it started with attitude changes, then atmospheric changes, and finally an action change, we were able to rather comfortably codify what had become a new cultural behavioral norm.

When I talk about the culture of health, let me be very clear. This is not going to happen by this time next year. We have to look at this as a cultural shift. It may take five years. It may take ten. It may take longer, but I think it can be done within ten years. It requires change through advertising, education, and attitudinal change. It requires atmospheric change, where we take the candy and the sodas away from the kids, as we have done. President Clinton and I co-chaired the Alliance for a Healthier Generation and got a voluntary agreement from the soft drink companies to take all sugared beverages out of schools nationwide — a pretty huge step for those companies to do that — and replace it with bottled water, with pure fruit juice, and with nonsugared sports drinks. That is not going to singularly fix obesity in children, but it was a very important atmospheric change. It just said to kids, "You just can't go in there and have sugared drinks all the time anytime you want."

Tom Harkin, Democratic Senator from Iowa, and I recently had a wonderful meeting in his office. He had an interesting idea: the atmospheric change of putting fruit in the classrooms and saying to students, "Anytime you want an apple or a banana or a handful of grapes or strawberries, here's the fruit dish. Come get it." What they discovered in the schools where they experimented with this was that kids who ordinarily would never have picked fruit started getting fruit, and they liked it. And they would go home and ask their parents, "Would you get some grapes? Could we have some strawberries? Can we have some bananas or apples?" We helped change their habits by changing the atmosphere in which they were able to receive those kinds of things. I wish there was a national program where, instead of putting candy in front of kids, we gave them healthier choices and helped condition them to think in terms of the things that were good for them, because after they started trying it, they would find out these are really good.

Then there is the action phase when government has to take the tough steps. We have to do this. If we do it, we not only save an American generation from early death but also we save our economy, and we save our capacity to be competitive. If we do not do it, think of the trends. Today GM spends more money on

When I talk about the culture of health, let me be very clear. This is not going to happen by this time next year. We have to look at this as a cultural shift.

health care benefits for its employees than it does on the steel that goes into the construction of a new car. When you buy a GM car today, you are really not buying a car. You are buying health benefits for the people who assembled it. They are giving you the car as a thank-you gift for helping their employees have health insurance. Howard Schultz, the CEO and founder of Starbucks Coffee, flew to Little Rock to meet with me about some of the things we were doing in Arkansas in terms of incentives for better health. I asked him, "Howard, out of curiosity, why would you fly from Seattle to Little Rock, Arkansas? Why is this such an important issue?" He said, "This year I will spend more money on health benefits for the employees at Starbucks than I do in purchasing coffee beans for the entire Starbucks chain." You thought you were buying a latte. You are buying health benefits for the person who fixed it. The latte is the thank you.

When you buy a GM car today, you are really not buying a car. You are buying health benefits for the people who assembled it.

Incentives, the kind of programs that we can do that change the culture of health, are critical. We started giving our state employees walk breaks because it occurred to me that if employees smoked, they got to go outside a couple of times a day on our time, and go out beyond the buildings and puff away. In other words, we paid them to hurt themselves. If, however, they wanted to go for a walk or exercise, what we said was: "Do it on your lunch hour." Now what kind of message is that? If you want to hurt yourself, we got you covered. You want to improve yourself? You are on your own. The whole system is upside down. After we started giving employees walk breaks, we found that when they went back to their desks, they were more productive because the exercise had awakened their senses. Some people who really had never thought of exercise got into the group habit. We started giving people up to $500 a year off their health insurance premiums if they would do a health risk assessment. We would provide patches, counseling, whatever it took to get them off tobacco. That would be on us because it was in our best interest. Every dime we would spend getting somebody off the nicotine addiction was money back to us in terms of decreased costs of health services.

The Central Arkansas Veterans Health System found that for every dollar they spent in preventive health, they saved $8 on the long-term return. We found out that a lot of our employees did not get regular screenings — mammograms, prostate cancer exams, or colonoscopies after the age of 50. Why not? It was because the copayments and the deductibles were an impediment. The fact is that a couple hundred dollars is what many state employees needed to send their kid to camp or to buy food or to buy clothes.

So we did something radical. We took away all the copayments and the deductibles for the screenings. If employees want the screenings, there are now no copayments or deductibles. It is in our best interest

as an employer to have people with prevented illness rather than a treated illness. With our Medicaid population, we became the first state in the country that said if you will get off tobacco, we will help you with cessation tools and a toll-free number you can call for counseling. We will give you patches and nicotine gum, whatever it takes to get you off the addiction to tobacco, because between the cost of the cigarettes and the cost of the extended health care, it is a huge financial risk.

We did something radical in schools. We calculated the body mass index for every student. Arkansas right now is the only state in the country that has experienced a reversal of our childhood obesity rates. After a 25-year trajectory of straight up and off the charts, in the first year we saw an arrest in the rate and in the second, a slight decline. My great worry is that, in this legislative session, the new governor is thinking about tinkering with that and changing it, which is just beyond me. It is one of the most progressive and successful things we have done. It does not fix kids, but it sends an alert to parents.

In another example of an action phase, we did several things in terms of health coverage. In 1997 we innovated the plan that preceded State Children's Health Insurance Program (SCHIP), called the "ARKids First" program that put a health coverage safety net under every kid of working parents in the state. It really was the bridge to get people off welfare. Frankly, a lot of people criticized folks for being on welfare. But the reason they were on welfare was because it made more sense economically than it would to go get a job where they did not have health coverage and they could not afford to have their kid break his arm on the playground. So the dumb thing was we were griping at people for actually making a pretty darn responsible decision to give their kids better coverage. By giving them coverage, we gave them a way out. It worked beautifully. We had over 200,000 kids over the course of time covered by health insurance.

My point is that we change the culture by changing it one step at a time and creating incentives so that this entire health system of ours, which is totally upside down, is put right side up. Think about it. Our medical schools do not teach medical students how to prevent a disease. It teaches medical students how to diagnose and treat the disease. Doctors are not reimbursed for making you well. They are reimbursed for treating you when you are sick. It would be revolutionary if all the insurance companies gave doctors bonuses beyond the point of service for actually seeing a patient's blood sugar, blood cholesterol, and heart rate decrease. I mean, there would be a built-in financial incentive. Right now doctors do not have the luxury of much more than a seven-minute visit: "Here is your prescription, go to the pharmacy, get it filled, try to lose weight, exercise, yeah, yeah, yeah, take your pill, come back, and

see me in six weeks." That is about all we get because the insurance companies, the whole medical system, everything about the system is geared toward the culture of disease. We will not change this country until we have a culture of health, not a culture of disease. That is our challenge.

The key role the health care industry needs to play is changing these rules. Right now the health care industry is still geared toward reimbursement for point of service, and we need to start reimbursement for prevention. Here is something I never understood, there is no coverage to visit a nutrition counselor. That might cost $75. But insurance will cover a quadruple bypass that might cost $120,000. It would make more sense if we started providing more coverage on the preventive side because right now most insurance reimbursement do not do anything to cover the prevention side. It covers you when you are really, really sick. It does not help you to keep from being sick. It will provide certain levels of medication and surgical intervention and medical intervention. But what are the things that would keep people from getting to that point where they had some major medical intervention? Cover that, and I think that we will start to see a shift.

We change the culture by changing it one step at a time and creating incentives so that this entire health system of ours, which is totally upside down, is put right side up.

Companies must start establishing wellness centers and fitness rooms and giving their employees incentives to take better care of themselves. Some of it is as simple as changing the atmosphere of what you can bring into work in terms of sharing with employees. It cannot be all doughnuts and cakes and pastries. I know that sounds harsh, but, folks, this is a crisis. You know, we would not let employees bring loaded guns into the workplace and say, "Play with them during the lunch hour," and hope nobody gets hurt.

J.B. Hunt Trucking Company in Arkansas saved $4.5 million the first year they put in a preventive plan where they gave their truck drivers access to health coaches on better nutrition, exercise while they were out on the road, and tips on how to better manage their back injuries. It was a preventive program that they really focused on, and it saved $4.5 million the first year they did it.

So let me suggest that we start looking differently at this issue than we have ever looked at it before, and we start seeing that the future is about preventing the disease rather than just treating it, and that we start putting the money on wellness and health, not just on all the treatment. The grants you give certainly will always be critical to dealing with some of the acute issues we face, and I am not suggesting that we do otherwise. I would suggest that we also make sure that there is an ample amount of investment in any and every thing that will help those laboratories of learning, often in states, transform a culture and change us into a culture of health.

A few years ago, when Mike Leavitt was governor of Utah (he is now Secretary of Health and Human

Services), he invited me to come out to Salt Lake City for a weekend and be a part of a conference he was hosting. It was in February of 2001, which was exactly one year before the Winter Olympics would be held in Salt Lake City. So a couple of other governors and I went to Salt Lake to be with Governor Leavitt. We were on a program together that evening. At the end of it he got up and he said, "Ladies and gentlemen, tomorrow we have a special treat for everybody who's here. As you know, the Olympics are next year, and the Olympic site is ready. The athletes are training, and we're going to go out to the Olympic Village, and we're going to treat you to something special: visits with the athletes, the opportunity to see the Olympic village, and to be a part of the governor's bobsled competition."

I thought, "Gee, that sounds interesting. I guess they're going to name bobsleds after the governors, and then we'll watch and cheer them on." He kept talking and describing this event, and it sounded a lot like he expected the governors to actually be in the bobsleds. Now, this was problematic for me because my only experience with bobsleds growing up in the Deep South, where we hardly ever see snow, is that little opening scene on *The Wide World of Sports* where you see this very graceful ski jumper land, and the announcer says, "The thrill of victory." And then you see a bobsled careening off the side of a mountain, probably decapitating both people in it, and the announcer says, "And the agony of defeat." That image was indelibly impressed upon my mind. So after he described this bobsled deal, I went up to him afterwards, and I said, "Mike, you weren't serious. You don't really mean we're going to be in bobsleds." He said, "It'll be fine. We're going to give you some training in the morning." I went back to my hotel that night. I fired up my laptop computer and did a Google search on bobsleds. That was one of the dumber things I had ever done because the more I learned about a bobsled, the more I realized I had no business getting in a bobsled. This was 110 pounds ago for me, and the first thing I learned about a bobsled was that they are gravity driven. The more weight in the bobsled, the faster they go. I got out there the next day and he introduced me to my trainer, a 16-year-old Junior Olympic athlete. No offense, but I do not want to learn how to drive anything from a 16-year-old kid. My training was they put these spikes on our boots. We started at the bottom of the bobsled track, which is a one-mile track of solid ice, and the kid walks us up from the bottom to the top of the track, describing each of the curves in the bobsled track and telling us where we need to put the skids as we get into that curve.

We get to the top, and by this time I am hyperventilating, in part because I am scared out of my brains and the other, I am exhausted. I have just walked a mile up solid ice with a 16-year-old kid trying to make me remember when the skids go on all the curves. The people at the top

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get us ready, and they squeeze my big body down into that bobsled. The kid's job is brakeman (which is ridiculous because there are no brakes on a bobsled). His job is to push us off from the top, then he jumps in behind, and I hope he prays a lot because that is the only role I see for him after that. I am supposed to steer us down the bottom of the track.

Just before we took off down that hill, the kid gave me a piece of advice that I will never forget. He said, "Now, once we start down this hill, we're going to pick up speed at an amazing pace. As soon as we come off the crest of the top, you're going to see the first curve. You want to steer into it, and as soon as you're thinking about it, you're probably going to be in it." He said, "Now, first of all, if you think you're making a mistake in the curve, forget about it. The centrifugal force will be in control. There's not a thing you can do about it once we're in the curve. And for heaven's sake, don't think about what you did before because the ice behind you cannot hurt you. As soon as you get to that curve, you'll see the next one. And as soon as you see it, steer for it. By the time you react to it, you'll be in it. And when you're in that one, as soon as you get through it, you'll see the next one, and steer for it." He said, "Just always remember to steer for the curve ahead. Just steer for the curve ahead; we'll be fine."

As I got in that bobsled, and as I made my way down, and as I thought about it later, I realized that the kid had given me profound advice, not just good for getting a bobsled down to the end of the track. It was great advice as a husband, a father, as a governor, and for all of us here. Forget about the ice behind us. We can talk all day about the mistakes we have made as a culture. It cannot help us, and it cannot really hurt us. We can argue with each other about what we are doing now, but the centrifugal force of the moment is probably such that there is not a lot we can do to change this very single moment we are in. But what we can do, what we must do, and what will change the course of our children's future, is if we start steering for the curve ahead.

It takes some will and some genuine courage for us to look out there at the future of our kids and realize that this is a cultural shift that requires a generational change.

It takes some real guts to live for tomorrow and not just for today. It takes some will and some genuine courage for us to look out there at the future of our kids and realize that this is a cultural shift that requires a generational change. But if we really do want to make America a nation that is on top, and stays on top, physically and economically, then we only have one choice. We have got to steer for the curve ahead.

ABOUT GIH

With a mission to help grantmakers improve the health of all people, Grantmakers In Health (GIH) seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and on-line; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field. As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens and takes on operational issues in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs that fund in health and information on their grants and initiatives. Drawing on their expertise in health and philanthropy, GIH staff advises grantmakers on key health issues and synthesizes lessons learned from their work. The Resource Center database, which contains information on thousands of grants and initiatives, is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization).

Advice on Foundation Operations

GIH focuses on operational issues confronting both new and established foundations through the work of its Support Center for Health Foundations. The Support Center offers an annual two-day meeting, The Art & Science of Health Grantmaking, with introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments. It also provides sessions focusing on operational issues at the GIH annual meeting, individualized technical assistance, and a frequently asked questions (FAQ) feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues, experts, and practitioners to one another through its Annual Meeting on Health Philanthropy, the Fall Forum (which focuses on policy issues), and day-long Issue Dialogues, as well as several audioconference series for grantmakers working on issues such as access to care, obesity, public policy, racial and ethnic health disparities, and health care quality.

Fostering Partnerships

Grantmakers recognize both the value of collaboration and the challenges of working effectively with colleagues. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and connect grantmakers to organizations that can help further their goals.

To bridge the worlds of health philanthropy and health policy, we help grantmakers understand the importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we work to strengthen collaborative relationships between philanthropy and government.

Educating and Informing the Field

GIH publications inform funders through both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data and sketching out roles funders can and do play. The *GIH Bulletin,* published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Funding Partner Network (available only to GIH Funding Partners), and the Support Center's FAQs. Key health issue pages provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

DIVERSITY STATEMENT

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the nation's health. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

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