

SOCIAL INEQUALITIES IN HEALTH

Keynote Addresses from
the Annual Meeting
on Health Philanthropy

F E B R U A R Y
1999

Foreword

This report presents four major addresses from Grantmakers In Health's 1999 Annual Meeting on Health Philanthropy. Focusing on the broad theme of social inequalities in health, the meeting explored the roots of social inequalities and what grantmakers can do to eliminate disparities. Keynote speakers and panel sessions focused on the role of philanthropy, strategies at the community level, and lessons learned in crafting initiatives.

Nicole Lurie of the U.S. Department of Health and Human Services kicked off the meeting with her remarks focusing on the efforts of the federal government, particularly in addressing racial and ethnic disparities in health, and opportunities for collaboration between the public and private sector. Robert Evans of the University of British Columbia set the issue in context with his analysis of multiple sources of data documenting the range of determinants affecting health. Velvet Miller of Children's Futures-New Jersey commented on the possibilities of philanthropy, speaking from the perspective of someone moving from state government into the grantmaking arena. And John Murphy, recipient of the Terrance Keenan Leadership Award in Health Philanthropy, touched all with his wise and poignant remarks about what it takes to make a difference as a grantmaker. Our thanks to all the speakers for sharing their insights with us.

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Meeting Agenda

Grantmakers In Health
Annual Meeting on Health Philanthropy
February 18-19, 1999

Social Inequalities in Health

Tempe Mission Palms in Tempe, Arizona

THURSDAY, FEBRUARY 18

8:00am-8:30am Welcome/Opening Remarks

Karen Wolk Feinstein, Ph.D., Chair, Grantmakers In Health
Lauren LeRoy, Ph.D., President and CEO, Grantmakers In Health

8:30am-9:30am Keynote Address

What is the impact of social inequalities in health on the nation? What will it take to reduce them? How can philanthropy and the federal government work towards common goals?

Nicole Lurie, M.D., M.S.P.H., Principal Deputy Assistant Secretary for Health
Office of the Secretary, Office of Public Health and Science
U.S. Department of Health and Human Services

9:30am-10:30am Keynote Address

What do we know about the factors affecting health? What is the role of medical care versus other determinants such as nutrition, housing, and social issues? What do the data suggest about the types of strategies that might be pursued to improve health status?

Robert Evans, Ph.D., Centre for Health Services and Policy Research,
University of British Columbia

10:45am-12:15pm Plenary Session

What strategies are grantmakers adopting to address social inequalities in health? This panel discussion will probe the diversity of approaches being taken by leading grantmakers, how they arrived at these strategies, and the challenges presented.

Moderator: George Strait, Medical Correspondent, ABC News and Chair, The Henry J. Kaiser Family Foundation

Panelists: Tom David, Executive Vice President, The California Wellness Foundation
Sandra Hernandez, M.D., President and CEO, The San Francisco Foundation
Terri Langston, Ph.D., Program Officer, Public Welfare Foundation
Betty Wilson, Executive Director, The Health Foundation of Greater Indianapolis, Inc.

12:30pm-2:00pm Luncheon

Presentation of the Terrance Keenan Leadership Award in Health Philanthropy

Recipient: **John W. Murphy, The Flinn Foundation**
Presenter: **Margaret E. Mahoney, MEM Associates, Inc.**

2:30pm-4:30pm Concurrent Sessions

Access for All

Chair: **Len McNally, The New York Community Trust**
Panelists: **Cathy Dunham, The Access Project**
Barbara Lyons, Kaiser Commission on the Future of Medicaid and the Uninsured
Margaret O'Bryon, Consumer Health Foundation

Research: A Vital Link to a Healthy Future

Co-chairs: **Martha Peck, The Burroughs Wellcome Fund**
Susan Fitzpatrick, James S. McDonnell Foundation

Panelists: **Max Pastin, The Blowitz-Ridgeway Foundation**
Diane Rowland, The Henry J. Kaiser Family Foundation
Ira Strumwasser, Blue Cross Blue Shield of Michigan Foundation

Environmental and Human Health: The Connection for Health Grantmakers

Chair: **Rachel Pohl, Jessie B. Cox Charitable Trust**
Panelists: **Maureen Byrnes, The Pew Charitable Trusts**
Dick Jackson, National Center for Environmental Health

Health On-Line: Making the Most of the Internet

Chair: **Anne Schwartz, Grantmakers In Health**
Panelists: **Marjorie Cahn, National Library of Medicine**
Marla Bolotsky, The Henry J. Kaiser Family Foundation
Sandra Davis, Charles Stewart Mott Foundation

Raising the Value of Philanthropy

Chair: **Karen Feinstein, Jewish Healthcare Foundation**
Panelists: **Karen Davis, The Commonwealth Fund**
Margaret Mahoney, MEM Associates, Inc.
Denis Prager, Strategic Consulting Services

FRIDAY, FEBRUARY 19

8:00am-8:45am Morning Briefing

Is the Health System Ready for Y2K? Are You and Your Grantees?

Charles Halpern, President, The Nathan Cummings Foundation
Cassandra Junker, Executive Vice President, Rx2000 Solutions Institute

- 9:00am-10:00am Keynote Address
- Placing Philanthropy's Role in a Broader Societal Context**
- Velvet Miller, Director, Children's Futures-New Jersey**
- 10:15am-2:15pm Consensus Building Around a Health Agenda
- Larry Susskind, President and CEO, Consensus Building Institute**
- 10:15am-12:15pm Concurrent Sessions
- The Graying of America: A Grantmaker's Menu for Health and Aging
- Chair: **David Colby, The Robert Wood Johnson Foundation**
- Panelists: **Bob Eckardt, The Cleveland Foundation**
Jan Eldred, California HealthCare Foundation
Donna Regenstreif, The John A. Hartford Foundation, Inc.
Nancy Zionts, Jewish Healthcare Foundation
- Integrating Strategies for Community Development and Health
- Chair: **Ed Meehan, The Dorothy Rider Pool Health Care Trust**
- Panelists: **Mark Bendick, Bendick and Egan**
Patrick Chaulk, The Annie E. Casey Foundation
Bob Haigh, State of Pennsylvania, Department of Health and Human Services
Gloria Smith, W.K. Kellogg Foundation
- Looking Into the Kaleidoscope: Multiculturalism and Health Care
- Chair: **Elize Brown, The Robert Wood Johnson Foundation**
- Panelists: **Philip Belcher, The Duke Endowment**
Karen Scott Collins, The Commonwealth Fund
Jai Lee Wong, The California Endowment
- Beyond the City Limits: Building Rural Health Systems
- Chair: **Martha Campbell, The James Irvine Foundation**
- Panelists: **Steve McDowell, Rural Health Consultants**
Dorothy Meehan, Sierra Health Foundation
- 12:30pm-2:00pm Luncheon Address
- Marni Vliet, President, Kansas Health Foundation**
- 2:30pm-4:30pm Site Visit to Guadalupe

Creating Partnerships to Reduce Social Inequalities in Health

*Nicole Lurie, M.D., M.S.P.H.
Principal Deputy Assistant Secretary for Health
Office of the Secretary, Office of Public Health and Science
U.S. Department of Health and Human Services*

Every day that I go running on the Mall in front of the U.S. Capitol, I try to convince my colleagues at the U.S. Department of Health and Human Services (HHS) to come and join me, and I remind them that public health begins at home. As a country, we stand in need of new innovative and unprecedented partnerships in and with our communities to improve the health of our nation's many and diverse populations.

We have three evolving priorities at HHS. Briefly, they are: eliminating racial and ethnic disparities in health, creating a balanced and effective community health system, and enhancing global health. My remarks today will focus on the first two of these.

Eliminating Racial and Ethnic Disparities

One year ago, the President announced that he was expanding his overall initiative on race to include an emphasis on health. In this bold new plan on race and health, the President committed the nation to eliminating racial and ethnic disparities in health by the year 2010.

In addition, Healthy People 2010, the sequel to Healthy People 2000 that sets our nation's health agenda for the first decade of the new millennium, has taken an historic, philosophical turn. In the past, the nation has had different goals for different kinds of people, particularly for different racial and ethnic groups. For example, we had different targets for infant mortality and immunizations for blacks and whites and Native Americans and whites. Now, the goals are the same for everyone. This marks the first time that the federal government has made a commitment to eliminate these disparities, which is fundamentally different from simply studying and documenting their existence.

The specific focus of the race and health initiative is in six clinical areas:

- infant mortality,
- cancer screening and prevention,
- cardiovascular disease,
- diabetes and its complications,
- HIV/AIDS, and
- child and adult immunization.

There are also a number of important crosscutting issues ranging from smoking to mental health. We decided to start with what could be measured and achievable if we pushed ourselves, recognizing that we will have to push ourselves to reach our goal.

Current racial and ethnic inequalities in health are alarming. Many data are unavailable or incomplete; only recently have we in the federal government focused on collecting information on racial and ethnic subgroups.

The gaps in infant mortality are huge. A baby born to an African-American mother today has twice the risk of dying in the first year of life than a white baby. An American Indian baby is 1.5 times as likely to die.

Sudden infant death syndrome (SIDS) is a major contributor to infant mortality. Although we've started to see declines in SIDS among both blacks and whites, large gaps remain. As HHS has started to examine this trend and determine why there were big declines in some areas and not in others, we realized that much of our programming wasn't focused on African-American and Hispanic communities. We've taken steps to change that.

The news is better for childhood immunizations. Although we're not yet at the year 2000 target, we probably will be soon. We have come a long way in closing the gap, largely because people all over the country have worked on this issue and have thought of ways to get out of the health care box and link immunizations to other kinds of services.

We're not as far along with adult immunizations, which cause a tremendous amount of morbidity and mortality among our senior citizens. Likewise with pneumococcal immunization. Once again, there are substantial gaps and we have not gotten much closer to closing them.

Similarly, for influenza or flu shots, we've achieved our year 2000 target for whites, but not for other groups. Again, the disparities in the resulting morbidity and mortality persist.

Another area where we've made tremendous progress is in cancer screening and prevention, particularly for mammography. Here, in fact, we have closed the gaps for women getting a first-time mammogram, although we still have a long way to go in terms of getting women repeat mammograms.

We still have a long way to go in eliminating disparities among racial and ethnic groups with other types of cancer screening. For example, Vietnamese women in this country experience cervical cancer at five times the rate of white women. Hispanic women over 65 have twice the risk.

Coronary heart disease is another area where we have tremendous disparities. Black men are more than twice as likely as white men to have coronary heart disease and about 2.5 times as likely to die of stroke.

The HIV/AIDS epidemic has become an epidemic of poor people, young people, women, and people of color.

These are just a few of the disparities before us. For all of the medical and basic science breakthroughs during the past century, we still see large gaps in both the prevalence of health conditions and the burdens of illness they create in different racial and ethnic groups in this country.

People often ask me whether all of these disparities are simply a function of poverty. My response is two-fold. First, it is true that after adjusting for differences in socioeconomic status and education, the differences get smaller, but they do not disappear. Second, in a sense, it doesn't matter. These disparities are here. Just as we spent years addressing de facto segregation, it is now time to address de facto disparities in health outcomes.

It is important to point out that eliminating disparities is not something that we view as a zero-sum game. By focusing on those who are left behind, we are not diverting attention from anyone else. We are simply saying that we can't accept two standards when it comes to measuring health in this country.

History and science have taught us that to the extent we care for the needs of the most vulnerable among us, we do the most to protect the health of the entire nation. In fact, it is that principle that forms the bedrock upon which the Public Health Service was created 200 years ago.

Developing a More Effective Community Health System

How do we plan to meet this challenge? At the Department of Health and Human Services, we are working to develop a more balanced and effective community health system. Under such a system, first and foremost, one wouldn't need to get sick to get well. Or, as a colleague of mine says, one wouldn't need to enter the health care food chain to attend to one's health. A balanced community health system would offer equal attention to health promotion, disease prevention, early diagnosis, and universal access to care.

Such a system will have to be grounded at a community level and it must call upon the serious involvement of civic and other local groups, community schools, faith-based organizations, and others. Finally, it must be supported by the best available science, based on a balanced research agenda.

Since the President introduced his health care reform agenda in 1993, the ranks of the uninsured have grown to close to 50 million people. Of the working insured, more than 80 percent are currently enrolled in some form of managed care. Both the working insured and the Medicare insured switch health plans on a regular, if not almost predictable, basis.

There is no seamless, integrated system to improve the health of our communities in a comprehensive way. There is no locus of accountability for the health of communities.

We now spend \$1 trillion each year on health care. Only 1 percent of that money is allocated to population-based prevention. It is not difficult to argue that the quality of our health care is, at best, uneven and that we have made it more balanced.

Recently, several colleagues, including Dr. David Satcher, the U.S. Surgeon General, visited an Indian Health Service hospital in Fort Yates, North Dakota. They came back rather concerned. This is a small hospital with only 25 beds and a fairly small census. And yet, those beds were virtually full: Twenty-five patients a day were receiving dialysis there because of end-stage kidney disease from diabetes.

On many Indian reservations, more than half of adults over age 50 are diabetic. Diabetes is becoming increasingly common in children, as we as a nation witness the serious effects of the first wave of childhood obesity.

Yet for all we know about prevention, most of our efforts are on expenditures heavily weighted toward treating the complications of diseases like diabetes, rather than preventing them. This is true in Fort Yates and it is true of our efforts as a nation. A balanced community health system has a long way to go.

A Healthy Start for Every Child

A balanced community health system should ensure that every child has an opportunity for a healthy start in life. This encompasses a range of issues, including the health of parents, especially mothers. It also means having parents who are prepared to be parents when their child arrives. It means ensuring access to quality prenatal care, and it means reducing the risk of HIV transfer from mother and child, and avoiding exposure to alcohol, tobacco, and crack cocaine in utero.

A healthy start also means a safe environment that is nurturing and free from toxins, violence, abuse, and injury. We know that children develop best in supportive environments, where there are loving, caring adults who will take the time to read to them and stimulate their senses. Providing healthy environments for children means many other things. It means being sure that children get their immunizations on time and it means being sure that they're breastfed during the first year of life. It means placing babies to sleep on their

backs, and not on their stomachs, to reduce the incidence of sudden infant death syndrome. It means creating safe areas for children and families to live, grow and play, and it means stopping the violence.

Promoting Health Lifestyles

Next, a balanced community health system promotes healthy lifestyles. That obviously includes paying greater attention to physical activity. This is particularly important issue for our young people. As a nation, we have regressed in this regard. Currently, no state in the United States requires physical education in schools. It is a district-by-district decision. Some children have it, and some don't. Again, we have another disparity. Nearly all of our elite private schools around the country have well developed physical education programs. But our public schools do not.

This is also an issue for our older citizens and for their children, our aging baby boomers, who should consider not only the care that they may one day need for themselves but the care that they may one day have to provide to their elderly parents.

We must pay greater attention to nutrition. Just recently I was reading about the increase in substitution of soft drinks for milk among young people. This is a particular problem among young girls, who face a double challenge in preventing obesity and osteoporosis.

We must encourage people to avoid toxins like tobacco and drugs and educate them so that they will commit to responsible sexual behavior.

A New System of Mental Health

Finally, in developing a balanced community health system we have to build a caring and supportive mental health system that looks very different from the mental health system we have today. No priority has generated as much interest and enthusiasm as this one. Perhaps this is because we as a nation have been in the habit of stigmatizing and blaming those who suffer from mental illness, leaving them isolated and unable to seek the care that they need when they need it.

A new mental health system must include sound strategies for suicide prevention and violence prevention. Few people realize that for every two people killed in this country, three commit suicide. We must devote our efforts to becoming better at recognizing the signs and symptoms of mental illness. After all, depression causes as much impairment in function as do common medical conditions like high blood pressure and diabetes.

In developing a mental health system, we must focus on the well-being of both the individual and the community. In both cases, our challenge is to facilitate a transformation from hopelessness to hopefulness. This means addressing a number of other serious health problems often related to mental illness, including substance abuse, violence, and homelessness. As many as 50 percent of homeless individuals in this country are in that situation because of mental illness.

Removing Barriers to Access

Ensuring a healthy start for children, promoting healthy lifestyles, and developing a mental health system are three prerequisites for a balanced community health system. But there's more.

In developing a comprehensive approach to health that will help us eliminate disparities, we also have to remove barriers that block access to quality health care, particularly as they continue to relate to the uninsured and the underinsured.

In addition to the growing number of uninsured adults, there are more than 11 million children who are uninsured in this country. That's one in seven children. The new federally funded Children's Health Insurance Program, which are now in most states, will provide health insurance to about 2.5 million of those children during the next few years.

But this growth in the uninsured suggests that relying only on a health insurance system -- rather than on a health system that achieves health for communities -- is not the best strategy. So the Department has stepped up its efforts and has proposed, in its year 2000 budget, an important initiative to get health, rather than health insurance, into communities by strengthening and adding efficiencies and continuity to systems of care for uninsured workers.

We must also address cultural issues, which are critical barriers to care. To solve this problem, we need a diverse health care work force, not just for physicians, but across the board. We need to be willing to discuss and understand the racial and cultural issues that act as barriers not only to care, but in the relationships between physicians and other caregivers and their patients.

An excellent book on this subject is called *The Spirit Catches You and You Fall Down* by Anne Fadiman. It's a story of a Hmong family with a child with a seizure disorder trying to interact with our health care system. What was stunning to me was that everyone in this book had the best of intentions. Everyone was incredibly committed. And yet cultural rifts precluded a good outcome for everyone.

We must eliminate disparities in our research agenda. We know that we must increase minority representation at clinical trials in order to be sure that our understanding of the mechanisms of disease and of effective treatments is broadly applicable. In many areas, we know that equal treatment leads to equal outcomes. In others, this may not be the case, so we need to know when and why, and we need to understand how to get equal treatment to people across the board.

We also need answers to other, more challenging questions. For example, why do disparities still exist, even when after accounting for poverty, education, and a host of other factors? What factors can be modified? What does prevention look like in this arena?

We need to understand clearly what kinds of interventions work and how to effectively implement what works in very diverse communities with very diverse populations. There is no one-size-fits-all solution, even though there may be common themes across many communities.

Federal Efforts

At the Department of Health and Human Services, there's been an important philosophical shift in some of our program development. Just before I came to the Department, a number of African-American community leaders and political leaders went to the Centers for Disease Control and Prevention (CDC) for a briefing on HIV/AIDS. As they saw the data that showed the huge racial disparities in this disease, they became increasingly upset. Finally, they actually stopped the meeting and demanded to see the director of the CDC. Their view was that the time for documenting this problem has passed; now it is time for action. They then went ahead and, through the Congressional Black Caucus, challenged HHS to take a hard look at what we were doing.

And as we examined the Department's programs in this area, we realized that although the epidemic had changed dramatically since the mid-1980s, our programs hadn't. We were still funding programs like the ones we were funding in the mid-80s, even though this is a totally different kind of disease, affecting different populations, which our efforts weren't really targeting.

This recognition has led to a tremendous philosophical shift that says, in all areas, that our funding must keep pace with the changing demographics and epidemiology of health conditions. The challenge of implementing this approach is daunting. But as a start, Congress and the Department together came up with about \$156 million in new funding to target HIV in minority communities. Having spent the past few months on working to develop this plan, I am excited that we are in fact changing the way we do business.

In addition, as we try to address these disparities, we recognize that we have to engage not only the Department but the rest of the health care system. And so we've set about doing that. We've been working closely with people in Medicare and the Health Care Financing Administration. This year, all of the peer review organizations throughout the country will be required to begin projects that aim to eliminate disparities in outcomes for their elderly populations.

We've also been working with the Department of Veterans Affairs to begin examining disparities in the veterans population, using quality measures to see how patient outcomes differ by race and ethnicity and then identify problems that need to be addressed.

We are beginning to have similar conversations with managed care organizations around the country. The Commonwealth Fund has just agreed to help us by cosponsoring a conference with several managed care organizations on this subject.

In addition, the Centers for Disease Control is awarding developmental and planning grants in 30 communities around the country to address health disparities. This is an excellent opportunity for partnerships with community-based organizations to address these disparities. The budget this year for that program is \$10 million; we hope to increase it to \$35 million next year, so that we can fully fund all of the plans that look promising and move forward with them.

Within the Health Resources and Services Administration, which funds community-based clinics, there is about \$65 million in new money this year for examining disparities among safety net systems, particularly in the areas that I've mentioned, and moving forward to address them. We have increased our investments, particularly in HIV and diabetes, and we are in the process of defining a research agenda for better investment of our scientific resources.

Finally, we've been working to build an infrastructure that will support the collection and dissemination of data, both nationally and at a local level. Our Office of Minority Health now has minority health coordinators in every region of the United States and in most states. A large part of their new job will be to collect and disseminate data about disparities on a local level, so that local health officials can identify issues that are important to their communities and do something about them.

Building Community Partnerships

Despite all of our ambitious initiatives and our plans on the federal level, it is abundantly clear that the government can't do this job alone. Not only do we need federal and state partnerships, but we need community-to-community partnerships at a local level.

Most of us know from our personal and our professional lives that partnerships work best when our partners share common goals but have different and synergistic strengths. I believe that government and grantmakers have many common goals, but we look to you both locally and nationally to do here what government cannot.

You as grantmakers play unique roles in your own communities as conveners, catalysts, and funders, bringing together diverse groups of people to examine health-related disparities in your communities and address them.

You can help build core capacity in your communities. For example, as we've tried to address HIV, we've recognized an enormous need to build the capacity of minority-serving organizations at the local level. This is an issue where grantmakers can help, not only for HIV, but across the board.

Grantmakers can help establish the cross-sectoral links that go beyond traditional medical care to providing preventive strategies. A lot of exciting work is underway around the country because of the challenges of welfare-to-work programs and their relationships to health. That is just one example, but this is a broad area where all grantmakers can contribute.

You as grantmakers can work differently than we can with community-based and minority advocacy organizations. You can help them to develop leadership and to understand and use data about disparities to promote changes in their communities.

And finally, you can help us build new solutions and share with us the models that work. There are some fine models already, and we have to find ways to share them with each other. There are many wonderful initiatives and projects in place at many foundations, but there is no one single resource we can tap to find models that work.

What do these ongoing disparities mean for us as a nation? In other words, what if we do nothing? What difference would it make? In my mind, it would make a big difference. First, obviously there are basic issues of equity. We know from other countries that when income and health disparities are larger, health indices ranging from infant mortality to years of productive life lost are worse.

If we do nothing, we will continue to treat different populations differently, with predictably different outcomes. The effects of this inaction ricochet throughout our entire social fabric. Our populations, which are becoming increasingly different and multicultural, continue to be more alienated from one another than ever. Communities, many of which are fragile at best, will become increasingly difficult to sustain. I know from my experience as a primary care doctor in my own community that children need to be healthy to be able to learn, achieve, graduate from high school, and go on to college or beyond. We absolutely must attend to disparities in the health of children, if for no other reason than so that they can learn and have equal opportunity.

A number of large employer groups have told me recently about their difficulties finding people who are healthy enough, both physically and mentally, to come to work in an extremely tight labor market. Our economy is booming and yet public health isn't working as it should because we haven't yet made the investment, both financial and psychological, to make it work.

It will take a community-level effort, too, to change our current societal views about mental health. But an interesting window of opportunity and an interesting set of partnerships are available to us now in this regard, not only between government and philanthropy but between government, philanthropy, and the employer and private sector.

My own experience has shown me that it is often necessary for me to help my patients become healthy enough, both physically and mentally, to enable them to go back to work and get jobs, to return to the work force, or to get involved in volunteer activities and contribute to their own communities.

It's necessary, too, to help communities address their own issues, from asthma to violence, so that they can stabilize their neighborhoods, and, in some sense, to help to them find hope as communities, to eliminate urban flight and provide families with continuity and stability.

I know that if we do nothing, if we pretend that these disparities don't exist, they won't go away, and that the downward spirals will get worse. It sometimes seems all too easy to look at the data and feel like we can do nothing because the problems are somebody else's or because it's hopeless. It's not hopeless. And I know firsthand, both from my own patients and from working with my own community, that it's not hopeless.

When I was growing up I was raised, like many people, to believe that all people were the same. I grew up believing that differences in advantages because of race, socioeconomic status, and gender didn't exist, and that we all could -- and that we all would -- have equal outcomes.

So strong was this ideology in my family and in my community that it became politically incorrect and downright uncomfortable to talk about the differences between us, the unequal advantages and the unequal outcomes. My friends in elementary school, high school, college and I never really talked about those issues. We all just went on pretending, on the surface, that we were all the same. But deep down we knew that, for better or worse, we weren't, and that we had very different advantages in life.

About two years ago, in a desperate attempt to communicate more effectively with one of my patients, an African-American man, about why he wasn't making progress, I took what was for me a very difficult step. And it was difficult because it seemed so politically incorrect.

I asked him whether our differences in race and social status were keeping us from working more effectively together. The relief in his face and his voice, and probably in mine, when we both had permission to talk openly, was blatantly evident. We began having an honest discussion about what I did and didn't understand about his life as an African-American man in our community.

As I've started to have these kinds of discussions more routinely, I've learned much more about how to be an effective doctor for my patients -- and for my community. It's a little tougher when I have to work through an interpreter, but the conversations are no less stunning and no less poignant.

My patients have related differently, too. The issues that we work on together are different, and the level of trust is different. I've learned through my patients that it's only when we put these issues on the table for open discussion that we own the problems together and that we can work on them together and try to resolve them. As I've done this more, it has seemed less politically incorrect. The conversations have become easier and I keep learning new things.

The issue about disparities is on the table openly and for discussion. We can get beyond our discomfort and talk about these problems because we all know that they exist and because we know that they're serious.

I believe that our communities are ready and, in many cases, have already begun to have the kinds of difficult and honest conversations that let them face the issues and design solutions. Now is the time that healing can begin.

What We Do -- and Don't Know -- About Social Inequalities in Health

*Robert G. Evans, Ph.D.
Centre for Health Services and Policy Research
University of British Columbia*

My task this morning is to review what we actually know about the determinants of health -- as well as what we do not know. I start here because people's willingness to reduce social disparities in health depends very much on two things: the extent to which they believe that they know what to do about a particular problem, which is part of the theory of causality, and on the nature of the causality that they infer. In other words, if you think that that a person's health experience is basically his own fault, you are probably not very interested in supporting programs to do something about it.

"It's their fault" is a very powerful theory; presumably, it is one that could be tested through data. Here, I will discuss data from a number of different sources. This research focuses on health in the very narrow sense of mortality, a very clear outcome on which a good deal of data is collected. This narrow definition of health permits researchers to examine a broad range of possible determinants of health.

The core idea for thinking about the determinants of health is population-based heterogeneity. In other words, people differ, but they differ in systematic ways. So if you partition a population along some axis of interest -- for example, income, social status, education, race, or gender -- you will find systematic differences across populations, which means that you have information. You don't know necessarily what that information is, but you know that it's there somewhere.

The Power of Data

Take, for example, the relationship between age-standardized mortality rates and income inequality. Work by George Kaplan and John Lynch in the United States shows that the degree of income inequality by geographic region is fairly tightly related to the mortality rate. Now we all know that where you stand in the income distribution curve is related to your life expectancy and your expectancy for a healthy life. This is a powerful notion that says that, for the community as a whole, it appears that greater income inequality is associated with lower overall health status, at least as measured by mortality.

Similar types of data from Canada, however, don't demonstrate as clearly a negative relationship as do the American data. It turns out that that a good deal of this relationship depends on the age of the population. In Canadian infant mortality data, that negative correlation is much more apparent. But if you look at populations above the age of 65 and then break them down by males and females, while the downward trend is still there, it is much more scattered. For working-age people, the relationship is not as tight as it is for infants, but it doesn't blow up the way it does for elderly people. Across all age-adjusted data, there is a relationship that is kind of an average, but it breaks down in the elderly segment.

This all goes to show several things. First, this is a clear example of partitioning a population -- in this case, geographically -- and discovering that there are systematic differences in health status that are connected with another variable of interest, the distribution of income. Second, we don't know from these data exactly what we have found. There is some pretty powerful information here, but it's not obvious what exactly it is. Third, these measures are not person-specific. In discussing the determinants of health, there is an intuitive tendency to fall back on measures of behavior or lifestyle. The result: eventually, it all comes out as their own fault through measures of individual behavior and characteristics. Those are not unimportant. However,

these data emphasize a relationship with a characteristic that is defined only at a community level, or in this case a state or a province level. It is not defined at an individual level. The distribution of income is not an individual characteristic; it is a collective community characteristic. Bottom line -- these data demonstrate that something is happening at the level of communities that is not simply a property of individuals. That is an extremely important point.

Linking Data to Theory

Everything that we do in interpreting the determinants of health and trying to understand the sources of social inequality is rooted in theory. But we need to have a number of theories and avoid get wedded to any one of them too early. As they say about cosmologists: Often wrong, but never in doubt. And I think that is the spirit in which we should approach these issues, that we have to make an energetic attempt to understand what is going on, with the rider that we frequently will be wrong.

When we fail to drag our theories out into the light and test them adequately, we wind up with the persistence of theories that are not congruent with the facts. Then they become more like ideologies, which enable you to dismiss or ignore new information. Theories are what you generate by looking at data. Ideologies are what you suffer from.

We operate in an ideological world -- or, perhaps, more kindly, a theoretical framework -- that says that, for reasons unspecified, health status deteriorates among people of lower incomes. The recording of that deterioration then leads to a response by the health care system and that response brings about an improvement in health status. In other words, what do you need to do to be healthy? The answer is: Spend more on health care. That, in fact, is what we do. Canada's federal budget will provide another \$11.5 billion in federal transfers for health to the provinces over the next five years. That is a fairly substantial sum. Multiply that by 10 to get a corresponding value for the United States.

So we spend a lot of time in health research worrying about that bottom line. Is the care effective? Does it meet the needs of the people? When we talk about access, we are worrying about the top line. Do people who have health problems actually get into the system? Does the system respond in an appropriately? Do people in fact get better? Over time, the response to concerns about health has been to pump more resources through that top line.

We approach social inequalities in health in a spirit that says not that this model, this theory, is inaccurate -- not that health care has nothing to do with health. Instead, the question is: To what extent does it fall short? What information do we have that would suggest that we need to go beyond this model? And what does that information tell us about where we might need to go?

A Survey of Relevant Health Data

In the United Kingdom, Thomas McKeown produced a series of studies on mortality patterns from infectious diseases. His tuberculosis study demonstrated that changes in mortality occurred long before the development of any effective therapy. So, for the celebrants of modern medicine who like to claim that the huge advances in human life expectancy during the last century or so are connected with the advances in medicine, temporally speaking, that doesn't seem to be the case. However, if you magnify those data for a shorter time period, they actually show a dramatic fall in mortality from tuberculosis after effective therapies were introduced. The cognitive dissonance becomes understandable. We can see why there is an opportunity for considerable misunderstanding and disagreement between the advocates of the medical care system and those who point to a much broader range of determinants of health. Simply failing to look at the data in their appropriate time context creates an opportunity for unnecessary conflict.

Another source of confusion here is that you can use the McKeown data to say that not only did medical care not make much difference, neither did public health efforts. So efforts to clean up the water supply couldn't have made an impact because tuberculosis is not a water borne disease.

There are two answers to that. First, tuberculosis is an opportunistic infection. Although it may not be water borne, it takes hold more easily if you're already suffering from an infection that is water borne. So cleaning up the water supply could very well have had an indirect effect on tuberculosis. Second, nutrition is a factor here, but nutrition is not the same as diet. How much nutrition you get out of your diet depends to some extent on whether you're suffering from gastrointestinal problems, many of which are water borne.

So it is far too simple to say that this public health intervention had no effect on tuberculosis. What these data illustrate is that you've got a fairly complex interactive system here and that you need to be careful in jumping to conclusions one way or the other.

The McKeown data raise fundamental questions about the role of the medical care system. Another example, from a completely different angle, comes from John Bailar, III. He became extremely unpopular by pointing out that the U.S. war on cancer had no discernible effect during its first 25 years, and that billions of dollars essentially were being wasted. What these data remind us, if we need reminding, is that there is more going on here than just medicine.

The drug evaluation literature offers another fascinating example. About 20 years ago, *the New England Journal of Medicine* published a classic study of drug called clofibrate, which was supposed to help people who had a heart attack. It turned out that the drug itself had no beneficial effects at all. But the five-year survival rates were substantially higher for the people who took their pills than they were for the people who didn't take their pills. It didn't matter whether the pills had the active ingredient or whether they were just sugar pills; the effect was the same. If you took your pills, you lived much longer than if you didn't take your pills.

Those results obviously suggest that compliance is associated with other factors related to lifestyle and attitude. But the researchers couldn't find any baseline measures of physiological characteristics that correlated with compliance. So you're left with the conclusion that there was something about the personalities or the attitudes of people who believed in the efficacy of what they were doing, compared with those who didn't, that had a measurable effect on five-year survival rates. That's a fairly straightforward outcome: life or death. Some of these people died and some lived.

In a trial of beta blockers, the drug proved to be effective, but the size of the effect was about the same as the effect of differences in social connectedness and social isolation. In other words, you could either take your drugs or go and find a friend and it would have about an equivalent impact on your mortality rate.

It is too easy to dismiss this kind of evidence as merely a placebo effect. It is much more difficult to look at it and find out what really is going on. Ultimately, death is a biological event, and events are taking place that are finding their way down biological pathways. So there is a range of other factors that can be shown to be related to health but that are separate from the medical care system.

Data from the World Bank's 1993 World Development Report show that over time, outcomes are improving at any given income level. But the shape of the curve also shows that there clearly is a strong relationship between mortality outcomes and income levels in the country studied. Increasingly, over time we're seeing that when making comparisons among countries, there doesn't seem to be much relationship between income and health outcome past a certain threshold level of income.

So from the aggregate inter-country data, you've got a story that says that income is an important factor in health, up to a point. But then once you go past a certain range, which all countries in the developed world have by now, income no longer matters. But the intriguing thing is that income matters a lot within a

country. This is an interesting puzzle: Not only does income have an important relationship to health, but that relationship across countries or societies apparently is not the same as it is within them.

Consider mortality data for Canada Pension Plan members. These data showed that mortality rates after retirement are related to pre-retirement income. In fact, these data indicate that pre-retirement income level has substantial bearing on probability of mortality soon after retirement.

The classic Black Report data on mortality by social class show the persistence of differential mortality rates over time -- and, furthermore, the fact that they are spreading. After about 1930, they started to grow. Remember that in 1948, the British introduced a universal health plan, the National Health Service. There is no evidence in these data that universal health care made any difference at all on mortality rates. That's not to say that it wasn't worth doing, but that the availability of universal health care has had no impact on whatever causes people to die.

To sum up: First, over time, the factors that cause people to die have changed substantially. They don't die of the same causes now that they died of in 1911. Second, the level and quality of health care have expanded enormously. Third, access to health care has become much more equal. Finally, the differential mortality rates persist. They don't seem to be affected. All of which leads to the conclusion that there is something else going on here as well, because whatever is happening at the time that causes people to die -- whether it's cancer, tuberculosis, AIDS, etc. -- if you're at the low end of the distribution, it will get you first.

Michael Marmot and his colleagues did some extraordinary work in the Whitehall studies in the British civil service that go back now more than 20 years and that involve 12,000 to 14,000 people. If you look at 10-year mortality rates by grade in the civil service, you will see that the pattern of mortality differs greatly, depending on where you are in the service. Those differentials are large and they are gradient; that is, they go up in steps as you go down the distribution of status. Poverty is not involved here. All of these people are employed. The people at the bottom may not make a great deal of money, but they're all employed, they're all working full time, and almost all of them are in the London area. Yet the mortality differentials are huge.

Again, this is not an argument that ill health is not correlated with poverty, because it is. Rather, this is an argument that the overall structure of hierarchy somehow has a significant effect on health, over and above the general issue of whether people are suffering from material deprivation. That effect applies to health not only in terms of mortality but also morbidity, as data from Marmot and others demonstrate.

So what we see are large effects on mortality and morbidity that are associated with hierarchy and that persist through time and that don't seem to be particularly sensitive to changes in the health care system. But we still don't know what is causing these effects.

Marmot's data also support the observations from the Black Report, that although causes of mortality in a society may change over time, the pattern of social inequalities does not. Marmot's Whitehall study shows the same pattern, from a slightly different perspective. The gradient persists over time in whole range of different causes of death. So regardless of the causal factor, the lower you are in the social hierarchy, the sooner it will hit you. Even for a condition such as cardiac heart disease, after risk adjusting for the various kinds of factors identified in the Framingham Heart Study, the gradient weakens as age increases, but it still persists. That intrigues me, because, as I mentioned earlier, the relationship between income distribution and mortality seems to weaken in the North American data toward the top end of the age distribution. I don't know, however, whether these two things are connected.

We can delve into social context by looking at descriptions that people in different grades give to their jobs. Again, many kinds of negative features that are associated with work environment, in fact, correlate with grade.

Even in egalitarian Sweden, the data show the same kind of gradient that we saw in Britain in the Black Report, but the differences are not nearly as big. It is interesting that the gradient in Britain is not only bigger, but that overall it is worse. The worst-off among the Swedes do better than the most well-off among the British.

So the environmental effect on this gradient is very pronounced. In other words, the kind of society you live in does, in fact, affect your health. In the inter-country comparisons, the extent to which being at the top or the bottom makes a difference to your health status is very much conditioned by the kind of society you're in.

There have to be biological pathways through which social factors operate, however, because at the end of the day, death and disease are biological events. Data from the Whitehall study showed that blood pressure elevation was the same for both high-status and low-status civil servants. Both groups experienced high blood pressure at work. That's not surprising. But when they got home, blood pressure for the high-status employees fell quite sharply; it went down for the low-status employees as well, but not as much. What is interesting is not the differential response but the differential rate of decline in the two groups: the rate at which they recovered from stress rather than the stress per se.

That brings me to another remarkable long-term study. Michael Marmot's studies are done, one might say, in the Whitehall ecosystem among a free-living primate population of civil servants. Robert Sapolsky at Stanford has also done a 20-year study of the free-living primate population of the Serengeti made up of olive baboons.

It turns out that baboons have a clear ranking structure -- as clear as the ranking structure for civil servants. In addition, you can identify physiological characteristics of high- and low-ranking animals in the baboon population.

Most significantly, the dominant animals turn their fight-or-flight switches on and off much more efficiently than sub-dominant animals do. When faced with an imminent threat, these animals instinctively know that it's time to move fast or do something aggressive or get energy to the large muscles quickly. They shut down their immune systems, forget all thoughts of reproduction, put all long-term growth and repair functions on hold for the moment, and activate only those functions that will get them out of danger immediately. That, of course, is an extremely important evolutionary adaptation.

But just as in a human organization, if you permanently put your growth and repair functions on hold while you're wrestling with alligators or other serious threats, eventually you deteriorate. Your organization deteriorates because you aren't investing in growth and repair.

The same thing happens with the individual organism. If you are constantly under the pressure of fight or flight, slowly you will, in fact, find your health deteriorating in various ways. For example, the level of glucocorticoids in the bloodstream elevates significantly. Sapolsky found that the sub-dominant animals were in a state of permanent arousal -- partly because of constant threats from the dominant animals and partly because once that state was triggered, physiologically they were changed in ways that made it difficult for them to turn off that fight-or-flight switch. In other words, they were physiologically changed by the experience of their rank and position.

The earlier studies were done on male baboons, because it was much easier to rank them and identify aggressive behavior. Similar work is now coming out on females, with several differences. First, rank tends to be stable among females. For males, rank goes up and down, depending on how big you are and whether you're at the peak of your form or whether you're juvenile or elderly. But for females, rank seems to be associated with bloodlines. It's where you were born, who your mother was, and which particular subgroup you belong to. That rank is carried through life.

Furthermore, it is much more difficult to determine exactly what the activities are whereby higher-status females exert stress on the lower-status ones. For the males, it's pretty obvious; they show their teeth and fight. But the ranking behavior among females is much more subtle and difficult to identify.

There is a different rank pattern, and there are differences in behavior, depending on the stability of the society. Among the male animals, the ranking stability is disrupted if an alpha male dies, and physiological malfunction becomes much more evident among the dominant males as well, as they try to figure out who is going to come out on top. The researchers also found some very definite personality differences among the animals, differences in coping style that had a bearing on how they were affected by the experience of position and hierarchy.

What this says is that, using animal experience, you can find physiological relationships with hierarchy that seem to be consistent with the kinds of differences in health outcome that you get in human communities.

Another long-term study looked at caged animals that were all in exactly the same physical environment, had exactly the diets, and differed only in their position in the social structure within each cage. These animals were put on a moderately high-cholesterol diet to induce heart disease, which in fact occurred. But the level of arterial plating differed, depending on whether the animal was a dominant or sub-dominant animal in the cage. The sub-dominant animals had more heart disease than the dominant ones. Among females, that differential was even more striking than among the males, although overall occlusion was lower for the females.

When the colonies were destabilized by constantly mixing the animals up and putting them into new cages so that they had to fight their way back to the top again, that effect was reversed. The dominant animals remained dominant. They climbed to the top again in the new cages, but now they suffered more heart disease because of the stress of having to keep fighting their way to the top. Intriguingly, that result did not hold true for the female animals. The female dominant animals also rose to the top in an unstable environment, but they didn't suffer an increase in heart disease.

Animal researcher Steve Suomi and his colleagues have identified a gene that defines a high level of vulnerability or sensitivity to external threats and changes in the environment. And they found that if you cross-breed vulnerable males with particularly nurturing mothers, it doesn't make much difference on the offspring, at least for Rhesus monkeys. The highly sensitive individuals may, in fact, have at least as good and sometimes better outcomes than the less sensitive ones. But if you are a highly sensitive male Rhesus monkey and you don't get particularly good mothering, there's a pretty good chance that you're going to die during adolescence. You won't make it from your natal troop into your next troop. You just get knocked off.

These findings emphasize that there is a genetic component to vulnerability but that early life experiences cannot only compensate for that genetic effect but may even turn it into an advantage. It's not an exclusive relationship that says that only your contemporary environment matters or that only your genes matter. Instead, this suggests an interesting and complex interaction between the genetic material you start with, the way you're treated in early life, and the particular contemporary environment you find yourself in.

Taking the Sapolsky data back to humans, the argument here is that persistently elevated glucocorticoid levels, the stress response found in baboons, affects the size of the hippocampus and the deactivation of cells in the hippocampus that affect learning, coping mechanisms, and the ability to deal with new situations and with stress. In other words, chronic stress attacks precisely the parts of the brain that help develop strategies for dealing with stress and actually reduces the size of the brain. Other, early-life research shows that high levels of environmental interaction promote neuronal growth. Without that environmental interaction, you wind up with, again, a different brain, a brain that has simply not undergone a normal level of neuron development and that later may well be more vulnerable to Alzheimer's disease.

This is all by way of moving from animals to humans, and thinking about the way that biological pathways connect with social hierarchy and health status.

More recent data from the Whitehall studies adjusted for certain job characteristics, including demand (how much is expected of you), control (how much ability you have to react to your environment), and effort reward (what you get for your efforts). So the jobs differ according to the relationship between effort and reward and demand and control. If you adjust for those factors, you get some pretty good results. The work of Karasek and Theorell showed that if you have a situation of low control and high demand, you have a very high risk of heart disease, because you are unable to react to this constant barrage of pressure. But if you have low demand and high control, you'll live much longer.

This demonstrates the relationship between demand, control, and effort reward across the different ranks in the service. Not surprisingly, the effect is quite different depending on where you are in the ranking, and when you standardize for these characteristics, much of the gradient disappears.

Richard Wilkinson went beyond the job environment to the total environment to start thinking about control as expressed through relative income level. The idea is that in a highly inegalitarian society, many people don't have much control over their environments. Wilkinson studied data from several European countries; however, there are many weaknesses in the data, so they are quite controversial. Whether people buy into Wilkinson's work depends on their political orientation. If you're basically an egalitarian, your conclusion is that not only is inequality bad for the people at the bottom, it's bad for anybody. But if you disagree with that idea, you can attack these data pretty hard.

This leads us to policy responses, because the question is: What is going on in different countries with respect to inequality?

Data from Canada show the extent to which the market generates income inequality and to which the tax system buffers that inequality. In Canada, as in the U.S., the market is generating increasing inequality in our societies, which should be a threat to health, but our social structure and our tax policies have largely buffered that difference.

However, if we look at countries generally, we find that the market everywhere is tending toward greater inequality. In Mrs. Thatcher's Britain, public policy exacerbated the inequality that the market was generating on its own. In the U.S., little if anything was done about inequality. Most of the income growth in this country is in the top decile of the population. Sweden, interestingly, has become more inegalitarian. And in Canada, the market has generated almost as much inequality as in the U.K. and the U.S.

We might think that these income differences would become even clearer if we examined data at the city level, rather than at the state or country level. But data from Kaplan and Lynch on American metropolitan statistical areas and Canadian census metropolitan areas show that is not the case. In fact, the whole relationship explodes.

Moving from Data to Information to Action

It seems to me that we are dealing with a lot of data that show that there are powerful factors outside the health care system and they seem to be associated with hierarchy. However, it is not clear that those forces are necessarily associated with income.

Kaplan argues that money can buy people out of an awful lot of stresses, while Wilkinson attributes these differences to psychosocial perception of status. Both may be right. If you're in the United Kingdom like Wilkinson, the accent you speak with carries a lot more weight than whether you have money. And yet, if you're in the United States, just about everything gets mediated through money: your access to safe

environments, your access to health care, your access to education. Your ability to control all of the stresses of life depends primarily on how much money you have, and that's not true in a number of other developed societies. So Kaplan may, in fact, be right for the United States, that the relationship between hierarchy and inequality and inequality of health outcomes is primarily mediated through income. And yet, that may not be true in other societies where the market doesn't control so many aspects of life that are connected with stress.

There is a great deal more that I could say on this subject. But what I want to emphasize is this: We have a lot of information that indicates where we should be looking for answers to our questions about determinants of health. But we also have a lot of information that is not explained adequately -- at all. For that reason, it's important to keep an open mind as we continue to explore these questions. It is possible to be pretty definite about some of these things -- and yet to be very clearly wrong. So like the cosmologists, let us resolve to be never in doubt, even though we may be wrong.

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Placing Philanthropy's Role In a Broader Societal Context

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I have been asked today to offer a sense from outside the field of the role of philanthropy and what philanthropy could be doing in areas where it shares mutual interests with the public sector and others in non-profit organizations. The foundation world is a new world for me. Prior to joining Children's Futures-New Jersey, I was the deputy commissioner in the Department of Human Services in New Jersey, and a great deal of my perspective has been shaped by the various roles I've held in state government. The view I am providing is that of someone in transition between two worlds with a great deal of opportunity for working together.

I will address three questions. First, what is the social context in which we find ourselves? Second, what is the role of foundations and how do those outside the foundation world perceive foundations? Third, what are the opportunities and observations and the futures that we can look for together?

The Social Context

Let's look at the current social context with which we must all contend. What is this broader world of American society that we're all in together?

For instance, we've been dealing for more than a year with questions of morality and ethics and hypocrisy or impropriety to a degree that most of us have only read about or never even considered. And in particular, we are asking: What does this mean and how do we explain it to our children or grandchildren?

Many of us don't care any more. We're supersensitized to some of these issues and we tell ourselves, "I just don't want to hear it any more." But what does that mean? I start here because it raises a broader question of how can we reflect the times with these types of moral issues on the forefront.

Financially, the news is great. Our economy is booming. The United States is in a rare position, and it just seems to get better. The Dow Jones keeps going up. Businesses are happy, and the returns on investment are great. The stock market is happy. But the gaps between those of us who are well off and those of us who are not are widening very rapidly.

The question arises: Isn't someone worried about this? Let's think about the times we're in and the driving sentiments that led to a major social overhaul called welfare reform. Some may consider those sentiments to be mean-spirited. Others may say it's about time. And some may say let's just try to make lemonade out of whatever lemons we've got.

We are in the midst of an extraordinarily dynamic, changing health care system. First, we have managed care, and I think it is fair to say here that managed care has not fulfilled its promises. We have an increasing number of mergers, acquisitions, collaborations, and partnerships between hospitals, practices, and health plans. It's very difficult to keep up with, because organizations that are partners today were competitors yesterday and might be enemies again tomorrow.

We have massive going-out-of-business activity among health care providers and systems. We have an explosion of information technology, which to some of us is rather overwhelming and frightening. We also have a changing workforce, with different roles, skills, and expectations. So the dynamics of a changing health care system are part of the social context within which we are working.

In addition, the roles of regulators, administrators, legislators, and the judicial system are changing in a fascinating way. Many more decisions are being made in the courts than on legislative floors or in regulators' offices.

What does that mean for us in this health care system? It certainly is evident with tobacco. It's evident with guns and violence. It's even evident with prescription drugs and how folks in general are being treated in a changing health care system.

Recently, particularly in my new role as director for Children's Futures, I am becoming more concerned about what the youth today are thinking and how they view their current lives and their future. Here are two examples that gave me pause.

In the movie "Grand Canyon," there is a scene in which Danny Glover, playing an uncle, tells his nephew, "Don't go into gangs. Stay away from them. Don't you want to see 25? What are you going to be when you're 25 years old?" And the nephew says, "I won't live to see 25." That has stayed with me.

In a recent survey of youth in Philadelphia, adolescents in particular said that they saw no hope for today. But there is hope, they said, for tomorrow. And that gave me pause again. They said that they don't believe there's much hope for them today, but maybe there is for others tomorrow. And if they live to be 25, maybe there's hope beyond there.

These are very interesting messages that help describe the social context within which we in the foundation world find ourselves.

The Role of Foundations

So what is the role of the foundations as we know them today? How are they perceived by people on the outside? What are some of the expectations?

I'm learning that it's a very strange and wonderful world, full of contradictions, full of potential, and, at times, very confusing. The foundation world has some incredible advantages. In fact, it enjoys a certain degree of independence that most sectors do not enjoy. It is sort of privileged.

Here's another story. When I was in eighth grade, my favorite class was English and my favorite teacher was my English teacher, Mr. Strebic. He was just great. He knew me from when I was a little kid and he knew my family. So Mr. Strebic was like a family friend.

One day, class was over, and I was packing up my things as everyone else was leaving. One of my classmates asked Mr. Strebic a question. I don't even know what the question was because I wasn't paying attention, but I did hear the answer. The answer was: "Of course, Michael; you're free, white, and 21. Of course you can do that."

That answer gave me pause, and I'll never forget it. There are some things I'll never be, and there are some things foundations can be, because in many ways they hold a position of privilege. From the outside looking in, it's a rare, wonderful position to be in.

Foundations enjoy a unique legal status, and they have a rare and wonderful opportunity to use grantmaking as a tool to leverage lasting and meaningful change. They have a unique opportunity to do something of value.

I'll repeat that: Foundations have a rare, great chance to do something of value. And the means through which they can do this is money. They've got the money.

In the foundation world, you don't have to worry about many of the things that those of us in the public sector have to worry about. You don't have to worry about being popular. You can make unpopular decisions. You don't have to worry about being in favor or being careful. A colleague I met recently reminded me of my years in the public sector. She asked me four times if I had selected a city yet for Children's Futures-New Jersey. I found four ways of saying "no." That's one of those skills you learn in the public sector.

Foundations don't have to do that. You don't always have to worry about the bottom line -- or at least that's the outside perception. You don't have to worry about a return on investment. You don't have to worry about explaining a skyrocketing expenditure.

Because of all of these factors and advantages, you in the foundation world have choices. You can take risks. You can even spend some time thinking. That's a rare gift. You can make decisions in a world, it seems, without the intensity and the demands that affect many folks in other sectors. You don't even have to get in there every day to do the work. You can just say, "Here's the money, go use it, and do good."

There is one element that I question, and that is accountability and effectiveness. I'm not talking about evaluations of independent programs or individual programs. But at best, foundations have not tested themselves to really assess the measure of their effectiveness and the measure of their impact.

Seeing these advantages has caused me to step back and say, "Now wait a minute, what is the real mission of the foundations?" Here are a few.

One foundation is a national, endowed foundation that supports nonpartisan analysis, study, and research on significant issues in health policy. Another is a private, charitable organization dedicated to helping build better futures for disadvantaged children, and to fostering public policies, human service reforms, and community programs that more effectively meet the needs of today's vulnerable children and families. Another foundation says its mission is to be a resource for innovative people and institutions that strengthen democratic values, reduce poverty and injustice, promote international cooperation, and advance human achievement. And another says its mission is simply to help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations.

Those mission statements are pretty profound. Now if these organizations have the advantages I described and these are their missions, I think the question should be asked: Have those missions been fulfilled? And what has been the overall impact of these activities?

I believe that achieving those missions and achieving the potential that foundations carry is fraught with challenge, because foundations seem to be full of contradictions. These contradictions revolve around a set of questions that I think foundations should be asking themselves.

Should you put your money into innovation or into sustaining successful efforts? Should you be out there on the cutting edge, or should you be responsive or reactive? Should you promote social change or should you promote change within a health care system, or should you promote change in the health behaviors of individuals? Should your grantmaking be for particular programs or should you focus on contracting, so that you can hold whomever you give money to accountable for what you're expecting?

Opportunities and Challenges for the Future

It is time for us to ask whether foundations have missed opportunities to maximize and deploy resources to fulfill their missions and sufficiently attended to social context and the very complex environments, natures of systems, and individual behaviors. Perhaps it is time for us to seize the moment to influence policy in ways that we haven't yet.

There is an awful lot of competition and duplication among foundations, and we should try to change that. Here is one example. Within the Children's Health Insurance Program (CHIP), many creative efforts are focusing on fostering and supporting outreach to get more children enrolled and covered. And there are so many foundations tripping over each other to fund different ways of enrolling as many kids as possible in these health care insurance programs. As a result, it is very hard to know what's happening, make sense out of it, and apply it.

This would be an opportune time for us to use the power of collaboration and avoid overlap in these programs, or build a repository of resources for information on issues like, for example, the issue of so-called crowd-out under CHIP. Particularly for those of us in state government who need quick answers or information, there's a missed opportunity here that competition and duplication of effort do not enhance. If we want to take advantage of the current opportunity and maximize what we have available to us, then let us recognize that the sum truly can be greater than its parts. If we collaborate, we could take this much further and move ahead more in our efforts to advance health care for kids.

A second issue relates to communication and dissemination. There are some extraordinarily successful models and programs funded by foundations, but many of us don't know them. We can't find them. You at the foundations know about them, and your boards know about them, and maybe you've published something somewhere. But most of us don't know about them.

Dissemination of information on successful models has not been done very well. And yet I can give examples of folks from whom I've learned a great deal. I have a booklet on new futures for children that I've read for my new role in Children's Futures-New Jersey. It contains the most candid discussions of common mistakes and lessons learned, and it is excellent. So I've taken those lessons learned and put them on a big sheet of paper, and they will guide me as I proceed with this new endeavor. But that sort of publication is not done very often. The Kaiser Foundation does a wonderful job of sharing facts. I know I can find the latest on Medicaid trends across the country from Kaiser faster than I can get them from the National Association of State Medicaid Directors. Kaiser's information is also clearer, easier to read, and it's at my fingertips. These are examples of how dissemination can help.

This is a great challenge and an opportunity that requires us to think of different kinds of vehicles for sharing information and getting it out, using all forms of media. And it requires us, as members of the foundation world, to think strategically about when and to whom and how to get information, as it may provide us with an opportunity to influence the future.

Sustainability of funding is another issue that often is overlooked. As a state government official, I wished that some of the projects funded by foundations had been funded long enough for me to argue successfully that they made a difference. Funding for two or three years sometimes does not make a convincing case for people who are skeptical of new and different approaches to health care. Sustained project funding provides an opportunity for foundations to make a long-term commitment and build a capacity for a program that, if it is successful after a certain number of years, could be continued.

It has seemed to me many times that foundations are afraid of talking to or having anything to do with policymakers in state government, local government, or federal government. There is a fear that any activity that looks like an attempt to influence policy is akin to being politic and too cozy with politicians.

We are missing a great opportunity. There are things that foundations can and should be doing right now if we're to fulfill the mission of our organizations and the challenges they present. There is a chance for real capacity building, and teaching others, if you will, how to fish. By convening or shaping the implementation of projects, we may be able to influence and maximize what we can learn from them, including the evaluation component. We have an opportunity to foster linkages and eliminate turf issues and use those successes for teaching others at the community level.

One of the challenges we faced recently in New Jersey had to do with the changing roles of federally qualified health centers, often referred to as FQHCs. Many foundations have proceeded to fund FQHCs with large amounts of money to sustain them. The question I have is: Should we be sustaining them, or should we be helping them adjust to a changing health care environment? In New Jersey, we in the state government put the message out to the FQHCs that we wanted to work together to prepare for a changing environment and discuss with them where they would fit within this changing environment. But with the FQHCs receiving so much money from the federal government and from foundations, weren't they also receiving mixed messages? Foundations have an opportunity to shape and influence policy by talking with people in policy and at least understanding what is happening on the policy front.

A final area of opportunity is racial disparity. I applaud the Surgeon General for being the first and most senior health care official in this country to say that we will eliminate disparity in health care based on race. I particularly also applaud Grantmakers In Health and all the other agencies that were a part of a conference in September 1998 that focused on racial disparities in health care, as well as the theme for this conference.

The question is: Now what? I've spent a lot of time thinking about the issue of racial disparity and inequitable health care, and my frustration increases when not much is done. So what are we at the foundations going to do now? Here's an opportunity.

In talking to folks in Kansas City who are working to improve children's health recently, I learned about a Hopi tradition in which you ponder, on a quarterly basis, on the issues and concerns of your community. You think about this all day and all night. And the next morning the question is: Is this in the best interest of our future? The campaign in Kansas City is extraordinary because it's taken this question, this process, and used it as a campaign, calling it the No. 1 question. Their No. 1 question is: Is this in the best interest of our children? How will this affect our children? I think it's a wonderful template.

Here's my challenge to all of us in the foundation world. Why don't we use that No. 1 question and apply it to racial disparities and their elimination? When you look at grants you are making, when you are looking at programs you're interested in, could not the No. 1 be: How will this program help eliminate disparities and inequities? How will it address the social context in which we live, and move us toward a more equitable society?

I challenge all of us to make that commitment, and link together and individually to make that change. In an article I just read written by Dennis Beatrice, he made the following observation: "If someone asks you what you have done as a grantmaker and the response is a list of grants, you've failed."

Forging Ahead

We need to step back and think about where we are within this social world or context. What are the mission, roles, or changing values of our organization? What are the opportunities that we may have missed but still have a chance to seize? And how do we get there?

I am a very vivid dreamer. I dream in color, with lots of action, and I remember many of my dreams. And in the midst of implementing welfare reform in the state of New Jersey I had this dream, and I drew an important message from it.

Friends of mine who were in their mid to late 40s had their first child, and they were overwhelmed. In my dream, I went to visit them and they just didn't know what to do. This baby was wonderful, giggly, and happy, but the parents were so tired. So I offered to give them a break and take the baby with me on my travels. I had to go to Iowa, Minnesota, someplace in Wisconsin, and then up to New York. "No problem," I said, "I'll take the baby with me, and you'll have a break."

I packed up the baby and we went on one plane after another. The baby was the cutest little thing, cooing and kicking, and everyone was attentive. We landed in Iowa and Minnesota, places that I'm unfamiliar with, and then we went on to Albany. I know the Albany airport well; I used to live in Albany. But when I went to the baggage claim area, I lost the baby. I couldn't find the baby. I was so upset, because how could I have done this? Where was this baby?

Here's how I chose to interpret this dream. I chose to consider that in the process of doing new things and implementing new strategies, it's important for us not to forget our essence and those things that are fundamental to what we are. For me that meant, in welfare reform, keeping the face of the people in front of you.

For us in the foundation world, I suggest that we keep our essence -- the meaning, the core of what we are, and our missions -- in front of us. Keep focused, please. Essence is an important component to helping us move on. Understanding our values and being clear about them are equally as important.

I also believe that there's an element of passion that must be a part of us as we face new challenges. If we can't get passionate about something, we should step back and consider: Is this where we want to be? It's the zeal. It's what makes you really want to do what you're doing.

Another element that I value greatly is courage. For us in the foundation world, that's the courage to respect the timing of our activities, and to know when to move. It's the courage to listen, particularly to listen to external messages and voices. It's the courage to communicate with each other about our warts or our successes, our worries and our dreams. And it's the courage to stay relevant. If you will, declare your courage and wear it every day.

On The Role of the Local Foundation:
Remarks for the Acceptance of the
1999 Terrance Keenan Leadership Award

John W. Murphy, M.A.
Executive Director, The Flinn Foundation

Having had a hand while I was a member of the Board of Grantmakers In Health in the establishment of this award and the decision to name it for Terry Keenan, I am truly humbled to stand here as its recipient. Having also previously chaired the selection committee for this esteemed award, I must assume there was a shortage of nominees this year.

To receive it from my dear friend and celebrated colleague, Maggie Mahoney, makes this occasion very special to me. Prior to coming to the podium she looked me in the eye and said, "I'm going to embarrass you" -- and she did!

The recipient of this award is asked to address those assembled about philanthropy, and my prognosis for its future. Lest I stray, I shall read much of my text in order to restrain the very strong emotions I feel this day, and also to avoid my tendency for going on somewhat excessively about something I feel is important.

On Taking the Fork

Each of us is a product of our past. We are what we are because of those who have gone before, who reached out and showed us a better path. Maggie Mahoney has written eloquently about the role of the mentor, that person or persons who, when you were young, helped you to see the world as a more profound place, and gave you sound advice to help you make your way through it. In my foundation career, I was fortunate to have been in the right place at the right time, and to have been tutored by the best -- including Maggie.

That great American philosopher, Yogi Berra, once advised that "If you see a fork in the road, take it."

Being a slow learner, I initially ignored that fork. It came about when the physician head of the then unknown Robert Wood Johnson Foundation (RWJF) called me in the fall of 1972 to say he was seeking a writer to help get the word out about his foundation, and that a mutual friend had given him my name.

This physician (who was, of course, Dr. David Rogers, a hero to many of us) explained that his foundation was about to receive a sizable bequest which would make it second in assets only to The Ford Foundation, and that it would target the health care field.

Without meaning to sound arrogant, I candidly told David that I knew nothing about the health care field, and that I was known to faint in a hospital lobby! I said I did not seem a good fit for his needs.

Whether David appreciated my candor or was desperate, I do not know, for he simply said I could learn about the health care field if I were willing, and asked if I would visit him and his small staff. Given a second chance, I took the fork.

David's "small staff" included a bright young economist named Bob Blendon; David's own physician-mentor, Dr. Walsh McDermott, a founder of the Institute of Medicine and a pre-eminent medical leader; and two of the most knowledgeable and creative foundation professionals in the health field -- Margaret

Mahoney, who came from the Carnegie Corporation, and Terry Keenan, from The Commonwealth Fund. Counting the receptionist and bookkeeper, I became #7 on the RWJF staff.

Immersion & The Brain Trust

My first day at RWJF marked a change in my career; indeed, my life. It began in a most innocent way. Taped to my desktop that day was a yellow sheet of paper (everything at RWJF in those days was typed on yellow paper, and I still have no idea why). The simple note read: “John: Off to Bermuda for a few days to write a report on medical education. Start reading, and we’ll talk when I get back next week. Terry.”

I grinned: here was clear evidence that indeed the foundation side of the fence was greener! Imagine, a week in Bermuda to write a report! I could handle that without fainting! (Parenthetically, Terry’s report became for its time the seminal reference on the financing and structure of medical education.)

At that point, David Rogers entered my little office, closed the door, propped his feet upon my desk, and said: “Terry suggests we start writing the annual report to tell people what we are going to do with all this money. Where shall we start?”

My immersion into medicine and health care and foundations and policy formulation and how social change happens began in the first of many lengthy sessions with David Rogers, followed by others with Terry, Maggie, Bob, and Walsh -- and it hasn’t stopped.

For young novices like myself, the RWJF brain trust provided an intellectual incubator par excellence. Amid the daily volume of proposals to review, sites to visit, and agendas to prepare, there were frequent daylong seminar discussions on various health issues, often led by experts, and preceded by voluminous background reading materials. In discussions, each staff member’s opinion, regardless of how ill informed or poorly shaped, such as my own, was solicited. These sessions helped to shape the RWJF strategies, and added to my grasp of the role of foundations.

First Lessons

The lessons I learned at Johnson about the role of foundations are somewhat commonplace today, but seemed fresh and startling then. The fundamental premises underlying the initial Johnson agenda were described in a May 1972 Board agenda document. First, it read, given the immensity of federal funding in health, even a foundation as large as RWJF would need to target its funding with precision if it were to have any impact.

Second, rather than adopting broad *process* goals, such as fighting cancer or preventing disease, the Johnson Foundation would adopt *outcome* goals. Indeed, RWJF had in mind a specific outcome goal which was tied to a specific national health policy, described in the document as follows:

The nation has reached the culmination of a 40-year debate over the need to eliminate economic barriers to access to personal health services. Thus, *within three years* we believe we are likely to see the enactment of some form of national health insurance.

OK, so the RWJF brain trust was a little off in its timing. But the Johnson agenda was *not* the shape or details of national health insurance, but the fact that the nation’s health care system was ill prepared to cope with the ensuing demands. That first Board agenda observed:

National financing of health services will undoubtedly open up a vision to Americans of a life in which needed health services are continuously and fully available. In the short run,

these expectations are not likely to be fulfilled. As presently structured and organized, the nation's health services can do little to expand their capacity. The increase in demand will thus serve to escalate costs and diminish quality, without making a significant difference in availability.

As the largest single source of private developmental capital in the health field, we are recommending that the RWJF use its funds to reshape the structure for delivering health care.

No other national foundation was addressing this capacity issue and none was so targeted on a single national policy issue. RWJF would limit its work in this field to just 4 or 5 problem areas; emphasize large-scale field trials of promising new ideas so that other groups could visit the showroom to kick the tires and test the horn; and invest heavily in objective, third-party evaluations of the results of these field trials so there was some measure of effectiveness.

It was a bold agenda, disappointing to those who desired a broader, more conventional role for the largest private-sector source of developmental capital in the health field. It met with a good measure of criticism at that time.

Applying the Lessons at Flinn

The RWJF brain trust had taken this young novice who fainted in the hospital lobby and couldn't explain the difference between Medicare and Medicaid, and molded him in directions that I did not fully grasp until years later, when somehow The Flinn Foundation board was persuaded that this rookie was the right person to launch a health care foundation in a state that had never had one.

The question which haunted me in the move to Arizona was how the Johnson strategy could be adapted on a smaller scale. A narrow agenda with defined outcome goals seemed essential to me, if we were to use our modest funds strategically. But clearly, we could not afford to fund field trials and costly evaluations.

We could, however, demonstrate on a small-scale how targeted efforts to reach hard-to-serve populations could work; we could help the state shape its new Medicaid program and assess its impact; we could fund a commission to examine the need for and how long-term care services might be added to that Medicaid program; we could demonstrate that schools were a logical and appropriate site to provide basic care and referrals for young children who lacked insurance and a medical home.

It didn't take long for me to appreciate the distinction between the role of the national and local foundation. As I was about to present the first study results of the state's new Medicaid program (AHCCCS), a state legislator asked: "Who authorized you to do this study?"

Inherent in his question, beyond evident ignorance of the independent role of private foundations, was Tip O'Neil's dictum that "all politics is local." Our data would be public and could help make or sink an innovative managed-care Medicaid program. Even more, they might be used to help or hinder a political career. Like it or not, many of our projects and studies carried local *political* implications. Who we were and why the Foundation was taking this action assumed an importance far beyond the data. RWJF had not prepared me for this.

That message was reinforced a few weeks later when I attended a meeting of the Governor's advisory council on aging as an invited observer. I wanted to learn what this group of leaders saw as the critical issues facing Arizona's growing elderly population. During the meeting a Secret Service-type young man slipped into the

room, spoke quietly to the council's chair, came to where I was seated, tapped me on the shoulder and said, "The Governor would like to see you."

Not having previously met the Governor, at first I froze: "How did the governor know my driver's license had expired?" Then, I recalled parting advice from Dr. Walsh McDermott at RWJF. Walsh had worked in Arizona for 10 years and served on a panel advising the state on its new medical school. I had consulted him at length about my decision to join the Flinn Foundation. As I was packing to leave RWJF, Walsh stopped by my office to bid farewell and offered this parting shot: "John, heading this new foundation there, at some point you'll meet the governor. It's really not such a big deal. In a small state like Arizona, at some point everybody meets the governor!"

But to be summoned by the governor from a meeting and to have him ask how the foundation might help craft a long-term care strategy for the state was a heady moment, and made clear to me an important role for *local* philanthropy. He sought our counsel and credibility, not our dollars.

Those experiences helped me grasp the singular importance of the local foundation and its potential to use far fewer dollars strategically to impact events and decision making. The key at Flinn, as it must be with most smaller foundations, is finding the critical niche where our dollars will go further. Contrasted to the large national canvas we were painting at RWJF, the Flinn canvas is far smaller, but the impact more immediate, more visible.

We must be sensitive that a grant "do no harm" to local infrastructure and relationships. To many non-profits, getting a Flinn grant gives a group confidence and is often a form of endorsement to attract other local donors or even a RWJF or Kellogg grant. Being part of the local scene also means that you may encounter at some evening event the same people you faced across the table hours earlier and discouraged from seeking a grant.

At RWJF, you hope to attract to your showroom influentials of national decision-making stature and tell them about 15 similar projects around the country. At Flinn, the showroom is only slightly larger than a phone booth and as a consequence, the results must be clear and quickly grasped. After all, we are not importing some model which works elsewhere; we are showcasing what is or can be made to work locally; we are family.

The Challenge to Local Foundations

Though our experience at Flinn suggests otherwise, some contend that with quite modest assets, the local foundation should use its funds to ensure the stability and continuity of the local non-profit sector. This financial transfer theory serves a useful social function, but hardly a vital one, as Wally Nielsen has observed. He notes that the monies foundations can provide this sector, "even under the most favorable circumstances," cannot be more than a small fraction of their needs, and run the risk of helping to sustain some whose mission is perhaps no longer so vital.

By contrast, John Gardner wrote that to justify their existence foundations "should take infinite pains in husbanding our modest income and devoting it to precisely those projects which will have the most leverage in moving one or another field ahead."

There is underway in this country at present a momentous shift in responsibility for many health and social programs from the federal to the state and local level. This shift provides local foundations in the health field a rare opportunity to validate the value-added premise for our existence.

Local foundations, with their breadth of contacts and credibility in the local community, are especially well positioned to bring together influential people and organizations. Our specialized knowledge of the local

health scene can add immeasurably to how the health and welfare reforms underway in *our* state or community can best be shaped. To me, this is the moment for the local foundation; we must seize it; we must be engaged.

Years ago, in helping mold a pro-active agenda for the Carnegie Corporation, John Gardner best expressed how to go about this task:

When a new project comes up for review," he wrote the staff at Carnegie, "it will *not* be sufficient to know that a terribly competent man proposed it, or that it is a socially desirable project, or that it is feasible and well-formulated. Rather, we will want to know whether this project is *relevant* in terms of our basic strategy, whether it is *the next logical step* toward attainment of one or another of our objectives.

Hockey star Wayne Gretzky said it more succinctly: "Don't skate to where the puck is," Gretzky advised, "aim for where the puck *will be*."

A Personal Note

Whatever has been accomplished by Flinn is testimony to the quality of tutoring by my RWJF mentors, and to the Flinn Foundation board of directors who gave me and my own talented brain trust sufficient slack to seize opportunities when we saw them -- even to fail at some. It is also tribute to my wife and daughters who conceded my endless days, nights and weekends of reading and writing, and my frequent absences.

In closing, I would like to share with you a brief dialogue from one of my favorite films. "A Man for All Seasons" is about Sir Thomas More and his stand for principle. This dialogue provides perspective on priorities in one's life and takes me back to the note Terry Keenan left on my desk.

This brief dialogue is between Thomas More and his ambitious pupil, Richard Rich. Rich sought More's advice about a future career.

"Why not be a teacher?" More asks Rich. "You'd be a fine teacher. Perhaps even a great one."

But Rich, who aspires to the wealth and prestige of More replies: "And if I were, who would know of it?"

More answers: "You. Your pupils. Your friends. God. Not a bad public *that*."

Well Terry, I never made it to Bermuda. But today I stand before friends and colleagues whose work I admire, and state with deep affection and gratitude: Not a bad public *this*.

There is no greater, more cherished honor you could have given me than the Terrance Keenan Award. Thank you.

Speaker Profiles

Nicole Lurie, M.D., M.S.P.H.

Nicole Lurie has served since September 1998 as principal deputy assistant secretary for health at the U.S. Department of Health and Human Services (HHS). Dr. Lurie came to HHS from the University of Minnesota School of Medicine, where she directed primary care research and education and the Division of General Internal Medicine. Based at Hennepin County Medical Center, she had taught within the University's system since 1985, serving in various professorships in the fields of medicine, public health, family practice, and community health. While at the University, she conducted research on improving access to health care among low-income patients, particularly in regard to the treatment of breast cancer, asthma, diabetes, and mental health. Prior to her time in Minnesota, Dr. Lurie served as a consultant for the RAND Corporation in Santa Monica, California, and as an assistant professor of medicine at the University of California at Los Angeles (UCLA). She has served as the councilor, treasurer, and president of the Society of General Internal Medicine, was senior associate editor of *Health Services Research*, and has been honored by *The Minnesota Physician* for her research efforts. Dr. Lurie received her M.D. from the University of Pennsylvania, and her M.S.P.H. from UCLA.

Robert G. Evans, Ph.D.

Robert Evans is a professor with the Department of Economics at the University of British Columbia (UBC) and has been a National Health Research Scientist at UBC since 1985. He is also a faculty member of the UBC Centre for Health Services and Policy Research. Dr. Evans is a fellow of the Canadian Institute for Advanced Research and was director of the Institute's Program in Population Health from 1987- 1997. His interest in the economics of health care has led him to participate in the development of policies for the Canadian health care system. He is also a health care consultant in Europe, Asia and the United States. Dr. Evans is currently a member of the National Academy of Social Insurance (United States) and the Advisory Committee on Health Goals for British Columbia. He was a member of the National Forum on Health, chaired by the Prime Minister of Canada, from 1994-1997, and currently serves on the board of editors for *the Journal of Health Politics, Policy, and Law*, *International Journal of Technology Assessment*, and *Annals of Internal Medicine*.

Velvet G. Miller, Ph.D.

Velvet Miller is director of Children's Futures-New Jersey, a newly funded program of The Robert Wood Johnson Foundation that will devote considerable resources over an extended period of time to improving the health and future of children in a New Jersey community. Dr. Miller began her career as a professional nurse in a variety of clinical and academic settings. She most recently served as deputy commissioner of the New Jersey Department of Human Services, and has also held several senior state positions, including New Jersey's director of medical assistance and health services, and assistant and associate commissioner for health services for the State of New York and the Commonwealth of Massachusetts. Dr. Miller has published, taught and spoken on a wide variety of topics, including access to health care, political and consumer activism, and conflict resolution. She is a faculty member at Harvard University School of Public Health's Program for Health Care Negotiation and Conflict Resolution. Dr. Miller was awarded a Pew Fellowship for doctoral studies in health policy and received her Ph.D. from Boston University. She has also earned degrees from

Wagner College School of Nursing, Temple University School of Education, and Harvard University's Kennedy School of Government.

John W. Murphy, M.A.

John Murphy has served as executive director of The Flinn Foundation since 1981. As its first professional staff officer, Mr. Murphy has overseen tremendous expansion of the Foundation's health care initiatives and has energized its commitment to improving the quality of life and health care in Arizona. In leading the Foundation, he has instituted comprehensive school-centered and community-linked initiatives to improve the health of pregnant and parenting teens and uninsured children; launched a biomedical research initiative to establish centers of excellence in multi-disciplinary research at Arizona's universities; advocated the development, testing and implementation of the Arizona State Infant Immunization System; and established the Phoenix Area Medical Education Consortium and the Arizona Health Information Network. He also directs the Flinn Scholars Program, an innovative college scholarship program for gifted high school students. Prior to assuming his position with the Foundation, he served as a program officer with The Robert Wood Johnson Foundation. Mr. Murphy is a founding member and past chairman of Grantmakers In Health, a member and past president of the Conference of Southwest Foundations, and a founding member and member of the executive committee of the Arizona Grantmakers Forum. He received his M.A. in mass communication from the University of Iowa.